



Knowledge and acceptance of caesarean section among pregnant women attending antenatal clinic in federal teaching hospital, Ido-Ekiti, Ekiti State, Nigeria

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Abstract

Context: Caesarean section (CS) is a vital obstetric intervention for preventing maternal and neonatal morbidity and mortality when medically indicated. However, acceptance of CS in Nigeria remains suboptimal despite increasing awareness. This study assessed the level of knowledge and acceptance of CS among pregnant women attending antenatal clinic (ANC) at the Federal Teaching Hospital, Ido-Ekiti (FETHI).

Materials and Methods: A descriptive cross-sectional study was conducted among 152 pregnant women selected through systematic random sampling. Data were collected using a structured, pre-tested questionnaire. Knowledge of CS was assessed using a scoring system and categorized as good or poor. Acceptance was measured as willingness to undergo CS if medically indicated. Data were analyzed using SPSS version 27. Associations were tested using Chi-square statistics, with $p < 0.05$ considered statistically significant.

Results: Awareness of CS was universal. Overall, 61.8% of respondents had good knowledge of CS, while 38.2% had poor knowledge. Acceptance of CS if medically indicated was reported by 74.3% of respondents. Acceptance was significantly higher among women with good knowledge of CS compared to those with poor knowledge ($p < 0.001$).

Conclusion: Knowledge and acceptance of CS among pregnant women attending ANC at FETHI were relatively high. Good knowledge was a significant predictor of acceptance. Strengthening antenatal education on CS may further improve timely acceptance and reduce preventable obstetric complications.

Keywords: Caesarean section, knowledge, acceptance, antenatal care, Nigeria

Introduction

Caesarean section (CS) is a surgical procedure used to deliver a baby through incisions made in the abdomen and uterus and is one of the most commonly performed major surgical operations globally.¹ Caesarean section (CS) is an essential component of comprehensive emergency obstetric care and a proven

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life-saving intervention when vaginal delivery, the natural birth process, poses risks to the mother or fetus in situations such as cephalo-pelvic disproportion, obstructed labor, placenta praevia, and fetal distress, high estimated foetal weight.²

The Royal College of Obstetricians and Gynecologists, classified CS into 4 categories.²

Category 1 involves immediate threat to the life of the mother or fetus requiring emergency CS, category 2 indicates maternal or fetal compromise that is not immediately life-threatening, category 3 applies when there is no compromise but delivery is needed sooner than planned, and category 4 refers to an elective CS which is timed to suit the mother and/or obstetrician.² While CS can be an essential and life-saving surgery, it has some risks such as accidental damage to the mother's bladder or bowel and an increase in the incidence of breathing difficulties in the baby. These must be made clear prior to obtaining consent for the surgery.³

The World Health Organization recommends a CS rate of 10–15% at the population level, indicating adequate access without unnecessary use.¹ Despite the clear medical benefits of CS, access and acceptance remain inequitable, especially in low- and middle-income countries, where cultural, social, and economic factors heavily influence maternal health decisions.³ Nigeria continues to record low CS rates, far below global recommendations, alongside persistently high maternal mortality ratios.^{4,5} Nevertheless, the persistently high maternal mortality ratio in Nigeria suggests that beyond medical availability, factors such as knowledge and acceptance of CS among pregnant women may influence utilization of this procedure.^{4,6}

Knowledge of CS plays a critical role in shaping women's willingness to consent to the procedure, especially in emergency situations. Inadequate understanding of indications, benefits, and safety of CS can result in fear, delay, rejection or outright refusal, increasing the risk of adverse maternal and neonatal outcomes.⁶ Studies show that many women obtain information about CS from informal sources such as peers, family members, and the media, which may perpetuate misinformation and fear about the procedure.⁷ For example, a cross-sectional study conducted in the Upper West region of Ghana showed that 51.8% of respondents expressed reluctance to undergo CS due to fears of prolonged recovery and inability to resume household duties and other responsibilities in due time.⁸ Furthermore, a study in Zamfara State, Nigeria revealed that although 68.2% of pregnant women were fairly knowledgeable about CS, 54.5% had a poor perception of it, and 31% clearly rejected its use, primarily due to cultural myths, financial concerns, and lack of partner support.⁹

The gap between knowledge and acceptance of CS has serious public health implications, as delayed consent during obstetrics emergencies is often associated with preventable maternal and fetal morbidity and mortality. This delay in decision-making can lead to adverse maternal outcomes such as postpartum hemorrhage (41.3%), hypertensive disorders of pregnancy (37.3%), prolonged obstructed labor (23%), puerperal sepsis (18.6%), severe anemia (14.6%) and even maternal death.¹⁰ In addition to these maternal complications, fetal outcomes are equally affected, with reported cases of intrapartum asphyxia, stillbirth, long term neurodevelopmental impairment.¹¹

In Ekiti State, this problem is not just clinical it is social and systemic. The rejection of CS is further complicated by its higher cost compared to vaginal delivery and mistrust in health professionals, with some believing that doctors recommend CS primarily for financial gain, regardless of medical need.^{12,13} This sentiment fuels resistance, even when the woman herself is medically vulnerable.

Limited facility-based evidence exists in Ekiti state, focusing specifically on the relationship between women's knowledge of CS and their acceptance of the procedure. This study therefore assessed the level of knowledge and acceptance of CS and the relationship between both, among pregnant women attending antenatal clinic at Federal Teaching Hospital, Ido-Ekiti. Findings will also provide empirical data for the hospital, Ekiti state and national health policy makers, as well as developing targeted strategies to improve antenatal care programs and design. This study will also add to limited literature on CS and its barriers in southwestern Nigeria, providing a foundation for future studies and interventions.

Materials and Methods

Study Design and Area

A descriptive cross-sectional study was conducted at the antenatal clinic of the Federal Teaching Hospital, Ido-Ekiti (FETHI) located in Ido-Osi Local Government Area (LGA) of Ekiti State, southwestern Nigeria. Ido-Ekiti is both a semi-urban and agrarian community, lying within latitude 7.85°N and longitude 5.18°E and FETHI is the only tertiary hospital in the area and serves as the referral center for the neighboring LGAs and even states. It is one of the fastest growing tertiary health service

providers and clinical training institutions in the country, established 1998 by the federal government. It houses a well-established Obstetrics and Gynaecology department, offering services such as antenatal care (ANC), labour and delivery, family planning, and emergency obstetric care including CS, which qualifies it as a referral center for high-risk pregnancies and labour complications from other facilities within the state.

Study Population

The study population comprised pregnant women aged 15 to 49 years (WHO reproductive age) attending ANC at FETHI during the study period. The study excluded those who were critically or mentally ill.

Sample Size and Sampling Technique

The sample size was calculated using Taro Yamane's formula, $n = N / 1 + N(e)^2$, where N represents the estimated ANC attendance and e is the margin of error. The calculated sample size was then adjusted for potential non-response, resulting in a final sample of 152 respondents. The study employed a systematic random sampling technique which involved obtaining the ANC attendance register from FETHI to determine the total number of pregnant women attending ANC during the study period and estimating the daily average number of attendees which was approximately 15. Antenatal clinic at FETHI runs twice a week (Tuesdays and Thursdays), which sums up to 8 clinic days monthly and 16 clinic days over study period of two months. On each ANC day, every 2nd eligible pregnant woman was selected from the registration list. The first respondent was selected by simple random sampling from 1- K where K is 2 (i.e. the sampling interval) and subsequent respondents followed at intervals of 2. Any patient meeting the inclusion criteria were recruited. In circumstances where a selected participant declined or was ineligible, the next eligible person was selected. This technique continued every clinic day until the calculated sample size of 152 was achieved.

Data Collection

Data were collected using a structured, pre-tested questionnaire adapted from relevant literature.^{9,14,15} The questionnaire covered questions on respondent's socio-demographic characteristics, knowledge of

Caesarean section and acceptance of CS if medically indicated. Two clinical epidemiologist and Obstetrician appraised the study instrument for face and content validity. Pre-testing was done among pregnant women attending ANC at Ekiti State University Teaching Hospital, Ado-Ekiti which is about 65minutes drive from FETHI.

Measurement of Variables

- **Knowledge of CS:** Assessed based on 10 questions. Correct answers scored 1 point each. Scores $\geq 50\%$ were classified as good knowledge, while $< 50\%$ were classified as poor knowledge.
- **Acceptance of CS:** Measured as willingness to undergo CS if recommended by a doctor.

The independent variables in this study include: the socio-demographic factors of the respondents, which were assessed and measured using 11 questions, structured and unstructured, as well as the levels of knowledge. The outcome variable: acceptance of CS among pregnant women attending the antenatal clinic at the Federal Teaching Hospital, Ido-Ekiti.

Data Analysis

Data were analysed using IBM SPSS version 27. Descriptive statistics were used to summarize findings. Knowledge score was determined by giving a score of one (1) to the correct answers, while the incorrect answers and don't know were scored zero (0)}, then frequency tables were generated, mean score calculated and cross-tabulations were done. Chi-square test was used to assess association between knowledge and acceptance of CS. Statistical significance was set at $p < 0.05$ and 95% confidence interval.

Ethical Considerations

Ethical approval (ERC/2025/08/07/1326B) for this study was obtained from the Human Research and Ethics Review Committee of the Federal Teaching Hospital, Ido-Ekiti, Ekiti State Nigeria. Written informed consent was obtained from all the respondents using signatures and thumb prints. Confidentiality was assured by using anonymous questionnaires, also name or code tagging of the questionnaire was duly avoided, and cross-interference among respondents was prevented as the research tool was administered one doctor per time during data collection. Furthermore, the data was kept secured in an electronic computer that is

password-protected, the password was known only to the principal investigator. The research was conducted in accordance with tenets of the Helsinki Declaration as it did no harm to any of the research participants.

Results

Socio-demographic Characteristics

A total of 152 pregnant women participated in the study (100% response rate) with a mean age of 31.8 ± 6.8 and more than one-third (34.3%) were above 35 years of age. Most were married (86.8%) and in terms of education, 79% had tertiary education. A greater proportion, (72.4%) were civil or public servants, Christianity was the predominant religion with (86.8%) adherents and Yoruba ethnicity accounted for 90.8%, reflecting the study setting's demographics. [Table 1]

Table 1: Socio-demographic characteristics of respondents

Variable	Frequency (n) N = 152	Percentage (%)
Age group (years)		
18–24	23	15.1
25–29	33	21.7
30–34	44	28.9
35–39	35	23.1
≥40	17	11.2
Mean ± SD	31.8 ± 6.8	
Marital status		
Single	20	13.2
Married	132	86.8
Educational level		
Primary	4	2.6
Secondary	28	18.4
Tertiary	120	79.0
Occupation		
Employed	110	72.4
Unemployed	42	27.6
Religion		
Christianity	132	86.8
Islam	20	13.2
Ethnicity		
Yoruba	138	90.8
Others	14	9.2
Residence		
Urban (city)	38	25.0
Semi-urban (town)	83	54.6
Rural (village)	31	20.4

Obstetrics Characteristics of the Participants

About four out of five respondents (80.3%) had experienced two to four pregnancies, representing the largest proportion of the study population. Similarly, 69.1% had two to four deliveries. Less than half of the respondents attended antenatal care one to two times during pregnancy, while the

majority (80.3%) had no history of caesarean section (Table 2).

Table 2: Obstetrics Characteristics

Variable	Frequency(n) N = 152	Percentage(%)
Gravidity		
1	19	12.5
2–4	122	80.3
≥5	11	7.2
Parity		
0–1	43	28.3
2–4	105	69.1
≥5	4	2.6
Number of antenatal visits so far		
1–2	71	46.7
3–4	24	15.8
≥5	57	37.5

Knowledge of CS among Respondents

All participants (100.0%), had heard about CS and majority (98.0%) believed that it is a surgical delivery through the abdomen.

Two-thirds (67.1%) correctly identified prolonged labour as a possible indication for the procedure, the same fraction (67.1%), knew that breech presentation could necessitate CS and a significant number (84.2%) knew that CS is performed to save the life of the mother, the baby or both. However, 41.4% believe that CS is not more painful than vaginal birth. A large number of the respondents (64.5%) did not believe that CS always leads to infertility. However, most respondents (77.0%) believed that a woman can have a vaginal delivery after a CS. In addition, about half (50.7%) thought that women can safely undergo CS three or more times and a substantial majority were aware that CS is available at FETHI. Based on the overall knowledge assessment, 61.8% had a good knowledge of CS. [Table 3]

Acceptance of CS

Amongst the 152 pregnant women surveyed, 50 (32.9%) reported that decisions regarding the mode of delivery are made by their doctors while only 1 respondent (0.6%) attributed the decision to a religious leader such as a pastor or imam. However, 113 (74.3%) stated that they would willingly accept CS if advised by a healthcare professional. [Table 4]

Associations between Knowledge and Acceptance of CS

There was a strong and statistically significant

Table 3: Knowledge of CS

Variable	Frequency(n) N = 152	Percentage(%)
Ever heard of Caesarean Section (CS)		
Yes	152	100.0
Definition of CS		
A natural form of delivery	2	1.3
Surgical delivery through the abdomen (correct)	149	98.0
I don't know	1	0.7
CS is used when (MR)		
The baby is too large	94	61.8
The woman is lazy (incorrect)	14	9.8
There is prolonged labour	102	67.1
It is the woman's choice	38	25.0
The baby is in breech position	102	67.1
I don't know (incorrect)	24	15.8
CS can save the life of a mother and/or baby (correct)		
True	128	84.2
False	10	6.6
I don't know	14	9.2
CS is more painful than vaginal birth		
True	40	26.4
False	63	41.4
I don't know	49	32.2
CS always leads to infertility		
True	17	11.2
False	98	64.5
I don't know	37	24.3
Can a woman have a vaginal delivery after CS?		
Yes	117	77.0
No	7	4.6
I don't know	28	18.4
How many times can a woman safely undergo CS?		
Once	3	2.0
Twice	35	23.0
Three or more times	77	50.7
I don't know	37	24.3
Is CS available at FETHI?		
Yes	135	88.8
No	12	7.9
I don't know	5	3.3
Assessment of Knowledge of CS		
Good ($\geq 70\%$)	94	61.8
Fair (50 - $<70\%$)	45	29.6
Poor ($<50\%$)	13	8.6

Table 4: Acceptance of CS

Variable	Frequency(n) N = 152	Percentage(%)
Would you willingly accept CS if advised (Acceptance)		
Yes	113	74.3
No	39	25.7
Who makes decisions about your delivery mode?		
Self	45	29.6
Husband	12	7.9
Mother in law	5	3.3
Joint decision	39	25.7
Doctor	50	32.9
Pastor/Imam	1	0.6

relationship between knowledge and acceptance ($\chi^2 = 23.438$, $p < 0.001$). Women with good knowledge of caesarean section were more likely to accept it, as 82 (87.2%) of them expressed willingness to undergo the procedure compared to 26 (57.8%) of those with fair knowledge and only 5 (38.5%) among those with poor knowledge. [Table 5]

Table 5: Associations between Knowledge and Acceptance of CS

Variable	Acceptance of CS		Chi square	p-value
	Yes n (%)	No n (%)		
Assessment of Knowledge of CS				
Good ($\geq 70\%$)	82 (87.2)	12 (12.8)	23.438	$<0.001^*$
Fair (50 - $<70\%$)	26 (57.8)	19 (42.2)		
Poor ($<50\%$)	5 (38.5)	8 (61.5)		

Discussion

This study found a relatively high level of knowledge of CS among pregnant women attending ANC at FETHI, with over sixty percent demonstrating good knowledge. This finding aligns with studies from other tertiary health facilities in southern Nigeria where respondents demonstrated good knowledge of the procedure.^{16,17} In another study conducted in Delta state,¹⁸ Nigeria, increased exposure to skilled healthcare providers and antenatal education has been associated with better understanding of obstetric interventions. These findings contrast sharply with results from Jigawa State in northern Nigeria,¹⁹ where most respondents had inadequate knowledge, a gap possibly linked to lower educational attainment and limited access to health information.

Beyond Africa, the findings of this study differ from those of research conducted in Saudi Arabia,²⁰ which reported low levels of knowledge and persistent misconceptions about CS, possibly influenced by religious beliefs and cultural attitudes toward childbirth. Nevertheless, it is noteworthy that more than one in three participants in the present study also demonstrated poor knowledge of CS. Collectively, these findings suggest that while basic knowledge/awareness of CS is fairly widespread, depth of understanding remains uneven, influenced by factors such as education, region, culture and access to credible health information. These variations highlight the need for context-specific health education strategies and further qualitative research to explore how socio-cultural factors could shape women's understanding of caesarean delivery. Acceptance of CS was also high, with over three-quarters of respondents willing to undergo the procedure if medically indicated. This acceptance rate is higher than figures reported in several other Nigerian settings,^{16,21} particularly in rural and semi-urban areas, suggesting that access to tertiary care and structured antenatal counselling at FETHI may

positively influence decision-making.

However, about one-quarter of respondents in this study remained unwilling to undergo CS stating fear of death, pain, and the high cost of surgery as the main reasons. These findings highlight that while knowledge and perception play a role in shaping acceptance, emotional, financial, and cultural factors remain central. These concerns reflect broader patterns documented in Enugu, where fear of death and financial burden were the leading deterrents to CS.²² To overcome these barriers, multifaceted interventions are required. Health workers should prioritize preoperative counselling that explains anaesthetic safety, pain control, and post-surgical care. Health policies should address financial constraints through improved health insurance coverage and government-subsidized emergency obstetric care. Moreover, community-level advocacy should be strengthened to rebuild trust and normalize CS as a safe and beneficial medical procedure.

A key finding of this study is the strong and statistically significant association between knowledge and acceptance of CS. Women with good knowledge were significantly more likely to accept CS than those with poor knowledge. This supports the premise that improving knowledge through antenatal education can enhance informed consent and timely acceptance of life-saving interventions. These findings underscore the importance of continuous, targeted health education during antenatal care, focusing not only on awareness but also on correcting misconceptions and reinforcing the medical indications and safety of CS.

Conclusion

Knowledge and acceptance of Caesarean section among pregnant women attending ANC at Federal Teaching Hospital, Ido-Ekiti were relatively high. Good knowledge of CS was a significant predictor of acceptance. Strengthening antenatal health education on CS is essential to sustain and further improve acceptance, thereby reducing delays in consent and preventable maternal and neonatal complications.

The study highlights that improving maternal and neonatal survival through CS requires more than just the availability of surgical services. It calls for comprehensive and sustained efforts that integrate health education, cultural sensitization, financial

accessibility, and male involvement. Acceptance of CS should be framed not as a failure of womanhood but as a safe and essential intervention that preserves life and guarantees positive outcomes. Strengthening antenatal education, ensuring financial protection, and promoting community trust in healthcare services are therefore indispensable to improving maternal outcomes in Nigeria.

List of abbreviations

ANC: Antenatal Clinic

FETHI: Federal Teaching Hospital, Ido Ekiti

CS: Caesarean Section

Consent for publication: Not applicable

Availability of data and materials: The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request

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