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Factors influencing acceptability of caesarean section among multiparous pregnant women attending antenatal clinic at Mother and Child Hospital, Akure

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Abstract

Overview: Caesarean section is the most common obstetric operation performed worldwide and has contributed to improving maternal and foetal outcome. This study assesses the factors influencing the acceptability of caesarean section among multiparous pregnant women attending antenatal clinic at Mother and Child Hospital, Akure, Ondo state.

Method: A total number of 306 respondents were recruited for this study and 300 presented for analysis which translates to a response rate of 98%. Pertinent and relevant literatures were reviewed both conceptually and empirically and inferences made where necessary.

Results: Findings of the study showed that majority were between 30 and 39 years, married and belong to Yoruba tribe. Only few (29%) have had caesarean section in the past with major indications being prolonged labour (19.5%), fetal distress (20.7%), prolonged pregnancy (7%) and congenital abnormalities (7%). Majority (70%) agreed that Caesarean section is a method of delivery of babies and 46% agreed that CS is a safe method of delivery. Overall, 60% and 66.7% of the pregnant women have good knowledge of CS and perception about CS respectively. Furthermore, only 16% agreed to have CS in the next pregnancy if indicated. The following were agreed to and accepted by the respondents to influence acceptance of Caesarean section: fear of death, cost of the procedure, fear of discrimination, fear of husbands' rejection, pain of previous labor, concerns about babies' safety and desire to keep genital tract intact. Furthermore, there is a significant relationship between educational status, tribe, religion and acceptability of caesarean section among respondents ($p < 0.05$) while there is no significant relationship between previous obstetric experiences and acceptability of caesarean section.

Conclusion: Conclusively, this study has shown that most of the respondents have good knowledge and perception of Caesarean Section (CS); however, the rate of acceptance of CS as a mode of delivery is low with factors influencing such including fear of death, cost of the procedure, fear of discrimination, fear of husbands' rejection and concerns about babies' safety.

Keywords: Caesarean Section; Pregnant Women; Acceptability of Caesarean Section; Influencing factors

1. Introduction

Caesarean section (CS) is one of the most commonly performed surgical procedures in obstetrics [1] and is certainly one of the oldest surgeries. Probably the term Caesarean was derived from the decree in Roman law, which made it

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mandatory for the operation to be performed on women dying during child birth, a term called Lex Caesarean [2]. This surgery has been reported throughout medical history and has steadily progressed from being fatal resulting in mortality for the mother or the child to being rendered safe for both mother and fetus during the 20th century [2]. Caesarean section has greatly contributed to improved obstetric care throughout the world but social economic and other factors seem to have greater influence on the decision to perform caesarean section at times than the expected medical benefits [3].

Caesarean Section normally is carried out when the normal way of delivery (vaginal delivery) will put both the mother's and baby's life at risk, but sometimes mothers request for it even when there is no risk at all. In recent years different studies show the rate has risen in different countries. In China by 46% and 25% or above in many Asian and European countries, Latin America and USA. Nowadays CS is common surgical operation for delivering one or more babies, prevalence ranges from 4% in Africa to 40.5% in Latin America and Caribbean [4]. Some of the indications for CS delivery include; Repeated CS delivery, pelvic abnormalities, malpresentations, skeletal disorders, abnormal placentation, cephalopelvic disproportion, situations in which labor is contraindicated. Caesarean Section (CS) has been part of human culture since ancient times both in the Western and non-Western cultures [5].

In 1998, 21% of Australian women gave birth by CS and it increased to 30.9% by 2007. And 31.1% of all births were carried out by CS in 2006 in the USA. In the UK the overall rate of CS birth accounts for almost 25% of all births from 2007 to 2008, Birth rates via CS vary considerably across Europe, ranging from 15% in Norway and Netherlands, 17% in Sweden and Finland and 37.8% in Italy. Because of the negative view and perception of CS by women in developing countries the rate is small, example in the Sub-Saharan African Countries (like Burkina Faso and Niger) it is 2%. [6]. This surgery has been reported throughout medical history and has steadily progressed from being fatal resulting in mortality for the mother or the child to being rendered safe for both mother and fetus during the 20th century. Caesarean section has greatly contributed to improved obstetric care throughout the world [3].

In Tehran Iran, Fatemeh G. et al did a study in 2012 it was a study done on women's knowledge and attitude towards mode of delivery and frequency of CS on mother's request in six public and private hospitals. The knowledge of the mothers overall attained poor score in 333 (55.6%) and 228 (37.9%) found out to score intermediate while 39 (6.5%) attained good scores on their knowledge towards the mode delivery. And mothers who have old age were found to have higher level of knowledge [7]. Despite good knowledge of caesarean section of as high as 79.8%, majority, 68.5%, still have negative perception of caesarean section as a mode of delivery [8].

To determine the attitude towards CS, a study was done by Michael A., et al in 2017, among antenatal women who come for care at the University of Benin Teaching Hospital in Nigeria, 413 successive women who came for the antenatal care were interviewed with a structured questionnaire. All the participant women reported that they have heard about CS from different sources. However, it was reported that all the women have heard about CS and out of four options given to them they were all able to identify that CS is delivering a baby by operation through the abdomen. From the study population some women said that they would have CS by their own choice, their reason for choosing it was mainly fear of labor pain as well as concerns about their baby's wellbeing. These women add up to be 25(6.1%) of the study number. The majority, 338(81.8%) would accept CS if they know that the situation they are in will put their life or that of the baby at risk, while 246 (59.7%) say that they would allow it if the doctor said so. However, 50(12.1%) said that they would not accept CS under any of these 3 cases mentioned. [20] Fear of death when having CS, pain after having CS that will be associated with CS, concerns or feelings of failure, husband's disapproval, the view of this mode of delivery as not being part of their culture, friends may laugh at them and the charge/price for the operation were some of the reasons given by the participants when asked about their refusal to CS. Other factors for their refusal were previous successful vaginal delivery, previous forceps usage and women not having had a previous CS.

Caesarian section (C/S) is still being perceived as an abnormal means of delivery by many antenatal women in Nigeria. Notwithstanding the undeniable role of caesarian section in successful childbirth and the safety of the procedure in modern times, Nigerian women have developed aversion to caesarian section for various cultural reasons. The studies that reported the lowest CS preference rate came from Nigeria. The reasons given from these were the complications that followed the procedure and the discriminatory attitudes of others towards them. This finding has confirmed the suspicion that some inappropriate motherhood choices that Nigerian mothers make emanate from superstition and misconceived cultural and religious beliefs.

Just as there has been growing concern about rising Caesarean section rates, there has been an increase in the number of women in the United States who choose to have an elective Caesarean delivery; the Caesarean section on demand.

In developed countries, the increase in Caesarean section rates was more related to previous Caesarean delivery than other clinical factors²⁷ whereas in developing countries, it was more related to fetal distress and labour dystocia. Policies promoting subsequent cs, and discouraging vaginal birth after cs, technological monitoring of labour, fear of malpractice suites in case of breech or forceps delivery and older age of mothers are some other contributing factors to increasing cs rate in developed countries. [9] Consequently, there is a trend of performing more elective Caesarean deliveries in developed countries than in developing countries where majority of Caesarean sections are performed as emergency procedures [10].

Caesarean section preference is strongly associated with fear of birth, previous CS and previous negative birth experience compared to women with preference for vaginal delivery. Between 6-10% of women are said to suffer from tocophobia which is the fear of childbirth and is a major psychological cause for Caesarean Section due to Maternal Request (CSMR). [11]

In a statement released in 2013, the ACOG recommends that in the absence of medical indications, vaginal delivery should be recommended. However, if Caesarean section is performed on maternal request, it should not be performed before 39 weeks of gestation and it should not be motivated by absence of effective pain management [12] The popular press criticized a popular model and footballer's wife in the UK for having her three children by Caesarean saying she was 'too posh to push'. In South African studies, Caesarean on demand is not a major contributor to Caesarean section rates in public hospitals; it probably plays a greater role in the private hospitals where Caesarean section rates of up to 60% have been reported. Pregnant medical professionals have been reported to have a high Caesarean delivery rate in South Africa [13].

2. Methodology

2.1 Research design

This study will be a descriptive cross sectional study. This single-center, cross sectional study will recruited pregnant women who have had at least one delivery before. Following approval of the study protocol by the Hospital research and ethics committee, all women fulfilling the recruitment criteria will receive informative discussion about the nature of the study. Those that agree to enter the study will sign a written informed consent.

2.2 Setting for the study

The Mother and Child hospital is a secondary health facility dedicated to the care of pregnant women and children. It is situated around the Akure city center which is the capital of Ondo state. The hospital serves the entire city in terms of mother and child care and receives referrals from various primary health centers, comprehensive health centres, mission house and even traditional birth attendant homes around. The hospital records about 1500 deliveries every year.

2.3 Target population

The study population consisted of multiparous pregnant women attending the ANC of the Mother and Child Akure. The Mother and Child hospital is a secondary health facility dedicated to the care of pregnant women and children.

2.4 Sampling procedure

Sampling was by random selection of pregnant women that meet the inclusion criteria. Alternate pregnant women were selected as they come until the sample size of 306 which includes allowance for attrition was completed

2.5 Sample size determination

The Study is a descriptive study. The following formula was used to calculate the sample size.

$$N = \frac{4(Z_{\text{crit}})^2 p(1-p)}{D^2}$$

Where Z_{crit} is standard normal deviate corresponding to chosen Confidence interval. For Confidence interval of 95%, it is 1.96

P is pre-study estimation of proportion to be measured

D is the width of confidence interval.

Therefore

$$N = \frac{4 \times (1.96)^2 \times 0.96(1 - 0.95)}{0.05^2}$$

$$N = 291.96$$

$$N = 292$$

Adding the allowance for attrition of 5% (14) to above gives total Sample size of 306.

2.6 Instrument for data collection

A simple structured questionnaire was used as instrument for collecting data. It was written in plain English language and provision for interpretation made for those that cannot understand or read English.

2.7 Method of data collection

Adequate information concerning the study was given to the participants following which informed consent were obtained from them. The researcher personally administered the questionnaire to the participants. The questionnaire was written in English but provision for interpretation was made for those that don't understand English language.

2.8 Method of data analysis

Data was processed by feeding the information into SPSS and then analysed using the SPSS version 20. Proportions were calculated using percentages and crosstabulation of related variables done to find out relationship between the variables and statistical significance by chi-square.

Statistical Package for Social Sciences (SPSS) version 20.0 was used for data statistical analysis. Demographic data, and primary and secondary outcomes of both groups were compared with t-test (for quantitative measures). Categorical variables were compared by cross-tabulation with chi-square and significance determined. Charts were produced using the chart builder soft wear on SPSS.

2.9 Ethical considerations

Ethical clearance will be obtained from the institutions ethical committee. Verbal and written consent will be obtained from the participants as well. Patient's refusal to participate in the study will be respected with no attempt at coercion or inducement to gain consent. Moreover, decline in participation by any patient will not adversely affect their management in any way.

Confidentiality of information will be ensured by the use of initials to identify patients.

3. Results

3.1 Preamble

The results of the study are presented in this chapter. Results are presented with the use of frequency tables, bar and pie charts. A total number of 306 respondents were recruited for this study and 300 presented for analysis which translates to a response rate of 98%.

Table 1 below presents the sociodemographic characteristics of the respondents. It can be shown that more than half of the respondents (53%) were between 30 and 39 years, 33.3% between 20 and 29 years, 7% between 40 and 49 years, 5.7% lesser than 20 years, while only 1% were between 50 and 59 years. 87% were married, 10% single, 2% divorced while 1% were widowed. 63%, 28%, 8% and 1% were from Yoruba, Igbo, Hausa and other tribes respectively. 7% had primary education, 12% secondary education, 49.7% post-secondary education while 31.3% were graduate. 7%, 34.7%, 30.7% and 27.7% were full housewife, artisans, business women and civil servant respectively. Based on the classification of Olusanya et al into socioeconomic class, 10% were in class I, majority 51% were in class II, 23.3% in class III while 15.7% were in class IV.

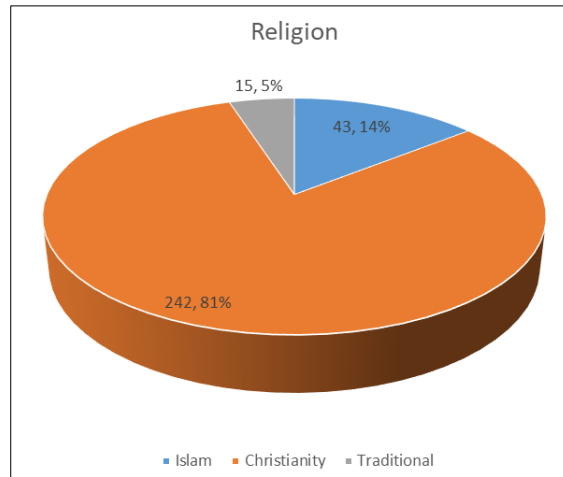


Figure 1 The religion distribution of respondents

From the pie chart above; majority 242(81%) were Christians, 43(14%) were practicing Islam while 15(5%) were traditional worshippers.

3.2 Socio-demographic characteristics of respondents

Table 1 Socio-demographic data of respondents

Variables		Frequency (N = 300)	Percent (%)
Age(in years)	< 20	17	5.7
	20-29	100	33.3
	30-39	159	53.0
	40-49	21	7.0
	50-59	3	1.0
Marital status	Single	30	10.0
	Married	261	87.0
	Divorced	6	2.0
	Widowed	3	1.0
Tribe	Yoruba	189	63.0
	Igbo	84	28.0
	Hausa	24	8.0
	Others	3	1.0
Educational status	Primary	21	7.0
	Secondary	36	12.0
	Post-secondary	149	49.7
	Graduate	94	31.3
Occupation	Full house wife	21	7.0
	Artisan	104	34.7
	Business women	92	30.7
	Civil servant	83	27.7

Social class	I	30	10.0
	II	153	51.0
	III	70	23.3
	IV	47	15.7
	Total	300	100.0

3.3 Obstetric data of respondents

From table 2 below, 4% were having their pregnancy less than 8 weeks old, 19% between 8 and 16 weeks, 27% between 17 and 32 weeks, 43% between 33 and 40 weeks while 7% were greater than 40 weeks of gestation. In their last delivery, 6% delivered at less than 34 weeks, 37.7% between 34 and 37 weeks, 46.3% between 37 and 40 weeks while 10% delivered greater than 40 weeks. Moreover, 80.3% indicated that the baby from their last delivery survived, 6.7% indicated that the baby died while 13% indicated that the baby suffered injury. Furthermore, only 87(29%) have had Caesarean section (CS) before, with 55.2% of the women first agreeing to the CS, in 41.4% of them, it was the husband while 3.4% the relatives in others.

Table 2 Obstetrics information of respondents

Variables		Frequency (N =300)	Percent (%)
Gestational age	< 8 weeks	12	4.0
	8-16 weeks	57	19.0
	17-32 weeks	81	27.0
	33-40 weeks	129	43.0
	> 40 weeks	21	7.0
Gestational age at last delivery	< 34 weeks	18	6.0
	34-37 weeks	113	37.7
	37 - 40 weeks	139	46.3
	> 40 weeks	30	10.0
Outcome of last delivery	Baby survived	241	80.3
	Baby died	20	6.7
	Baby suffered injury	39	13.0
Have you had caesarean section before?	Yes	87	29.0
	No	213	71.0
Who first agreed with the decision to have caesarean section? N = 87	Myself	48	55.2
	My husband	36	41.4
	Relatives	3	3.4

From the table below, among the respondents that have done CS before, majority (20.7%) had it because of fetal distress, 19.5% because of prolonged labour, 7% due to prolonged pregnancy and congenital abnormalities, 5.7% because of inadequate pelvis, 4.6% due to abruption placentae and cord prolapse while 3.4% because of cephalopelvic disproportion, hypertensive diseases, macrosomia, maternal exhaustion, maternal request, obstructed labour, oligohydramnios, placenta praevia and previous CS.

Table 3 Indications for CS among respondents

	Variables	Frequency (N = 87)	Percent
Indication for the CS	Abruptio placenta	4	4.6
	Cephalopelvic disproportion	3	3.4
	Congenital abnormality	6	7.0
	Cord prolapse	4	4.6
	Fetal Distress	18	20.7
	Hypertensive disorders	3	3.4
	Inadequate Pelvis	5	5.7
	Macrosomia	3	3.4
	Maternal Exhaustion	3	3.4
	Maternal request	3	3.4
	Obstructed Labour	3	3.4
	Oligohydramnios	3	3.4
	Placenta Praevia	3	3.4
	Previous CS	3	3.4
	Prolonged Labour	17	19.5
Prolonged pregnancy	6	7.0	

3.4 Knowledge of respondents on Caesarean Section

Table 4 Knowledge about Caesarean Section among multiparous pregnant women

Statements	Agree	Disagree	Undecided	Remarks
Caesarean section is a method of delivery of babies	210(70%)	30(10%)	60(20%)	Good
There are specific indications for carrying out caesarean section	217(72.3%)	12(4%)	71(23.7%)	Good
Caesarean section has its own known complications	231(77%)	9(3%)	60(20%)	Good
Previous caesarean section has effect on delivery in another pregnancy	102(34%)	87(29%)	111(37%)	Poor
You have to wait for your husband to sign consent for you to have caesarean section when needed	80(26.7%)	83(27.7%)	137(45.7%)	Poor

0-50% = poor knowledge, 50-100% = good knowledge

Knowledge decision

Criteria	Frequency	Percentage	Remarks
Good	3	60%	Good knowledge
Poor	2	40%	Poor knowledge

From the tables above, 210(70%) agreed that caesarean section (CS) is a method of delivering babies, 217(72.3%) agreed that there are specific indications for carrying out CS, and 77% agreed that CS has its own complication. However, 34% only agreed that previous CS has effect on delivery in the next pregnancy, 29% disagreed and 37% were undecided. Furthermore, only 26% agreed that they have to wait for their husband before signing consent form, 27.7% disagreed while 45.7% were undecided. Overall, it can be deduced that 60% of the respondents had good knowledge of caesarean section while 40% had poor knowledge.

3.5 Perception of respondents towards Caesarean Section

Table 5 Perception of multiparous pregnant women towards Caesarean Section

Statements	Agree	Disagree	Undecided	Remarks
Caesarean section is a safe method of delivery	138(46%)	36(12%)	126(42%)	Poor
Women with previous caesarean cannot deliver babies again	0(0.0%)	230(76.7%)	70(23.3%)	Good
Babies delivered by caesarean section are normal babies	255(85%)	12(4%)	33(11%)	Good
Women that deliver by caesarean section are not sub-human	292(97.3%)	0(0.0%)	8(2.7%)	Good
It is not a taboo to deliver by caesarean section	291(97%)	0(0.0%)	9(3%)	Good
I will agree to have caesarean section next delivery if indicated	48(16%)	69(23%)	183(61%)	Poor

0-50% = poor perception, 50-100% = good perception

Perception decision

Criteria	Frequency	Percentage	Remarks
Good	4	66.7%	Good perception
Poor	2	33.3%	Poor perception

From the tables above, only 46% agreed that CS is a safe method of delivery while 42% were undecided. Furthermore, 76.7% disagreed that women with previous CS cannot deliver babies again while 23.3% were undecided. 85% agreed that babies delivered by CS are normal babies and 97.3% also agreed that women that deliver by CS are not sub-human. 97% agreed that it is not a taboo to deliver by CS. However, only 16% agreed that they will have CS in their next delivery if indicated while 61% were undecided. Overall, it was shown that 66.7% of the respondents had good perception towards CS, while 33.3% had poor perception.

3.6 Factors Influencing the Acceptance of Caesarean Section.

Table 6 factors influencing the acceptance of caesarean section among multiparous pregnant women

Statement	Agree	Disagree	Undecided
Fear of death is one of the reasons why women don't want to do caesarean section	260(86.7%)	0(0.0%)	40(13.3%)
Cost of caesarean section procedure is one of the reason why women don't want to have caesarean section	277(92.3%)	9(3%)	14(4.7%)
Fear of discrimination is a reason why women don't want to have caesarean section	228(76%)	24(8%)	48(16%)
Fear of husbands rejection is one of the reasons why women don't want to have caesarean section	236(78.7%)	36(12%)	28(9.3%)
Pain of previous labour is one of reasons why women request for caesarean section	217(72.3%)	36(12%)	47(15.7%)
Concerns about babies safety is one of reasons why women request for caesarean section	252(84%)	10(3.3%)	38(12.7%)
Desire to keep genital tract intact is one of reasons why women request for caesarean section	214(71.3%)	69(23%)	17(5.7%)

0-50% = disagreed/rejected, 50-100% = agreed/accepted

From table 6; majority of the respondents (86.7%) agreed that fear of death is one of the factors limiting against CS, 92.3% agreed that cost of the procedure, 76% fear of discrimination while 78.7% agreed that fear of husbands’ rejection. Furthermore, 72.3% agreed that pain of previous labour can positively influence CS, 84% indicated concerns about the babies’ safety and 71.3% indicated desire to keep genital tract intact may make women request for CS.

Overall, with a percentage of greater than 50% the following were agreed to and accepted by the respondents to influence acceptance of Caesarean section: fear of death, cost of the procedure, fear of discrimination, fear of husbands’ rejection, pain of previous labor, concerns about babies’ safety and desire to keep genital tract intact.

3.7 Research Hypotheses

3.7.1 Testing Hypothesis one:

There is no significant relationship between educational status and acceptability of caesarean section among respondents.

Table 7 Relationship between educational status and acceptability of caesarean section

I will agree to have caesarean section next delivery if indicated								
		Agree	Undecided	Disagree	Total	X2	Df	p-value
Educational status	Primary	3	18	0	21			
	Secondary	0	18	18	36	61.976	6	0.000
	Post-secondary	12	95	42	149			
	Graduate	33	52	9	94			
Total		48	183	69	300			

Table 7 above revealed that the p-value is less than 0.05. The null hypothesis was rejected and the alternative accepted. Therefore, there is a significant relationship between educational status and acceptability of caesarean section among respondents.

3.8 Testing Hypothesis two

There is no significant relationship between traditional and religious belief and the acceptability of caesarean section among respondents

Table 8 Relationship between traditional and religious believes and acceptability of caesarean section

I will agree to have caesarean section next delivery if indicated								
		Agree	Undecided	Disagree	Total	X2	Df	p-value
Tribe	Yoruba	36	123	30	189			
	Igbo	3	45	36	84			
	Hausa	9	15	0	24	51.563	6	0.000
	Others	0	0	3	3			
Religion	Islam	12	25	6	43			
	Christianity	36	152	54	242	18.181	4	0.001
	Traditional	0	6	9	15			
Total		48	183	69	300			

Table 8 above revealed that the p-values are less than 0.05. The null hypothesis was rejected and the alternative accepted. Therefore, there is a significant relationship between traditional and religious belief and the acceptability of caesarean section among respondents.

3.9 Testing Hypothesis three

There is no significant relationship between previous obstetric experiences and acceptability of caesarean section

Table 9 below revealed that the p-value is greater than 0.05. The null hypothesis was accepted. Therefore, there is no significant relationship between previous obstetric experiences and acceptability of caesarean section.

Table 9 Relationship between previous obstetric experiences and acceptability of caesarean section

		I will agree to have caesarean section next delivery if indicated						
		Agree	Undecided	Disagree	Total	X ²	Df	p-value
outcome of last delivery	Baby survived	39	145	57	241			
	Baby died	6	11	3	20	5.317	4	0.256
	Baby suffered injury	3	27	9	39			
Total		48	183	69	300			

4. Discussion

4.1 Sociodemographic and Obstetrics Characteristics

This study assessed the factors influencing the acceptability of caesarean section among multiparous pregnant women attending antenatal clinic at Mother and Child Hospital, Akure, Ondo state. Majority of the respondents were between 20 and 39 years; this age range represent the reproductive age in which most women were active in childbearing. Most of the respondents were Yoruba and Christians, this is partly due to the study area which is a Yoruba speaking area. Literacy rate among pregnant women in the study seems to be high with at least half (49.7%) having post-secondary education and 31.3% having tertiary education. This may be due to Akure being an urban centre, this is similar to the study of Umar (2017) where 61% literacy rate was reported too. [14] Most of the respondents were artisans and business women, this shows that they have at least a good source of income. Presently, during the study most pregnant women were in their 33rd to 40th of week of gestation and majority had their last birth between 37 and 40 weeks, which is the normal count for a term baby. 6.7% of the babies in the last birth were still birth, this is similar to the study of Okonofua et al, in 2019). [15]

4.2 Prevalence and Indications for Caesarean Section

Among the respondents 29% have had caesarean section before similar to 19.9% caesarean section rate reported by Awoyemi (2020) in his study [16]; however, in contrast to the study of Ashimi et al in 2013 carried out in Jigawa state, [17] this may be due to differences in the settings. Pertaining to the indications for Caesarean section (CS), majority were due to fetal distress, prolonged labour and presence of congenital abnormalities. This is similar to the findings of Akinola et al (2014), which reported commonest indication to be failure to progress labour/obstructed labour [18]. On consent giving, more than half of those that have had CS gave consent on their own not waiting for the husband; this is corroborated by the study of Ogunbode, Oketona and Bello (2015) were 64% of the patients for CS gave consent for surgery on their own. [19]

4.3 Knowledge of Caesarean section among respondents

As regards knowledge of CS among the respondents, majority agreed that CS is a method of delivery and that there are specific indications for it. More than three-quarter affirmed that CS has its own complications while only 34% agreed that previous CS can have effect on next delivery while only few agreed that they should wait for their husband before signing a consent. Overall, only 60% had good knowledge of CS among the respondents. In the study of Ashimi et al (2013), 94.4% of them said they know that vaginal delivery is possible after CS delivery and overall, the authors concluded that the knowledge of CS is still low among the respondents. [17]

4.4 Perception of Caesarean Section among respondents

This study further revealed that only 46% agreed that CS is a safe method of delivery while 42% were undecided. Furthermore, 76.7% disagreed that women with previous CS cannot deliver babies again. However, only 16% agreed that they will have CS in their next delivery if indicated while 61% were undecided. Overall, it was shown that 66.7% of the respondents had good perception towards CS, while 33.3% had poor perception. This is in contrast with most study reviewed; most of the women surveyed by Asimi et al in 2013 were aware and would accept to have CS if indicated. However, Aziken et al in 2007 reported that 6.1% of their respondents were accepting CS as a way of bringing their babies to the world, however 81% said they will be willing to go through it if it is indicated. [20]

4.5 Factors influencing acceptability of caesarean Section among respondents

Results from this study further showed that with a percentage of greater than 50% the following were agreed to and accepted by the respondents to influence acceptance of Caesarean section: fear of death, cost of the procedure, fear of discrimination, fear of husbands' rejection, pain of previous labor, concerns about babies' safety and desire to keep genital tract intact. This is in line with the study of Michael et al in 2007 where the factors influencing the practice of CS among their respondents include fear of death when having CS, [21] pain after having CS that will be associated with CS, concerns or feelings of failure, husband's disapproval, this mode of delivery as not being part of their culture, friends may laugh at them and the charge/price for the operation were some of the reasons given by the participants when asked about their refusal to CS. Other factors for their refusal were previous successful vaginal delivery, previous forceps usage, women not having had a previous CS and having confidence of having a successful vaginal delivery . [22]

It must be noted that even in some areas where there is government policy of free maternity care, caesarean section acceptance is still low maternity care [23]

4.6 Relationship between some sociodemographic factors and acceptance of CS among respondents

Furthermore, there is a significant relationship between educational status, tribe, religion and acceptability of caesarean section among respondents ($p < 0.05$). This is in line with Olajubu et al in 2018 where there is a significant relationship between religion and acceptance of CS. [24] Also it was shown in the study of Oshodi et al in 2020 that the factors that positively influence the acceptance of caesarian section were ethnicity and educational status $P = 0.000$. There is no significant relationship between previous obstetric experiences and acceptability of caesarean section. This may not be unconnected with the fact that most of the times, the need to have caesarean section is unplanned for. It is determined based on the progress of labour. Hence, the woman still believe they may not need caesarean section for subsequent pregnancies. [25]

4.7 Implication to Nursing

Nurses and midwives are the custodian and backbone of antenatal clinics and maternity wards; hence their information are highly regarded by pregnant women. Findings from this study showed that two-third of the respondents were knowledgeable about CS and have good perception towards it. Nurses can further give health education on the advantage of cesarean section to pregnant women especially in situations that can lead to mortality.

Nurses can also prepare pregnant women through the concept of birth preparedness and complication readiness as this would have keep them ready for any complications that might arise during the process of labour.

Nurses can allay the fear of pregnant women and prepare them psychologically so as to serve as serve as example for fellow pregnant women. They can also inform them that Caesarean section is not a death sentence if performed in a recognized and standard hospital.

Limitations of the study

In carrying out this study, the following limitations were encountered:

- The findings of this study may not be generalized across every pregnant woman
- There might be some kind of bias during the study as a result of the questionnaire; a qualitative research design will be recommended so as to get in-depth answers.

Attitude of most of the respondents towards the question, as they felt it's a sensitive issue, however, they were reassured of confidentiality and anonymity.

5. Summary

Caesarean section is the most common obstetric operation performed worldwide and has contributed to improving maternal and foetal outcome. This study assessed the factors influencing the acceptability of caesarean section among multiparous pregnant women attending antenatal clinic at Mother and Child Hospital, Akure, Ondo state. A total number of 306 respondents were recruited for this study and 300 presented for analysis which translates to a response rate of 98%. Pertinent and relevant literatures were reviewed both conceptually and empirically and inferences made where necessary. Findings of the study showed that majority were between 30 and 39 years, married and belong to Yoruba tribe. Only few (29%) have had caesarean section in the past with major indications being prolonged labour (19.5%), fetal distress (20.7%), prolonged pregnancy (7%) and congenital abnormalities (7%). Majority (70%) agreed that Caesarean section is a method of delivery of babies and 46% agreed that CS is a safe method of delivery. Overall, 60% and 66.7% of the pregnant women have good knowledge of CS and perception about CS respectively. Furthermore, only 16% agreed to have CS in the next pregnancy if indicated. The following were agreed to and accepted by the respondents to influence acceptance of Caesarean section: fear of death, cost of the procedure, fear of discrimination, fear of husbands' rejection, pain of previous labor, concerns about babies' safety and desire to keep genital tract intact. Furthermore, there is a significant relationship between educational status, tribe, religion and acceptability of caesarean section among respondents ($p < 0.05$) while there is no significant relationship between previous obstetric experiences and acceptability of caesarean section.

6. Conclusion

Conclusively, this study has shown that most of the respondents have good knowledge and perception of Caesarean Section (CS); however, the rate of acceptance of CS as a mode of delivery is low with factors influencing such including fear of death, cost of the procedure, fear of discrimination, fear of husbands' rejection and concerns about babies' safety.

Recommendation

- Women should be encouraged to take appropriate decisions as it concerns their health during the birth process.
- Nurses, Midwives and other stakeholders in obstetric care should give health education and proper counselling during antenatal care to women on Caesarean section as well as birth preparedness and complication readiness.
- Non-governmental organizations can also help in doing mass campaigns and awareness on birthing process as it concerns CS.
- Religious and traditional organizations and leaders need to assist in improving the dearth of knowledge as it concerns CS in the community by partnering with health workers.
- Government should make maternal and child health care accessible and affordable by building more maternity centres and subsidising the payments.

Suggestion for Further Studies

The researcher suggested that further study should be conducted among pregnant women using wider qualitative research design so as to generalize the findings. The researcher also suggest pregnant women in rural and semi-urban areas should be recruited too.

Compliance with ethical standards

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Disclosure of conflict of interest

No any conflicts of interest on the part of any of the authors.

Statement of informed consent

Informed consent was obtained from all individual participants included in this study.

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