

Perception and Acceptance of Caesarean Section among Pregnant Women Attending Antenatal Clinic in Oba Ademola Maternity Hospital, Ijemo, Ogun State, Nigeria

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Abstract

Introduction: Caesarean section (CS) is a life-saving procedure that reduces maternal and neonatal mortality. However, reluctance to accept CS persists in many cultural and socio-economic contexts. This study assessed the perception and acceptance of Caesarean section among pregnant women attending the antenatal clinic at Oba Ademola II Maternity Hospital, Ijemo, Abeokuta, Ogun State.

Methods: This study employed a quantitative, cross-sectional descriptive research design, and a total of 209 respondents participated. A self-designed questionnaire with closed-ended questions was used to gather information from the respondents. The statistical tool used for this study was the Statistical Package for the Social Sciences (SPSS) version 23. Ethical approval was obtained from the Oba Ademola II Maternity Hospital Health Research Ethics Committee.

Results: The study found a high level of knowledge and generally positive acceptance of CS among respondents. Nearly half (48.3%) were aware of the risks and complications of CS, while 50.7% expressed willingness to undergo CS if adequately informed about the procedure. Most respondents rejected the perception that CS signifies failure (39.7% disagreed vs. 22.0% agreed, $p < 0.05$) or that it deprives women of important life experiences (37.8% disagreed, $p = 0.031$). Key factors associated with acceptance included educational level and previous obstetric experience ($p < 0.05$).

Conclusion: Pregnant women in this study demonstrated good knowledge, positive perceptions, and willingness to accept CS when indicated. Nonetheless, cultural misconceptions remain barriers. Strengthened health education, community sensitisation, and partner-inclusive counselling are recommended to improve acceptance and maternal health outcomes.

Keywords: Acceptance, Caesarean section, Knowledge, Perception, Pregnant women, Strategy

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Introduction

Perception of caesarean section (CS) varies widely across cultures and societies and has a significant impact on maternal healthcare outcomes. Caesarean section (CS) is a life-saving surgical procedure for high-risk pregnancies and obstetric complications (1). However, women's attitudes towards CS remain mixed, with some studies showing reluctance to accept repeat procedures or elective CS due to cultural, financial, or personal reasons (2, 3).

Globally, CS rates continue to rise, particularly in high- and middle-income countries, with the highest prevalence

reported in Eastern Asia (63%), Latin America and the Caribbean (54%), and Western Asia (50%) (4). By contrast, many low-income countries report significantly lower CS rates, such as Nepal (5%), Ghana (11.4%), and Nigeria, where rates vary between 2–3% in community-based surveys and 15–25% in facility-based studies (5, 6). This discrepancy highlights both limited access in rural populations and rising reliance on CS within hospital settings.

Maternal mortality remains a pressing global challenge. According to WHO (2020), about 70% of maternal deaths occur in Sub-Saharan Africa, with Nigeria contributing significantly to this burden (7). Although CS has the potential

to reduce maternal and neonatal mortality, reluctance to accept the procedure persists. Nigerian studies have shown that many women prefer vaginal delivery and may only accept CS if their husband consents (8). Cultural beliefs, economic concerns, fear of surgery, and inadequate counselling during antenatal care have been identified as major barriers (9, 10).

Traditionally, Caesarean section is sometimes perceived as a sign of reproductive failure in Nigerian society, discouraging women from accepting it even in life-threatening situations (11). Despite these perceptions, CS remains an indispensable intervention in preventing maternal and perinatal morbidity and mortality. Understanding women's perceptions and acceptance of CS is therefore critical to designing effective maternal health interventions.

Previous studies in Nigeria, including those from Ogun State (12), have explored CS knowledge and attitudes. However, most were conducted in tertiary hospitals or urban centres. Limited research has been carried out in maternity hospitals that cater to semi-urban populations, where unique cultural and socioeconomic factors may shape women's attitudes towards CS.

To address this gap, this study was conducted to explore the perception and acceptance of caesarean section among pregnant women attending the antenatal clinic at Oba Ademola II Maternity Hospital, Ijemo, Abeokuta, Ogun State, Nigeria. Findings will provide evidence to strengthen antenatal education, improve maternal preparedness, and reduce delays in consenting to CS when medically indicated.

Methods

Study setting and design

The study was conducted at Oba Ademola II Maternity Hospital, Ijemo, Abeokuta, Ogun State. The facility is a government-owned health centre providing antenatal, intrapartum, and postnatal care to women within Abeokuta South Local Government Area and its environs. A descriptive cross-sectional design was employed to assess knowledge, perception, acceptance, factors influencing, and strategies to promote the acceptance of Caesarean section.

Study Population and Sampling

The study population comprised pregnant women attending the antenatal clinic at the hospital within the last three months, with an average monthly attendance of 436. Using Taro Yamane's formula with a 5% margin of error, the required sample size was 209 respondents. A convenience sampling technique was employed to recruit consenting pregnant women who met the inclusion criteria. While this method facilitated recruitment, it may limit the generalizability of findings, as participants may not be fully representative of all pregnant women in the study setting.

Data Collection Instrument

Data were collected using a self-designed, structured questionnaire developed after a review of related literature

and guidelines on maternal health. The questionnaire comprised six sections:

Section A: Socio-demographic characteristics

Section B: Knowledge of CS (e.g., "Caesarean section is only performed in emergencies")

Section C: Acceptance of CS (e.g., "I would undergo Caesarean section if my close friend or family consented to it")

Section D: Perception of CS (e.g., Women who deliver through caesarean section miss an important life experience")

Section E: Factors influencing acceptance (e.g., "Previous experience with childbirth")

Section F: Strategies to promote acceptance (e.g., "Encouraging open conversations about delivery fears in clinics can build confidence in CS.")

Validity and Reliability

The instrument was subjected to expert review, including the research supervisor and senior academic staff members in the Department of Nursing, Crescent University, to ensure content validity. Modifications were made to improve clarity, accuracy, and relevance. A pilot study was conducted with 10% of the calculated sample size ($n = 21$) among pregnant women with similar characteristics to the study population to test for comprehension and clarity.

Reliability was assessed using the test-retest method and measured with Cronbach's alpha of 0.89. This value demonstrates high internal consistency.

Data Collection Procedure

Questionnaires were administered to eligible respondents during antenatal clinic visits by research assistants after obtaining informed consent. An expert supervised data collection and checked responses for accuracy and completeness, and ensured anonymity.

Data Analysis

Data were analysed using SPSS version 23. Since missing data was minimal and completely at random, they were deleted. Descriptive statistics (frequencies, percentages) summarised socio-demographic characteristics, knowledge, perception, and acceptance of CS. Inferential statistics, including Chi-square tests, were performed to determine associations between selected socio-demographic variables, knowledge, and acceptance of CS. Statistical significance was set at $p \leq 0.05$. Chi-square results are presented where statistically significant relationships were found.

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Results

Table 1 presents the socio-demographic profile of the 209 pregnant women who participated in the study. Most respondents were aged 26–35 years (51.2%), followed by those aged 16–25 years (38.8%). Respondents aged 36–45 years and 46 years and above constituted only 7.7% and 2.4%, respectively. Regarding educational attainment, most respondents had completed secondary education (53.1%), while 30.6% had tertiary education. A small proportion had primary education (13.9%), and only 2.4% had no formal education. Most respondents were of Yoruba ethnicity (64.6%), followed by Igbo (15.8%) and Hausa (12.4%), with other ethnic groups making up 7.2%. Christianity was the predominant religion (62.2%), followed by Islam (36.4%) and other religions (1.4%). Occupationally, half of the respondents were self-employed (50.7%), 22.5% were civil servants, 23.0% were employees in other sectors, and 3.8% were unemployed. Most respondents had 1–2 children (51.2%), while 27.8% had 3–4 children. Very few had 5–6 children (7.2%) or seven or more children (1.4%). Most of the respondents are young, educated, Yoruba, and self-employed, which may influence knowledge, perception, and acceptance of Caesarean section.

Table 1: Socio-Demographic Profile of Respondents (n= 209)

Variable	Category	Frequency	Percentage (%)	Cumulative Per cent (%)
Age	16-25	81	38.8	38.8
	26-35	107	51.2	90.0
	36-45	16	7.7	97.6
	46 & above	5	2.4	100.0
	None	5	2.4	2.4
Educational level	Primary	29	13.9	16.3
	Secondary	111	53.1	69.4

Occupation	Tertiary	64	30.6	100.0
	Civil Servant	47	22.5	22.5
	Self Employed	106	50.7	73.2
	Employee	48	23.0	96.2
	Unemployed	8	3.8	100.0
Religion	Christianity	130	62.2	62.2
	Islam	76	36.4	98.6
	Others	3	1.4	100.0
	Yoruba	135	64.6	64.6
Ethnicity	Igbo	33	15.8	80.4
	Hausa	26	12.4	92.8
	Others	15	7.2	100.0
	None	26	12.4	12.4
	1-2	107	51.2	63.6
Number of Children	3-4	58	27.8	91.4
	5-6	15	7.2	98.6
	7 and above	3	1.4	100.0

As shown in Table 2, respondents generally demonstrated good knowledge of Caesarean section (CS). A large majority (93.8%) were aware of what a CS is, with 46.4% strongly agreeing. Over three-quarters (77.2%) recognised that CS reduces the risk of complications during labour, and 97.1% acknowledged the potential benefits for both mother and baby. Most respondents (97.2%) knew the importance of following post-operative care instructions, and 85.1% reported being informed about the risks and complications associated with CS. Additionally, 96.2% indicated they had

received adequate information from healthcare providers. Conversely, misconceptions persist among some respondents. About 33.9% agreed or strongly agreed that CS is not safe for both mother and baby, and 34.0% agreed that CS limits the number of children a woman can have. Notably, only 34.0% believed that giving birth via CS is abnormal, showing a relatively balanced perception of its normalcy. Overall, respondents have high awareness and knowledge of CS, though targeted education is needed to correct lingering misconceptions about safety and fertility implications.

Table 2: Knowledge of Caesarean Section among pregnant women (n= 209)

Statement	Strongly agree (%)	Agree (%)	Disagree (%)	Strongly Disagree (%)
I am aware of what a Caesarean section (CS) is	97 (46.4)	99 (47.4)	13 (6.2)	0 (0.0)
Caesarean section is only performed in emergencies.	64 (30.6)	99 (47.4)	25 (12.0)	21 (10.0)
A caesarean section will reduce the risk of complications during labour and delivery.	65 (31.1)	115 (55.0)	18 (8.6)	11 (5.3)
Caesarean section has potential benefits for both the mother and the baby.	97 (46.4)	106 (50.7)	4 (1.9)	2 (1.0)
I know the importance of following post-operative care instructions after a caesarean section.	76 (36.4)	127 (60.8)	3 (1.4)	3 (1.4)
It is not normal for a woman to give birth through caesarean section	12 (5.7)	59 (28.2)	89 (42.6)	49 (23.4)
I am informed about the risks and complications associated with caesarean sections.	77 (36.8)	101 (48.3)	20 (9.6)	11 (5.3)
Caesarean section isn't safe for either the mother or the baby	17 (8.1)	18 (8.6)	100 (47.8)	74 (35.4)
I have received adequate information about the Caesarean section from healthcare providers	81 (38.8)	120 (57.4)	8 (3.8)	0 (0.0)
Caesarean section doesn't limit the number of children	34 (11.5)	63 (30.1)	75 (35.9)	47 (22.5)

As presented in Table 3, acceptance of CS was high among respondents. All respondents agreed that they would accept CS if medically necessary for their health or their baby's health. A majority (60.3%) strongly agreed with this

statement. Most respondents (55.5%) indicated they would not feel ashamed or stigmatised for undergoing CS. Knowledge also influenced acceptance: 50.7% stated they would undergo CS if better informed about risks and

procedures. Convenience and family influence were moderately impactful, with 44–45% agreeing they would accept CS for convenience or if encouraged by close friends/family. However, 25.3% disagreed with undergoing CS if their husband did not consent, highlighting the influence of spousal opinion on decision-making. While acceptance is generally high, social factors and knowledge gaps may influence some respondents' willingness to undergo CS.

Table 3: Acceptance of Caesarean section among pregnant women (n= 209)

Statement	Strongly agree (%)	Agree (%)	Disagree (%)	Strongly Disagree (%)
I would accept a caesarean section if it is medically necessary for my health or the baby's health	126 (60.3)	83 (39.7)	0 (0.0)	0 (0.0)
I would not feel ashamed or stigmatised for having a caesarean section	93 (44.5)	116 (55.5)	0 (0.0)	0 (0.0)
I would undergo a Caesarean section if my close friend or family consented to it	49 (23.4)	126 (60.3)	32 (15.3)	2 (1.0)
I would accept a caesarean section if it is convenient	92 (44.0)	94 (45.0)	14 (6.7)	9 (4.3)
I would undergo a caesarean section if I were more knowledgeable about the risk and procedure	106 (50.7)	99 (47.4)	4 (1.9)	0 (0.0)
I would accept a caesarean section even if my husband didn't consent to it	60 (28.7)	96 (45.9)	46 (22.0)	7 (3.3)

Table 4 showed that respondents' perceptions of CS were mixed. About 34.9% strongly disagreed that CS is an abnormal method of delivery, while 35.1% agreed or strongly agreed that it is abnormal. Recovery perceptions were divided, with 33.5% agreeing that women recover faster after CS and 34.0% disagreeing. 41.4% agreed that CS could make mothers feel less confident, while 34.4% disagreed. Less than half (44.5%) disagreed that babies born by CS are healthier than those delivered vaginally. About 33–39% disagreed with statements such as CS being performed for weak women or that women miss an important life experience. While respondents generally accept CS, cultural and personal beliefs create mixed perceptions regarding its normalcy, safety, and emotional impact.

Table 4: Perception of Caesarean section among pregnant women (n= 209)

Statement	Strongly agree (%)	Agree (%)	Disagree (%)	Strongly Disagree (%)
Abnormal method of delivery	26 (12.4)	47 (22.5)	63 (30.1)	73 (34.9)
I believe that a woman recovers faster after a caesarean section than after vaginal birth	42 (20.1)	70 (33.5)	71 (34.0)	26 (12.4)
Women who deliver through caesarean section miss an important life experience	23 (11.0)	70 (33.5)	79 (37.8)	37 (17.7)
Caesarean section doesn't create an affectionate mother-baby relationship.	28 (13.4)	51 (24.4)	66 (31.6)	64 (30.6)
Caesarean section is performed for weak women	26 (12.4)	82 (39.2)	55 (26.3)	46 (22.0)
Caesarean section is not a safe procedure	24 (11.5)	50 (23.9)	92 (44.0)	43 (20.6)
Caesarean section is preferable as the pain of vaginal delivery is unpleasant.	20 (9.6)	67 (32.1)	79 (37.8)	43 (20.6)
A caesarean section could make mothers feel less confident in their ability to give birth.	19 (9.1)	86 (41.4)	72 (34.4)	32 (15.3)
I believe that having a vaginal birth is a more remarkable experience than delivering by caesarean section	47 (22.5)	72 (34.4)	56 (26.8)	34 (16.3)
Babies born by caesarean section are healthier than those delivered through vaginal delivery	8 (3.8)	31 (14.8)	93 (44.5)	77 (36.8)

Table 5 showed that factors influencing perception and acceptance of CS included fear of pain (67.4% agreed), fear of death (59.3%), and cost of the operation (57.9%). Cultural beliefs, religion, and previous experiences were less influential, with most respondents disagreeing that these factors affected their perception or acceptance. Fear of pain, death, and financial cost are the primary concerns shaping respondents' perception and acceptance of CS. Social and cultural factors appear less influential in this population.

Table 5: Factors Influencing the Perception and Acceptance of Caesarean section among pregnant women (n= 209)

Statement	Strongly agree (%)	Agree (%)	Disagree (%)	Strongly Disagree (%)
Fear of death	40 (19.1)	84 (40.2)	54 (25.8)	31 (14.8)
Fear of pain	50 (23.9)	91 (43.5)	49 (23.4)	19 (9.1)
Cost of the operation	39 (18.7)	82 (39.2)	68 (32.5)	20 (9.6)
Being seen as a failure	24 (11.5)	46 (22.0)	83 (39.7)	56 (26.8)
Cultural belief	27 (12.9)	50 (23.9)	90 (43.1)	42 (20.1)
Being a subject of ridicule by friends	10 (4.8)	29 (13.9)	105 (50.2)	65 (31.1)
Husband	5 (2.4)	19 (9.1)	90 (43.1)	95 (45.5)
Religion	3 (1.4)	41 (19.6)	98 (46.9)	67 (32.1)
Previous experience with childbirth	13 (6.2)	70 (33.5)	93 (44.5)	33 (15.8)

Table 6 highlights several strategies that could enhance the perception and acceptance of Caesarean section (CS). Health talks during antenatal visits were widely supported, with 69.4% strongly agreeing and 23.9% agreeing that such sessions help dispel myths about CS. Similarly, clear explanations from nurses and midwives regarding the benefits and safety of CS were unanimously endorsed, with 71.8% strongly agreeing and 28.2% agreeing.

The use of local languages and culturally familiar terms was also considered highly effective, with all respondents agreeing that it improves understanding. Encouraging open conversations about delivery fears and allowing women to ask questions during antenatal visits were strategies strongly favoured by respondents, reflecting the importance of interactive and patient-centred education. Visual and written materials, including posters, leaflets, and videos, were similarly seen as valuable tools, with 100% of respondents agreeing on their usefulness.

In contrast, involvement of husbands and family members in antenatal education was not universally considered

beneficial. Nearly half of the respondents (49.8%) strongly disagreed, and 30.6% disagreed with the statement that such involvement may increase acceptance. Similarly, reducing the cost of CS alone was not seen as a sufficient motivator, with 50.2% strongly disagreeing and 17.7% disagreeing. Religious leaders could play a positive role, as 60.8% strongly agreed and 16.7% agreed that their engagement may improve acceptance, though some respondents disagreed. Opinions were divided regarding the impact of displaying birth success stories in hospitals, indicating that while many believe these can have a positive influence on attitudes, a substantial number remain unconvinced. Overall, respondents emphasised that education, clear communication, culturally appropriate messaging, and interactive engagement are the most effective strategies to promote CS acceptance. Financial incentives and family involvement, although relevant, appear to have less influence than knowledge-based interventions.

Table 6: Strategies that can promote perception and acceptance of Caesarean section among pregnant women (n= 209)

Statement	Strongly agree (%)	Agree (%)	Disagree (%)	Strongly Disagree (%)
Health talks during antenatal visits can help clear myths about Caesarean section.	145 (69.4)	50 (23.9)	8 (3.8)	6 (2.9)
Involving husbands and family members in antenatal education may not increase acceptance.	20 (9.6)	21 (10.0)	64 (30.6)	104 (49.8)
Nurses and midwives should explain the benefits and safety of Caesarean delivery clearly	150 (71.8)	59 (28.2)	0(0.0)	0(0.0)
Reducing the cost of a caesarean section will not encourage more women to accept it.	38 (18.2)	29 (13.9)	37 (17.7)	105 (50.2)
Community awareness campaigns can't change negative beliefs about Caesarean section	13 (6.2)	16 (7.7)	57(27.3)	123 (58.9)
Using local languages and culturally familiar terms helps in explaining CS effectively.	148 (70.8)	61 (29.2)	0(0.0)	0(0.0)
Encouraging open conversations about delivery fears in clinics can build confidence in CS.	175 (83.7)	34(16.3)	0(0.0)	0(0.0)
Religious leaders can be engaged to speak positively about medically necessary Caesarean delivery.	127(60.8)	35 (16.7)	16 (7.7)	31 (14.8)
Posters, leaflets, and videos in clinics can help pregnant women understand the importance of CS.	176(84.2)	33 (15.8)	0(0.0)	0(0.0)

Ensuring respectful treatment of women during antenatal clinics cannot improve trust and willingness to undergo it	11(5.3)	17(8.1)	46(22.0)	135(64.6)
Giving room for patients to ask questions about CS during antenatal visits can reduce fear.	157(75.1)	52(24.9)	0(0.0)	0(0.0)
Displaying birth success stories, including CS, in hospital corridors may not influence positive attitudes.	35(16.7)	40(19.1)	56(26.8)	78(37.3)

Discussion

Knowledge about Caesarean Section

This study revealed that most respondents were aware of what a Caesarean section (CS) entails. Most participants recognised that CS reduces the risk of complications during labour and delivery and acknowledged its potential benefits for both the mother and the baby. These findings align with previous research in Ogun State, Nigeria, where pregnant women demonstrated adequate knowledge about CS (12). Similarly, Chongo et al. reported that over half of their respondents had a high level of knowledge about CS (13). The high awareness observed in this study may be attributed to regular antenatal education, higher education levels among participants, and exposure to health information, suggesting that targeted education is effective in improving knowledge and dispelling misconceptions.

Acceptance of Caesarean Section

Respondents generally demonstrated a high level of acceptance toward CS. Most indicated willingness to undergo CS if medically necessary, if they had more knowledge about the procedure, or even without spousal consent. This is consistent with Abiodun-Ojo et al., who reported that women were more likely to accept CS when medically indicated or when husbands gave consent (14). In contrast, Chongo et al. (2024) observed lower acceptance in some populations (13), with 71% of respondents expressing reluctance toward CS. The findings of the current study may reflect a shift toward greater autonomy among pregnant women, as well as increased trust in healthcare providers' recommendations.

Perception of Caesarean Section

Perceptions of CS were largely positive. Most respondents disagreed with misconceptions such as CS being abnormal, unsafe, or a sign of weakness. While some participants viewed vaginal birth as a more remarkable experience, the majority did not perceive CS as detrimental to maternal confidence or mother-baby bonding. These findings are in line with Maitanmi et al. and Chongo et al., who reported that most women held positive perceptions of CS (12, 13). Conversely, Omotayo et al. found that only 46% of respondents perceived CS as safe, indicating persistent stigma in certain populations (15). The current findings suggest that culturally sensitive counselling and repeated antenatal education can help correct misconceptions and reinforce positive attitudes.

Factors Influencing Acceptance of Caesarean Section

Several factors were identified as influencing respondents' acceptance of CS, including fear of death or pain, cost of operation, cultural beliefs, prior childbirth experience, and spousal or community approval. These findings are consistent with prior research. Omotayo et al. reported fear of death (86.7%), cost (92.3%), and husband's disapproval (78.7%) as major barriers (15). Similarly, Chongo et al. noted that 64% of women required partner approval, while 92% expressed fears about surgical complications (13). Karim et al. highlighted the role of previous birth experiences and medical advice in shaping CS acceptance (16). The present study underscores that fear, economic constraints, and social pressures remain important determinants, emphasising the need for multifaceted interventions addressing both knowledge and psychosocial barriers.

Strategies to Promote Acceptance of Caesarean Section

Respondents emphasised that comprehensive, continuous health education during antenatal visits is crucial for shaping positive perceptions of CS. Clear explanations from nurses and midwives, culturally sensitive messaging, and interactive discussions were strongly supported. Financial considerations were also significant, with participants indicating that reducing costs or providing health insurance coverage would increase willingness to undergo CS. Community outreach, public health campaigns, and correcting cultural or religious misconceptions were identified as effective strategies. These findings align with Maitanmi et al. and Chongo et al., highlighting the importance of knowledge-based interventions combined with culturally appropriate and practical support to improve acceptance (12, 13).

Implications for Nursing Practice

The findings reveal critical areas for nursing intervention. Nurses should engage pregnant women in empathetic, culturally sensitive discussions, ensuring they are fully informed about delivery options. Tailored education can address knowledge gaps and misconceptions, while post-operative support can aid physical and emotional recovery after CS. Nurses should anticipate common fears, such as concerns about pain, maternal confidence, or social stigma, and provide targeted guidance to improve decision-making and overall maternal health outcomes. Integrating male partner education and community engagement may further enhance acceptance, particularly in culturally conservative settings.

Conclusion

This study revealed that most pregnant women demonstrated adequate knowledge of Caesarean section, held positive perceptions, and showed a high level of acceptance toward the procedure. However, a notable proportion of respondents still perceived CS as a sign of weakness or feared social stigma, such as ridicule from friends.

These findings highlight the need for targeted interventions to further improve understanding and acceptance of Caesarean delivery. Nurses and healthcare providers should engage in comprehensive antenatal education, culturally sensitive counselling, and open discussions to address misconceptions, alleviate fears, and support informed decision-making. Financial considerations and male partner involvement should also be addressed to facilitate acceptance.

For future research, studies should evaluate the effectiveness of tailored health education programs, explore strategies to reduce socio-cultural barriers, and assess the impact of interventions designed to enhance male partner and community engagement in delivery decisions. Implementing these measures could improve maternal health outcomes and ensure safer childbirth practices.

Abbreviations

ANC: Antenatal Clinic

MMR: Maternal Mortality Ratio

CS: Caesarean Section

SPSS: Statistical Package for Social Sciences

WHO: World Health Organisation

Declarations

Ethics Approval and Consent to Participate: Ethical approval for this study was obtained from the Health Research Ethics Committee of Oba Ademola II Maternity Hospital, Ijemo (OAMH/ETH/Vol I/06). A formal proposal was submitted through the Department of Nursing, Crescent University, Abeokuta, following approval from the research supervisor. Participation in the study was entirely voluntary. Written informed consent was obtained from all respondents, and confidentiality and anonymity were assured. No personal identifying information was collected at any stage of the research.

Data Availability: The data supporting the findings of this study are available from the corresponding author upon reasonable request.

Competing Interests: The authors declare that there are no competing interests.

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Author contributions: SJO conceived and designed the study, supervised the research process, curated and validated the data, and led the drafting of the original manuscript. She also contributed to the development of the study

methodology and coordinated the ethical approval process. ETI assisted in the development of the study methodology, managed project administration, and was responsible for data visualisation. Both authors contributed to resource mobilisation and the review and editing of the manuscript. All authors read and approved the final version of the manuscript.

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References

1. Edward MI, Bolarinwa OS, Ajibade OS, Aregbesola TM. Effect of guided education on perception and attitude of childbearing women towards caesarean section in Nigeria. *NSC Nursing*, 2(5), 85–106. <https://doi.org/10.32549/OPI-NSC-90>
2. Maduka RN, Enaruna NO. Acceptance of repeat cesarean section and its determinants among a Nigerian pregnant women population. *Sahel Medical Journal*. 2021 Jun 1;24(3):104-10. https://doi.org/10.4103/smj.smj_4_20
3. Sys D, Kajdy A, Baranowska B, Tataj-Puzyna U, Gotlib J, Bączek G, Rabijewski M. Women's views of birth after caesarean section. *Journal of Obstetrics and Gynaecology Research*. 2021 Dec;47(12):4270-9. <https://doi.org/10.1111/jog.15056>
4. Betran AP, Ye J, Moller AB, Souza JP, Zhang J. Trends and projections of caesarean section rates: global and regional estimates. *BMJ Global Health*. 2021 Jun 1;6(6):e005671. <https://doi.org/10.1136/bmjgh-2021-005671>
5. Osayande I, Ogunyemi O, Gwacham-Anisiobi U, Olaniran A, Yaya S, Banke-Thomas A. Prevalence, indications, and complications of caesarean section in health facilities across Nigeria: a systematic review and meta-analysis. *Reproductive health*. 2023 Jun 2;20(1):81. <https://doi.org/10.1186/s12978-023-01598-9>
6. Adewuyi EO, Akosile W, Olutuase V, Philip AA, Olaleru R, Adewuyi MI, Auta A, Khanal V. Caesarean section and associated factors in Nigeria: assessing inequalities between rural and urban areas—insights from the Nigeria Demographic and Health Survey 2018. *BMC Pregnancy and Childbirth*. 2024 Aug 14;24(1):538. <https://doi.org/10.1186/s12884-024-06722-6>
7. Okonji OC, Nzopotam CI, Ekholuenetale M, Okonji EF, Wegbom AI, Edet CK. Differentials in maternal mortality pattern in Sub-Saharan Africa countries: evidence from

- demographic and health survey data. *Women*. 2023 Mar 9;3(1):175-88. <https://doi.org/10.3390/women3010014>
8. Waniala I, Nakiseka S, Nambi W, Naminya I, Osuban Ajeni M, Iramiot J, Nekaka R, Nteziyaremye J. Prevalence, indications, and community perceptions of caesarean section delivery in Ngora District, Eastern Uganda: mixed method study. *Obstetrics and Gynaecology International*. 2020;2020(1):5036260. <https://doi.org/10.1155/2020/5036260>
 9. Ogunkorode A, Omolekan T, Alade MI, Adebisi SO. Perceptions and attitudes of pregnant women towards caesarean section in Ado Local Government Area, Ekiti, Southwest Nigeria. *African Journal of Reproductive Health*. 2023 Sep 13;27(6s):28-35.
 10. Oyediran OO, Ademuyiwa IY, Afolabi EK, Ayandiran FS. Factors Associated with Delay Recovery Rate and Surgical Outcome among Caesarean Section Patients in Selected Hospitals in Ibadan, Nigeria. *Tropical Journal of Health Sciences*. 2021 Apr 29;28(1):25-33.
 11. Abood FM, Alsafi AM. Assessment of women's knowledge toward caesarean section complications in Baghdad Teaching Hospital 2022. *Iraqi Journal of Medical Sciences*. 2023 May 17;21(1).
 12. Maitanmi BT, Oluyomi OV, Aderemi IO, Maitanmi JO, Aminu A, Ojewale MO, Okundu OE, Akingbade O. Knowledge, attitude and perception of caesarean section among pregnant women attending antenatal clinic at Babcock University Teaching Hospital, Ilishan-Remo, Ogun State. *The Journal of Maternal-Fetal & Neonatal Medicine*. 2023 Dec 15;36(2):2278019. <https://doi.org/10.1080/14767058.2023.2278019>
 13. Chongo HS, Masumo M, Nankamba N. Acceptability of Caesarean Section among Pregnant Women Seeking Antenatal Care at Women and Newborn Hospital-University Teaching Hospitals, Lusaka, Zambia. *Open Journal of Obstetrics and Gynecology*. 2024 May 8;14(5):721-43. <https://doi.org/10.4236/ojog.2024.145061>
 14. Abiodun-Ojo OE, Owolabi BA, Olubodun AP. Acceptance of Caesarean Section Among Pregnant Women Attending Antenatal Clinic in A Tertiary Hospital in Ekiti State. *Commonwealth Journal of Academic Research (CJAR EU)*. 2022 Mar 31;3(3):1-1.
 15. Omotayo SE, Omotayo RS, Ayodeji FM, Logo A. Factors influencing acceptability of Caesarean section among multiparous pregnant women attending antenatal clinic at Mother and Child Hospital, Akure. *GSC Adv Res Rev* 2022; 11: 180-192. <https://doi.org/10.30574/gscarr.2022.11.1.0102>
 16. Karim F, Ali NB, Khan AN, Hassan A, Hasan MM, Hoque DM, Billah SM, El Arifeen S, Chowdhury MA. Prevalence and factors associated with caesarean section in four Hard-to-Reach areas of Bangladesh: Findings from a cross-sectional survey. *PLOS One*. 2020 Jun 9;15(6):e0234249. <https://doi.org/10.1371/journal.pone.0234249>