

Awareness and attitude towards modes of delivery among pregnant women attending at teaching hospital bharatpur

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ABSTRACT

For a healthy women population, the choice of delivery option is an important decision. Expectant parents make many choices which usually include the site for delivery (hospital, birth centre, or home), and the choice between spontaneous vaginal delivery and caesarean section. The main objective of this study was to assess awareness and attitude towards the modes of delivery among pregnant women attending teaching hospital. A descriptive cross-sectional study was undertaken in ANC OPD of Chitwan Medical College Teaching Hospital, Bharatpur. A total of 106 pregnant women attending ANC OPD who were at 28 weeks and above gestation at the time of data collection were selected by using the convenience sampling technique and were interviewed with a structured questionnaire. A questionnaire consists 17 questions for knowledge assessment and 20 questions for attitude assessment. Obtained data were entered into SPSS version 20 for window and analysed using descriptive statistics. The finding of the study revealed that among 106 pregnant women, 67.9% were

aware of modes of delivery and more than half (52.8%) had a positive attitude towards modes of delivery. There was a significant association between pregnant women's awareness and education status ($p < 0.012$). The attitude of pregnant women is significantly associated with age ($p < 0.017$) and previous mode of delivery of first child ($p < 0.000$). This study also showed statistically significant relationship between the total score of awareness and attitude towards modes of delivery ($p < 0.001$). The study concluded that a considerable proportion of pregnant women are not aware and have a negative attitude towards modes of delivery. So there is a need to organize the program for pregnant women to enhance further awareness and attitude towards modes of delivery along in safe motherhood program.

Keywords: Awareness, Attitude, Modes of Delivery, Pregnant Women

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INTRODUCTION

Delivery mechanism is a spontaneous process with implemented advances in medical technology now has drastically reduced maternal and infant mortality [1]. For a healthy women population, the choice of delivery option includes site for delivery and the choice between spontaneous vaginal delivery and caesarean section [2]. Vaginal delivery can be spontaneous i.e. unassisted or assisted [3] and Caesarean section (CS) is the most commonly performed major obstetric operation in the world and has contributed to improved obstetric throughout the world [4].

Historically, vaginal delivery has always been perceived as safer than CS and requests for elective CS without any medical indication have usually been refused but this view is changing with advancement in obstetric, surgical and anaesthetic techniques [5]. An increasing rate of CS is an issue of concern in many countries despite the recommendations by WHO that no region in the world is justified to have a CS rate greater than 10-15%, it is the most common obstetrical operation worldwide, [6] in case of Nepal, the CS rate is significantly higher in urban areas than in rural [7]. The cause of increased CS rate depends

on a variety of factors including previous CS, multiple gestations, malpresentation, fetal distress and failure of progress during labour [8].

Many studies have shown that women who have caesarean section without medical necessities are at high risk for infection, pain, pre-hospitalization, breastfeeding challenges, and complications in future pregnancies and even death of childbearing women. Additionally, babies delivered by caesarean sections have higher rates of hospital admission, need for ventilation, respiratory morbidity and mortality [9] whereas babies delivered vaginally have greater immunity against disease and get used to breast feeding more easily as well as women can regain their pre-pregnancy weight and activity level faster after a normal delivery than after caesarean section birth [10].

Vaginal delivery does carry some risks, the strain on the pelvic muscles may lead to urinary or bowel incontinence later in life and prolonged process of labor can harm babies as well as tears in the vagina and cervix may cause heavy bleeding and require suturing under anaesthesia which can be risky and quite painful. All modes of delivery carry a certain risk but an informed decision coupled with adequate monitoring during the delivery usually results in good outcomes for the mother and baby [11].

While deciding the type of delivery, most women feel stressed [12] including fear of pain, shame and pungency, low perceived behavioural control, improper subjective norms: encouragement from family members, husbands and physician on vaginal delivery to have elective caesarean section for parturition. Wrong attitude about vaginal delivery such as self confidence about the baby's health, unawareness about parturition process and anaesthesia duration, comfort in caesarean section in comparison to vaginal delivery and earlier preparation knowledge of exact time of delivery, these all are the factors that support to select caesarean selection delivery [13].

Main reason of choosing caesarean section by some pregnant women is fear and lack of sufficient knowledge about normal vaginal delivery thus request this procedure even where vaginal delivery could have been achieved safely [8]. Women preferred caesarean delivery because they were concerned about being pregnant at an advanced age, were worried about labor pain and perineum tearing, wanted to have a better plan for maternity leave, had chosen an auspicious date to deliver, and perceived that caesarean is a more convenience way to deliver [12].

In Nepal, rate of caesarean section delivery is higher in private institutes probably due to maternal choice regarding mode of delivery and partly due to obstetrician's convenience or for not liking to take risks. Some women felt that they should have right to choose caesarean section on demand but without knowing the benefit and consequences of caesarean delivery. knowledge assessments of 200 women regarding the mode of delivery clearly indicates the need for strengthening counselling aspect of antenatal care and awareness program regarding mode of delivery [14]. Till date, there is limited study done in Nepal regarding awareness and attitude towards modes of delivery among pregnant women.

The general objective of this study was to assess the awareness and attitude towards the modes of delivery among pregnant women.

METHODOLOGY

Descriptive cross sectional research design was used to find out awareness and attitude towards modes of delivery among pregnant women in their third trimester attending ANC OPD of Chitwan Medical College Teaching Hospital, Chitwan. Pregnant women who were from medical and paramedical field were excluded from study.

Sample Size

The sample calculation was done at 95% confidence interval with 5% allowable error and formula used was

$$n_o = z^2 pq / d^2 \quad \text{Where,}$$

$$P = \text{prevalence} = 50\% = 0.5$$

$$d = \text{allowable error} = 5\% = 0.05$$

$$q = 1 - p = 0.5$$

$$n = \text{desired sample size}$$

Using the formula,

$$n_o = z^2 pq / d^2 = (1.96)^2 * 0.5 * 0.5 / (0.05)^2 = 384.16 = 385$$

Where N= Assumed population

The total population of pregnant women (28 weeks and above gestation) in last month (Baishak) = 289

And in half month the population was about 145. So, the total assumed population for my study was 145.

$$n = no * N / N + (no - 1) = 385 * 145 / 145 + (385 - 1) = 105.5$$

Therefore, total sample size of the study was 106.

Sampling Technique

Non – probability convenience sampling technique was used to collect samples within the period of data collection. Researcher had selected pregnant women attending ANC OPD of selected hospital who met the inclusion criteria and agreed to take part in data collection.

Research Instrument

Structured interview schedule was developed by reviewing the related literatures. The research instrument consists of three parts:

Part I: Questions related to socio-demographic data

Part II: Questions related to awareness regarding modes of delivery

Part III: Question related to Attitude regarding modes of delivery

The content validity of the instrument was established by verifying the developed tools from various subject experts pretesting of the tool was done by collecting data from 11 respondents at similar setting and those were excluded from main study. Administrative approval and written permission was taken from concerned authority of Chitwan Medical College, School of Nursing. Verbal informed consent was taken from each respondent prior to data collection. Respondent's dignity was maintained by allowing them to terminate their participation at any time during data collection period without any penalty. Confidentiality was maintained by not disclosing the information given by them to other. The privacy was maintained by taking the information from respondents separately in separate corner. After taking ethical clearance from Chitwan Medical College-Institutional Review Board (CMC-IRC), permission for research study was taken from the concerned authority as well as ANC OPD staff. Then the researcher introduced herself to the respondents to ascertain their cooperation for the study. Study respondents were requested for participation and informed and explained about the purpose of the study. Verbal informed consent was taken from each respondent and data was collected via face to face interview using structured questionnaire separately in ANC corner. Data was collected within 2 weeks.

The data was obtained from 8 – 9 respondents each day. Each interview schedule was of 25 – 30 minutes.

The collected data were checked, reviewed and organized daily for its completeness, accuracy and consistency. The collected data were coded, organized and then entered into IBM Statistical Package for Social Science (SPSS) version 20.0. Descriptive statistics was used to calculate frequency, percentage, mean and standard deviation and inferential statistics (Chi-square test) was used to measure the association between the variables. The findings of the study were presented in different tables.

RESULTS

Among the 106 respondents, most (38.7%) were from age group 25 to 29 years and 11.3% were from age group less than 20 years. Regarding the religion, most of the respondents (83%) were Hindu and regarding ethnicity, highest (46.2%) were Janjati. Majority (90.6%) of them were literate but still more than half (56.6%) of them were homemaker. Regarding family income, 50.9% respondents had monthly income of 5000 NPR to 20000 NPR and 68.9% respondent's decision regarding antenatal care were made by themselves and their husband while 5.7% respondent's decision were made by family member other than their husband. More than half (43.8%) of respondents receive information regarding modes of delivery from health personal and only 8% receive information from family and friend. Among respondents, more than half (53.8%) were multigravida where 90.57% were prime parity. Regarding modes of delivery, 69.23% had delivered their first child by vaginal and remaining 30.7% delivered by caesarean section. Sixty percentages of respondents had delivered their second child through vaginal delivery and remaining 40% through caesarean section. Regarding place of delivery, 92.3% respondents had delivered their first child in hospital whereas only 1.9% had delivered in home. And 40% respondents had delivered their second child in hospital whereas 60% had delivered health post. Majority i.e. 67.9% of respondents were aware towards modes of delivery (vaginal and caesarean modes of delivery) whereas 32.1% were unaware towards modes of delivery. Similarly, more than half i.e. 52.8% of respondent had positive attitude towards modes of delivery and 47.2% of respondent had negative attitude towards modes of delivery as shown in Table 1.

Table 1

Respondent's level of awareness and attitude towards modes of delivery

Level of Awareness	Frequency	Percentage
Aware (≥ 13)	72	67.9
Unaware (<13)	34	32.1
Total	106	100
Level of Attitude	Frequency	Percentage
Positive (≥ 80)	56	52.8
Negative(<80)	50	47.2
Total	106	100

Table 2 shows respondent's responses on awareness statement towards modes of delivery. It includes statement regarding two modes of delivery (vaginal delivery and caesarean section) and there advantages and disadvantages.

TABLE 2

Respondent's awareness towards modes of delivery

Statement	Correct Responses	
	Frequency	Percentage
Vaginal and caesarean section delivery are two different modes of delivery.	105	99.1
In vaginal delivery, mom can usually able to hold her baby and start breastfeeding sooner	93	87.7
In vaginal delivery mother can return in her daily activities soon.	88	83
Neonatal respiratory disorder is less frequent in vaginal delivery than caesarean section.	74	69.8
Pain in vaginal delivery is more severe than caesarean delivery.	85	80.2
Infection risk of vaginal delivery is less than caesarean delivery.	95	89.6
Perineal trauma from vaginal delivery can lead to urinary retention.	83	78.3
Damage or weaken pelvic floor muscles from vaginal delivery	96	90.6

can lead to uterine prolapsed.		
The average amount of blood loss in caesarean section delivery is higher than average amount of blood loss in vaginal delivery.	38	35.8
Risk of maternal complication is more frequent in caesarean delivery.	91	85.8
Due to wound infection, postpartum sepsis is more prevalent in caesarean section than vaginal delivery.	96	90.6
Caesarean delivery is mandatory after one caesarean delivery.	35	33
In Primigravida, caesarean section delivery is an optional for breech presentation.	96	90.6
Venous thromboembolism is more frequent in vaginal delivery than caesarean delivery.	59	55.7
Caesarean section delivery can decrease the risk of birth injury.	76	71.7
	89	84
There is an increased risk for rupture of C-section scar during subsequent deliveries and subsequent pregnancy.		
	98	92.5
Caesarean section delivery is an optional for tubal ligation as a family planning.		

Table 3 shows respondent's responses on attitude statement towards modes of delivery. The positive statement with highest score was "In vaginal delivery, it is pleasant for a mother to see her baby immediately after birth" (4.88 ± 0.330 , 87.7% strongly agreement). The negative statement with highest score was "If there is no financial problem, Caesarean section is much better" (3.95 ± 1.090 , 33% strongly disagreement).

TABLE 3

Respondent's attitude towards modes of delivery

n=106

Statements	SA No.(%)	A No.(%)	N No.(%)	D No.(%)	SD No.(%)	Mean (SD)
Vaginal delivery is a natural method of delivery.	89 (84)	17 (16)	—	—	—	4.84 (0.369)
In vaginal delivery, it is pleasant for a mother to see her baby immediately after birth.	93 (87.7)	13 (12.3)	—	—	—	4.88 (0.330)
The mother recovers sooner after vaginal delivery.	68 (64.2)	26 (24.5)	2 (1.9)	10 (9.4)	—	4.43 (0.926)
Emotional relationship between mother and the infant is better after vaginal delivery.	38 (35.8)	34 (32.1)	18 (17)	16 (15.1)	—	3.89 (1.063)
In terms of operative fear, vaginal delivery is preferable.	37 (34.9)	48 (45.3)	5 (4.7)	16 (15.1)	—	4.00 (1.005)
Vaginal delivery is much better in long term than caesarean section.	45 (42.5)	50 (47.2)	6 (5.7)	4 (3.8)	1 (0.9)	4.26 (0.808)
I prefer vaginal delivery because I don't like the scare of surgery on my abdomen.*	14 (13.2)	38 (35.8)	9 (8.5)	43 (40.6)	2 (1.9)	2.82 (1.161)
If there is no financial problem, Caesarean section is much better.*	4 (3.8)	13 (12.3)	2 (1.9)	52 (49.1)	35 (33)	3.95 (1.090)
Caesarean section is preferable as mother's position on the delivery table is unpleasant.*	1 (0.9)	22 (20.8)	4 (3.8)	58 (54.7)	21 (19.8)	3.72 (1.040)
Caesarean is preferable because it is less painful than vaginal delivery.*	—	22 (20.8)	7 (6.6)	47 (44.3)	30 (28.3)	3.80 (1.073)
Infants born by Caesarean are healthier than those born by vaginal delivery.*	2 (1.9)	25 (23.6)	8 (7.5)	53 (50)	18 (17)	3.57 (1.087)
Caesarean is associated with complication.	30 (28.3)	63 (59.4)	3 (2.8)	10 (9.4)	—	4.07 (0.831)
If I knew caesarean complications, I would never request caesarean delivery.	28 (26.4)	60 (56.6)	3 (2.8)	15 (14.2)	—	3.95 (0.930)
Caesarean should be performed to save mother	82 (77.4)	24 (22.6)	—	—	—	4.77 (0.420)

and baby when vaginal delivery is risky.						
Mother can feel more weakness after CS than VD.	67 (63.2)	33 (31.1)	2 (1.9)	4 (3.8)	—	4.54 (0.719)
CS helps to assure delivery at specific delivery date.	64 (60.4)	37 (34.9)	3 (2.8)	2 (1.9)	—	4.54 (0.650)
CS has no vaginal trauma.	46 (43.4)	50 (47.2)	3 (2.8)	7 (6.6)	—	4.27 (0.811)
Women who had her first delivery with caesarean may not have caesarean again.	17 (16)	26 (24.5)	3 (2.8)	56 (52.8)	4 (3.8)	2.96 (1.257)
CS should be performed as a choice of the mother.	20 (18.9)	63 (59.4)	5 (4.7)	17 (16)	1 (0.9)	3.79 (0.963)
Caesarean is safe to mother and baby than Vaginal delivery.*	15 (14.2)	49 (46.2)	9 (8.5)	30 (28.3)	3 (2.8)	2.59 (1.128)

SA: Strongly Agree A: Agree N: Neutral D: Disagree SD: Strongly Disagree (*) indicate negative statement

Table 4 shows that level of awareness towards modes of delivery is statically significant with education status ($p < 0.012$) and other variables such as age, religion, ethnicity, occupation, family income, decision making during antenatal period, gravid, pervious mode of delivery and previous place of delivery is not statically significant ($p < 0.05$).

TABLE 4

Association between respondent's level of awareness towards modes of delivery and selected variables

n= 106

Variables	Level of Awareness		χ^2	P value
	Aware No. (%)	Unaware No. (%)		
Age				
≤25	35(61.4)	22(38.6)	2.407	0.121
>25	37(75.5)	12(24.5)		
Religion				
Hindu	60(68.2)	28(31.8)	0.016	0.900
Other than Hindu	12(66.7)	6(33.3)		
Ethnicity				
Brahmin/Chhetri	35(71.4)	14(28.6)	0.514	0.474
Others	37(64.9)	20(35.1)		
Education status				
Illiterate	3(30)	7(70)	7.289	0.012

Literate	69(71.9)	27(28.1)		
Occupation				
Homemaker	37(61.7)	23(38.3)	2.485	0.115
Other than homemaker	35(76.1)	11(23.9)		
Family income				
≤20,000	39(67.2)	19(32.8)	0.027	0.868
>20,000	33(68.8)	15(31.2)		
Decision making during antenatal period				
Self	12(70.6)	5(29.4)	0.066	0.797
Other than self	60(67.4)	29(32.6)		
Gravid				
Primigravida	31(63.3)	18(36.7)	0.908	0.341
Multigravida	41(71.9)	16(28.1)		
First child mode of delivery				
Vaginal	27(75)	9(25)	0.843	0.508
Caesarean	10(62.5)	6(37.5)		
First child place of delivery				
Hospital	36(75)	12(25)	4.497	0.067
Other than hospital	1(25)	3(75)		

Level of Significance at 0.05

Table 5 shows that respondent attitude towards modes of delivery is statically significant with age ($p= 0.017$) and pervious mode of delivery of first child ($p=0.000$) whereas other variables such as religion, ethnicity, education status, occupation, family income, decision making during antenatal period, gravid and previous place of delivery is not statically significant ($p>0.05$).

TABLE 5

Association between respondents' level of attitude towards modes of delivery and selected variables
n=106

Variables	Level of Attitude		χ^2	P value
	Positive No. (%)	Negative No. (%)		
Age				
≤ 25	24(42.1)	33(57.9)	5.692	0.017
>25	37(75.5)	12(24.5)		
Religion				
Hindu	49(55.7)	39(44.3)	1.691	0.193
Other than Hindu	7(38.9)	11(61.1)		
Ethnicity				
Brahmin/Chhetri	24(49)	25(51)	0.542	0.462
Others	32(56.1)	25(43.9)		
Education status				
Illiterate	4(40)	6(60)	0.729	0.393
Literate	52(54.2)	44(45.8)		
Occupation				
Homemaker	30(50)	30(50)	0.444	0.505
Other than homemaker	26(56.5)	20(43.5)		
Family income				
<20,000	29(50)	29(50)	0.412	0.521
>20,000	27(56.2)	21(43.8)		
Decision making during antenatal period				
Self	12(70.6)	5(29.4)	2.562	0.109
Other than self	44(49.4)	45(50.6)		
Gravid				
Primigravida	24(49)	25(51)	0.542	0.462
Multigravida	32(56.1)	25(43.9)		
First child mode of delivery				
Vaginal	26(72.2)	10(27.8)	12.840	<0.001
Caesarean	3(8.9)	13(81.2)		
First child place of delivery				
Hospital	27(56.2)	21(43.8)	0.058	1
Other than hospital	2(50)	2(50)		

Level of Significance at 0.05

Table 6 presents respondent's relationship between score of awareness and attitude towards modes of delivery. Correlation (r) = 0.316 so, there was positive low correlation between total score of awareness and attitude towards modes of delivery and p -value = 0.001 so, there was statistically significant relationship between them.

TABLE 6

Relationship between score of awareness and attitude towards modes of delivery

n = 106		
Variables	r	P value
Awareness	0.316	0.001
Attitude		

r = Spearman's Correlation

DISCUSSION

The study population consisted of 106 pregnant women attending Chitwan Medical College teaching hospital, among which most 38.7% of the respondents belong to age group of 25 to 29. All most all i.e. 90.6% of respondent were literate with maximum completing the higher secondary level. More than half 56.6% of respondent was homemaker and most of respondent i.e. 43.8% received information regarding modes of delivery from health personal. More than half of respondents i.e. 53.8% were multigravida and among which 69.23% of respondent had vaginal method as first child mode of delivery.

Among 106 respondents, 67.9% were aware towards modes of delivery. This finding is supported by study conducted in Baghdad [15] reported that 50% respondent had good knowledge about modes of delivery as well as similar study conducted in Malaysia [16] showed the majority of the respondents (51.4%) have good knowledge about vaginal and caesarean section delivery. But this finding is inconsistent with study conducted in South-west, Nigeria [17] 85.6% of pregnant women scored poor on knowledge about modes of delivery. Good knowledge among participants in this study may be due to information they receive from health personal during their antenatal visit regarding different modes of delivery.

This study shows the significant association between education status and awareness of pregnant women towards modes of delivery. The literate pregnant women are

comparatively more aware than pregnant women with no education ($p < 0.05$). A similar study in Nepal Medical college teaching hospital showed there is significant difference in the knowledge of those who were better or highly educated as compared to those who were not ($p < 0.001$) [18].

This study shows that more than half (52.8%) had positive attitude towards modes of delivery. This finding is consistent with study conducted in where majority of pregnant women had a positive attitude towards both VD and CS [16]. In addition, majority of respondent (87.7%) completely agreed that it is pleasant for a mother to see her baby immediately after vaginal delivery which is similar to the finding in Punjab, India [8] where 86% respondent completely agreed with statement as well as with finding in the study done where most of respondent 92.6% completely agreed with this statement [19].

This study shows that respondent attitude towards modes of delivery is statically significant with age ($p = 0.017$) that is similar to the finding of related study that also showed association between age and attitude towards mode of delivery where more no of younger pregnant women had over all positive attitudes towards vaginal delivery as compared to elder women [18].

This study also shows that respondent attitude towards modes of delivery is statically significant with pervious mode of delivery of first child ($p < 0.001$). Similarly, in a study by Zamani-Alavijeh et al. (2018) stated that attitude is significant factor for pregnant women's belief towards mode of delivery ($p < 0.001$) [20]. The women who gave birth vaginally had significantly higher attitude score than who gave birth by caesarean. Likewise another study also shows association between history of previous CS and positive attitude towards modes of delivery ($p = 0.001$) [15].

This study showed that there was statistically significant relationship between total score of awareness and attitude towards modes of delivery where Correlation (r) was 0.316 and p -value was 0.001 which is similar to the study that reported significant relationship between knowledge and attitude towards caesarean and vaginal delivery ($p < 0.001$) [21].

CONCLUSION

Based on finding, it is concluded that more than half of the pregnant women are aware towards modes of delivery and more than half of the pregnant women have positive attitude towards modes of delivery. There is significant association between level of awareness and education status of pregnant women. And there is significant association between level of attitude and age of pregnant women and modes of delivery of first child. There is statistically significant relationship between awareness and attitude towards modes of delivery of pregnant women. Data collection was limited only in Chitwan Medical College teaching Hospital, Bharatpur in particular timing of two weeks period and with convenience sampling technique. It is recommended to Chitwan Medical College and Teaching hospital to include counselling program related to advantage and disadvantage of different modes of delivery along in safe motherhood program.

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