ATTITUDE TOWARDS ACCEPTANCE OF CESAREAN DELIVERY AMONG MOTHERS ATTENDING ANTENATAL CARE AT PRIMARY CARE HEALTH CENTERS IN OYI LOCAL GOVERNMENT AREA, ANAMBRA STATE.

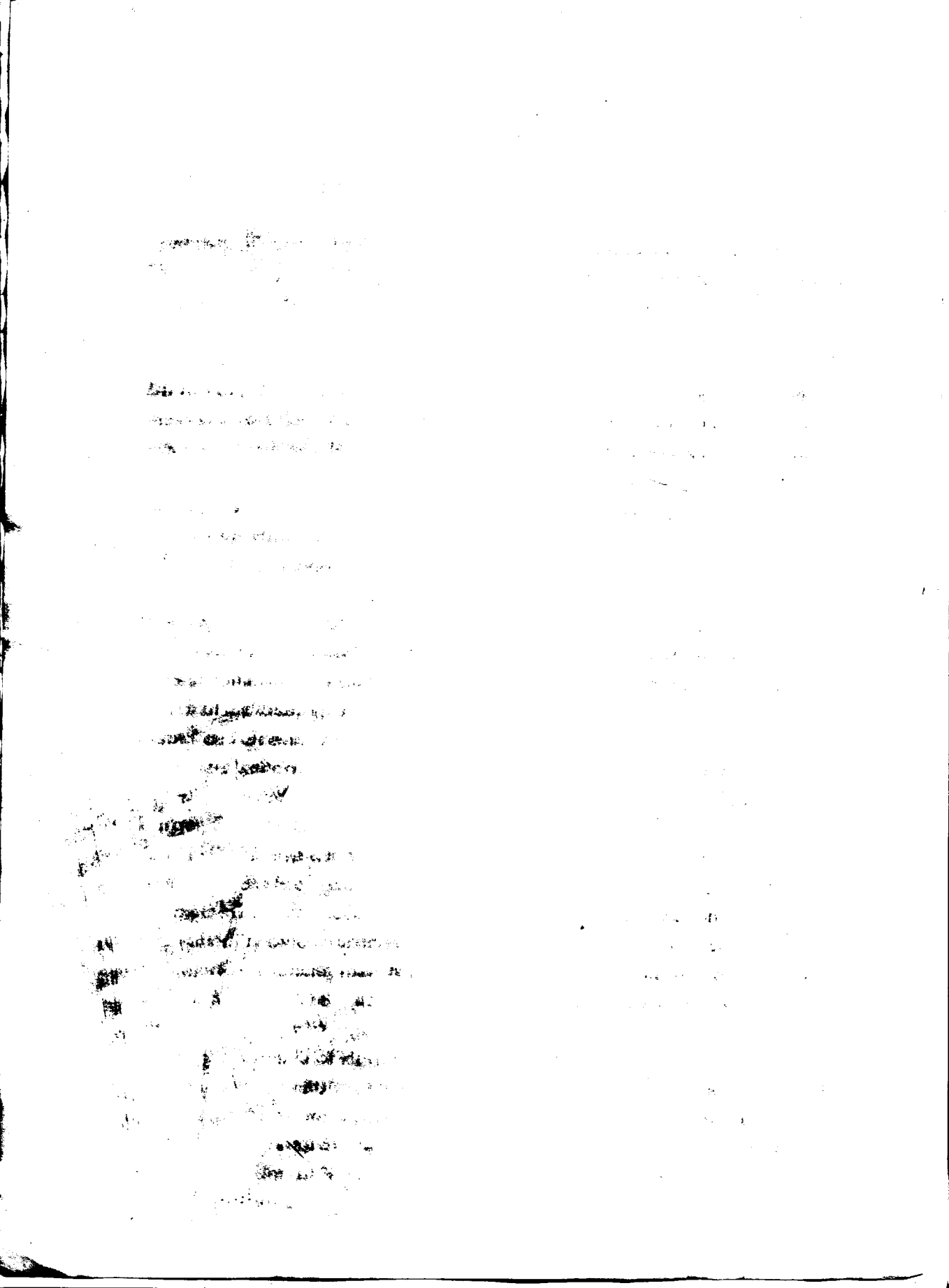
Akwuba , S. E. [1], Samuel E. S. [2], Onyekwere , O. K. [3] and Oko, I. O. [4]

Abstract

The study was conducted to determine the acceptance of cesarean section among mothers attending antenatal care at primary health care centers in Oyi Local Government Area of Anambra State. Two specific objectives were formulated with two corresponding research questions and one null-hypothesis was postulated to guide the study. The descriptive survey research design was used for the study. The sample for the study was three hundred and twenty six (326) mothers. A two-sectioned researcher designed questionnaire was the instrument used for data collection. The instrument was validated by five experts from the department of Health and Physical Education, University of Nigeria, Nsukka. Means was used to answer the research questions while ANOVA was used in testing the hypothesis at .05 level of significance. The results of the study showed that the overall attitude of mothers towards accepting cesarean section was negative. Parity had no significant influence at .05 level of significance on attitude of mothers towards accepting cesarean section. Following from the findings, recommendations were made among which is that health planners need to recognize that the objectives of safe motherhood initiative to reduce maternal mortality cannot be realized if the mothers are ignorant of cesarean section as a life saving procedure.

Key words: Acceptance, Cesarean section and Mothers.

[1,2,3,4] **Department of Health and Physical Education, University of Nigeria, Nsukka.**



Introduction

The rate of acceptability of cesarean delivery has been on the increase in the developed countries due to the current safety of the procedure while in the developing countries, the change in cesarean delivery rate has been less dramatic. While developed countries are dealing with the ethical and legal issues associated with caesarean delivery on maternal request, developing countries are still struggling with issues of refusal of caesarean delivery even in the face of obviously defined risks of maternal and perinatal morbidity and mortality. Kwawukume (2001) stated that in developed countries women often accept caesarean delivery because of their improved understanding of its role and safety, and the increasing importance of the right of self decision making regarding mode of delivery. By contrast, in developing countries women are reluctant to accept cesarean delivery, which may be as a result of many factors such as their traditional beliefs and socio-cultural norms as well as financial problems.

A cesarean section (C-delivery) is a surgical procedure in which one or more incisions are made through a mother's abdomen (laparotomy) and uterus (hysterectomy) to deliver one or more babies (Roberts, Algert & Douglas, 2002). A C-delivery is usually performed when a vaginal delivery would put the baby's or mother's life or health in jeopardy; although in recent times it has been also performed upon request for childbirths that could otherwise have been natural. According to Olsen, Ndeki and Norheim (2005) the procedure has been included in the package of comprehensive emergency obstetric care by World Health Organization (WHO). For the purpose of this study, C-delivery is defined as the surgical removal of a baby through a cut (incision) in the mother's belly and uterus used when natural delivery (vaginal delivery) is unsafe for the mother, baby or both.

Though the actual population of women who reject caesarean delivery in real-life clinical practice has not been established in the previous studies in an African setting, but many studies have reported that there is a mass rejection of cesarean section in Africa and other developing countries. For example a study conducted by Saoje, Nayse, Kasturwar and Relwani (2011) revealed among other findings that 91.5 per cent of the women in their study show preference to vaginal delivery against cesarean section when asked for their preferred mode of delivery. This could be as a result of the attitude of the mothers as well as the attitude of significant others towards cesarean section.

Attitude is a predisposition to act in a certain way towards some aspect of one's environment including other people, object and events. Attitudes as defined by Allport, (1985) are the tendencies to evaluate an entity

with some degree of favour or disfavour ordinarily expressed in cognitive, affective, and behavioral responses and formed on the bases of cognitive, affective and behavioral process. It can be positive or negative and can affect the behaviour of an individual. When attitude relates to cesarean section, it is called attitude to cesarean section. Attitude to cesarean section in the context of this study is the feelings which predispose pregnant mothers to respond either positively or negatively towards C-delivery. This study sought to find out the attitude of the pregnant mothers towards accepting or rejecting C-delivery.

A mother as defined by Brocklehurst and Volmink (2003) is a female person who is pregnant with, or gives birth, to a child. A pregnant mother is a woman carrying one or more foetuses, in the womb. For the purpose of this study, a mother is a female person who is pregnant, or has had previous pregnancies. Pregnancy being one of the most important periods in the life of a woman, a family and a society, necessitates that an extra care be given to the pregnant mother.

Ideally, C-delivery should not replace the normal birth method-vaginal delivery. If a woman is pregnant, there are chances that she will be able to deliver through the birth canal (vaginal birth). But there are cases when a C-delivery is needed for the safety of the mother or baby. When possibility of normal delivery is remote and threatens the life of the mother, child or both, an alternative means must be employed. C-deliveries are performed as a result of obstetric complications which may develop anytime during the pregnancy. These complications as noted by Finger (2003) are breech presentation, dystocia, fetal distress, cord prolapsed, placenta previa, placental abruption, failure to progress in labour, uterine rupture, multiple births, cephalopelvic disproportion, active genital herpes, diabetes preeclampsia, birth defects and repeat cesarean section. The majority of C-deliveries are performed because of some difficulty arising during the labor and delivery process. One may be pushing with all her might, but baby still refuses to make his or her way down the birth canal. In cases like these, a C-delivery is often recommended. However, Onah (2002) submitted that Nigerians appear to view childbirth as a natural, at times, lengthy phenomenon and as such it is not unusual to avoid analgesia and medical intervention, such as C-delivery. This perception may be a contributing factor to maternal and fetal mortality in Nigeria and other African coutries. Okonufua (2011) affirmed that the negative view and perception of C-delivery by women in the developing countries has led to gross underutilization of the procedure compared to the large burden of obstetric morbidity requiring resolution by C-delivery.

When a mother dies, children lose their primary caregivers, communities are denied her paid and unpaid labour, and countries forego her contribution to economic and social

development. A woman's death is more than a personal tragedy. It represents an enormous cost to her nation, her community, and her family. Any social and economic investment that has been made in her life is lost. Her family loses her love, her nurturing, and her productivity inside and outside the home. Thus, it is very necessary that women possess a positive attitude towards this life saving procedure (C-delivery), which will go a long way in reducing the number of lives that is lost as a result of pregnancy. Some demographic factors have been found to influence the mother's attitude towards cesarean section.

Objectives of the study

The purpose of this study was to determine the attitude towards acceptance cesarean section among mothers attending antenatal care at primary health care centers in Oyi. L. G A. Anambra State. Specifically, the study determined the attitude of mothers;

1. towards accepting cesarean section,
2. towards accepting cesarean section according to parity;

Research Questions

These research questions were posed to guide the study.

1. What is the attitude of mothers towards accepting cesarean section?
2. What is the attitude of mothers towards accepting cesarean section according to parity?

Hypothesis

One null hypothesis was postulated and tested at .05 level of significance.

1. There is no significant difference in the attitude of the mothers towards cesarean section according to parity.

Methods

The research design adopted for this study was the cross-sectional research design which provides a snapshot of a situation in a population, and the characteristics associated with it at a specific point in time (Levin, 2006). The population for the study consisted of 3256 mothers attending antenatal clinics at the primary health care centres in Oyi local government of Anambra State. The sample consisted of 326 mothers selected through random sampling technique. The instrument for data collection was a structured questionnaire on attitude of mothers towards accepting cesarean section (AMTACDQ). It had two sections. Section "A" contained the bio-data of the respondents while section "B" contained five item arranged in four point scale aimed at determining the acceptance of cesarean section by pregnant mothers. The test-retest method was used to establish the reliability of the instrument and it had a reliability of .78correlation co-efficient. Mean was used to answer the research questions while analysis of variance (ANOVA) was

used to test the only hypothesis at .05 level of significance at the appropriate degree of freedom at appropriate degree of freedom.

Results

Table 1 **Mean Ratings of the Attitudes of the Women towards Accepting Cesarean Section (N = 325)**

Item	$\overline{X}$	SD	DECISION
1. Cesarean section is acceptable to me provided that decision concerning mode of delivery is taken without considering the views and advice of significant other (parents, husbands, religious leaders, in-laws and friends).	1.44	0.813	negative
2. Cesarean section is a necessary option to save the lives of the mother and baby when pregnancy poses a great to their lives and should be accepted whenever it is indicated.	2.67	1.082	positive
3. Cesarean section is unacceptable to me because it is expensive	3.15	0.896	positive
4. Cesarean section should not be accepted by anyone because God's promise to his children is safe natural/vaginal delivery.	2.60	1.039	positive
5. Cesarean section is acceptable to me because it makes me not to experience the pains of nature child birth.	1.14	0.424	negative
Grand Mean	**2.20**	**0.8508**	**negative**

Data Table 1 indicated that the women had a grand mean score of $\overline{X} = 2.20$ which is below the criterion mean of ($\overline{X} = 2.50$). This implies that the women had a negative attitude towards accepting cesarean section. The Table further reveals that the women had mean scores above the criterion mean of 2.50 in the individual items "Cesarean section is a necessary option to save the lives of the mother and baby when pregnancy poses a great threat to their lives and should be accepted" whenever it is indicted ($\overline{X} = 2.67$), "Cesarean section is unacceptable to me because it is expensive" ($\overline{X} = 3.15$) and "Cesarean section should not be accepted by anyone because God's promise to His children is safe natural/vaginal delivery" ($\overline{X} = 2.60$). This implies that the women had positive attitude towards the items. The Table further indicates that he women had mean scores less than the criterion mean of 2.50 in items "Cesarean section is acceptable to me provided that the decision concerning mode of delivery is taken without considering the views and advice of significant others (parents, husbands, religious leaders, in-laws and friends)" ($\overline{X} = 1.44$) and "Cesarean section is acceptable to me

because it makes me not to experience the pains of natural child birth" (1. 14). This implies that the women had negative attitude towards the items.

Table 2: **Mean Ratings of the Attitude of Women towards Accepting Cesarean Section According to Parity (N = 325)**

Items	None (N=46) $\overline{X}$	1 (N=63) $\overline{X}$	1-2 (N=134) $\overline{X}$	more than 3 (N=82) $\overline{X}$
6. Cesarean section is acceptable to me provided that the decision concerning of delivery is taken without the views and advice of significant others (parents, husband, religious leader, in-lows friends).	1.37	1.29	1.55	1.40
7. Cesarean section is a necessary option to save the life of the mother and baby when pregnancy poses a threat to their lives and should be accepted whenever it is indicated.	2.76	2.73	2.84	2.30
8. Cesarean section is unacceptable to me because it is expensive	2.96	1.17	3.11	3.32
9. Cesarean section should not be accepted by anyone because God's promise to his people is safe natural/vaginal delivery.	2.54	2.43	2.57	2.82
10. Cesarean section is acceptable to me because it makes me not to experience the pains of natural child birth.	1.17	1.11	1.19	1.07
Grade Mean	**2.16**	**1.15**	**2.25**	**2.18**

Data in Table 2 above indicated that women of different parity status in the study demonstrated negative attitude towards accepting cesarean. The Table also revealed that regarding item cesarean section is acceptable to me provided that the decision concerning mode of delivery is taken without the views and advice of significant others (parents, husband religious leader, in-laws friends), mothers who have had 2-3 previous deliveries had a mean score $\overline{X} = 1.40$ followed by mothers with no previous deliveries $\overline{X} = 1.37$ than mothers who have had 1 previous delivery $\overline{X} = 1.29$. Table 2 also revealed that regarding item "cesarean section in a necessary option to save the life of the mother and baby when pregnancy poses a threat to

their lives and should be accepted whenever it is indicated", mothers who have had 2-3 previous deliveries had a mean score $\overline{X}$ = 2.84 higher than those who had no previous delivery $\overline{X}$ = 2.76, higher than those who had 1 previous delivery $\overline{X}$ = 2.73, than those who had more than 3 previous deliveries $\overline{X}$ = 2.30. Regarding item on cesarean section is unacceptable to me because it is expensive, the Table revealed that mothers who have had more than 3 previous deliveries had a higher mean score = 3.32 than those who have had one previous deliveries $\overline{X}$ = 3.17. Furthermore, mothers who had 2-3 previous deliveries had higher mean score $\overline{X}$ = 3.11 than mothers who had no previous deliveries $\overline{X}$ = 2.96 though all of them demonstrated appositive attitude towards the item. Furthermore, the Table also revealed that regarding item "cesarean section should not be accepted by anyone because God's promise to his people is safe natural/vaginal delivery" all the mothers of different parity status demonstrated positive attitude except those who had one previous delivery. Mothers who had more than three previous deliveries had a mean score $\overline{X}$ = 2.82 higher than those who had 2-3 children $\overline{X}$ = 2.57 and those who had no previous delivery $\overline{X}$ = 2.54. Finally, the study revealed that all the mothers demonstrated a negative attitude towards item "Cesarean section is acceptable to me because it makes me not to experience the pains of natural child birth". Mothers who had 2-3 previous deliveries had a mean score $\overline{X}$ = 1.19 higher than those who had no previous deliveries $\overline{X}$ = 1.17, those who had one previous delivery $\overline{X}$ = 1.11 and those who had more than three previous deliveries.

Table 3: Summary of ANOVA Analysis testing the Null Hypothesis of No Significant Difference in the attitude of women towards cesarean section according to parity.

	Sum of Squares	df	Mean Square	F	P-value
Between groups	4.257	3	1.419	.558	.643
Within groups	815.694	321	2.541		
Total	819.951	324			

Table 3 shows the calculated F-vale of .558 with a corresponding p-vale of .643, which was greater than .05 level of significance at 324 degrees of freedom. The null hypothesis

of no significant difference in the attitude of mothers towards accepting cesarean delivery according to parity is therefore accepted. This means that the attitude of mothers of different parity status towards accepting cesarean section is the same.

Discussion

The finding of the study in Table 1 shows that the overall attitude of mothers towards accepting cesarean section was negative. These findings were expected and therefore not surprising because it was in agreement with the findings of Sunday-Adeoye and Kalu (2011) who reported that only 4 (1.4%) of their respondents per cent viewed cesarean section as good and would readily accept it whenever it is indicated while 81 will reluctantly accept the procedure if their life or that of their fetus is in great danger. It also agrees with the findings of Ezechi, Fasubaa, Kalu, Nwokoro and Obiesie (2004) who reported that 71.1 per cent will not accept caesarean delivery for any reason. About 26.8 per cent of the patients that have had previous caesarean section preferred to die while attempting vaginal delivery than to have a repeat caesarean section.

Results in Table 2 revealed that mothers of different parity status in the study demonstrated negative attitude towards accepting cesarean section. The Table further shows that mothers that have had more 3 pregnancies and those in their 2nd pregnancy had a positive attitude towards those that undergo cesarean section while women with no previous delivery and those who have had 2-3 previous pregnancies had negative attitude towards them. This finding is surprising and not expected because it disagrees with that of Luthy, Malmgre, Zingheim and Leininger (2003) which stated that nulliparity (first pregnancy) has been identified as a factor that influences acceptance of C-delivery while multiparity (more than one pregnancy) influences non acceptance of C-delivery. All the mothers of different parity status had positive attitude towards the medical staff that execute cesarean section.

The finding in Table 3 Shows that there was no significant different in the attitude of the mothers towards cesarean section according to parity. This agreement could be attributed to similarity in the composition of the respondents as well as their geographical and culture background. However, it disagrees with the finding of Buyukbarrak and Luffi (2010) which reported that parity was found to be one of the influencing factors for maternal preference for mode of delivery.

Conclusions

The findings affirm previous result that a significant number of mother have unfavourable attitude towards accepting cesarean section and parity had little or no

effect on their attitude towards cesarean section.

Recommendation

The following recommendation was made

1. Health planners need to recognize that the objective of the Safe Motherhood Initiative to reduce maternal mortality cannot be realized if the mothers are ignorant of the necessity of cesarean section as a life saving procedure.

References

Allport, G. W. (1985). *Introduction to social psychology.* New York: McGraw Hill.

Awoyinka, B. S., Ayinde, .O. A., & Omighodun., A. O. (2006). Acceptability of cesarean delivery to antenatal patients in a tertiary health facility in South-West Nigeria. *Obstetric Gynecology, 26,208-10.*

Aziken, M., Omo-Aghoja, L., & Okonofua., F. (2007). Perceptions and attitudes of pregnant women towards caesarean section in urban Nigeria. *Acta Obstetricia et Gynecological Scandinavica, 86*, 42-47.

Basavanthappa, B. T. (2008). *Community health nursing.* New Delhi: Japec Brothers Medical Publishers Ltd.

Behaque, D. P. (2002). Beyond the simple economics of Caesarean section Birthing: Women resistance to social inequality. *Culture, Medicine and Psychiatry,* 26, 473-507.

Breckler, S. J., & Wiggins, E. C. (1992). *On defining attitude and attitude theory: Once more with feeling.* In Pratkanis, A. R., Breckler, S. J. & Greenwald, A. C. (Eds.), *Attitude structure and function.* Hillsdale, NJ: Erlbaum. Pp. 407-427.

Brocklehurst, T. & Volmink, B. Y. (2003). Antiretrovirals for reducing the risk of mother-to-child transmission of HIV infection (Cochrane Review). *The Cochrane Library,* 34, 8-12.

Chigbu, C, O. & Iloabachie, G C. (2007). The burden of cesarean section refusal in developing country setting. US National Library of Medicine National Institutes of Health. *British Journal of Obstetrics & Gynaecology, 14*(10), 1261-1511.

Dumont, A., De-Bernis L., Bouvier-Colle, M. H., Breart, G., & Moma, L. (2001). Caesarean section rate for maternal indication in sub-Saharan Africa: a systematic review. *Lancet, 16* (12), 1328-1333.

Ezechi, O. C., Fasuba, O. B., Kalu, B. E., Nwokoro, C. A., & Obiesie, L. O. (2004). Cesarean section: why the aversion. *Tropical Journal of Obstetrics and Gynecology* (21), 164-176.

Finger, C. (2003). Caesarean section rates skyrocket in Brazil. *Lancet, 362* (84), 628-634.

Gonen, R., Tamir, A. & Degani, S. (2002). Obstetricians' opinions regarding patient choice in cesarean delivery, *American journal of Obstetrics & Gynecology*; (99), 77-80.

Hellums, E. K., Lin, M. G, & Ramsey, P. S. (2007). Prophylactic subcutaneous drainage for prevention of wound complications after cesarean delivery—a Meta analysis. *American Journal of Obstetrics Gynecology, 6* (197), 229-35.

Kwawekume, E. Y. (2001). Cesarean section in developing countries. *Best Pract Res Clin Obstet Gynaecol , 15*, 165-178.

Luthy, D. A., Malmgren, J. A., Zingheim, R. W. & Leininger, C. J. (2003). Physician contribution to a cesarean delivery risk model. *American Journal of Obstetrics and Gynaecology*; *188*(6), 1579-87.

Okonufua, F. (2001). Optimizing Caesarean section rates in West Africa. *Lancet,* (358), 128-135.

Olusanya, B. O. & Solanke, O. A. (2009). Adverse neonatal outcomes associated with previous cesarean section in an inner-city maternity hospital in Lagos, Nigeria. *International Journal of Gynecology and Obstetric*, *21*(12), 65-67.

Olsen, O. E., Ndeki, S., & Norheim, O. F. (2005). Human resources for emergency obstetric care in northern Tanzania: distribution of quantity or quality? *Lancet,* (27),14-21.

Onah, H. E., (2002). Formal education does not improve the acceptance of cesarean section among pregnant Nigerian women. *International Journal of Gynaecology and Obstetrics, 76*(3), 321–336.

Orji, E. O., Ogunniyi, S. O. & Onwudiegwu, U. (2003). Beliefs and perception of pregnant women at Ilesa about cesarean section. *Tropical Journal of Obstetrics and Gynaecology, 20* (2), 141–164.

Park, K., (2009). *Preventive and social medicine (20th Ed).* India: banarsidas bhanot publishers.

Pieter, W. J. & Dongen, V. (2009). Caesarean section: etymology and early history. *African Journal of Obstetrics and Gynecology, 23*(12), 25-31.

Risse, G.B. (1990). *Mending bodies, saving souls: a history of hospitals*. Oxford: Oxford University Press.

Roberts, C. L., Algert, C. S., & Douglas, I. (2002). Trends in labour and birth interventions among low-risk women in New South Wales. *Australian and New Zealand Journal of Obstetrics and Gynaecology, 42* (2), 176-81.

Ronsmans, C. & Graham, W. J., (2006). Maternal mortality: who, when, where, and why. *Lancet*, (368), 1189-1200.

Saoji, A. 1., Nayse, K. N., & Relwani, N. (2011). *Women's knowledge, perceptions, and potential demand towards caesarean section.* Department of Science and Human Resource Development, University of Rajshahi, Bangladesh.

Sunday-Adeoye, I. & Kalu, C. A. (2007). Pregnant Nigerian women's view of cesarean section. *Nigeria Journal of Clinical Practice* (14), 276-291.

World Health Organization (2006). Pregnancy, childbirth, postpartum and newborn care: A guide for essential practice: Geneva.

Ximena, A., & Ibañez, H. (2008). Evidence Regarding Maternal Mortality: Brazil, Nigeria and India. *Centere for reproductive health.* United Kingdom Parliament, Westminster, London.