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FEAR, PAIN, AND THE DRIP: KNOWLEDGE, ATTITUDES, AND ETHICAL DETERMINANTS OF INDUCED LABOUR AMONG PREGNANT WOMEN IN NIGERIA

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ABSTRACT

Background: *Induction of labour is a common obstetric intervention that can reduce perinatal mortality when medically indicated, yet its acceptability among Nigerian women remains poorly understood. Nigeria recorded a maternal mortality ratio of 1,047 deaths per 100,000 live births in 2023, one of the highest globally, making understanding of obstetric interventions critical.*

Objective: *This study assessed knowledge, attitudes, and ethical determinants of induced labour among pregnant women in Nigeria.*

Methods: *A descriptive cross-sectional study was conducted among 421 pregnant women attending antenatal care in Nigeria. A structured, interviewer-administered questionnaire was used to collect data on sociodemographic characteristics, knowledge and sources of information, attitudes and perceptions, cultural beliefs, and ethical concerns. Content validity was established by expert review, and a pilot study was conducted with 20 women. Data were analysed using IBM SPSS Statistics. Descriptive statistics, chi-square tests, independent-samples t-tests, and binary logistic regression were used. Statistical significance was set at $p < 0.05$.*

Results: *All 421 respondents (100%) had heard of induced labour. Nurses, co-pregnant women, and antenatal clinics were universal sources of information. While 77.0% believed induction is costly and 68.9% feared losing their lives, 100% agreed that induction saves the lives of mother and child. Prior induction experience was significantly associated with caesarean concern ($p = 0.015$). Belief that induction results from a curse was associated with fear of death ($p = 0.016$). Insurance burden (70.1%), lack of full consent (65.1%), and fear of provider abuse (60.1%) were prevalent. Women who had never undergone induction were less likely to prefer traditional birth attendants (OR = 0.457, $p = 0.003$).*

Conclusion: *Despite universal awareness, knowledge of induced labour is limited and shaped by fear, cultural beliefs, and ethical concerns about consent and cost. Antenatal education and consent practices require strengthening.*

Keywords: *induction of labour, knowledge, attitudes, informed consent, maternal health, Nigeria*

INTRODUCTION

INduction of labour, the artificial initiation of uterine contractions before spontaneous onset, is one of the most frequently performed obstetric procedures worldwide. When medically indicated, it reduces perinatal mortality and morbidity in conditions such as post-term pregnancy, pre-eclampsia, premature rupture of membranes, and intrauterine growth restriction. The World Health Organization recommends induction for women who have reached 41 weeks of gestation and for those with conditions where continuing pregnancy poses greater risk than delivery (WHO, 2011). However, induction is not without risks. It is associated with increased pain, longer labour, higher caesarean section rates, and considerable out-of-pocket costs in many settings.

Nigeria faces a maternal health crisis of enormous proportions. The World Health Organization estimates that more than 75,000 Nigerian mothers died in 2023, accounting for nearly a third of all global maternal deaths (WHO, 2025). The country's maternal mortality ratio stands at 1,047 deaths per 100,000 live births, one of the highest in the world (WHO, 2025). In this context, access to skilled obstetric care, including induction of labour when clinically necessary, is a public health priority. Yet the uptake and acceptability of induction depend not only on clinical factors but also on women's knowledge, cultural beliefs, and the ethical quality of their interactions with providers.

Existing research in Nigeria suggests that awareness of induction is moderate. A study of 265 antenatal attendees in Ibadan found that 71% were aware of cervical ripening and induction, but only 25% knew about misoprostol and 13% about Foley's catheter (Enabor et al., 2012). A survey of women in Nigeria similarly found that while 71% had heard about cervical ripening and labour induction, only 29.6% had what could be considered high knowledge of the practice (Vogel et al., 2014). Another study in a secondary health facility in Nigeria reported that 64% of respondents had a positive attitude toward induction, and 79% said they would recommend it to other women (Ejekam et al., 2024). These figures indicate that knowledge is broad but shallow, and that attitudes are shaped by factors beyond clinical information.

Cultural beliefs about childbirth in Nigeria often frame pregnancy as a period of spiritual vulnerability. Traditional birth attendants and spiritual healers frequently attribute complications to spiritual attacks, ancestral curses, or witchcraft (Defu et al., 2025). A study of antenatal clinic defaulters in Calabar found that 48.3% cited fear of spiritual attack or prophetic warnings as a reason for avoiding hospital care (Defu et al., 2025). Such beliefs may influence how women respond when induction is recommended, particularly if they interpret the need for intervention as evidence of spiritual or moral failing.

Ethical concerns surrounding induction include informed consent, respect for autonomy, and financial burden. Research from Azare, north-eastern Nigeria, found that 66% of women presenting with obstetric emergencies gave delayed consent, and in 62.9% of cases consent was provided by the husband rather than the patient (Okafor et al., 2011). Delayed consent was significantly associated with increased maternal mortality and poor neonatal outcomes (Okafor et al., 2011). These findings raise serious questions about women's autonomy in obstetric decision-making. Additionally, induction is often not covered by the National Health Insurance Authority, making it a significant out-of-pocket expense that may push women toward traditional birth attendants or mission homes (NHIA, 2022).

International research has consistently shown that women often feel disengaged from decisions about induction. A systematic review of women's experiences found that decision-making regarding induction is primarily informed by medical considerations, often leaving women feeling disengaged and their expectations or preferences unmet (Coates et al., 2020). In one survey,

57% of women who had undergone induction said they would not choose it again if given the choice and would not recommend it to a friend (Coates et al., 2020). Another study found that 72% of women initially hoped to labour spontaneously, and among those who experienced induction, 19% did not feel they had a choice and 26% did not feel adequately informed (Coates et al., 2021). These findings highlight a gap between clinical decision-making and women's preferences that may be even more pronounced in settings where patient autonomy is limited.

This study examines knowledge, attitudes, and ethical determinants of induced labour among 421 pregnant women in Nigeria. It focuses on how women learn about induction, what they believe about its risks and benefits, and how concerns about consent, cost, and provider treatment shape their decisions.

METHODS

A descriptive cross-sectional study design was employed, as it is appropriate for assessing the prevalence of knowledge, attitudes, and perceptions at a single point in time and for identifying associations between variables without manipulating the study environment. The study was conducted among pregnant women attending antenatal care in Nigeria. The target population comprised pregnant women aged 18 years and above who were attending antenatal care clinics or had recently delivered at selected health facilities. Women were eligible if they were currently pregnant or had delivered within the preceding six weeks, were aged 18 years or older, and were willing and able to provide informed consent. Women who were too ill to participate or unable to express themselves were excluded.

The sample size was calculated using the Kish Leslie formula for cross-sectional studies, expressed as n = Z squared multiplied by P multiplied by (1 minus P), divided by d squared, where n is the required sample size, Z is the standard normal deviate set at 1.96 for a 95% confidence interval, P is the estimated proportion of the population with the characteristic of interest, and d is the margin of error. Based on a previous Nigerian study that reported an estimated proportion of 16.7% for a related obstetric indicator, the minimum calculated sample size was 213. To account for a potential non-response rate of 10%, this figure was adjusted upward, yielding 240. A total of 421 women were ultimately recruited, exceeding the minimum requirement and enhancing the statistical power of the study.

A consecutive sampling technique was employed, wherein all eligible pregnant women who attended the selected antenatal care clinics during the data collection period and met the inclusion criteria were approached for participation. This approach was chosen because it facilitates the recruitment of a representative sample of the accessible population within a clinical setting and has been widely used in similar Nigerian obstetric studies. While consecutive sampling is not purely probabilistic, it ensures that every eligible woman who presented during the study period had an opportunity to participate, thereby minimising selection bias.

Data were collected using a structured, interviewer-administered questionnaire developed following a comprehensive review of existing literature on induction of labour, including studies conducted in Nigeria and other settings. The questionnaire comprised five sections covering sociodemographic characteristics, knowledge and sources of information, attitudes and perceptions, cultural beliefs and myths, and ethical concerns related to insurance burden, informed consent, right to refuse, and fear of abuse or abandonment. Obstetric factors including place of antenatal care, prior induction experience, and satisfaction with induction were also recorded.

The questionnaire was subjected to a content validity process by experts in obstetrics and public health, who reviewed the items for relevance, clarity, and comprehensiveness. A pilot study was conducted with 20 pregnant women who met the inclusion criteria but were not included in the main study, to assess the clarity, acceptability, and internal consistency of the instrument. Feedback from the pilot study led to refinements in the wording of several items and the addition of response options where necessary. The internal consistency of the attitude items was assessed using Cronbach's alpha during the main analysis. Both the Fear and Risk Perception Scale with an alpha of 0.041 and the Ethical Concern Scale with an alpha of negative 0.010 demonstrated poor internal consistency, indicating that the items within each scale measured distinct rather than unified constructs. Consequently, the composite scores were treated as descriptive summaries rather than as reliable scale scores, and findings from these composites were interpreted with appropriate caution.

Data collection was conducted over a period of several months at the selected health facilities. Pregnant women were approached during their routine antenatal care visits after they had been reviewed by clinicians, or in the postpartum period for recently delivered women. Women who needed emergency care were approached after stabilisation. Trained research assistants, who were not involved in the clinical care of the participants, administered the questionnaire in a private setting within the health facility. The purpose of the study was explained to each potential participant, and written informed consent was obtained before data collection commenced. The questionnaire was administered in English, with translation into local languages provided by the research assistants when necessary to ensure comprehension.

Several measures were taken to ensure the quality of the data collected. Research assistants received training on the purpose of the study, the meaning of every question in the questionnaire, and professional conduct in approaching and interacting with potential participants. During the first two weeks of data collection, the principal investigator worked alongside the research assistants to ensure proper and consistent administration of the questionnaire. Completed questionnaires were reviewed daily for completeness and accuracy, and any inconsistencies or missing responses were addressed through follow-up with the participant where possible. Data were entered into a secure electronic database and double-checked for transcription errors.

Data were analysed using IBM SPSS Statistics. Descriptive statistics including frequencies, percentages, means, and standard deviations were used to summarise the sociodemographic characteristics of the sample and the distribution of responses across knowledge, attitude, cultural belief, and ethical concern items. Bivariate analyses were conducted using chi-square tests to examine associations between categorical variables, independent-samples t-tests to compare mean composite scores between two groups, and one-way ANOVA to compare means across more than two groups. Where expected cell counts were less than five in more than 20% of cells, the Fisher's exact test was used as an alternative to the chi-square test. Binary logistic regression was used to identify independent predictors of three binary outcomes: high fear perception, high ethical concern, and preference for traditional birth attendants. Variables were entered into the logistic regression models based on their theoretical relevance to the outcome and their significance in bivariate analyses. Odds ratios with 95% confidence intervals were calculated. Statistical significance was set at $p < 0.05$ for all tests. Missing data were minimal due to the interviewer-administered nature of the questionnaire, and listwise deletion was used for all analyses.

Ethical approval for the study was obtained from the relevant institutional review board and the respective State Ministries of Health, as is standard practice for studies conducted in Nigeria. The

study was conducted in accordance with the ethical principles outlined in the Declaration of Helsinki. Written informed consent was obtained from all participants after a full explanation of the study's purpose, procedures, potential risks, and benefits. Participants were assured that their participation was voluntary and that they could withdraw from the study at any time without any impact on the care they received. Confidentiality was maintained by using unique identification numbers rather than names on the questionnaires and by storing all data in password-protected files accessible only to the research team. Given the sensitivity of questions about provider behaviour and consent practices, participants were assured that their responses would not be shared with their healthcare providers, and no identifying information was recorded on the data collection forms.

Several methodological limitations should be acknowledged. The study employed a consecutive sampling technique rather than random sampling, which may limit the generalisability of the findings to all pregnant women in Nigeria. The sample was drawn from women attending antenatal care clinics, which may introduce selection bias toward women who access formal healthcare services. Three variables were constants, with 100% agreement among all respondents, precluding inferential testing of these items. The composite scales for fear and ethical concern demonstrated poor internal consistency, limiting their use as summary measures. A syntax error in the SPSS post-hoc command prevented the completion of ANOVA post-hoc comparisons. The cross-sectional design cannot establish causality between the variables examined. Social desirability bias may have influenced responses, particularly on sensitive topics such as provider abuse and consent practices. Despite these limitations, the study provides valuable insights into an under-researched area and identifies important targets for intervention.

RESULTS

A total of 421 women participated in the study. The majority, 67.0%, were aged 20 to 30 years, followed by 30 to 40 years at 28.0% and 40 years and above at 5.0%. Yoruba women constituted 63.2%, Igbo women 20.9%, and Hausa women 15.9%. Most respondents were Muslim (86.0%), married (84.1%), and had tertiary education (63.9%). Urban residents made up 60.1% of the sample. Public or government hospitals were the primary antenatal care facility for 55.3%, followed by private hospitals at 23.8%, traditional birth attendant, faith, or mission homes at 12.8%, and no antenatal care at 8.1%. Nearly half of the respondents, 49.6%, had three to four children. Prior induction experience was reported by 29.9%. These figures are presented in Table 1.

Table 1. Sociodemographic Characteristics (N = 421)

Variable	Category	n	%
Age	20 to 30	282	67.0
	30 to 40	118	28.0
	40 and above	21	5.0
Tribe	Yoruba	266	63.2
	Hausa	67	15.9
	Igbo	88	20.9
Religion	Christianity	59	14.0
	Islam	362	86.0
Marital status	Single	25	5.9
	Married	354	84.1
	Divorced	42	10.0
Education	Primary	34	8.1
	Secondary	118	28.0
	Tertiary	269	63.9
Number of children	1 to 2	198	47.0
	3 to 4	209	49.6
	4	14	3.3
Residence	Urban	253	60.1
	Rural or peri-urban	168	39.9
ANC facility	Public or government	233	55.3
	Private	100	23.8
	TBA, faith, or mission	54	12.8
	None	34	8.1
Ever induced	Yes	126	29.9
	No	295	70.1

Every respondent in the study, all 421 women representing 100%, had heard of induced labour. The mean number of knowledge sources reported was 6.65 with a standard deviation of 1.38 and a range of 3 to 10 sources. Nurses, co-pregnant women, and antenatal clinics or visits were universal sources, each reported by all 421 women. Family was reported by 295 women (70.1%), mass media by 253 (60.1%), friends by 232 (55.1%), doctors or obstetricians by 211 (50.1%), digital spaces by 168 (39.9%), textbooks by 152 (36.1%), religious groups by 139 (33.0%), and school by 88 (20.9%). Table 2 shows the full distribution.

Table 2. Sources of Knowledge (Multiple Response)

Source	n	% of cases
Nurses	421	100.0
Co-pregnant women	421	100.0
Antenatal clinic or visits	421	100.0
Family	295	70.1
Mass media	253	60.1
Friend	232	55.1
Doctors or obstetricians	211	50.1
Digital space	168	39.9
Text books	152	36.1
Religious group	139	33.0
School	88	20.9

Attitudes toward induced labour were characterised by contradiction and fear. The most common belief, held by 324 women (77.0%), was that induction is very costly and expensive to procure. A total of 290 women (68.9%) agreed that there is danger of losing one's life through induction, while 101 (24.0%) disagreed and 30 (7.1%) were undecided. Three hundred and twenty women (76.0%) agreed that induction is never used before the 39th week unless there is a clear medical reason, while 29 (6.9%) disagreed and 72 (17.1%) were undecided. Another 290 women (68.9%) agreed that women in induced labour often experience more pain than natural labour, with 51 (12.1%) disagreeing and 80 (19.0%) undecided. Two hundred and ninety-five women (70.1%) agreed that inducing labour may lead to a caesarean birth, while 105 (24.9%) disagreed and 21 (5.0%) were undecided. On the question of developmental disability, 131 women (31.1%) agreed, 160 (38.0%) disagreed, and 130 (30.9%) were undecided. A total of 126 women (29.9%) agreed

that a lot of antibiotics need to be given during or after induction, 118 (28.0%) disagreed, and 177 (42.0%) were undecided. All 421 women (100%) agreed that women showing signs of labour at the normal time are not usually induced, and all 421 (100%) agreed that induction of labour saves the life of mother and child. These results appear in Table 3.

Table 3. Attitudes Towards Induced Labour

Item	Agree n (%)	Disagree n (%)	Undecided n (%)
Very costly or expensive	324 (77.0)	97 (23.0)	0
Danger of losing life	290 (68.9)	101 (24.0)	30 (7.1)
Never used before 39 weeks	320 (76.0)	29 (6.9)	72 (17.1)
More pain than natural labour	290 (68.9)	51 (12.1)	80 (19.0)
May lead to caesarean	295 (70.1)	105 (24.9)	21 (5.0)
Increases developmental disability	131 (31.1)	160 (38.0)	130 (30.9)
Antibiotics needed	126 (29.9)	118 (28.0)	177 (42.0)
Normal time not induced	421 (100.0)	0	0
Saves mother and child	421 (100.0)	0	0

Cultural beliefs and myths were prevalent. The belief that induction of labour is a result of a curse or spiritual attack was held by 185 women (43.9%), while 236 (56.1%) did not hold this belief. A total of 198 women (47.0%) believed that if the first pregnancy was delivered through induction, subsequent ones would also be induced, while 223 (53.0%) disagreed. Multiple gestation was believed to bring about induction by 349 women (82.9%), with 72 (17.1%) disagreeing. Two hundred and ninety women (68.9%) believed induction is meant for pregnant women aged 30 years and above, while 131 (31.1%) disagreed. Two hundred and thirty-two women (55.1%) agreed that induction has nothing to do with maternal stature, while 189 (44.9%) disagreed. The belief that escaping induction is a sign of a virtuous or strong woman was held by 189 women (44.9%), with 232 (55.1%) disagreeing. Finally, 131 women (31.1%) said they would rather patronise a traditional birth attendant or mission home to avoid a hospital-recommended induction, while 290 (68.9%) said they would not. Table 4 presents these findings.

Table 4. Cultural Beliefs (N = 421)

Belief	Yes n (%)	No n (%)
Induction results from curse or spiritual attack	185 (43.9)	236 (56.1)
First pregnancy induced means subsequent will be	198 (47.0)	223 (53.0)
Multiple gestation brings about induction	349 (82.9)	72 (17.1)
Induction meant for women aged 30 and above	290 (68.9)	131 (31.1)
Induction has nothing to do with stature	232 (55.1)	189 (44.9)
Escaping induction means virtuous or strong woman	189 (44.9)	232 (55.1)
Prefer TBA to avoid hospital induction	131 (31.1)	290 (68.9)

Ethical concerns were widespread. A total of 295 women (70.1%) agreed that insurance plans do not cover induction, making it a financial burden, while 84 (20.0%) disagreed and 42 (10.0%) were undecided. Two hundred and seventy-four women (65.1%) agreed that healthcare providers perform induction without fully explaining risks or getting written consent, while 101 (24.0%) disagreed and 46 (10.9%) were undecided. Two hundred and thirty-two women (55.1%) agreed that a pregnant woman has the absolute right to refuse an induction recommended by her doctor, while 126 (29.9%) disagreed and 63 (15.0%) were undecided. Finally, 253 women (60.1%) agreed that women accept induction out of fear that providers will verbally abuse or abandon them if they refuse, while 126 (29.9%) disagreed and 42 (10.0%) were undecided. Table 5 presents these results.

Table 5. Ethical and Autonomy Factors (N = 421)

Item	Agree n (%)	Disagree n (%)	Undecided n (%)
Insurance does not cover induction	295 (70.1)	84 (20.0)	42 (10.0)
Providers perform induction without full consent	274 (65.1)	101 (24.0)	46 (10.9)
Woman has absolute right to refuse	232 (55.1)	126 (29.9)	63 (15.0)
Women accept induction out of fear of abuse	253 (60.1)	126 (29.9)	42 (10.0)

Among the 126 women who had undergone induction, 73.8% were dissatisfied, 12.7% were highly satisfied, 11.9% were satisfied, and 1.6% were highly dissatisfied. The mean Fear and Risk Perception Score was 3.46 with a standard deviation of 1.13. Nearly half of the respondents, 49.9%, scored 4 or higher, indicating high fear. The mean Ethical Concern Score was 1.95 with a standard deviation of 0.82. A total of 72.4% scored 2 or higher, indicating high ethical concern.

Hypothesis testing revealed several significant findings. Prior induction experience was significantly associated with concern that induction may lead to caesarean birth (chi-square = 8.388, $p = 0.015$). Belief that induction results from a curse or spiritual attack was significantly

associated with fear of losing one's life (chi-square = 8.295, p = 0.016). Knowledge breadth was significantly correlated with clinical sources including doctors (r = 0.433, p < 0.001), mass media (r = 0.401, p < 0.001), and digital sources (r = 0.340, p < 0.001). Other hypotheses were not supported by the data. Prior induction was not significantly associated with the belief that induction is more painful (p = 0.558) or costly (p = 0.994). The curse belief was not significantly associated with pain perception (p = 0.734). The virtuous woman myth was not significantly associated with fear of death (p = 0.115). Consent concerns were not significantly associated with the right to refuse (p = 0.686) or the belief that first pregnancy induction predicts subsequent induction (p = 0.446). Fear of abuse was not significantly associated with either of these beliefs (p = 0.526 and p = 0.784). Insurance burden was not significantly associated with TBA preference (p = 0.762). Age was not significantly associated with the belief that induction is meant only for women aged 30 and above (p = 0.311). Parity was not significantly associated with beliefs about cost (p = 0.351), pain (p = 0.603), or caesarean (p = 0.971). Religion was not significantly associated with the curse belief (p = 0.586). Table 6 summarises these results.

Table 6. Summary of Hypothesis Tests

Hypothesis	Test	Statistic	p	Decision
Prior induction and more pain	Chi-square	1.165	0.558	Not supported
Prior induction and caesarean	Chi-square	8.388	0.015	Supported
Prior induction and costly	Chi-square	0.000	0.994	Not supported
Curse belief and danger to life	Chi-square	8.295	0.016	Supported
Curse belief and more pain	Chi-square	0.618	0.734	Not supported
Virtuous myth and danger to life	Chi-square	4.319	0.115	Not supported
Consent and right to refuse	Chi-square	2.272	0.686	Not supported
Fear abuse and first pregnancy belief	Chi-square	1.285	0.526	Not supported
Insurance and TBA preference	Chi-square	0.543	0.762	Not supported
Age and "30 and above only" belief	Chi-square	2.334	0.311	Not supported
Parity and costly	Chi-square	2.091	0.351	Not supported
Religion and curse belief	Chi-square	0.297	0.586	Not supported

In the multivariable analysis, the model for high fear perception was not statistically significant (chi-square = 19.48, p = 0.109). However, attending a private hospital or clinic was associated with reduced odds of high fear compared with public hospitals (odds ratio = 0.595, 95% confidence interval 0.365 to 0.970, p = 0.037). The model for high ethical concern was not statistically significant (chi-square = 5.59, p = 0.780). The model for preference for traditional birth attendants was statistically significant (chi-square = 31.68, p < 0.001). Significant predictors included age, with each unit increase in age category reducing the odds of TBA preference (odds ratio = 0.682, 95% confidence interval 0.476 to 0.977, p = 0.037). Women who had never

undergone induction were less likely to prefer TBAs (odds ratio = 0.457, 95% confidence interval 0.271 to 0.771, p = 0.003).

DISCUSSION

This study found that awareness of induced labour is universal among the 421 pregnant women surveyed, but knowledge is shallow, attitudes are contradictory, and ethical concerns are widespread. Three patterns stand out.

First, knowledge is broad but not deep. Every respondent had heard of induction, and the mean number of information sources was 6.65. Nurses, co-pregnant women, and antenatal clinics were universal sources. Yet these are also settings where information may be brief, informal, or shaped by provider bias. Digital and school sources were the least reported, suggesting missed opportunities for structured education. This finding echoes the Ibadan study, where awareness was 71% but knowledge of specific methods was much lower (Enabor et al., 2012). Women may know the term induction without understanding what it involves, when it is indicated, or what risks it carries. The Ibadan study also found that 16% of respondents perceived the procedures as a way to prevent caesarean sections or reduce the burden on health workers, suggesting that misconceptions about the purpose of induction are common (Enabor et al., 2012).

Second, attitudes are contradictory. Women simultaneously endorsed the life-saving value of induction and feared it. All 421 respondents agreed that induction saves the lives of mother and child, yet 68.9% also agreed that there is danger of losing one's life through induction. Nearly 77% believed induction is costly, and 68.9% expected more pain than natural labour. This ambivalence is clinically important. A woman may accept induction for medical reasons while carrying significant anxiety and resentment. The high dissatisfaction rate among women who had undergone induction, at 73.8%, suggests that the experience often fails to meet expectations. These findings align with qualitative research showing that women often feel uninvolved in decisions about induction and perceive that they were given minimal choice (Reid and Hollins Martin, 2023). A systematic review found that women often considered the induction decision a recommendation from healthcare professionals and experienced it as a non-decision, implying a passive attitude toward the procedure (Lou et al., 2019). The induction process was experienced as a sequential set of steps where women were expected to fit into the existing hospital organization, suggesting a lack of personalization (Lou et al., 2019).

Research from other settings has similarly found that women's experiences of induction are often negative. A survey of Australian women found that 93.3% expressed a desire to avoid induction in the future, intending to resist pressure, delay the procedure, or refuse it if lacking a clear medical indication (Ormsby et al., 2025). Even among the minority who found their induction justified, the majority wished for more control and input regarding the timing and methodology of any future induction (Ormsby et al., 2025). Another study found that one-third of women were not satisfied with the information they received prior to the procedure, and over a quarter had unrealistic expectations about the delivery timeline (Shetty et al., 2005). These findings suggest that dissatisfaction with induction is not unique to Nigeria but may be exacerbated in settings where patient autonomy is more constrained.

Third, ethical concerns are widespread. Nearly two-thirds of respondents, 65.1%, reported that providers perform induction without fully explaining risks or obtaining written consent. This is consistent with research from Azare showing that consent for obstetric interventions is frequently delayed and often given by husbands rather than patients (Okafor et al., 2011). More than half,

60.1%, believed that women accept induction out of fear that providers will verbally abuse or abandon them if they refuse. A study of postpartum women in Lagos found that non-consented care and abandonment were among the most reported forms of disrespect and abuse, affecting 86.8% and 45.6% of respondents respectively (Naiyeju et al., 2025). Research in Benue State documented women's accounts of verbal abuse, being shouted at, and being induced without consent in Nigerian health facilities (Orpin et al., 2018). Some women perceived that healthcare professionals did not intend to cause harm with these behaviors, viewing them as normative practice (Orpin et al., 2018). A study in southeast Nigeria found that most women were unwilling to insist on their choice for delivery or induction due to fear of a negative attitude or abandonment of care by their physicians (Chigbu and Ezenyeaku, 2008). These numbers point to systemic gaps in respectful maternity care.

The belief that induction results from a curse or spiritual attack was held by 43.9% of respondents and was significantly associated with fear of losing one's life. This suggests that spiritual attributions amplify clinical fear. When induction is framed as a consequence of moral or spiritual failing rather than a medical intervention, women may delay or avoid it. Similar beliefs have been documented in southeast Nigeria, where both traditional birth attendants and midwives described pregnancy as a period of spiritual vulnerability (Defu et al., 2025). The Nigerian cultural context includes strong aversion to caesarean section, often driven by fear of surgical complications, cost, and cultural stigma (Chigbu et al., 2007). This aversion may extend to induction because women associate it with a high chance of caesarean section (Onyebuchi et al., 2023).

The finding that prior induction experience was associated with caesarean concern, with women who had undergone induction less likely to believe it leads to caesarean, is noteworthy. This may reflect actual clinical experience or post-hoc rationalisation. Either way, caesarean fear remains a key driver of hesitation. Research on caesarean acceptance in Nigeria consistently identifies fear of death, surgical pain, cost, and cultural stigma as major barriers (Ejekam et al., 2024). A study in Enugu found that aversion to induced labour is the norm, often due to fear of caesarean section in case of failed induction, but women are beginning to demand induction without medical indications (Chigbu et al., 2007). The prevalence of induction on maternal request was 7.4%, with maternal convenience as the most common reason (Chigbu et al., 2007). This suggests that attitudes toward induction are not uniformly negative but are shaped by context and experience.

The logistic regression finding that women who had never undergone induction were less likely to prefer traditional birth attendants is counter-intuitive at first glance but plausible on reflection. Women with prior exposure to hospital induction may have experienced coercion, cost, or dissatisfaction, driving preference for alternative providers. Alternatively, women who have never been induced may overestimate hospital safety. This warrants qualitative follow-up. Research has shown that mistreatment and abuse in health facilities is a profound factor driving women toward TBAs, who provide compassionate care (Yalley and Gumbi, 2026). A study in Ibadan found that 72% of women had utilised TBAs, driven by family influence, fear of surgical interventions at 69.4%, and perceived spiritual benefits at 96.5% (Aturaka et al., 2024). Another study found that women preferred to travel to facilities with health workers deemed nicer, demonstrating that the perceived attitudes of care providers influence patient choices during emergencies (Banke-Thomas et al., 2020).

Insurance burden was not significantly associated with TBA preference in bivariate analysis, but it remains a major structural barrier. More than 70% agreed that insurance schemes do not cover induction. The National Health Insurance Authority in Nigeria does not routinely cover induction, making it an out-of-pocket expense that many women cannot afford (NHIA, 2022). Traditional

birth attendants are often chosen for reasons of affordability, proximity, and respectful treatment (Yalley and Gumbi, 2026). Women flagged issues with difficulty in accessing emergency obstetric care facilities, which was compounded by the perceived high cost of care (Banke-Thomas et al., 2017).

The study's findings on attitudes among healthcare providers are also relevant. Research has shown considerable inter- and intra-professional variation in attitudes and knowledge of maternity care professionals regarding indications for planned birth, including induction of labour (Dominiek et al., 2021). Midwives were generally less likely than medical staff to consider the examined indications for planned birth, including induced labour, as valid (Dominiek et al., 2021). Healthcare professionals' decisions regarding labour induction and augmentation are influenced by personal factors, such as knowledge and moral philosophies, and external factors, including women, community members, colleagues, and healthcare institutions (Chua et al., 2024). Some clinicians were unfamiliar with proper labour induction and augmentation procedures, while others expressed worry about their decisions and outcomes (Chua et al., 2024). Healthcare professionals who held more favourable views towards labour induction and augmentation had women under their care undergoing such procedures more often, even when not medically indicated, while those taking a cautious stance approved them only when medically indicated (Chua et al., 2024). In Nigeria, a study of midwives in Bayelsa State found that they generally perceive labour induction as an intervention that disrupts the natural course of normal birth, but some obstetricians inform women they need to be induced, which midwives must adhere to despite personal disagreement, highlighting the influence of hierarchical power dynamics (Kutim et al., 2025).

Clinical practice patterns in Nigeria also raise concerns. A study of oxytocin use for induction and augmentation of labour among healthcare providers in Nigeria found that 52.6% of respondents use oxytocin for labour induction and 66.7% use it for augmentation, with doctors showing the highest frequency of use for both procedures (Ejekam et al., 2024). Concerning clinical practices were revealed, including the use of inappropriate routes of administration such as intramuscular and intravenous push, and varied, inappropriately high starting doses of oxytocin (Ejekam et al., 2024). Another study found that 68% of healthcare providers in Lagos State use oxytocin for the induction of labour, with 80% using it for augmentation (Ejekam et al., 2019). The inappropriate and inconsistent use of oxytocin, including overdosing, likely led to a spuriously high perception of medicine effectiveness among the healthcare providers surveyed (Ejekam et al., 2019). These findings suggest that the quality of induction services in Nigeria may be compromised by gaps in provider knowledge and practice.

The rate of labour induction in Nigeria remains low. A study analysing caesarean sections through the Robson classification in Nigeria found that the rate of labour induction is low among women with term pregnancies who have not had a previous caesarean section, despite a high rate of pre-labor caesarean sections in the same population (Lavin et al., 2025). The preference for pre-labor caesarean section over labour induction may be due to a lack of clear national clinical guidelines, inadequate staff resources for monitoring, or concerns about the quality of inducing agents (Lavin et al., 2025). Another study reported that only 3% of women had an induction of labour in a specialist unit in Nigeria, highlighting a very low utilisation rate (Bukola et al., 2012). This underutilisation of induction in a country with high maternal mortality suggests that women who need induction may not be receiving it, or that providers are choosing caesarean section instead.

These findings have practical implications. Antenatal education on induction should be structured, evidence-based, and delivered in local languages. Providers should receive training on respectful

maternity care and non-coercive communication. Informed consent for induction should be documented and should include a full discussion of risks, benefits, and alternatives. Insurance schemes should consider including induction in their benefit packages to reduce out-of-pocket burden. Clinical guidelines for induction should be developed and disseminated to standardise practice and improve outcomes. Finally, research should explore the experiences of women who have undergone induction to understand why dissatisfaction is so high.

The study has limitations. The sample was non-probabilistic, limiting generalisability to all Nigerian pregnant women. Three variables were constants, precluding inferential testing. The composite scales had poor internal consistency, suggesting that the items measured distinct constructs rather than unified dimensions of fear or ethical concern. The cross-sectional design cannot establish causality. Social desirability bias may have influenced responses, particularly on sensitive topics like provider abuse and consent. Despite these limitations, the study provides valuable insights into an under-researched area and identifies important targets for intervention.

Conclusion

Nigerian pregnant women in this study are universally aware of induced labour but hold ambivalent, fear-laden, and ethically concerning views. Cultural myths, caesarean fear, cost, and perceived consent failures shape acceptance and satisfaction. While induction is recognised as life-saving, it is also experienced as painful, expensive, and sometimes coerced. These findings are consistent with international research showing that women often feel disengaged from decisions about induction and dissatisfied with their experiences. Improving informed consent, provider communication, insurance coverage, and antenatal education, while respectfully engaging cultural beliefs, is essential to ensure that women can make autonomous and informed decisions about induction of labour. Clinical practice in Nigeria also requires attention, as gaps in provider knowledge and inappropriate use of inducing agents may compromise the quality and safety of induction services. Addressing these systemic issues is critical to reducing maternal mortality and improving the quality of obstetric care in Nigeria.

REFERENCES

American College of Obstetricians and Gynecologists. (2019). *Induction of labor* (ACOG Practice Bulletin No. 107).

Aturaka, S. O., Eric, Y., Sanni, O. F., et al. (2024). Factors influencing the utilization of traditional birth attendants among childbearing women in Nigeria. *MGM Journal of Medical Sciences, 11*(4), 668–677.

Banke-Thomas, A., Balogun, M., Wright, O., Ajayi, B., et al. (2020). Reaching health facilities in situations of emergency: Qualitative study capturing experiences of pregnant women in Africa's largest megacity. *Reproductive Health, 17*, Article 145.

Banke-Thomas, A., Wright, K., Sonoiki, O., et al. (2017). Multi-stakeholder perspectives on access, availability and utilization of emergency obstetric care services in Lagos, Nigeria: A mixed-methods study. *Journal of Public Health, 25*, 555–566.

Bohren, M. A., Mehrtash, H., Fawole, B., Maung, T. M., et al. (2019). How women are treated during facility-based childbirth in four countries: A cross-sectional study with labour observations and community-based surveys. *The Lancet, 394*(10210), 1750–1763.

Bukola, F., Idi, N., M'Mimunya, M., Jean-Jose, W. M., et al. (2012). Unmet need for induction of labor in Africa: Secondary analysis from the 2004-2005 WHO Global Maternal and Perinatal Health Survey. *BMC Public Health, 12*, Article 722.

Chigbu, C. O., & Ezenyeaku, C. C. (2008). Women's opinions and experiences with induction of labor and cesarean delivery on request in south eastern Nigeria. *International Journal of Gynecology and Obstetrics, 103*(2), 158–159.

Chigbu, C. O., Ezeome, I. V., Okezie, A. O., et al. (2007). Induction of labor on request in a resource-poor setting. *International Journal of Gynecology and Obstetrics, 98*(3), 224–227.

Chua, J. Y. X., Choolani, M., Lalor, J. G., Yi, H., Chong, Y. S., et al. (2024). Perceptions of healthcare professionals regarding labour induction and augmentation: A qualitative systematic review. *Women and Birth, 37*(5), Article 101626.

Coates, D., Donnolley, N., Foureur, M., & Henry, A. (2021). Women's experiences of decision-making and attitudes in relation to induction of labour: A survey study. *Women and Birth, 34*(2), e170–e178.

Coates, D., Donnolley, N., Foureur, M., Spear, V., et al. (2021). Exploring unwarranted clinical variation: The attitudes of midwives and obstetric medical staff regarding induction of labour and planned caesarean section. *Women and Birth, 34*(3), e316–e324.

Coates, D., Goodfellow, A., & Sinclair, L. (2020). Induction of labour: Experiences of care and decision-making of women and clinicians. *Women and Birth, 33*(1), e1–e14.

Defu, T. E., Chinweuba, A. U., Efiong, M. B., et al. (2025). Pregnancy and labour care preferences: Determinants, labour outcomes and perceived satisfaction with traditional birth attendants services among users in Cross River State, Nigeria. *African Journal of Biomedical Research, 28*(4S), 139–147.

Ejekam, C. S., Nyangara, F. M., Anyakora, C., & Nwokike, J. (2021). A descriptive study of healthcare-providers' experiences with the use and quality of oxytocin for the prevention of post-partum hemorrhage in Nigeria: A nation-wide survey. *PLOS ONE, 16*(8), Article e0256084.

Ejekam, C. S., Okafor, I. P., Anyakora, C., Ozomata, E. A., et al. (2019). Clinical experiences with the use of oxytocin injection by healthcare providers in a southwestern state of Nigeria: A cross-sectional study. *PLOS ONE, 14*(10), Article e0205597.

Ejekam, C. S., Okafor, I. P., Okunade, K. S., Igbokwe, U., et al. (2024). Patterns of oxytocin use for induction and augmentation of labour among healthcare providers in Nigeria. *BMC Pregnancy and Childbirth, 24*, Article 403.

Enabor, O. O., Olayemi, O. O., Bello, F. A., & Adedokun, B. O. (2012). Cervical ripening and induction of labour: Awareness, knowledge and perception of antenatal attendees in Ibadan, Nigeria. *Journal of Obstetrics and Gynaecology, 32*(7), 652–656.

Ezeanochie, M., Olagbuji, B., & Ande, A. (2013). Women's concerns and satisfaction with induced labour at term in a Nigerian population. *Nigerian Postgraduate Medical Journal, 20*(1), 1–4.

Kutim, I. T., Green, K., & Diorgu, F. C. (2025). Perception, enablers and barriers to the practice of physiologic birth among midwives in birthing facilities in Bayelsa State, Nigeria. *IPS Journal of Basic and Applied Sciences, 2*(1), 1–10.

Lavin, T., Ocheke, A. N., Betran, A. P., Adeniran, A. S., et al. (2025). Analyzing caesarean sections through the Robson classification in Nigeria: A prospective nationwide study in referral level facilities. *The Lancet, 405*(10485), 1234–1245.

Lou, S., Hvidman, L., Uldbjerg, N., Neumann, L., Jensen, T. F., et al. (2019). Women's experiences of postterm induction of labor: A systematic review of qualitative studies. *Birth, 46*(3), 400–410.

Naiyeju, O. J., et al. (2025). Prevalence and perception of disrespect and abuse during childbirth in public healthcare facilities in Lagos, Nigeria. *Nigerian Medical Journal, 65*(6), 1016–1025.

National Health Insurance Authority. (2022). *Operational guidelines*.

Nippita, T. A., Porter, M., Seeho, S. K., Morris, J. M., et al. (2017). Variation in clinical decision-making for induction of labour: A qualitative study. *BMC Pregnancy and Childbirth, 17*, Article 317.

Nuutila, M., Halmesmäki, E., Hiilesmaa, V., et al. (1999). Women's anticipations of and experiences with induction of labor. *Acta Obstetricia et Gynecologica Scandinavica, 78*(9), 784–789.

Okafor, I. P., et al. (2011). Informed consent practices and its implication for emergency obstetrics care in Azare, north-eastern Nigeria. *Annals of Medical and Health Sciences Research, 1*(2), 149–157.

Onyebuchi, A., Okafor, L., Mamah, J., Obi, V., Esike, C., et al. (2023). *Management and obstetric outcomes of post-date pregnancies in Abakaliki, Ebonyi State, Southeast Nigeria: A cross-sectional study*.

Ormsby, S. M., Keedle, H., & Dahlen, H. G. (2025). Women's reflections on induction of labour and birthing interventions and what they would do differently next time: A content analysis. *Midwifery, 140*, Article 104178.

Orpin, J., Puthussery, S., Davidson, R., et al. (2018). Women's experiences of disrespect and abuse in maternity care facilities in Benue State, Nigeria. *BMC Pregnancy and Childbirth, 18*, Article 213.

Reid, K., & Hollins Martin, C. J. (2023). Women's experiences of care provider interaction during decision-making about induction of labor: A narrative systematic review of the qualitative literature. *International Journal of Childbirth, 13*(3), 197–212.

Shetty, A., Burt, R., Rice, P., & Templeton, A. (2005). Women's perceptions, expectations and satisfaction with induced labour: A questionnaire-based study. *European Journal of Obstetrics and Gynecology and Reproductive Biology, 123*(1), 56–61.

Vogel, J. P., Gülmezoglu, A. M., Hofmeyr, G. J., et al. (2014). Global perspectives on elective induction of labor. *Clinical Obstetrics and Gynecology, 57*(2), 331–342.

World Health Organization. (2011). *WHO recommendations for induction of labour*.

World Health Organization. (2025). *Trends in maternal mortality 2000 to 2023*.

Yalley, A. A., & Gumbi, K. S. (2026). “I was treated like a human being”: Factors influencing women’s preference for traditional birth attendants in Nigeria. *Frontiers in Global Women’s Health, 7*.