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Perception of Caesarean Section in Lower Middle-Income Countries: A Narrative Review

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ABSTRACT

Background: Caesarean section (CS) is an essential intervention that reduces maternal and neonatal morbidity and mortality when medically indicated. However, perceptions of caesarean delivery among women, families, communities, and healthcare providers in lower middle-income countries (LMICs) are shaped by cultural beliefs, socioeconomic conditions, healthcare experiences, and availability of resources. These perceptions influence acceptance, utilization, and decision-making regarding mode of delivery.

Aim: This narrative review examines perceptions of caesarean delivery in LMICs, exploring factors influencing acceptance or refusal, sociocultural beliefs, experiences of women, healthcare provider perspectives, and implications for maternal health services.

Method: A narrative review of published literature was conducted using electronic databases including PubMed, Scopus, and Google Scholar. Relevant studies addressing perceptions, attitudes, beliefs, experiences, and decision-making regarding caesarean delivery in LMICs were reviewed. Studies involving pregnant and postpartum women with their significant others, families, communities, and healthcare providers were included.

Results: Perceptions of caesarean delivery in LMICs are complex and vary between settings. While many women recognize CS as a life-saving procedure, others perceive it as unnatural, dangerous, expensive, or associated with social stigma. Fear of pain, death, infertility, poor recovery, and inability to perform domestic roles contributes to negative attitudes. Conversely, previous positive experiences, improved education, counselling, and respectful maternity care increase acceptance. Healthcare system factors, including provider communication, cost, and access to emergency services, strongly influence perceptions.

Conclusion: Improving perceptions of caesarean delivery in LMICs requires culturally sensitive education, respectful maternity care, improved communication, and equitable access to safe surgical services. Addressing misconceptions while respecting women's preferences is essential for reducing preventable maternal and neonatal complications.

KEYWORDS: Caesarean section; perception; maternal health; lower middle-income countries; cultural beliefs; childbirth; respectful maternity care.

INTRODUCTION

Caesarean section (CS) is one of the most commonly performed surgical procedures worldwide and remains an important component of comprehensive emergency obstetric care.[1] When medically indicated, CS prevents significant maternal and neonatal morbidity and mortality, particularly in conditions such as obstructed labour, placenta praevia, fetal distress, hypertensive disorders, and previous caesarean sections or other uterine surgeries.[1-3]

Despite its proven benefits, perceptions regarding CS differ widely across populations. In high-income settings, caesarean delivery is often viewed as a safe and predictable alternative to vaginal birth, whereas in many lower middle-income countries (LMICs), perceptions are influenced by cultural traditions, health system limitations, financial barriers, and previous experiences with healthcare services.[4-6]

LMICs face a dual challenge. On one hand, some regions experience inadequate access to emergency obstetric surgery, resulting in preventable maternal and perinatal morbidity and mortality. On the other hand, increasing rates of non-medically indicated CS in urban and private healthcare settings raise concerns about unnecessary interventions and inequitable resource distribution.[7,8]

Women's decisions regarding CS are rarely based solely on medical information. They are influenced by family members, community beliefs, religious and cultural values, previous childbirth experiences, media exposure, and interactions with healthcare providers. Understanding these perceptions is critical for developing interventions that improve maternal autonomy, informed decision-making, and safe maternity care.[9-11]

Perception of Caesarean Section in Lower Middle-Income Countries: A Narrative Review

AIM

This narrative review aims to explore perceptions of caesarean delivery in LMICs, including women's attitudes, sociocultural influences, healthcare provider perspectives, barriers to acceptance, and strategies for improving understanding and utilization of CS services.

METHOD

A narrative review approach was used to synthesize available evidence regarding perceptions of caesarean section in LMICs. Literature searches were conducted using PubMed, Scopus, and Google Scholar databases.

Search terms included combinations of: *caesarean section*, *caesarean delivery*, *perception*, *attitude*, *acceptability*, *beliefs*, *women's experience*, significant others, *maternal health*, and *low- and middle-income countries*.

Studies involving women of reproductive age, pregnant women, postpartum women, family members, communities, and healthcare providers were considered. Qualitative studies, quantitative surveys, systematic reviews, and relevant policy documents were included. Findings were synthesized narratively according to major themes.

RESULTS

General Perceptions of Caesarean Section

Perceptions of CS in LMICs are heterogeneous. Many women understand CS as a life-saving procedure, particularly when they have received adequate antenatal education or have witnessed successful outcomes among family members. Also postoperative management protocols employed, and duration of hospital stay following the procedure were also found to influence perceptions of CS.[12]

However, negative perceptions remain common. Caesarean delivery may be regarded as a failure of normal childbirth, a sign of personal weakness, or evidence that a woman was unable to deliver naturally. In some communities, vaginal birth is strongly associated with femininity, strength, and social approval.[9-12]

Cultural and Social Influences

Cultural beliefs strongly influence attitudes toward CS. In many LMIC communities, childbirth is considered a natural process that should occur without surgical intervention unless absolutely unavoidable. Common myths and misconceptions concerning CS include beliefs that: CS causes permanent weakness; women who have CS cannot perform household duties; CS reduces future fertility; children born by CS are less healthy; CS indicates inadequate maternal effort. Family members, particularly partners and older relatives (significant others), may influence decisions regarding acceptance or refusal of CS.[10-12]

Fear and Anxiety Associated with Caesarean Delivery

Fear is a major determinant of negative perceptions of caesarean delivery. Common fears and concerns include: fear of surgical and postoperative pain; fear of anaesthesia; fear of death during surgery; fear of infection; fear of prolonged recovery; fear of inability to care for the newborn due to postoperative incapacitation. Women who have not received adequate counselling may perceive CS as dangerous or traumatic.[11.12]

Financial Considerations

In many LMICs, cost significantly affects perceptions of CS. Where surgical delivery requires substantial out-of-pocket payment, women and families may view CS negatively because of financial burden, with regard to hospital costs, community costs and opportunity costs. The perception that CS is more expensive than vaginal birth may contribute to delayed acceptance of medically indicated surgery, increasing risks of morbidity and mortality for mothers and infants.[11-13]

Influence of Healthcare Providers

Healthcare providers play a central role in shaping perceptions. Positive communication, respectful care, and shared decision-making improve acceptance of CS.[14,15] These are important components of the WHO labour care guide which is a relatively new tool in the monitoring of labour. Conversely, poor communication, inadequate explanation of indications, or perceived coercion may result in mistrust and negative experiences.[14-16]

Some women report that they felt excluded from the decisions regarding their mode of delivery, particularly when emergency CS was recommended. Improving informed consent practices is therefore essential.[15-17]

Urban-Rural Differences

Perceptions vary between urban and rural populations. Urban women with higher educational levels and greater exposure to health information may demonstrate greater acceptance of CS. However, urban private-sector settings may also contribute to increased demand for elective CS due to convenience, fear of labour pain, or perceived safety. Rural populations may experience stronger traditional beliefs and greater barriers related to transportation, cost, and access to emergency obstetric services.[9-11,18]

Women's Experiences after Caesarean Delivery

Previous experience strongly influences future perceptions. Women who experience respectful care, effective pain management, and successful recovery often develop positive attitudes toward CS.[14,15] Negative experiences, including inadequate counselling, disrespectful treatment, separation from newborns, maternal and neonatal complications, and prolonged hospital stay may contribute to fear and avoidance of CS in subsequent pregnancies.[14-16]

Healthcare Provider Perspectives

Healthcare providers in LMICs often balance medical indications, patient preferences, institutional pressures, and limited resources. Challenges here include: shortage of skilled personnel; inadequate operating facilities; delayed referrals; and limited postoperative support.

Providers may perceive CS as necessary but also recognize social and financial barriers affecting acceptance.[18-20]

DISCUSSION

Perception of caesarean section in LMICs is influenced by complex interactions between cultural values, health literacy, economic circumstances, healthcare experiences, and health system capacity.[12]

A major challenge is achieving balance between preventing unnecessary CS and ensuring timely access to life-saving surgery. Negative perceptions may contribute to refusal or delayed acceptance of indicated CS, while increasing acceptance without appropriate indications may contribute to unnecessary surgical interventions. Education during antenatal care represents an important opportunity to improve understanding.[13-15] Women and families should receive accurate information about: indications for CS; safety of modern surgical techniques; recovery expectations; and future reproductive outcomes.

Respectful maternity care is equally important. Women are more likely to accept CS recommendations when they feel listened to, informed, and involved in decision-making. Community-based education may be particularly valuable in settings where family members and cultural leaders influence childbirth decisions.[14-16]

Healthcare systems must also address structural barriers. Improving affordability, emergency transport, surgical capacity, and postoperative support can improve confidence in maternity services.[21,22] The concept of patient-centred care should remain central. Women's preferences should be respected while ensuring that decisions are based on accurate information and clinical evidence.[23,24]

Studies have also shown that early hospital discharge after caesarean delivery results in reduced healthcare costs and enables patients to go home early with their babies.[12] This may help in promoting a positive perception of caesarean delivery in both the patients and their care-givers. A previous study found that early discharge following uncomplicated caesarean delivery was more cost-effective than a traditional hospital stay, considering community costs, and highly cost-effective with respect to only health system costs.[12,13] However, early discharge should not preclude the need in the lying-in ward during the immediate post-caesarean delivery period, to counsel women on breastfeeding, family planning, newborn care, and care of the surgical wound.[13] All these will ultimately help to enhance a positive perception of caesarean delivery.

CONCLUSION

Perceptions of caesarean delivery in LMICs are shaped by cultural beliefs, socioeconomic factors, previous experiences, and healthcare system characteristics. Although CS is increasingly recognized as a life-saving intervention, myths, misconceptions and fears remain common.

Improving perceptions requires comprehensive antenatal education, respectful communication, shared decision-making, improved access to safe surgical care, improved postoperative management protocols and reduced duration of hospital stay following the procedure. Understanding local beliefs and addressing community concerns are essential strategies for ensuring that women receive appropriate obstetric care while maintaining autonomy and dignity.

ABBREVIATIONS

CS – Caesarean section
LMIC – Lower middle-income countries
WHO - World Health Organization

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