

Women's involvement in decision-making before caesarean section and its influence on their satisfaction with procedure in a tertiary health institution Edo State - Nigeria

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Abstract

Caesarean section (CS) could cause considerable physical, psychological, financial and emotional stress. Hence, patients' involvement in the decision to have a CS and satisfaction with the procedure are important in the care of women requiring CS. The aim of this study was to assess women's involvement in decision-making before CS and its influence on their satisfaction with the procedure. The study was carried out in tertiary health institution, Edo State, Nigeria among women who have had CS. The objectives of the study were to determine if women are involved in the decision making for CS, identify the factors affecting women's decision and assess the satisfaction of women with the procedure of CS. A descriptive cross-sectional study was utilized. A convenience sample of 215 respondents was studied. The data were collected with the use of a semi structured questionnaire. Data were analyzed with Scientific Package for Scientific Solution (SPSS). Chi-square was used to test the hypothesis on the association between involvement in decision-making and satisfaction with CS. The result of the study showed that 56.3% of respondents were in the age group of 21-30 years. Over 88% of the respondents were told that they were going to have a CS while 84.2% consented to the procedure. Only 36.2% directly signed the consent forms. There was a statistically significant association between involvement in decision-making and satisfaction with CS ($p = 0.000$). It was concluded that health care providers should continue to provide adequate information on CS to women who have indication for it so as to enhance their involvement in the decision-making process.

Keywords: Caesarean section, Decision-making, Tertiary health institution, Women involvement,

1. Introduction

1.1. Background

The delivery of the fetus, placenta and other products of conception via an anterior abdominal wall incision is a major abdominal surgery, and the associated morbidity and mortality rates are greater than that of women who undergo vaginal delivery (Izbizky, 2008). Delivery by Caesarean section (CS) occurs in 10 - 25% of births (Caughey *et al.*, 2014, Berghella, 2015). Although CS rates have increased over the last 10 to 15 years, but the main clinical determinant of CS has not changed. The leading determinant is foetal compromise with 22%, failure to progress in labour 20%, multiple CS 14% and breech presentation with 11%. Like every other major surgery, caesarean section has considerable physical, psychological, financial and emotional stress. Hence, patient's satisfaction is the single most important criterion that needs to be addressed, irrespective of the nature of practice (Merkouris, 2004; Chang, 2005; Jagannathan, 2008). Patient's satisfaction is a useful indicator to the quality of health care services. However, there is no universally acceptable tool for measuring it. Women who have undergone CS usually have less satisfying experience probably due to natural stigmatization associated with it compared to women who had vaginal delivery.

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In this environment, most women who undergo caesarean birth, experience a feeling of resentment towards the physicians, profound disappointment at treatment expectation, and the loss of the happy moment of natural birth (Chu, 2012; Harrison and Goldenberg, 2016).

Sunday-Adeoye and Kalu (2011) reported that, the magnitude of impact of caesarean delivery on the woman varies enormously, and a number of variables are responsible for these variation observed. These variables could include a combination of the professional skills of the attending doctor, and ego strength. Other such contributory variables include; health care provider communication with patients, the empathy shown to her problem, the amount of time spent with them, the way their problems are handled personally rather than delegating the duty to juniors, and the way the relatives are handled. Satisfaction with care is a composite and subjective concept with still undefined boundaries and multiple interacting variables, according to which patients' satisfaction with nursing care is the degree of convergence between the expectations patients have of ideal care and their perception of the care they really get (Merkouris, 2004).

An elective CS with no emergency increases the maternal mortality with 2.84-fold, compared to vaginal delivery. Since a randomized controlled trial is not ethically possible, the UK data on 153,929 elective procedures have shown powerful enough evidence of the increased risk of maternal mortality with women's choice elective CS.

Due to the physiological and psychological changes associated with pregnancy and childbirth, the transition to motherhood constitutes a developmental crisis (Volling, 2012). Currently, policies on the provision of maternity care reflect the increasing importance attached to women's views and to women being at the centre of decisions about their intrapartum care (Scottish Office Home and Health Department, 2010). These mothers may have to cope with the physical and psychological impact of labour and sometimes of anaesthesia and major abdominal surgery, which may have occurred after a long and exhausting labour. Some women who undergo caesarean birth experience feelings of profound disappointment at the unfulfilled expectation and sometimes of failure and guilt (Hedhal, 2008). It is also well established that women's lack of involvement in making decisions concerning Caesarean birth is associated with litigations (Keedle, 2005; Muula, 2007).

Caesarean section is a major abdominal surgery and like any other major surgery, has considerable physical, psychological, financial and emotional stress. Patient's satisfaction was found to be the most important criterion that needs to be addressed irrespective of the nature of practice (Merkouris, Ppathanassoglou, and Lemonidou, 2004; Chang and Chang, 2005; Jagannathan and Tilak, 2008). It is known that women who feel in control of events during vaginal delivery are more satisfied and have greater emotional well-being post-natally (Green and Baston, 2003; Nilson *et al.*, 2013). Therefore the challenge to healthcare providers is to be responsive to the varying degrees to which any individual woman wants to be involved in making decisions regarding delivery.

There is need for pregnant women to be provided with evidence-based information so they can take part in discussions with their caregivers regarding mode of delivery and associated risks (Hildingsson, *et al.*, 2002). The researchers observed during the community midwifery posting had encountered an overdue pregnant woman with no signs of labour. She was advised to go for an ultrasound scan. The result showed that the baby had an abnormal lie. Caesarean section being the available and safest option for her well-being and that of her fetus was suggested. After much explanation and counseling to undergo the CS, she disapproved of it, and this led to the loss of her child. There is a dearth of empirical studies on the participation of women in decision making before caesarean section in Edo State, Nigeria. This study therefore aimed to assess women's involvement in decision-making before CS and its influence on their satisfaction with the procedure at tertiary hospital in Edo State - Nigeria. The study objectives are to determine if women are involved in the decision making for caesarean section, identify the factors affecting women's decision to have a caesarean section and to assess the satisfaction of women with the procedure of Caesarian section.

2. Methods and Materials

2.1. Study design

A descriptive cross-sectional study was utilized for this study. This design was chosen as the researcher assessed the study population at one point in time without trying to make inferences or casual statement (Araoye, 2004). This was considered appropriate for the study as a cross-section of women were easily gotten at the post natal clinic visits.

2.2. Study population

The study population consisted of women who have had caesarean section in the past one to three months at the time of the study, irrespective of the indication or whether it was an emergency or an elective caesarean section. One month after surgery was chosen in order to minimize recall bias. The research was carried out in the post natal clinics which usually hold on Tuesdays, Wednesdays and Thursdays every week subject to patients' consultant clinic days. The weekly average attendance of post natal women according to unit register was 100 out of which 20 are C/S cases.

2.3. Sample technique

Since the institution has a record of all women who delivered in the facility, a convenience sampling technique was utilized for the study. The investigator obtained a list of all women who have had caesarean section in the past three months, and administered questionnaires to those who were willing to participate in the study until the minimum sample size was completed.

2.4. Instrument for data collection

The data was collected with the use of a semi structured questionnaire adopted from previous study (Graham, 1999). The questionnaire was given by hand to the women at 4 to 12 weeks post-partum (i.e. at least after 4 weeks and not later than 12 weeks post-partum). This was to ensure that the women have recuperated from the physiological, psychological and emotional changes of pregnancy, so as not to significantly impact on their response. The questionnaire was composed of four sections. Section A focused on the socio-demographic characteristics of the respondents including age, sex, parity, religion, marital status, level of education and occupation. Section B focused on women's involvement in decisions regarding having caesarean section. The women's involvement was assessed by the degree of information received regarding the procedure and the indications for the procedure. This section sought to determine how much the respondents knew about caesarean section before the procedure. Section C sought to elicit the reasons for the decision to have a caesarean section and Section D assessed the women's satisfaction with the level of their involvement in the decision regarding caesarean section. Each question was presented as "satisfied", poorly satisfied, and "not satisfied".

2.5. Reliability and validity

Face and content validity was carried out by giving the questionnaire to experts in maternal and child health nurses who made criticisms and necessary corrections before the copies of the questionnaire were administered to participants. For reliability of the instrument, a pre-test study of the instrument was conducted using 10% of the sample size among women who had caesarean section in the maternity centre of University of Benin Teaching Hospital Benin City, Nigeria and corrections were effected before the commencement of the study. Data obtained was subjected to test-retest analysis and a Cronbach's Alpha value of 0.785 was obtained. The coefficient being greater than 0.7 means that the instrument was reliable

2.6. Method of data collection

First, there was recruitment and training of two research assistants on the purpose and nature of the study. The researchers proceeded to administer the questionnaire by hand only to respondents who were willing to participate in the study during the participants post natal clinics. A combination of self-administered and interviewer administered technique were used. Illiterate participants were assisted to complete the questionnaire by reading and explaining the questions to them in Pidgin English.

2.7. Data analysis

The data collected was entered into a spread sheet and analyzed using the Statistical Package for Scientific Solutions (SPSS) version 20. Frequencies and percentages were derived from the categorical variables while mean and standard deviation were derived from the numerical variables. All p-values were considered statistically significant if $p < 0.05$.

2.8. Ethical consideration

The study was reviewed and approved by the Ethics and Research Committee of Irrua Specialist Teaching Hospital, Edo State - Nigeria. Written informed consent was obtained from the participants before the administration of the questionnaire. No form of inducement was used to gain their consent and confidentiality was maintained as names were omitted from the questionnaires and replaced with codes, should there be need for tracing.

The informed consent page was read out clearly and in simple English for participants that were unable to read. Consent was then obtained and the questionnaire administered to the voluntary participants.

3. Result

Table 1: Socio-demographic characteristics of the respondents n=215

Variable	Frequency	Percentage
Age (years)		
- 21-30	121	56.3
- 31-40	61	28.4
- 41-50	15	7.0
- >50	18	8.3
Religion		
- Christian	169	78.6
- Islam	36	16.7
- African tradition	10	4.6
Level of education		
- No-Formal-Education	15	7.0
- Secondary	65	30.2
- Tertiary	135	62.8
Occupation		
- Farmer	15	7.0
- Artisan/Self Employed	49	22.0
- Civil Servant	90	42.0
- Trader	42	19.5
- Others	19	8.8
How many times have you delivered (Parity)		
- Once	79	36.7
- Twice	63	29.3
- Thrice	41	19.1
- Four time	32	14.9
How many times have you done Caesarean Section		
- Once	127	59.1
- Two or more times	88	40.9
What type was the last Caesarean Section		
- Emergency	93	43.4
- Elective/ Planned	122	56.7

3.1. Table 1 showed that 56.3% of respondents were in the age group of 21-30 years while those in age group of 31-40 years were 28.4%. Majority of the respondents 78.6% were Christians while Muslims were 16.7% of the study participants. The respondents with tertiary level of education constituted 62.8%. The civil servants made up 42.0% of the respondents, followed by artisan/self-employed 22.0% and traders 19.5%.

Table 2: Involvement of women in the decision to have a caesarean section n = 215

INVOLVEMENT	Frequency	Percent
Were you duly informed you were going to have a CS before the operation?		
- Yes	190	88.4
Were you told the indication (reason) for the CS?		
- Yes	193	89.8
Were you told you had a right to refuse the procedure?		
- Yes	180	83.7
Did you consent to the procedure?		
- Yes	181	84.2
Was there a signed written consent before the procedure?		

- Yes	181	84.2
If yes, who signed the consent?		
- Me	78	36.3
- My Husband	89	41.4
- My Relative	15	7.0
- My Pastor	0	0.0
- The Doctor	5	2.3
If yes, how much did the discussion help you to understand the risk involved? **		
- A Lot	89	41.4
- A Little	78	36.3
- Not At All	23	10.7
Did you think you really needed the operation?		
- Yes	183	85.1
Overall, how would you describe your contribution in the decision to have the CS		
- It was wholly my decision	50	23.3
- I became convinced after my doctor discussed with me	108	50.2
- It was wholly the recommendation of my doctor	31	14.4
- I wasn't convinced, but I had to agree	26	12.1

** indicate there were missing values that added up with frequency numbers

3.2. Table 2 indicated that the women were fully involved in decision making about the caesarean section with 190 (88.4%) that said yes. Almost all 176(81.9%) of the respondents affirmed yes that were well informed by the doctors about the risk involved in the caesarean section. Finally, many 50.2% of the women were fully convinced by the doctors, knowing the risks, and registered their consent in the involvement of making decision to have a caesarean section.

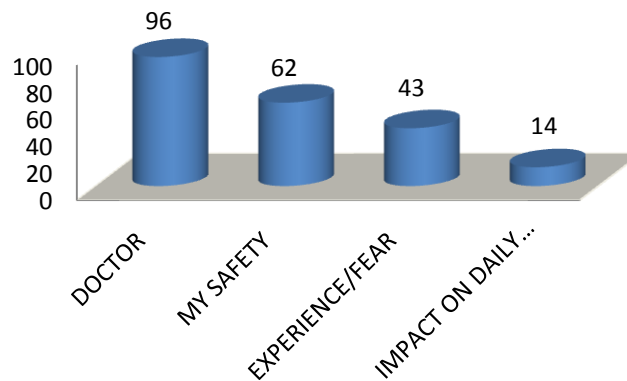


Figure 1: Factors affecting women's decision to have caesarean section

3.3. The information received from the administered questionnaire, showed that there were external factors affecting women's decision to have caesarean section. It was observed that doctors contribute the highest in the women's decision to have caesarean section with 96(44.7%), and 62(28.8%) of the women had caesarean section for safety reasons, while 43(20.0%) had experience fear and 14(6.5%) admitted that it was because of the impact the caesarean section has on their sex life.

Table 3: Respondent’s Satisfaction with Caesarean Section

Variables	Yes	A little	Not at all	Mean	S.D
Were you satisfied with the information received regarding the caesarean section	153	42	20	1.38	0.651
Were you satisfied with the quality of your involvement in the decision making	156	50	20	1.32	0.549
Were you satisfied with the quality of care you received before the operation	182	21	12	1.35	2.229
Do you think the doctor made you comfortable as much as possible during the operation	176	37	2	1.19	0.417
Were you satisfied with the number of people around you in the theatre	118	68	29	1.59	0.717
Were you satisfied with the duration/speed of the operation	154	44	17	1.36	0.625
Were you satisfied with the quality of care you received after the operation	154	49	12	1.34	0.581
Were you satisfied with the speed of your recovery?	131	64	20	1.48	0.662
Should you be pregnant again, would you prefer CS to Vaginal delivery?	81	10	33	1.78	0.695
Would you advise a close relative or friend to choose a CS rather than Vaginal delivery?	68	83	64	1.98	0.785

3.4. Table 3 displayed the respondents’ satisfaction with caesarean section, the overall results from the table clearly showed that the women were well informed, were fully involved in the decision making, satisfied with the care received before and after the operations, they were comfortable, they also enjoy the relationship of friend and family around them during the process. Their satisfaction was the speed recovery after the operation, and many of them would prefer the caesarean section again and recommended it for family and friends just because of their satisfaction.

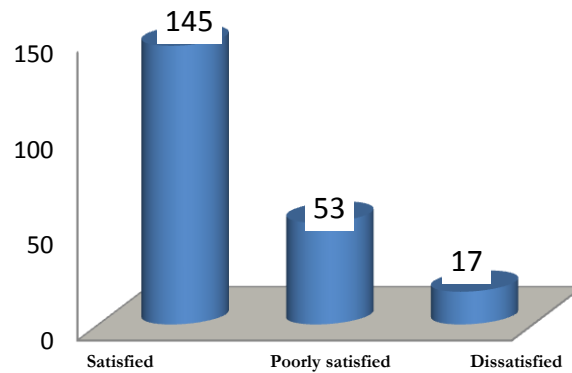


Figure 2: Respondent’s satisfaction with caesarean section

3.5. From the total number of 215 respondents, it was observed that the majority of the respondents were very satisfied with caesarean section 145(67.4%), and 53(24.7%) were poorly satisfied, while only a very few 17(7.9%) were dissatisfied with caesarean section.

Table 4: Testing of association between the women’s involvement decision in caesarean section and their satisfaction with the procedure.

Variables	Satisfaction of Respondents (n=215)			Total	X ²	p-value
	Satisfied	Poorly satisfied	Dissatisfied			
Women’s Involvement						
- Very much Involved	75	85	15	175	56.098	.000
- Partially Involved	5	7	10	22		
- Not involved	6	9	3	18		
Total	81	101	33	215		

3.6. Table 4 showed the measure of association between the women’s involvement in the caesarean section and their satisfaction with it. The test statistics table showed that the chi-square statistics was considered to be statistically significant (P=.000). This meant that there was a significant association between women’s involvement in the decision-making for caesarean section and their satisfaction with the procedure.

4. Discussion

The results of this study indicated high levels of women's contribution to the decision-making process for caesarean section. The involvement included being told the indication for the procedure and giving consent for it. Adageba *et al.*, (2008) found that almost all patients were desirous of pre-operative information on indications for CS. In a study done by Aziken, Omo-Aghoja and Okonofua, (2007) revealed that in UBTH, Benin City, Nigeria up to 81% of the respondents expressed their readiness to accept a CS if they knew the indication was a threat to their lives or that of their yet-to-be-born children. The responses in this study showed that majority of the women studied were aware of a consent form administered to them either signed by themselves or their husbands in most cases. These findings implied that there were ethical considerations adopted by the caregivers prior to commencement of CS for the women. By signing informed consent forms, patients authorize medical interventions. According to Kok *et al.*, (2017), a well-defined indication(s) is seen as part of evidence-based approach to health care, necessary rationale for diagnostic or therapeutic interventions in patient care. This ensures that unnecessary risks are minimized or altogether eliminated. As a further attestation to the involvement of women in taking decisions for CS procedure, majority of the respondents in this study indicated that the decision to have a CS was wholly theirs or followed adequate education from their doctors. In fact, 23% of women in this study said the decision for CS was wholly theirs. This compares to the findings in a study by Shoib *et al.*, (2012) where 20% of the respondents relied on self-decision for the chosen mode of delivery. Women have the right to accept or reject medical interventions even when it has been adequately explained to them. This is the essence of autonomy as an ethical principle which means a moral obligation to respect the decision of others in matters concerning them (Gillon, 2015).

Women's decision to undergo a caesarean section may be influenced by some factors. In this study healthcare provider (doctor), safety, previous experience and impact on daily living factors were found to affect decisions to have or not to have a CS. Specifically, strong recommendations from the respondents' doctors, desire of family members (including husband) and consideration of safety ranked the most among factors identified. In a study done in Ebonyi State- Nigeria, 12% of women said their decision for a CS was based on what the doctor told them (Sunday-Adeoye & Kalu, 2011). According to Atout, (2012), doctors are generally thought to play major roles in the medical care decisions. Indeed, some patients may leave the health-care related decision to the physician as was observed in this study. The reason for this may be because such women trust their knowledge and expertise of their healthcare providers.

Convenience and safety have been identified by a WHO study as some factors responsible for opting for CS by patients (Feng, Xu, Guo, and Ronsmans, 2012). In addition, patients usually consider health care providers' opinions when taking decision on medical/surgical procedure though some may still decline some procedures. In a study done in Calabar -Nigeria, 4.7% of subjects in the study refused a CS, resulting in delay to carry out the procedure (Inyang-Etoh, Umoiyoho, and Abasiattai, 2013). However, the reasons for the delay were not discussed by the authors.

As seen in this study, many factors influence the decision for CS. These factors cut across many aspects that include the choice of the women themselves, their family members, the health care system and the perceived risks as elicited by health care providers. This agrees with the opinion of Igwebueze, (2016) who posited that CS rates were largely driven by a complex multi-factorial labyrinth that involves the health systems, health care providers, fashion and influence of media. The implication of this is that both health care providers and the patients require common grounds in the decision for caesarean sections.

Majority of women in this study were satisfied with important aspects of care during caesarean section. The major aspects were involvement in decision-making, provision of information on the procedure, quality of care before and after the procedure and speed of recovery in which about 70-80% of women expressed satisfaction. This finding compares with a study done in University of Benin Teaching Hospital (UBTH), Benin City - Nigeria, where 80% of respondents expressed satisfaction with delivery with CS (Enabudoso & Isara, 2011). The authors also observed that initial reaction to the procedure was associated with satisfaction with CS. However, in a qualitative study done in Abuja, some women in the study expressed poor satisfaction with care during delivery and believed that they would be better supported during a home birth, and that they will be mistreated if they attend the hospital (Bohren *et al.*, 2017). Despite the large number of respondents who expressed satisfaction with CS in this study, only 37.7% of them expressed the desire to undergo another CS in the future and only about one-third intended to advise friends or relatives to undergo the procedure.

This finding suggests that despite the satisfaction expressed, the respondents would prefer other options of child birth if feasible in the particular circumstances. Konheim-Kalkstein, Barry, and Galotti (2014) found that women planning to have a vaginal delivery after a CS perceive a caesarean as the riskier option.

This study found a statistically significant association between women's involvement in the decision-making process for CS and their satisfaction with CS. A patient's involvement in the decision for a procedure to be done on them can affect their satisfaction with the procedure. This is because such involvement gives a feeling of being "carried along" as against being ignored which may in turn lead to the perception of lack of value for the patient's opinion. In Graham *et al.*, (1999) investigation of women's involvement in the decision to deliver by caesarean section found that majority of the women were satisfied with the information they received during pregnancy on caesarean section and with their involvement in making the decision. In another study, previous traumatic experience rather than involvement in decision making was responsible for the negative disposition towards CS (Stansfield & Brown, 2010).

5. Implications for Nursing

Nursing professionals are essential members of the health care teams for women requiring caesarean section for child birth. The high level of involvement of women in decision-making for caesarean section (CS) and the majority of respondents who were satisfied with the care they received during CS found in this study has implications for nursing practice and research. It is important for nurses and midwives to adequately educate antenatal care clients on the possibility and indications for a CS during their visits to antenatal care (ANC) clinics. This will prepare the clients' minds towards the options of delivery. Such health education may also include information on consenting process. In addition, sustaining the level of satisfaction found in this study is desirable. This is because patients' satisfaction is an important nursing care goal. Thus, nurses will be required to keep improving on the care provided for patients requiring CS.

6. Recommendations

Health care providers (including nurses and doctors) should continue to provide adequate information on caesarean section to women who have indication for it so as to enhance their involvement in the decision-making process for CS. Efforts should be made by health care teams involved in the care of women requiring CS to make sure such women have a good experience so as to accept the procedure in future if they so require another CS. Health care workers should be exposed to training on important areas in health service communication such as information on planned procedure, risk communication and consenting. This should be done by the hospital management in order to improve patients' satisfaction.

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Conflict of interest

The authors declared that there are no conflicts of interest regarding the publication of this paper.

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