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# Effect of Midwife-Led Education On Acceptance of Cesarean Section Among Pregnant Women in Selected Hospitals in Oyo State

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**Abstract:**

The study assessed midwife-led education on acceptance of caesarean section among pregnant women in Adeoyo Maternity Teaching Hospital and State Hospital, Oyo, Oyo State. A Quasi experimental study design was adopted and a sample size of 218 was calculated using Cochran's formula. Participants were selected via convenience probability sampling technique. A validated structured self-developed questionnaire with a reliability coefficient of 0.79 was used for data collection. Data were analyzed using descriptive statistical tools of frequencies and percentage. The relationship between variables was tested using the inferential statistical tool of t-test with level of significance set at 0.05 IBM SPSS version 25 was used to compute the data. The result showed that about two-thirds 132 (65%) had a high level of acceptance of CS, while 71(35%) had low level of acceptance prior to the intervention. Post-intervention, 149 (73.4%) had a high level of acceptance of CS while 54 (26.6%) had a low level of acceptance of CS. The respondents' pretest and post test knowledge of CS and acceptance of CS were significant. Similarly, the respondents' perception and acceptance of CS were significant. Despite this improvement, barriers such as high cost, fear of death, and family or partner decisions remained prevalent, though stigma and religious beliefs appeared less influential post-intervention. To improve caesarean section acceptance, healthcare providers should institutionalise targeted antenatal education to address misconceptions, emphasise joint decision-making, and use interactive

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methods such as testimonials and multimedia presentations. Additionally, policymakers should address financial barriers through subsidised fees, insurance coverage, and maternal health funds, while healthcare institutions implement psychosocial support and partner-inclusive counselling to reduce fear and foster informed decision-making.

**Keywords:** Midwife-Led Education, Acceptance, Caesarean Sections, Pregnant Women,

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## Introduction

Nigerian women traditionally resist caesarean sections due to the prevailing idea that abdominal delivery signifies reproductive failure, despite the possibility of vaginal birth after caesarean and the declining death rates associated with caesarean deliveries. It is important to include all pregnant women, regardless of their educational background and parity, in relation to caesarean section (CS) rates. The researchers noted that, despite the explanations provided to pregnant women during prenatal clinics, they still exhibit a negative and unfavourable opinion towards Caesarean sections when such procedures are necessary. Despite being labelled a risk to women of childbearing age and their partners, the Caesarean section has not received adequate attention, even though it is instrumental in reducing mortality among pregnant mothers, despite the explanations provided by health professionals and the availability of healthcare facilities offering these services. Pregnant women continue to have unfavourable perceptions and poor acceptability levels about Caesarean sections.

Among gynaecological procedures, caesarean sections are among the most common. Foetal delivery by caesarean section, an operating procedure that involves making an incision in the belly, has become more common in industrialised nations during the last 20 years. The present level of safety of the treatment allows for a high volume of caesarean sections performed for a variety of legitimate medical reasons, as well as non-medical ones (such as maternal request) and, on rare occasions, financial incentives (Akinyemi et al., 2021). In some situations, a caesarean section can save the life of the mother as well as the foetus.

In underdeveloped nations in sub-Saharan Africa, such as Burkina Faso and Nigeria, where the rate of caesarean section is less than 2%, some women still view it as an unnatural method of giving birth (Ezeome et al. 2018). Caesarean sections are still seen as a sign of weakness and a curse on unfaithful women among women in poor nations. The Yoruba women of southwestern Nigeria were found to have a negative attitude towards Caesarean sections, according to a research. They viewed them with suspicion, aversion, anxiety, guilt, unhappiness, and rage. Few women in underdeveloped nations consent to caesarean sections for reasons other than medical necessity, mostly because of the stigma associated with the operation (Anyasor et al., 2017).

Choosing a delivery option is a big deal for healthy populations. In addition to deciding between a caesarean section and a home birth, expectant parents often have a lot of other options, such as the location of the delivery (hospital, birth centre, or house). The worldwide incidence of caesarean sections has been rising for some time now. A portion of this growth goes to both the world's developed and developing nations. Women with more education had a greater risk of having a caesarean section, according to epidemiological research in Brazil and Chile; similarly, higher incidence of caesarean sections have been seen in African nations like Ghana and Nigeria. Nonetheless, the general public tends to think that West African women dislike caesarean sections. In impoverished nations like Nigeria, where many pregnant women hold the misconception that caesarean sections are only performed as a last option, it is not uncommon to hear that many pregnant women are vocal about their negative attitudes towards this type of delivery. For some, the news that they will have to have a caesarean section delivered is like signing a death sentence. When women and their families

are informed that the baby will be delivered through caesarean section, it can lead to psychological depression and affect their acceptance of the procedure, which in turn affects the outcome of the procedure (Faremi et al. 2014).

Amieghemeet al. (2014) indicated that women's limited educational attainment and previous successful vaginal and instrumental births were likely correlated with their rejection of caesarean sections.79% opposed delivery through customer service due of concerns about mortality.82% of the population opposed it owing to familial preference for vaginal birth.Sixty percent expressed objections due to the expense of computer science. Further investigation indicated that this mostly results from erroneous cultural attitudes around labour and caesarean sections among the cohort of women. Ntiense et al. (2018) report that 70.7% of pregnant women will consider this delivery option.23.3% will categorically reject caesarean section under any circumstances; factors such as residency, maternal education level, and location of the most recent birth were substantially correlated with the acceptability of caesarean section.

Panti et al. (2016) reported that 77.5% regarded the caesarean section technique as acceptable when indicated. The perception of the denial of femininity, suffering, significant expense, and fear of mortality were the primary reasons some individuals would not consent to a caesarean section. Anyasor and Adetuga (2017) reported that the acceptability of the surgery among women was comparatively low. Factors impeding acceptance include: the idea that caesarean sections are typically performed for indolent women (56.3%), financial limitations (54.4%), and experiences relayed by important people (50.5%).

Research conducted by Ezeome et al. (2018) in a specialised health facility in Enugu, Southeast Nigeria, indicated that 13% of pregnant women would refuse the surgery under any circumstances. The majority will consent to a caesarean section if their husband approves the operation. Young ladies believed that their husbands determined the method of delivery. Joint decision-making about the mechanism of delivery is favoured. Hofmeyr et al. (2015) reported that 95.7% of participants were amenable to caesarean section when deemed necessary, whereas 4.3% of pregnant women would decline the procedure if indicated.

Caesarean sections are often conducted when vaginal delivery poses a risk to either the foetus or the mother. Typical clinical grounds for a caesarean section encompass foetal discomfort, inability to progress in labour, prior caesarean delivery, and breech presentation, among others. An elective caesarean section may be advised by the healthcare professional or solicited by the customer (Ashimi et al., 2018).

Factors affecting healthcare practitioners' recommendations encompass foetal weight estimation (exceeding 3.0 kg), foetal hazards, and the likelihood of perineal damage, as well as urine and anal incontinence. Additional elements that affect physicians' decision-making about caesarean sections include personal views, healthcare system dynamics, and the clinician's individual attributes such as confidence, abilities, and convenience (Bello et al., 2017).

Conversely, when patients elect to undergo a caesarean section, their decision is frequently influenced by maternal and infant-related factors, societal pressures, assurance regarding the delivery timing, the selection of a propitious date for the child's birth, and prior negative

experiences with vaginal delivery (Panda et al., 2018). For a clinician's determination of the necessity for an elective caesarean section to be effective, it must be endorsed by the woman, therefore assuring favourable health outcomes for both the mother and the infant. This necessitates collaboration among the healthcare personnel, the client, and the family. The decision-making process for women encompasses several elements, including their understanding of the caesarean section technique, financial implications, and the accessibility of familial assistance for childcare. The understanding of caesarean sections among women markedly affects their decision-making, and a knowledge disparity persists between industrialised and poor nations (Vogel et al., 2015; Ejioye & Gbenga-Epebinu 2021). Research in Nigeria and Ghana indicates that many traditional women are reluctant to have caesarean sections due to the prevalent notion that abdominal birth signifies reproductive failure, while others dread potential mockery. Boatiet al. (2018) identified a considerable rate of caesarean section refusals among their research participants, leading to substantial adverse outcomes for both mothers and newborns.

Researchers have noted that women's authority in making healthcare decisions, especially in poor nations, is frequently constrained. The absence of autonomy may result in delays in obtaining essential healthcare treatments, hence exacerbating elevated maternal death rates (Osamor & Grady, 2016). In some societies, decision-making power is delegated to other family members, like the husband, mother-in-law, or grandmother of the expectant lady. Although caesarean sections are acknowledged as safe when conducted under suitable health circumstances and with adequate infrastructure and resources, apprehensions over the procedure's safety persist, affecting decision-making and its promptness. The involvement of other relatives in the decision-making process might influence the acceptance of a physician's advice for a caesarean section, potentially leading to health risks and issues for both the mother and the infant.

In instances of patient-initiated elective caesarean sections, the determinants affecting the decision-making process are well-established. Women evaluate the advantages of the surgery, its risks, and its impact on their daily life while making their decision. Understanding the elements that affect the decision-making process and the duration required to accept medically-indicated caesarean sections is crucial, as it impacts a woman's readiness for the postnatal period and efficient childcare, including breastfeeding. A woman's experience with a caesarean section might affect her emotional readiness to begin nursing. The objective of this study was to investigate the elements that women evaluate and the influences on their choice to undergo elective caesarean sections.

Further factors contributing to women's reluctance towards caesarean sections in underdeveloped nations encompass apprehensions regarding the procedure's morbidity and mortality, extended hospitalisations, and elevated medical expenses. Notwithstanding the existence of evidence-based safe practices and advancements, a considerable proportion of individuals in low-income nations continue to have pronounced unfavourable cultural attitudes about caesarean birth. Sunday and Kalu (2017) indicated that 34% of participants ascribed their unfavourable views about abdominal delivery to the cultural impact of their cultures. Furthermore, Aziken et al. (2017) indicated that 1.8% of women declined caesarean birth due to cultural unacceptability. Bello et al. (2016) reported that these cultural factors

encompass the notion that caesarean birth is a consequence of spiritual assaults, punishment for women's adultery, and an inability to perform reproductive duties.

The substantial expense linked to caesarean sections is a major factor in women's reluctance to undergo the surgery. Ezechi et al. (2016) discovered that 66.5% of participants in their study refused caesarean birth owing to cost considerations, particularly in environments without effective health insurance systems. Chibu and Ilobachie (2018) cited the exorbitant expense of caesarean sections as the principal cause for rejection. In low-income environments such as ours, characterised by minimal wages, ineffective implementation of the National Health Insurance Scheme, and low adoption of family planning practices, households encounter substantial economic burdens, resulting in insufficient resources for adequate healthcare maintenance (Aziken et al., 2017).

Gurol-Urganci et al. (2013) shown that, despite the rising prevalence of caesarean sections in low-income nations, women in Enugu, southeastern Nigeria, faced restricted access to the operation. Researchers identified that advancing age and socioeconomic characteristics, which function as indicators of income and healthcare accessibility, were significant drivers of access to caesarean sections. They suggested more study to examine the obstetric circumstances surrounding caesarean sections for women in this location and to analyse the influence of socioeconomic variables on access to the surgery. This study seeks to evaluate awareness and acceptability of caesarean delivery, while also investigating causes for possible aversion and factors influencing access to caesarean sections in a tertiary health facility in Abakaliki, southern Nigeria. This study's findings will yield local and regional statistics to guide the design, promotion, and execution of health programs and policies focused on enhancing women's care and improving pregnancy outcomes. In a research by Felicia et al. (2016) in a missionary hospital in Edo State, Nigeria, vaginal delivery was deemed safe albeit exceedingly unpleasant. The study found that 79.0% of participants declined caesarean procedures due to fear of mortality.

The results of this study reveal that 82.0% of participants decline caesarean procedures owing to familial preference for vaginal birth. This adverse reception may be ascribed to insufficient information and a limited educational background. These findings corroborate the research of Chibu and Iloabachie (2018), which indicated that a primary reason women refuse caesarean procedures is their want to undergo vaginal birth. Women face disappointment when they do not have a typical delivery and forfeit the associated sense of accomplishment. The survey indicated that cost is a significant constraint on the acceptance of caesarean sections, as 60% of respondents expressed a preference for vaginal birth due to the high expenses associated with the former. This conclusion aligns with the research conducted by Chigbu and Iloabachie (2018), which emphasised the economic challenges encountered by families in a nation with an average monthly wage of 58 US dollars, rendering the acceptability of caesarean sections difficult.

In view of the above, the study examined midwife-led education on acceptance of cesarean section among pregnant women in selected hospitals in Oyo state. The study specifically:

i. examined the effect of midwife-led education on pre and post intervention acceptability of C- section among pregnant women; and
ii. assessed the barriers to the acceptance of C-section among the pregnant women.

**Hypothesis**

$H_{o1}$: Midwife-led education has no significance effect on the level of acceptance of C- section among the pregnant women.

**Research Methods**

The research employed a non-equivalent quasi-experimental design to examine the influence of midwife-led education on the acceptability of caesarean sections among pregnant women. This approach was appropriate since it allowed the researcher to do comprehensive investigations, execute interventions, derive conclusions, and generalise results. The research focused on pregnant women visiting prenatal clinics at Adeoyo Maternity Teaching Hospital in Yemetu, Ibadan, and State Hospital in Oyo. The sample size, calculated using Cochran's method, was initially 196 and subsequently modified to 218 to accommodate a 10% non-response and attrition rate. Participants were proportionately allocated between the two study locations, with 131 replies from Adeoyo Maternity Teaching Hospital and 87 from State Hospital, Oyo, indicating disparities in prenatal booking data. The inclusion criteria comprised pregnant women aged 18 years and older who attended prenatal clinics at the designated hospitals and provided consent to participate. The exclusion criteria were pregnant adolescents, non-consenting pregnant women, individuals with a gestational age of 37 weeks or more, and women having a history of problematic caesarean deliveries.

A hybrid approach utilising both basic and convenience probability sampling approaches was implemented. Pregnant women visiting prenatal clinics at the two hospitals were picked based on inclusion and exclusion criteria, with respondents chosen via a simple random sampling method. The data collection utilised a standardised questionnaire segmented into four categories: demographic information, acceptability of caesarean procedures, obstacles to caesarean sections, and associated difficulties. The instrument's validity was confirmed by supervisor evaluation to verify language clarity, content validity, and relevance to the study's objectives. A pilot research with 22 pregnant women at Jericho Nursing Home was performed to determine reliability, resulting in a high overall Cronbach's alpha of 0.882, with subscale reliability scores of 0.672 for acceptance and 0.720 for hurdles.

Data collection occurred in two phases: pre- and post-intervention. The intervention involved comprehensive health education on caesarean sections, addressing their meaning, indications, benefits, and complications while dispelling myths and misconceptions. The intervention was delivered in four sessions, aiming to enhance participants' acceptance of caesarean sections through a structured teaching module. The training was interpreted into the local language to ensure comprehension. Data were analysed using IBM SPSS Version 25, with descriptive and inferential statistics applied to the pre- and post-test responses. Frequencies and percentages were used to describe socio-demographic characteristics and study objectives, while chi-square tests and paired sample t-tests were employed to examine relationships and differences in acceptance levels. Statistical significance was set at a 0.05 level. The findings provided valuable insights into the effectiveness of midwife-led education in addressing barriers to the acceptance of caesarean sections among pregnant women.

**Results**

**Table 1: Socio-demographic Characteristics of Respondents**

| Variables | Categories | Frequency (n=203) | Percent (%) |
|---|---|---|---|
| **Age** | 19-23 | 143 | 70.4 |
| | 24-28 | 37 | 18.2 |
| | 29-32 | 12 | 5.9 |
| | > 32 | 11 | 5.4 |
| **Marital status** | Married | 56 | 27.6 |
| | Single | 136 | 67.0 |
| | Divorced | 9 | 4.4 |
| | Widow | 2 | 1.0 |
| **Educational level** | Primary | 9 | 4.4 |
| | Secondary | 32 | 15.8 |
| | Tertiary | 154 | 75.9 |
| | None | 8 | 3.9 |
| **Religion** | Christian | 79 | 38.9 |
| | Islam | 99 | 48.8 |
| | Traditional | 19 | 9.4 |
| | None | 6 | 3.0 |
| **Occupation** | Civil Servant | 57 | 28.1 |
| | Trading | 60 | 29.6 |
| | Self employed | 86 | 42.4 |
| **Number of children** | None | 128 | 63.1 |
| | 1-2 | 57 | 28.1 |
| | 3-4 | 18 | 8.9 |
| **History of caesarean delivery** | Yes | 78 | 38.4 |
| | No | 119 | 58.6 |
| | I don't know | 6 | 3.0 |

The age distribution of the study participants revealed that the majority, 143 (70.4%), were aged between 19 and 23 years. In terms of marital status, 136 (67%) were single, while 56 (27.6%) were married. Regarding educational attainment, 154 (75.9%) possessed tertiary education, and 32 (15.8%) had completed high school. Concerning religious affiliation, approximately half, 99 (48.8%), identified as Muslims, while just over a third, 79 (38.9%), identified as Christians. In terms of occupation, a significant proportion, 86 (42.4%), were self-employed, with around one-third engaged in trading, 60 (29.6%), and civil service, 57 (28.1%). With respect to the number of children, the majority, 128 (63.1%), had no children, while 57 (28.1%) had 1-2 children. Only 78 (38.4%) had a prior history of caesarean delivery.

**Table 2: Pre-intervention Acceptance of C-section among the Respondents**

| Variables | Responses (n=203) | | |
|---|---|---|---|
| | Agreed f(%) | Disagreed f(%) | Undecided f(%) |
| I will be willing to accept caesarean section as a method of delivery | 129(63.5) | 64(31.5) | 10(4.9) |
| I will accept if my husband consent | 140(69) | 61(30) | 2(1) |
| I will accept caesarean section as a method of delivery if needed to save my life and that of my baby | 168(82.8) | 35(17.2) | 0(0) |
| I will accept caesarean section under any circumstances | 134(66) | 59(29.1) | 10(4.9) |

| | | | |
|---|---|---|---|
| I will accept the option of caesarean section if told the specific indication for the operation | 145(71.4) | 48(23.6) | 10(4.9) |
| Caesarean section is safer for advanced maternal age | 152(74.9) | 43(21.2) | 8(3.9) |
| My spouse decision will determine my acceptance of caesarean section | 130(64) | 65(32) | 8(3.9) |
| Acceptance of caesarean section will be a joint decision between I and my spouse | 141(69.5) | 52(25.6) | 10(4.9) |
| I can recommend caesarean section birth for my loved ones | 125(61.6) | 68(33.5) | 10(4.9) |
| I want caesarean section to be more emphasized on during antenatal clinic | 140(69) | 53(26.1) | 10(4.9) |
| I want my spouse to be informed about caesarean section ahead of time | 165(81.3) | 36(17.7) | 2(1) |

Table 2 shows the baseline acceptance of caesarean section among the respondents; majority 168(82.8%) agreed that they were willing to accept caesarean section as a method of delivery if needed to save their lives and that of the babies; majority 165(81.3%) wanted their spouse to be informed about caesarean section ahead of time; majority 152(74.9%) agreed that caesarean section is safer for advanced maternal age; majority 145(71.4%) were willing to accept the option of caesarean section if told the specific indication for the operation; majority 141(69.5%) indicated that their acceptance of caesarean section will be a joint decision between them and their spouses'; majority 140(69%) were willing to accept caesarean section if their husband consent; majority 140(69%) wanted caesarean section to be more emphasized on during antenatal clinic; two-third 134(66%) were willing to accept caesarean section under any circumstances; about two-third 130(64%) indicated that their spouse decision will determine their acceptance of caesarean section; majority 129(63.5%), were willing to accept caesarean section as a method of delivery; larger proportion 125(61.6%) can recommend caesarean section birth to their loved ones.

**Table 3: Post-interventional Acceptance of C-section among the Respondents**

| **Variables** | **Responses (n=203)** | | |
|---|---|---|---|
| | Agree f(%) | Disagree f(%) | Undecided f(%) |
| I will be willing to accept caesarean section as a method of delivery | 131(64.5) | 64(31.5) | 8(3.9) |
| I will accept if my husband consent | 149(73.4) | 50(24.6) | 4(2) |
| I will accept caesarean section as a method of delivery if needed to save my life and that of my baby | 171(84.2) | 28(13.8) | 4(2) |
| I will accept caesarean section under any circumstances | 145(71.4) | 52(25.6) | 6(3) |
| I will accept the option of caesarean section if told the specific indication for the operation | 163(80.3) | 38(18.7) | 2(1) |
| Caesarean section is safer for advanced maternal age | 157(77.3) | 42(20.7) | 4(2) |
| My spouse decision will determine my acceptance of caesarean section | 131(64.5) | 68(33.5) | 4(2) |
| Acceptance of caesarean section will be a joint decision between I and my spouse | 153(75.4) | 48(23.6) | 2(1) |
| I can recommend caesarean section birth for my loved | 137(67.5) | 52(25.6) | 14(6.9) |

| | | | |
|---|---|---|---|
| ones | | | |
| I want caesarean section to be more emphasized on during antenatal clinic | 144(70.9) | 53(26.1) | 6(3) |
| I want my spouse to be informed about caesarean section ahead of time | 167(82.3) | 34(16.7) | 2(1) |

Table 3 is on the level of acceptance of caesarean section among the respondents, following intervention; Majority 171(84.2%) will accept caesarean section as a method of delivery if needed to save their lives and that of their babies; majority 167(82.3%) wanted their spouse to be informed about caesarean section ahead of time; four out of every five 163(80.3%) will accept the option of caesarean section if told the specific indication for the operation; majority 157(77.3%) indicated that caesarean section is safer for advanced maternal age; majority 153(75.4%) indicated that acceptance of caesarean section will be a joint decision between them and their spouses; majority 149(73.4%) will accept caesarean section if their husband consent; majority 145(71.4%) were willing to accept caesarean section under any circumstances; majority 144(70.9%) wants caesarean section to be more emphasized on during antenatal clinic; majority 137(67.5%), indicated that they can recommend caesarean section birth for their loved ones; about two-third 131(64.5%) were willing to accept caesarean section as a method of delivery; larger proportion 131(64.5%) indicated that their spouse decision will determine their acceptance of caesarean section

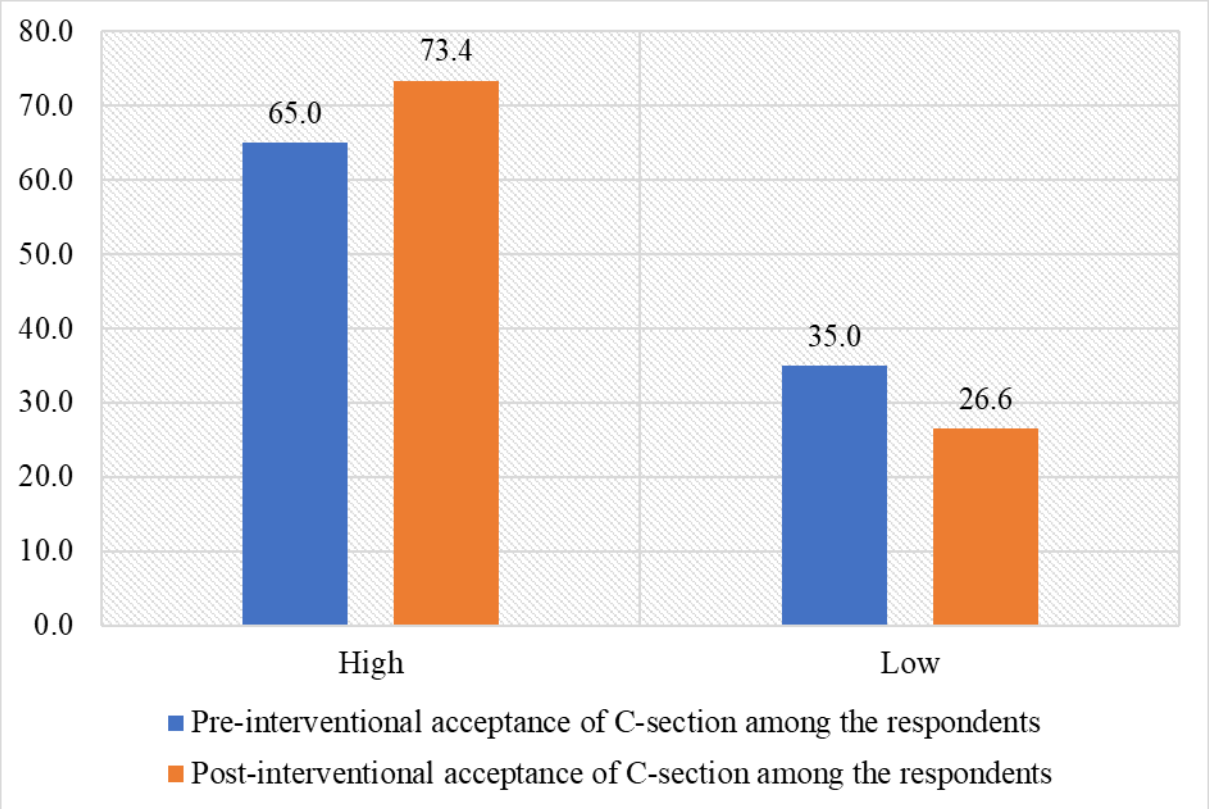

**Fig 1: Overall Pre and Post-intervention Acceptance of C-section among the Respondents**

Fig 1 is on the overall acceptance of caesarean section among the respondents, prior intervention, approximately two-third 132(65%) had high level of acceptance of caesarean section, while 71(35%) had low level of acceptance; post intervention, majority 149(73.4%) had high level of acceptance of caesarean section while 54(26.6%) had low level of acceptance of caesarean section. Participants' overall acceptance was determined based on positive responses to 11 questions on a 3-point Likert scale of Agree-3, undecided-2, disagreed-1 for positive statements and reverse coded for negative statements; participants with total scores greater than or equal to the mean baseline acceptance score (25-33), were adjudged to have high level of acceptance, otherwise, low acceptance.

**Table 4: Baseline Barriers to the Acceptance of C-section among the Respondents**

| Variables | Responses (n=203) | | |
|---|---|---|---|
| | Agree f(%) | Disagree f(%) | Undecided f(%) |
| High cost | 144(70.9) | 49(24.1) | 10(4.9) |
| Religious belief | 101(49.8) | 96(47.3) | 6(3) |
| Fear of future caesarean section | 117(57.6) | 82(40.4) | 4(2) |
| Partner or family member decision | 111(54.7) | 88(43.3) | 4(2) |
| Stigma | 102(50.2) | 97(47.8) | 4(2) |
| Long recovery time | 132(65) | 68(33.5) | 3(1.5) |
| Death of relative from caesarean section | 90(44.3) | 103(50.7) | 10(4.9) |
| Fear of death | 129(63.5) | 70(34.5) | 4(2) |

Table 4 shows the baseline barriers to the acceptance of caesarean section among the respondents; the barriers to the acceptance of caesarean section identified includes high cost 144(70.9%), long recovery time 132(65%), fear of death 129(63.5%), fear of future caesarean section 117(57.6%), partner or family member decision 111(54.7%), stigma 102(50.2%), religious belief 101(49.8%), death of relative from caesarean section 90(44.3%) and caesarean section is seen as reproductive failure 84(41.4%).

**Table 5: Post-interventional Barriers to the Acceptance of C-section among the Respondents**

| Variables | Responses (n=203) | | |
|---|---|---|---|
| | Agree f(%) | Disagree f(%) | Undecided f(%) |
| High cost | 143(70.4) | 60(29.6) | 0(0) |
| Religious belief | 81(39.9) | 116(57.1) | 6(3) |
| Fear of future caesarean section | 127(62.6) | 68(33.5) | 8(3.9) |
| Partner or family member decision | 114(56.2) | 85(41.9) | 4(2) |
| Stigma | 96(47.3) | 103(50.7) | 4(2) |
| Long recovery time | 95(46.8) | 96(47.3) | 12(5.9) |
| Death of relative from caesarean section | 103(50.7) | 94(46.3) | 6(3) |
| Fear of death | 127(62.6) | 68(33.5) | 8(3.9) |

Table 5 shows the post-intervention barriers to the acceptance of caesarean section among the respondents; the barriers to the acceptance of caesarean section identified includes high cost 143(70.4%), fear of future caesarean section 127(62.6%), fear of death 127(62.6%), partner or family member decision 114(56.2%), death of relative from caesarean section 103(50.7%), stigma 96(47.3%), long recovery time 95(46.8%), caesarean section is seen as reproductive failure 81(39.9%), and religious belief 81(39.9%).

**Hypothesis Testing**

Ho1 - Midwife-led education has no significant effect on the level of acceptance of C- section among pregnant women.

**Table 6: Effect of Midwife-led Education on the Level of Acceptance of C- section among Pregnant Women**

| Variables | Mean±SD | Mean Difference±SD | 95% CI of the Difference | | t | df | *P* |
|---|---|---|---|---|---|---|---|
| | | | Lower | Upper | | | |
| **Pre-interventional acceptance** | 25.434±4.111 | 0.483±4.245 | -0.10477 | 1.07028 | 1.620 | 202 | 0.107 |
| **Post-interventional acceptance** | 25.916±2.966 | | | | | | |

*t: t-value, df: degree of freedom, P: Probability value, *: significant at P< .050*

From Table 6, the null hypothesis was accepted, therefore, midwife-led education had no significant effect on the level of acceptance of C- section among pregnant women as there is no significant difference between the pre and post intervention level of acceptance of C-section among the respondents with (t= 1.620, *P*=.107) as *P*> .050. However, the level of acceptance of caesarean section was higher (25.916±2.966) following intervention compared to the pre-interventional level of acceptance (25.434±4.111). Although, the difference is not statistically significant as *P*> .050.

**Discussion of Findings**

The analysis revealed that previous to the intervention, over two-thirds of the respondents, 132 (65%), exhibited a high degree of acceptance of caesarean sections, whereas 71 (35%) shown a low level of acceptability. In the post-intervention phase, the majority, 149 (73.4%), exhibited a high degree of acceptance of caesarean sections, whereas 54 (26.6%) shown a poor level of acceptability. The baseline acceptance of caesarean section among the respondents revealed that a majority, 168 (82.8%), expressed willingness to accept this delivery method if necessary to safeguard their lives and those of their infants. Additionally, 165 (81.3%) preferred that their spouses be informed about caesarean sections in advance. Furthermore, 152 (74.9%) concurred that caesarean sections are safer for women of advanced maternal age, while 145 (71.4%) indicated readiness to consider the option if provided with a specific indication for the procedure. Post-intervention with midwives indicated that a significant majority of pregnant women, 171 (84.2%), would consent to a

caesarean section if necessary to preserve their lives and those of their infants. Additionally, 167 (82.3%) expressed a desire for their spouses to be informed about the caesarean section in advance. Furthermore, four out of five women, 163 (80.3%), would accept the caesarean option if provided with the specific rationale for the procedure. Lastly, 157 (77.3%) acknowledged that caesarean sections are safer for women of advanced maternal age.

The research conducted by Ntiense et al. (2018) indicated that 70.7% of pregnant women would consider delivery options, whilst 23.3% would categorically reject caesarean section under any circumstances. The study indicated that urban residency, maternal education level, and location of the most recent birth were substantially correlated with the acceptability of caesarean section. The research conducted by Anyasor and Adetuga (2017) indicated that the women's acceptability of the surgery was comparatively poor. The issues impeding acceptance include the assumption that caesarean sections are typically performed for indolent women, financial limitations, and experiences relayed by important others.

This study is analogous to that of Ezeome et al. (2018), who performed their research at a specialised health centre in Enugu. Their research indicated that 13% of pregnant women would refuse the surgery regardless of the circumstances. The majority indicated they would accept a caesarean section provided their husband consents to the operation. Younger women expressed the belief that their husbands determine the method of delivery. Joint decision-making about the way of delivery is highly desirable.

**Conclusion**

The findings reveal a significant increase in the overall acceptance of caesarean section among respondents following the intervention. Initially, while many participants indicated a willingness to accept caesarean section under life-threatening circumstances, post-intervention data showed an improved acceptance level across multiple scenarios, including joint decision-making with spouses and specific medical indications. Participants also expressed an increased willingness to recommend caesarean section to others and highlighted the importance of informing spouses and emphasising caesarean section during antenatal clinics. Despite this improvement, barriers such as high cost, fear of death, and family or partner decisions remained prevalent, though stigma and religious beliefs appeared less influential post-intervention. These findings underscore the positive impact of educational and supportive interventions on reducing misconceptions and improving the acceptance of caesarean section while highlighting the need to address persistent financial and psychosocial barriers.

**Recommendations**

Based on findings of this study, the following recommendations were made:

1. Based on the improved acceptance of caesarean section following educational interventions, healthcare providers should institutionalise routine and targeted education about caesarean section during antenatal care. This education should address common misconceptions, provide evidence-based information on the safety and necessity of the procedure, and emphasise the role of joint decision-making with spouses. Interactive sessions, such as discussions, testimonials from women who have undergone caesarean sections, and multimedia presentations, could be utilised to further demystify the procedure and normalise its acceptance.

2. To mitigate the persistent barrier of high cost, it is recommended that policymakers and healthcare institutions explore mechanisms such as subsidised fees, insurance coverage, and community-based financial support schemes. Governments and non-governmental organisations could collaborate to establish maternal health funds or grants that specifically support women requiring caesarean sections. Advocacy for the inclusion of comprehensive maternal care, including caesarean sections, in national health insurance schemes should also be prioritised to reduce financial burdens on families.
3. Addressing the fear of death and influence of family or partner decisions requires psychosocial interventions that foster supportive environments for women. Healthcare providers should implement counselling programmes for pregnant women and their families, focusing on reducing anxiety and encouraging informed decision-making. Partner-inclusive antenatal classes could further ensure that spouses are well-informed about caesarean sections, fostering their active participation in supportive decision-making. Additionally, community outreach programmes could be designed to sensitise extended family members and community leaders, addressing societal pressures that influence acceptance of the procedure.

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