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Exploring Perceptions of Cesarean Sections among Postpartum Women in Nigeria: A Qualitative Study

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Abstract: Cesarean sections have become increasingly common globally, including in Nigeria. This qualitative study explores the perceptions and experiences of postpartum women who underwent cesarean sections within the distinct contexts of Ibadan in Oyo State, Nigeria. In-depth interviews and focus group discussions were conducted with 24 postpartum women in selected health facilities in urban and rural areas. A diverse sample was purposively selected to capture a range of experiences based on age, residence, education, and cultural backgrounds. Thematic analysis was employed to identify patterns and themes within the data. The findings revealed diverse emotional responses among participants, ranging from relief and gratitude to disappointment and feelings of loss for not experiencing a vaginal birth. Societal pressures and cultural expectations played a significant role in influencing women's perceptions and experiences of cesarean sections. Future childbirth preferences and support systems, including healthcare provider–patient relationships and community support, were identified as crucial factors impacting postoperative recovery. This study contributes to the understanding of women's perceptions of cesarean sections within the local context of Ibadan, Nigeria. The findings underscore the importance of culturally sensitive healthcare practices, clear communication, and support systems to enhance the birthing experiences of women undergoing cesarean sections.

Keywords: cesarean sections; postpartum women; perceptions; experiences

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1. Introduction

Childbirth is a pivotal and transformative event in a woman's life, holding immense physical, emotional, and cultural significance [1,2]. In recent decades, the global landscape of childbirth has witnessed a notable rise in cesarean sections (CS), a surgical procedure aimed at delivering a baby through an incision in the mother's abdominal wall and uterus [3–5]. While cesarean sections can be lifesaving and medically necessary in certain cases, the increasing prevalence of elective or non-medically indicated CS births has raised concerns and sparked discussions about the perceptions and experiences of women who undergo this procedure [6–8].

The 2021 World Health Organization report highlights the global rise in the utilization of caesarean sections, accounting for 21% of all childbirths. Since 1990, worldwide rates have surged from approximately 7% to the current 21%, a trend expected to persist in the upcoming decade [9]. It is projected that nearly one-third (29%) of all births will involve caesarean sections by 2030 [9,10]. However, the accessibility of caesarean sections is markedly disparate, contingent on a woman's geographical location. In China, Latin America, and the Caribbean, caesarean section rates soar as high as between 41% to 54% of all births [4,11]. In five countries (the Dominican Republic, Brazil, Cyprus, Egypt, and Turkey), caesarean sections surpass vaginal deliveries [9,12]. Conversely, in the least

developed countries, merely about 8% of women undergo caesarean section, with a meager 5% in sub-Saharan Africa, illustrating a disconcerting lack of access to this lifesaving procedure [9,13]. The World Health Organization recommended a CS range of 10–15% for countries [14].

Nigeria, situated in sub-Saharan Africa, has not been immune to this global surge in caesarean section rates [2,15]. In Nigeria, there has been minimal fluctuation over the years in the proportion of births delivered via caesarean section, hovering at around 3% (3% in 1990, 2% in 2008, 3% in 2018, and 3.7% in 2021) [16,17]. Among this 3.7%, a subgroup of women opted for caesarean section before the onset of labor pains (1.8%), while others made the decision post-onset (1.9%) [17]. Notably, caesarean section delivery rates in Nigeria are evidently higher in urban areas (6.7%) than in rural regions (2.0%) [15,17]. A nine-year study investigating the correlation between maternal mortality and cesarean section rates in 25 selected Nigerian hospitals revealed a noteworthy trend. The research observed that a rise in cesarean section rates (12.2%) corresponded to a significant decrease in maternal mortality rates. Initially peaking at approximately 1868 per 100,000 at baseline, the maternal mortality rate dropped to 1315 per 100,000 by the conclusion of the study period [18]. This represented a relative reduction of about 30% in maternal mortality rates, highlighting the substantial impact of cesarean section rates on improving maternal health in Nigeria.

Despite this positive trend, Nigeria still grapples with a maternal mortality ratio of 512 per 100,000 live births, falling considerably short of achieving the Sustainable Development Goal 3 target to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030 [16,19]. The decision to deliver via CS or through vaginal birth is influenced by a complex interplay of medical, cultural, social, and individual factors [20,21]. In Nigeria, where maternal and neonatal health indicators are a priority concern, understanding the perceptions and attitudes of women who have recently undergone cesarean sections is of utmost importance [22–24]. Prior research has primarily employed a quantitative approach, emphasizing the prevalence and factors associated with cesarean sections in Nigeria [2,7,15]. In contrast, this study marks a novel contribution by adopting a qualitative approach to investigate the perceptions of cesarean sections among postpartum women in Nigeria. It focuses on the perceptions of women who underwent cesarean sections in their last pregnancy within the setting of Nigerian health facilities, providing a unique perspective on the subject.

The postpartum period presents a critical juncture where women have the opportunity to reflect on their birthing experience, make sense of their emotions, and share their narratives [25–27]. By delving into the lived experiences and perspectives of these women, this research aims to shed light on various aspects investigating the extent to which women perceive cesarean sections as medically necessary, their emotional responses, social and cultural influences, birth preparedness and decision-making, and implications for maternal health, preferences, and decisions for future childbirth [28–31]. By unraveling the multifaceted perceptions towards cesarean sections among women who have experienced this mode of delivery in Nigerian health facilities, this study aims to contribute to the existing body of knowledge on maternal health, inform policy discussions, and ultimately enhance the quality of care provided to women during the perinatal period in Nigeria.

2. Results

2.1. Participants' Socio-Demographic Characteristics

The study comprised 24 women who had given birth via caesarean section and were receiving postpartum care in Ibadan, Nigeria. Two focus groups were held (one in urban and one in rural areas). Eleven in-depth interviews were conducted (six in the urban and five in the rural areas). The participants ranged in age from 22 to 49 years. Participants with no formal education and primary, secondary, and post-secondary education were included (See Table 1).

Table 1. Participants' socio-demographic characteristics.

No of Participants (n = 24)	Interview Category	LGA	Residence	Age/Age Range (in Years)	Education
7	FGD 1	Ibadan North West	Urban	22–49	Primary/Secondary/ Post-Secondary
6	FGD 2	Ido	Rural	23–48	None/Primary/Secondary
1	IDI 1	Ibadan North	Urban	32	Secondary
1	IDI 2	Ibadan North	Urban	26	Primary
1	IDI 3	Ibadan North	Urban	42	None
1	IDI 4	Ibadan North	Urban	43	Post-Secondary
1	IDI 5	Ibadan North	Urban	33	Primary
1	IDI 6	Ibadan North	Urban	28	Secondary
1	IDI 7	Akinyele	Rural	40	Secondary
1	IDI 8	Akinyele	Rural	32	Post-Secondary
1	IDI 9	Akinyele	Rural	22	Secondary
1	IDI 10	Akinyele	Rural	34	None
1	IDI 11	Akinyele	Rural	37	Secondary

Note: FGD—focus group discussion; IDI—in-depth interview; and LGA—Local Government Area.

Table 2 depicts the study's primary theme, which is the perception of CS among postpartum women, as well as its five sub-themes, which were generated using code regrouping.

Table 2. Primary theme and sub-themes.

Primary Theme: Perceptions of Cesarean Sections among Postpartum Women	
Sub-Themes	**Overview of Sub-Theme**
Limited Understanding of Cesarean Section Reasons	Women reported that they had a limited understanding of the medical reasons behind their cesarean sections. Communication challenges with healthcare providers were also identified.
Diverse Emotional Responses	Some participants expressed relief and gratitude for a safe delivery, whereas others described feelings of disappointment and a sense of loss for not experiencing a vaginal birth.
Societal Pressures and Cultural Expectations	Participants reported societal pressures to have a "natural" birth, and how cultural beliefs influenced their perceptions of childbirth.
Support Systems and Recovery	The presence of strong support systems, including partners, family members, and healthcare providers, was instrumental in facilitating postoperative recovery.
Varied Effects on Future Childbirth Preferences	Some women saw CS as a means to ensure the safety of both mother and baby; others expressed a desire for vaginal births in subsequent pregnancies.

2.2. Primary Theme: Perceptions of Cesarean Sections among Postpartum Women

2.2.1. Sub-Theme 1: Limited Understanding of Cesarean Section Reasons

A significant number of postpartum women, particularly in the rural areas, reported that they had a limited understanding of the medical reasons behind their cesarean sections. They expressed a desire for more comprehensive explanations from healthcare providers regarding the indications for the procedure. The participants highlighted communication challenges with healthcare providers, particularly in terms of receiving

clear and understandable explanations about the cesarean section and informed consent. As reputed by the participants, inadequate communication led to feelings of confusion and anxiety. Though some participants stated that they had pleasant and effective communication with the healthcare providers, they also stated that they needed more information on unforeseen expenses such as additional blood bank, medications, and injections that could be incurred during the CS operations in addition to the actual fee charged by the hospital for the operation.

> "*Interactions with health care providers were pleasant. However, I was still faced with little information since I needed to fully understand the caesarean section and its implications in greater detail… the additional requirements such as extra blood bank, and injections needed and their costs.*" (FGD, 2)

> "*A high blood pressure was a problem for me while I was recovering from a CS operation. The healthcare providers did not tell me to keep taking the medicine to regulate my blood pressure.*" (IDI, 6)

Some interviewees further highlighted a well-informed decision-making process with their husband regarding the choice of a CS. They mentioned their husbands' involvement in the procedure, leading to a confident decision about CS. The decision to opt for a CS was portrayed as a strategic choice aimed at preventing stress for both the baby and the mother during labor. However, the interviewees point out a significant challenge related to limited information about additional costs associated with the CS operation. This lack of notification or anticipation of extra expenses adds unexpected financial pressure on the interviewee's husband, who had to find additional funds to cover unforeseen costs. This narrative underscores the importance of comprehensive communication not only about medical procedures but also about potential financial implications, emphasizing the need for transparency to better prepare families for the overall birthing experience, including associated expenses.

> "*My husband and I were given information about the caesarean section, so we chose it without any confusion… The process was meant to keep the baby and I from getting stressed out during labour… However, we were given limited information on additional costs spent during the CS operation, about which we were not notified, expected, or planned. It put a lot of pressure on my husband to come up with extra money for the unexpected expense.*" (IDI, 10)

2.2.2. Sub-Theme 2: Diverse Emotional Responses

Emotional responses among participants were diverse, with some expressing relief and gratitude for a safe delivery. Others described feelings of disappointment and a sense of loss for not experiencing a vaginal birth. Those who had emotional stability prior to CS mentioned how reading pertinent informative articles to boost their knowledge of CS and how preparing for it benefited them. They also recognized the significance of religious beliefs and prayers in lowering delivery anxieties connected with CS. Participants with emotional stability before and after CS expressed excitement about safe delivery by CS. They also highlighted their determination to recommend CS to anyone experiencing delivery issues.

> "*I felt calmer and more at ease when I knew that a caesarean section was an option for giving birth. I read more about the caesarean process and prayed for a safe, trouble-free operation instead of worrying about the issue… I am excited I had a safe delivery.*" (IDI, 3)

> "*It was two weeks ago that I had my first child through a caesarean section, and everything went smoothly… I was emotionally stabilized since I was advised that the only way to have a safe delivery was to overcome fear, which causes anxiety and difficulties during childbirth.*" (FGD, 1)

> "*My CS was an emergency, I decided to go for it when labor became too stressful and prolonged. . . I am glad I took the decision since the CS was truly a lifesaving option for me and my baby. . . Now, I can suggest CS to anyone experiencing similar labor or delivery challenges.*" (IDI, 7)

Some participants talked about how disappointed they were that they did not have a normal birth. They thought of CS as their last resort, something they had not planned to do but knew they had to do to safeguard their lives and the lives of their babies. Those who expressed disappointment suggested that giving birth through a natural birth was God's plan for women. One referenced "Hebrew women" in the Bible who gave birth naturally. Those who had an emergency CS recorded that they had a delay in breastfeeding their newborn babies.

> "*My hopes were for a natural birth experience and for there to be no thought of a caesarean section during the birth. When I realized, I had to go for CS, I was disappointed. . . I had an emergency CS, . . .I had a delay in breastfeeding my newborn*" (IDI, 1)

> "*I was expecting a vaginal birth. . . However, at the 8-month scan check-up, the nurse who tested for a fatal heartbeat was shocked that my baby was not yet in the anterior position. . . I was scheduled for scans every two weeks, but the findings suggest that the baby was in a transverse position. As a result, I was advised to undergo a caesarean section to avoid complications and have a safe delivery.*" (IDI, 4)

> "*Emotionally, I was disturbed since I had a strong faith in God's word, to have testimony to encourage other women to deliver safely through vaginal birth like the "Hebrew women.*" (FGD, 2)

2.2.3. Sub-Theme 3: Societal Pressures and Cultural Expectations

Social perceptions had a considerable impact on women's experiences, with some participants reporting societal pressures to have a "natural" birth. Women from various cultural backgrounds described how religious and cultural beliefs influenced their perceptions of childbirth. As reported by the participants, women who undergo CS are perceived by society as lazy women who are unable to strive to deliver naturally. They regard women who have CS deliveries as wasting their husbands' money because CS is significantly more expensive than vaginal delivery.

> "*According to women in our society, caesarean section is for lazy women who want to spend their husband's money and also lack the strength to deliver the baby on their own.*" (IDI, 5)

> "*The majority of people believe that caesarean sections are not God's plan for women. We should deliver naturally because we were born naturally.*" (FGD, 1)

Some participants highlighted a lack of direct societal or cultural conflicts in their own experience with childbirth, as it was their first encounter with the process. While parents and in-laws would have preferred to celebrate them as having had a natural birth, there was an understanding that a CS served the interest of the mother's and baby's health. Despite not experiencing personal or intrafamilial conflicts, the interviewees were conscious of and sensitive to the differing opinions within their family network, indicating the influence of societal and familial expectations on childbirth choices.

> "*I had never had any direct societal or cultural conflict over child delivery because this was my first experience, but I knew that my parents and in-laws wanted me to have a natural birth rather than a CS.*" (IDI, 8)

In the focus group discussions, participants expressed a prevalent misconception surrounding CS within their community. They mentioned being informed multiple times that undergoing a CS presents a 50:50 chance for a woman, suggesting an equal likelihood of survival and death during the procedure. This statement reflects a significant misconception or misinformation circulating within the community about the risks associated with

cesarean deliveries. It underscores the importance of accurate and accessible health information to dispel such myths and provide expectant mothers with a clear understanding of the safety and risks associated with different delivery methods. Addressing these misconceptions is crucial for promoting informed decision-making and reducing unnecessary fears surrounding cesarean sections.

> "*I have been told severally that CS is a 50:50 chance for a woman. That means she has a 50% chance of surviving and a 50% chance of dying during CS.*" (FGD, 1)

2.2.4. Sub-Theme 4: Support Systems and Recovery

The presence of strong support systems, including partners, family members, friends, and healthcare providers, was instrumental in facilitating postoperative recovery. Participants who felt understood and respected by healthcare providers reported more positive experiences. However, women who had previously experienced vaginal birth indicated that recovery through CS in their most recent birth was more complex and challenging than recovery through vaginal delivery.

> "*During my recovery from my caesarean section, I had a friend who cared for me at the hospital, and my husband was highly helpful in every aspect of the journey, as was my mother-in-law. . . This helped in quickening my recovery period*" (IDI, 9)

> "*My husband and I made the decision to have a caesarean section, so he was very supportive during the postoperative recovery stage. His support fastened my recovery*" (IDI, 11)

> "*Friends, family members, and my husband were all there to help me recover from CS. . . Their presence and support were very helpful. . . My first birth was through normal delivery. . . From my experience, recovery from CS is more difficult than recovery from normal delivery*" (FGD, 2)

Participants recognized the significance of postoperative recovery instructions and guidance from healthcare personnel. Respect and attention from healthcare providers hasten postpartum women's recovery after CS. For instance, the interviewees reflect a positive postoperative recovery experience following their cesarean section. They attribute their smooth recovery to diligent adherence to prescribed medications and proper wound care. The individuals express gratitude for the guidance received from healthcare workers, emphasizing the helpfulness of the advice provided during their CS recovery. This suggests a proactive and engaged approach to self-care, underscoring the importance of patient adherence to medical recommendations in ensuring a complication-free recovery.

> "*I experienced no difficulties throughout my postoperative recovery because I took all of the medications given and cleaned the wounds properly. The advice and directions provided by healthcare workers have been greatly helpful to my CS recovery*" (IDI, 3)

The participants in the focus group discussion recounted pleasant interactions with the medical staff throughout the entire process of the cesarean section, including the decision-making phase. The participants felt respected for their choice to undergo a cesarean section, contributing to a positive overall experience. This positive rapport with healthcare providers is seen as a significant factor influencing the participants' swift recovery post-caesarean section. The account highlights the impact of supportive and respectful healthcare interactions on a patient's emotional well-being and recovery journey after a cesarean delivery.

> "*My encounters with the medical staff before, during, and after the caesarean section were pleasant, and I was respected for making the decision. This aided my speedy recovery after giving birth.*" (FGD, 1)

2.2.5. Sub-Theme 5: Varied Effects on Future Childbirth Preferences

Women's experiences with cesarean sections varied in their impact on future childbirth preferences. Some felt empowered by the experience, seeing it as a means to ensure the

safety of both mother and baby. Others expressed a desire for vaginal births in subsequent pregnancies, often influenced by their last birth experience and cultural norms and expectations. Financial difficulties, discomfort, post-delivery pains, regular hospital visits and follow-up injection uptakes, and inconveniences associated with CS were identified as factors that could influence their non-choice of CS in the future if given the option to choose the desired mode of delivery. However, the women also underlined the need to follow medical advice in subsequent births, with an open acceptance of either CS or natural birth type to have a safe delivery.

> "*I had always wanted to have a vaginal delivery… Caesarean section is not a death sentence, but we must pay attention to the health care providers for the child's and mother's safety… CS is far more expensive than normal delivery*" (IDI, 6)

> "*I describe my experience of having a caesarean section, which was quite uncomfortable due to the series of intravenous injections, cleansing of the first skin layer around my vagina, and monthly hospital visits for proper supervision… Those who had vaginal deliveries did not have those experiences.*" (FGD, 1)

Participants listed their baby's position in the womb, their own health status, medical expert recommendations, and financial capabilities as common factors that could impact their preference for future deliveries.

> "*My experience with a caesarean section has had no negative effect on my thoughts or preferences for future childbirth… Because, depending on the child position and my health capability, I'm ok whether the next pregnancy is vaginal or caesarean.*" (IDI, 2)

> "*If I ever want another child, I would like to have a caesarean section… However, the most important factor influencing the selection will be financial capacity. If we can afford CS, we will go for it.*" (IDI, 7)

3. Materials and Methods

3.1. Study Setting

The study was set in the city of Ibadan, the capital of Oyo State in Southwestern Nigeria. Oyo State spans an approximate area of 28,454 square kilometers and is home to a population of 7,512,855, with women constituting 49% of the total population [32]. Ibadan is one of the largest cities in Nigeria and is divided into both urban and rural local government areas (LGAs). The study focused on understanding the perceptions of cesarean sections among postpartum women within these distinct local government areas. The urban component of the study was situated within Ibadan North and Ibadan North West Local Government Areas (LGAs), which encompass densely populated urban areas, healthcare facilities, and urban communities. The rural component of the study was located within Akinyele and Ido Local Government Areas, which include peri-urban and rural areas with a different socio-economic landscape compared to the urban setting. Health facilities in both urban and rural areas served as the primary sites for data collection. The selection of health facilities was based on their accessibility, willingness to participate, and diversity of patient populations. A mix of public and private healthcare facilities were included to capture a broad range of experiences.

3.2. Study Design

The study adopted a qualitative research design, which aimed to explore the depth and complexity of participants' experiences and perceptions of cesarean sections. Qualitative methods were well suited to capture participants' narratives and provide insights into their lived experiences. The Standards for Reporting Qualitative Research (SRQR) guided the writing of this manuscript [33].

3.3. Participant Recruitment and Sampling

Postpartum women who had recently undergone cesarean sections were recruited from the selected health facilities in both urban and rural areas. A purposive sampling strat-

egy was used. A total of twenty-four participants were sampled. Eleven in-depth interviews and two focus group discussions were conducted. Efforts were made to ensure diversity in the sample, including variations in age, educational background, socio-economic status, and cultural affiliations. The study's inclusion criteria specified that only women who had undergone cesarean sections during their most recent pregnancies and were within their 6-week post-delivery period were included. Exclusion criteria for this study encompassed women who did not undergo cesarean sections during their last pregnancies, those who were not within their 6-week post-delivery period, and those who were unable to provide informed consent for participation. The perspectives of healthcare providers, including obstetricians, midwives, and nurses, were not included in the study.

3.4. Data Collection

In-depth interviews (or rather, one-on-one interviews) were conducted with participants to allow them to share their experiences and perceptions in a confidential and respectful environment. Interviews were semi-structured to ensure consistency while allowing participants to elaborate on their responses. Focus group discussions were organized to facilitate group interactions and encourage participants to share their perspectives on common themes and experiences. The group sessions were conducted in comfortable settings within the selected health facilities. Trained local interpreters, where needed, assisted in overcoming language barriers. The interviews were conducted by trained female researchers using semi-structured interview guides as instruments, and consent for recording was obtained from all participants. Examples of interview questions asked are as follows: "How did you feel when you found out you would be having a cesarean section?", "Can you describe your emotions at that time?", "Were there any cultural beliefs or traditions that played a role in shaping your perceptions of childbirth?", "Did you have particular expectations or hopes regarding giving birth through a cesarean section?", "Can you tell me about your experience of giving birth through a cesarean section in a Nigerian health facility?", and "What is your opinion about cesarean section deliveries?"

3.5. Data Analysis

Thematic analysis was employed to systematically identify patterns, themes, and key insights within the collected data. This analytical process followed the iterative steps recommended for thematic analysis [34]. To begin, the audio recordings were meticulously transcribed into written text, ensuring transcription accuracy. Familiarity with the data was developed through repeated readings of the transcripts, aiming to comprehend both the content and context. Next, we initiated the coding process by generating initial codes, which served as concise labels summarizing essential concepts within the data. ATLAS.ti (version 23) coding software was utilized to facilitate data organization. Open coding was employed, involving the segmentation of data into meaningful units and the assignment of codes to these segments.

Subsequently, we examined relationships between codes, grouped similar codes into categories, and derived more comprehensive themes by selecting central categories and exploring their connections. Drawing on these categories, overarching themes emerged, reflecting broader patterns and central ideas present in the data. We also identified sub-themes within these larger themes, providing in-depth insights [35]. The themes were meticulously reviewed and accompanied by detailed descriptions and narratives, fostering a comprehensive understanding of each theme's essence. Subsequently, we compiled a thematic analysis report, encompassing the themes, sub-themes, their descriptive narratives, and interpretive insights. The use of direct quotes from participants added authenticity and resonance to their perspectives. Furthermore, we actively sought peer review feedback from colleagues and subject matter experts, reinforcing the rigor of our analysis. Subsequent to these feedback mechanisms and additional review, our themes and sub-themes were refined and finalized.

3.6. Ethical Considerations

Ethical approval was obtained from the College of Medicine and Health Sciences Afe Babalola University Health Research Ethical Committee (HREC) (Protocol Number: ABUADHREC/26/07/2023/2006). Informed consent was obtained from all participants, and their privacy and confidentiality were ensured throughout the study. Participants were informed about their rights to withdraw from the study at any point without penalties.

3.7. Enhancing the Study's Rigor

To fortify the rigor of this research, a methodological approach involving triangulation of data sources, reflexivity, member checking, and measures to ensure trustworthiness were thoughtfully employed. These strategies, as outlined by Creswell's seminal work, are fundamental to the research's integrity [36]. *Triangulation of Data Sources*: In this study, a triangulation method was implemented, involving interviews and focus groups. This multifaceted approach allowed for a more comprehensive understanding of the research topic by considering diverse perspectives and insights from participants. *Reflexivity:* The researchers approached this study with self-awareness, acknowledging potential biases and preconceptions that could influence data interpretation. By managing preconceived assumptions, the research strove to maintain a fair and unbiased stance. This approach promoted a deeper understanding of the broader social context and recognized the dynamic between the researchers and the researched. *Member Checking*: To enhance the credibility and reliability of the findings, participants were actively engaged in the research process. They were provided the opportunity to review and confirm the accuracy of the gathered data. This member-checking process not only validated the results but also empowered participants to contribute to the research's integrity.

3.8. Measures for Trustworthiness

Several measures were adopted to bolster the trustworthiness of the study, encompassing credibility, transferability, dependability, and confirmability. *Credibility:* Credibility was fortified through in-depth and extended interactions with study participants. These interactions were meticulously recorded, with participants' full consent, to ensure accuracy and facilitate comprehensive data analysis. *Transferability:* To enhance the study's applicability beyond its immediate context, comprehensive background information about participants and the research setting was meticulously provided. This enables readers to assess the potential relevance of the study's findings in different contexts. *Dependability:* The study's dependability was upheld by transparently describing the research methods employed. Field notes were cross-referenced with voice recordings to ensure data consistency and reliability. Data accuracy was further verified by comparing it with the recorded responses. *Confirmability*: To maintain confirmability, an independent researcher was actively involved in both data collection and analysis. This external perspective served to verify interpretations, scrutinize data accuracy, and validate the soundness of conclusions [33,37].

4. Discussion

The study reveals postpartum women showing both receptiveness and caution in considering their recent (and possibly future) caesarian sections. Some were guided by medical practitioners and healthcare workers to make the decision in the light of pregnancy-specific risks, and some took the decision with their husbands to ensure a stress-free birth process. Whatever the motivation, most of the women felt that they should have been better informed by the medical fraternity, particularly when a CS was advised for medical reasons. Many participants expressed a desire for clearer explanations from healthcare providers regarding the indications for the procedure, emphasizing the role of effective communication. Communication challenges with healthcare providers, as reported by participants, led to feelings of confusion and anxiety, aligning with findings from a study in Ghana [3] that highlighted poor knowledge about managing pain and healing in the

aftermath of a cesarean section. While some educated and urban participants in our study reported positive communication experiences, they emphasized the need for more information on unforeseen expenses associated with cesarean sections. This contrasts with a study in China [4], which found that poor communication led to the overutilization of cesarean sections, which women later viewed as problematic. Additionally, our study aligns with research in India, indicating an increasing association between the education and information that healthcare providers' offer and the willingness of women to undergo cesarean section deliveries [38], and a study in Pakistan associating cesarean section uptake with urban residence and lifestyle [39].

Emotional responses among participants varied, with some expressing relief and gratitude (given the reality of a less 'stressed' delivery), while others experienced disappointment and a sense of loss for not having a vaginal birth (given the adherence to cultural norms about womanhood and the normality of vaginal births). Emotional stability before and after cesarean sections, especially among women who had undergone elective cesareans, was sustained through reading informative articles, praying, and obtaining reassurances and support from husbands. These findings also align with studies in Ethiopia [8] and sub-Saharan Africa [13] that connected caesarean delivery with potential self-esteem loss and psychiatric morbidity. Participants who struggled emotionally were among those who were compelled to have a caesarian section and who felt disappointed, referencing cultural and religious beliefs. This aligns with a previous study in Nigeria that identified religious beliefs as a strong factor influencing cesarean section uptake [15].

Social perceptions impacted women's descriptions of their experiences. Participants reported the societal views of women undergoing elective caesarian deliveries as lazy and wasteful, echoing findings from studies in Cameroon [40] and Nigeria [41]. Contrarily, a study in Thailand found that negative experiences and beliefs about vaginal delivery increased cesarean section uptake among women. This also resonated in the sentiments of particular women who spoke positively about their experience of CS. This underscores the role of strong support systems in postoperative recovery, emphasizing helpful communication and displays of respect from healthcare providers.

The women's experiences with cesarean sections varied in their impact on future childbirth preferences. Some felt empowered by the experience and would be willing to do it again, while others expressed a desire for vaginal births, influenced by earlier experiences and cultural norms. Other issues negating the choice of caesarean sections included the costs involved, discomfort, post-delivery pains, hospital visits, and follow-up injections. The importance of following medical advice for subsequent births was emphasized, aligning with studies in Nigeria [42], Thailand [6], and the Democratic Republic of Congo [43]. This qualitative research shows that caesarian births are topical in the Nigerian context. They are accepted due to medical reasons and also as an elective procedure—but caesarian births will provide women and their families more confidence to make relevant decisions if the women are better informed and there is more care and engagement from the health sector.

5. Strengths and Limitations

On the strengths of the research, the study utilized qualitative research methods, including in-depth interviews and focus group discussions, which allowed for the collection of rich, in-depth data. This approach provided participants with the opportunity to share their experiences and perceptions in their own words. The study brought together participants who revealed differences in perceptions regarding CS. This diversity allowed for a broader understanding of cesarean section experiences. Member checking was employed to validate the accuracy of the findings, as participants were allowed to review and confirm the interpretation of their responses, contributing to the credibility of the study.

Despite the strengths of this study, the participants might have been influenced by social desirability bias [44], leading them to offer responses they perceived as socially acceptable rather than expressing their genuine feelings or experiences. Participants were

asked to recall their caesarean section experiences, which may have occurred some weeks in the past. This introduces the potential for recall bias, where participants may not accurately remember or report certain details or emotions. The use of trained researchers helped to reduce these biases. The study excluded an examination of pathologies associated with CS and subsequent pregnancies, as well as the birth condition of the newborns. Furthermore, qualitative research is inherently context-specific, and 24 women participated in the study; thus, the findings are not generalizable to all postpartum women or healthcare settings, especially outside the study setting. Therefore, caution should be exercised when applying these findings beyond the study context.

6. Conclusions

The findings from this study highlight the complex interplay of medical, emotional, cultural, and societal factors that shape the perceptions and experiences of postpartum women who have undergone caesarean sections in Nigerian health facilities. Frequently, logistical and organizational challenges within these hospitals impede the acquisition of informed consent from all patients. These insights emphasize the importance of clear communication, patient-centered care, and culturally sensitive support in ensuring a positive birthing experience for all women, regardless of their mode of delivery. Further research and policy deliberations are essential to address the multifaceted needs of women during the perinatal and postpartum periods in Nigeria. Additionally, future research should explore the perspectives of pregnant women prior to delivery to determine what type of delivery they would wish for themselves, given their knowledge, to clarify the information/misinformation currently circulating among Nigerian women about caesarian sections.

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