SOCIO-CULTURAL BARRIERS TO CAESAREAN MODE OF CHILDBIRTH AMONGST WOMEN OF REPRODUCTIVE AGE IN ANAMBRA STATE, NIGERIA

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ABSTRACT
Childbirth preferences, including the choice between vaginal delivery (VD) and Caesarean section (CS), are profoundly influenced by socio-cultural factors, particularly in low- and middle-income countries like Nigeria. Despite global efforts and World Health Organization (WHO) recommendations for optimal CS rates, Nigeria exhibits a significantly low CS prevalence (3.0% nationally, 1.5% in rural areas), suggesting an unmet need and highlighting the influence of non-medical factors. This study investigates socio-cultural barriers influencing the utilization of Caesarean mode of childbirth among women of reproductive age in Anambra State, Nigeria. Key barriers identified include cultural and religious beliefs that stigmatize CS as "unnatural" or a sign of weakness, patriarchal structures limiting women's autonomy in reproductive decisions, reliance on traditional birth attendants (TBAs), fear of medical complications, and misconceptions, influence of family pressure and community expectations.The study adopted mixed-research design combining quantitative and qualitative research methods.The target population for the study was 111,315 which was estimated population of women of reproductive age 15-49 in Awka North and South LGA by Nigerian Population Commission in 2023. The sample size for the study was 660 statistically determined using Cochran's formula. The multistage sampling procedure involving cluster, stratified, systematic and simple random sampling techniques at different stages in the sampling process was employed to select 660 respondents for the study The instruments for data collection included structured questionnaires and in-depth interviews,. Findings show that religious beliefs (39.9%) and cultural constraints (25.6%) are significant barriers to accessing Caesarean Section (CS) as childbirth. Addressing these barriers through community-based educational initiatives, strengthening healthcare infrastructure, and empowering women in decision-making is crucial for improving maternal and neonatal health outcomes in the region.

Keywords: Socio-cultural barriers, Caesarean section, Childbirth preferences, Reproductive age women, Anambra State, Nigeria, Maternal health.

INTRODUCTION
Childbirth is a profoundly significant life event, intricately shaped not only by physiological processes but also by a complex interplay of socio-cultural, economic, and healthcare factors. While contemporary medical advancements have broadened childbirth options to include both vaginal delivery and Caesarean section (CS), women's preferences for delivery are often profoundly influenced by deeply ingrained cultural norms, prevailing societal expectations, and various structural barriers within their communities especially in low and middle income countries like Nigeria. A comprehensive understanding of these multifaceted barriers is indispensable for the formulation of effective strategies that uphold women's reproductive

autonomy and enhance maternal health outcomes, particularly concerning the judicious utilization of critical medical interventions like CS.

Maternal and neonatal mortality persist as pressing global public health concerns, especially in low- and middle-income countries where healthcare systems frequently fall short of the minimum standards advocated by the World Health Organization (WHO). The alarming rates of maternal and neonatal mortality have driven significant shifts in global health priorities, notably through the establishment of Millennium Development Goals (MDGs) 4 and 5 in 2000, aimed at improving maternal health and reducing child mortality, and subsequently the Sustainable Development Goals (SDGs) 3.1 and 3.2 in 2015, which target substantial reductions in maternal and neonatal mortality by 2030. In spite of these concerted international efforts, maternal and neonatal mortality rates regrettably remain unacceptably high, particularly across sub-Saharan Africa. Nigeria, in particular, bears a disproportionate burden, with one of the highest maternal mortality rates globally, estimated at 576 deaths per 100,000 live births in 2022, and accounting for 19% of the world's total maternal deaths by 2015. Leading causes of maternal death, including haemorrhage, hypertensions, and infections, are often compounded by pre-existing medical conditions and entrenched childbirth practices.

Caesarean section, a critical medical intervention, has demonstrably improved birth outcomes globally, significantly reducing maternal and neonatal morbidity and mortality. The World Health Organization suggests an ideal CS rate for a country ranges from 5% to 15%, yet global rates continue to climb, with some countries exceeding 40%. However, in Nigeria, the national prevalence of caesarean deliveries was approximately 3.0% in 2018, with stark regional disparities: 5.8% in urban areas and a mere 1.5% in rural regions. A Caesarean (CS) rate lower than 10% signals an insufficient number of procedures, indicating that a substantial proportion of women who medically require a CS may not be receiving this life-saving intervention. Addressing the underlying barriers contributing to these low rates is paramount for achieving equitable maternal and child health outcomes across Nigeria.

Childbirth practices in Nigeria are profoundly influenced by socio-cultural factors that shape women's preferences for delivery methods, often manifesting as a strong inclination towards traditional vaginal delivery over Caesarean section. This preference is deeply rooted in cultural beliefs and societal norms that venerate natural birth processes. Several socio-cultural barriers impede women's access to preferred childbirth methods, including deeply held cultural and religious beliefs, traditional practices such as male-dominated decision-making (patriarchal structures), and a persistent reliance on traditional birth attendants (TBAs). For instance, certain cultural beliefs actively discourage CS, associating it with negative connotations or deeming it "unnatural". In some communities, undergoing a CS is perceived as a mark of a woman's inability to deliver naturally, which can lead to significant social stigma. TBAs, whose practices and advice are often deeply entrenched in tradition, can inadvertently discourage women from opting for CS, even when medically necessary. These socio-cultural barriers can culminate in adverse outcomes, such as delayed decision-making due to the fear of stigma associated with CS, leading to complications, a preference for home deliveries conducted without skilled attendants, increasing the risk of maternal and neonatal complications, and widespread misconceptions about the inherent dangers of CS as a surgical procedure. Research indicates that women who undergo CS may face social ostracism and stigmatization, being perceived as weak or inadequate, which discourages others from considering the procedure. Furthermore, factors such as a woman's age, education, income level, and place of residence also variously affect her access to preferred childbirth methods. While existing studies on maternal/child

health and delivery-related issues in Southeast Nigeria have largely concentrated on the place of delivery and access to skilled birth attendants, there has been a notable paucity of research exclusively focusing on socio-cultural barriers to the preferred mode of childbirth, specifically CS, by women of reproductive age in Anambra State. Given the rapid social changes spurred by globalization, urbanization, and technological advancements, juxtaposed with Nigeria's escalating socio-economic challenges and insecurity crises, a dedicated investigation into these socio-cultural barriers to CS has become imperative. This study is thus specifically designed to address this critical gap by investigating the socio-cultural barriers to Caesarean mode of childbirth among women of reproductive age in Anambra State, Nigeria.

The overarching goal of this study is to investigate the socio-cultural barriers to Caesarean mode of childbirth by women of reproductive age in Anambra State, Southeast Nigeria. Specifically, this study aims to:

1. Investigate the socio-cultural barriers to Caesarean (CS) mode of childbirth by women of reproductive age in Anambra State, Nigeria.
2. Examine the effects of the socio-cultural barriers to Caesarean mode of childbirth on safe childbirth choices by women of reproductive age in Anambra State, Nigeria.
3. Identify strategies to reduce the socio-cultural barriers to Caesarean mode of childbirth and promote its utilization for safe childbirth choices by women of reproductive age in Anambra State, Nigeria.

LITERATURE REVIEW

Literature consistently demonstrates that socio-cultural factors profoundly influence childbirth preferences and experiences, particularly concerning the utilization of Caesarean section (CS). In many Nigerian cultures, deeply entrenched patriarchal structures tend to foster power imbalances, thereby significantly limiting women's voice, autonomy, and decision-making capabilities regarding childbirth preferences. Men often wield substantial control over women's reproductive health, dictating their choices and experiences during childbirth. For instance, in Kusada, Katsina State, Nigeria, men are reported to hold the authority in deciding whether their wives should give birth at home, in a private hospital, or through CS. This pervasive patriarchal dominance frequently results in women being coerced into childbirth preferences that may diverge significantly from their own desires or actual medical needs. Empirical research by Bello et al. (2022) corroborates this, highlighting the impact of gender relations on maternal health literacy, utilization of maternal healthcare services, and ultimate pregnancy outcomes in Nigeria.

Beyond patriarchal influences, traditional practices and deeply held cultural beliefs also form substantial socio-cultural barriers to childbirth preferences. A common phenomenon in many local Nigerian communities is the preference for Traditional Birth Attendants (TBAs) over modern medical care, a choice often driven by cultural familiarity and social factors. While TBAs can offer valuable support and care, they demonstrably lack the necessary medical training, equipment, and resources to effectively manage complications that may arise during childbirth. Furthermore, cultural beliefs surrounding childbirth can lead to severe social repercussions, with women often stigmatized or shamed for opting for modern medical care, such as CS, over traditional practice or vaginal mode of delivery. As articulated by Eke et al. (2021), the pervasive fear, shame, and socio-cultural stigma associated with certain childbirth preferences, particularly CS, can significantly restrict women's choices. For example, in some parts of North and Southeast Nigeria, women who undergo CS are victimized and stigmatized for not achieving a 'natural' birth. Misconceptions about CS dangers due to surgical procedures

also deter acceptance. Family pressure further compounds these challenges, with women often facing immense pressure from family members or community leaders to adhere to traditional childbirth practices or preferences. This pressure is particularly acute for women who have limited access to education, stable income, or quality healthcare services. Nnebue et al. (2016) meticulously highlighted that socio-cultural barriers to childbirth preferences are intrinsically complex and multifaceted, reflecting the intricate interplay of patriarchal power dynamics, traditional birth practices, cultural beliefs, fear, shame, stigma, family pressure, and the general understanding of CS. Udenigwe et al. (2021) in their study in rural Nigeria, also identified that various perceptions of vaginal and caesarean birth, traditional practices, gender norms, power dynamics, social stigma, economic barriers, religious doctrines and the attitude of health professionals are major socio-cultural barriers to childbirth methods. The inability to choose a preferred mode of childbirth due to socio-cultural barriers carries profound implications for maternal and neonatal health outcomes. Women who succumb to societal pressure to conform to traditional childbirth practices may face elevated risks of complications due to constrained access to timely medical interventions, especially when required. For example, a marked reluctance to undergo CS, often stemming from cultural stigma or widespread misinformation, can precipitate prolonged labor, birth injuries, or tragically, maternal and infant mortality. Adedokun et al. (2023) further reported that effects of barriers to preferred childbirth include negative health-seeking behavior, low utilization of antenatal care services, increased maternal and infant mortality, delayed access to emergency care, emotional distress, loss of autonomy, and promotion of harmful birth practices. Additionally, healthcare provider biases and entrenched gender norms can inadvertently prevent women from exercising autonomous decision-making, leading to adverse childbirth experiences and dissatisfaction with maternal healthcare services. Addressing these deeply embedded barriers is therefore fundamental for enhancing childbirth safety and ensuring that all women receive the necessary care unencumbered by cultural or social constraints. Globally, it has been significantly revealed that the societal norms, values, and culture of any country have a substantial effect on its maternal mortality rate, often deeply rooted in the disadvantaged role and status of women within society. Sociocultural norms and traditional practices are significant factors in pregnancy, childbirth, postpartum, and children's survival. Key socio-cultural barriers affecting childbirth preferences, as identified by Alamrew, Sisay, Ayele, et al. (2024), include the perception of childbirth as a natural process, which fosters a preference for home births assisted by traditional birth attendants over institutional deliveries, and the profound influence of family and community members, especially male partners, in decision-making. Furthermore, concerns about disrespect or mistreatment within healthcare settings, coupled with economic and logistical constraints, deter women from opting for institutional deliveries, often leading to reliance on unskilled birth attendants. Lower levels of education and socioeconomic status are also strongly associated with reduced utilization of maternal healthcare services, further influencing delivery choices and increasing reliance on traditional methods. These socio-cultural barriers collectively impact women's access to and utilization of safe childbirth options, leading to adverse maternal and neonatal outcomes, including increased mortality, delayed emergency care, and underutilization of postpartum and antenatal services.

Literature also presents empirical insights into factors influencing CS acceptance. Ahmat et al. (2022) found that in Kaduna metropolis, 7% of urban obstetricians preferred elective CS for uncomplicated pregnancies, and 38% preferred it if the estimated foetal weight was 4.5 kg. Reasons given by women for preferring CS included less pain, easier method, safer method, and shorter labor duration. Okoli et al. (2020) in Enugu metropolis reported that while 86% preferred vaginal delivery, 14% preferred CS. Higher proportions of CS preference were

observed among women with tertiary education (19.3%), those living in larger households, married women, and those above 30 years. Similarly, women with a history of previous CS (54.2%) were more likely to prefer it again, and urban residents were 2.5 times more likely to prefer CS than rural residents. Anikwe et al. (2021) identified specific socio-economic factors affecting CS acceptance, including high cost, lack of certified gynaecologists, and perceived fear of pain or stigma. Maduka and Okubor (2024) in South-South Nigeria also found that perceived fear of complications, stigmatization, and cost were major socio-economic factors affecting CS access and acceptance. Notably, mothers with previous pregnancy complications and husband's approval showed a higher tendency to accept CS delivery.

THEORETICAL FRAMEWORK

This study is anchored on the Health Belief Model (HBM) and the Theory of Planned Behaviour (TPB). The Health Belief Model, initially developed to elucidate why individuals engage or refrain from engaging in preventive health services, posits that an individual's health-related behavior is profoundly influenced by their perceptions of susceptibility to a health condition, its perceived severity, the anticipated benefits of taking action, and the perceived barriers to that action. In the context of this study, HBM offers a valuable framework for understanding why women in Anambra State might choose to accept or reject CS. This can be understood through their perceived susceptibility to childbirth complications (e.g., prolonged labor leading to fetal distress), their assessment of the severity of those complications, their perceived benefits of undergoing CS (e.g., safety for mother and baby, avoiding perceived dangers of vaginal birth), and the perceived barriers to opting for CS (e.g., cultural stigma, fear of surgery, financial cost, social disapproval). To effectively address these socio-cultural barriers, the HBM suggests targeted interventions such as educating women about the benefits and risks of different childbirth modes, sensitizing healthcare providers and community leaders to cultural nuances, and empowering women through education and social support to enhance their self-efficacy and confidence in making informed decisions about their childbirth methods. The model's ability to predict female behaviour, particularly concerning method of childbirth, makes it apt for this study.

Complementing the HBM, the Theory of Planned Behaviour (TPB) suggests that an individual's intention to perform a given behaviour serves as the most immediate determinant of that behavior. This intention is shaped by three interconnected constructs: the individual's attitude towards the behavior (their positive or negative evaluation of performing the behaviour, such as their attitude towards CS), the subjective norm (the perceived social pressure to perform or not perform the behavior, reflecting beliefs about what important others—like family members, husbands, or community members—think regarding natural birth or CS), and perceived behavioral control (the perceived ease or difficulty of performing the behaviour, encompassing factors like access to healthcare facilities, financial resources, or the perceived ability to override family objections regarding CS). The Theory of Planned Behaviour helps in understanding how societal and cultural pressures, alongside individual beliefs and perceived control, influence women's decisions regarding CS in Anambra State. These models collectively provide a robust and nuanced framework for analyzing the complex interplay of individual beliefs, social norms, and practical constraints that shape childbirth preferences and decisions regarding CS in the study area. These models highlight that a woman's decision is not merely a medical one but is deeply embedded in her personal perceptions, social environment, and perceived ability to act within those contexts.

MATERIALS AND METHOD

The study rigorously employed a mixed-methods research design, integrating both quantitative and qualitative approaches within a singular study to achieve a comprehensive understanding of the socio-cultural barriers impacting the utilization of Caesarean mode of childbirth. This design was deliberately chosen over a purely quantitative or qualitative approach, as it allows for a more holistic and nuanced exploration of the research problem by combining the breadth of numerical data with the depth of experiential insights.

The research was geographically situated in Anambra State, Nigeria, a region strategically selected for its unique blend of traditional practices and modern influences, which provides a rich context for examining socio-cultural behaviors related to childbirth. Anambra State is predominantly inhabited by the Igbo ethnic group, known for their strong adherence to traditional beliefs, particularly those concerning family structures, childbirth rituals, and gender roles. Cultural expectations surrounding "womanhood" and the ideal of "strength in natural birth" remain prevalent, alongside perceptions that Caesarean section (CS) may signify weakness. These cultural nuances underscored the state's suitability as an ideal location for exploring how deeply ingrained norms shape childbirth preferences. The study specifically focused on two local government areas (LGAs) within Anambra State: Awka North, designated as a rural LGA, and Awka South, identified as an urban LGA.

The study population comprised women of reproductive age, defined internationally as females biologically capable of pregnancy and childbirth, typically ranging from 15 to 49 years old. The broader general population for Anambra State was estimated at 6,469,824 for 2023, projected using a 2.6% annual population growth rate. From this, the specific target population for the study, focusing on women of reproductive age in Awka North and Awka South LGAs, was estimated to be 111,315 individuals, based on the approximation that women of reproductive age constitute approximately 23% of the state's total projected population. A statistically robust sample size of 600 respondents was calculated using Cochran’s formula. This formula is typically employed for large populations when the proportion of the population with the attribute of interest is not explicitly known, thus assuming a proportion of 0.5 for maximum variability and a 4% margin of error for a 95% confidence level. This calculated initial sample size of 600.25 was adjusted for the finite population to 597, and then rounded up to 600 to ensure equal representation across the selected LGAs. The sample size was deemed sufficiently large to accommodate the statistical tools employed and to manage within the researcher's practical constraints of time and resources.

The multistage sampling technique was adopted to select the respondents for the quantitative component of the study, involving the application of different sampling methods at successive stages. In the initial stage, Anambra State was stratified into its 5 urban Local Government Areas (Awka South, Onitsha North, Onitsha South, Nnewi North, and Idemili North) and 16 rural Local Government Areas based on population size. From these strata, one urban LGA (Awka South) and one rural LGA (Awka North) were randomly selected using a simple random sampling technique (the ballot option). The in-depth interviews (IDIs) were conducted, with participants selected purposively to gain rich, nuanced perspectives. These IDI participants included three gynaecologists/surgeons, three married men, and three married women, and were distinct from the respondents who completed the questionnaires. The inclusion criteria for all study participants included being women aged 15-49 years, residents of Anambra State for at least 12 months, having experienced at least one childbirth (to ensure practical childbirth experience relevant to preferences and outcomes), and providing full informed consent. Nulliparous women (those who had never given birth) were explicitly excluded from the study

as their lack of direct childbirth experience would not align with the study's objective of understanding lived preferences and barriers. Data were systematically collected using two primary instruments: structured questionnaires for quantitative data collection and in-depth interview (IDI) guides for qualitative data collection. Questionnaires were self-administered to literate respondents and other administered to illiterate respondents..

The quantitative data was processed with Statistical Package for Social Sciences (SPSS) version 25.0 and analysed using the descriptive statistical tools such as simple percentages, frequency distribution tables, and cross-tabulations were employed for data analysis and interpretation. The formulated research hypotheses were rigorously tested using chi-square (X^2) inferential statistics. For the qualitative data, a manual thematic analysis approach was adopted. This involved a verbatim transcription of all nine interviews, followed by careful vetting and arrangement of the transcriptions in alignment with the study's research objectives.

FINDINGS

The comprehensive findings of this study provide crucial insights into the socio-cultural barriers to Caesarean mode of childbirth among women of reproductive age in Anambra State, Nigeria, and illuminate the subsequent effects of these impediments on safe childbirth choicesThe analysis is based on the 554 correctly filled and returned questionnaires, representing a 92.33% response rate from the distributed instruments.

Socio-demographic Characteristics of Respondents

The socio-demographic profile of the 554 respondents offers a foundational understanding of the study population.. The age distribution of the respondents, ranging from 15-49 years, which encompasses the entire childbearing age spectrum, was categorized into seven five-year intervals. A notable majority of respondents, specifically 51.2%, were aged between 35-39 years, followed by those aged 30-34 years, accounting for 22.7% of the sample. This age distribution was considered advantageous for the study, as it facilitated the collection of accurate information from individuals with actual experience of childbirth. Regarding educational attainment, a significant proportion, 24.9%, had secondary school education, while only 9.0% possessed higher degrees, indicating that the majority of respondents generally had a medium level of educational attainment. In terms of income, the financial landscape of the respondents revealed that 46.6% earned between N5,000.00 and N42,984.00, suggesting that a predominant portion of the sample belonged to a low-income group. The religious affiliation data showed a strong Christian dominance, with 95.9% identifying as Christian, 3.4% as Muslim, and 0.2% adhering to African Traditional Religion, which aligns with the known demographics of Anambra State. Occupationally, the respondents were largely engaged in productive activities: 36.5% were involved in business/trading, and 36.1% were civil servants, reflecting the enterprising spirit of the Igbo people and Anambra State's economic dynamism. The marital status of the respondents indicated that a substantial majority, 52.2%, were married.

Socio-cultural Barriers to Caesarean Mode of Childbirth

The study investigated the socio-cultural barriers that significantly influence the utilization of Caesarean section among women of reproductive age in Anambra State. As shown in table 1

Table 1: Barriers during Delivery Decision Making (CS-focused)

Barrier	Frequency	Percentage (%)
Religious belief	221	39.9
Cultural constraints	142	25.6
Access to healthcare facilities	86	15.5

Misinformation or myths	69	12.5
Influence of family/community	28	5.1
Fear of medical procedures	8	1.4
Total	554	100.0

Source: Fieldwork 2025

Table 1- vividly illustrates the specific barriers encountered during the delivery decision-making process. Religious beliefs were identified as a predominant barrier by 39.9% of respondents, making it the most frequently cited impediment. Cultural constraints followed closely, attributed by 25.6% of the respondents. Other significant barriers included access to healthcare facilities (15.5%) and misinformation or myths surrounding childbirth (12.5%). A smaller percentage, 5.1%, pointed to the influence of family/community, and only 1.4% cited fear of medical procedures as a barrier. These quantitative findings were strongly corroborated by qualitative insights. A male IDI participant (37, married, trader, Awka South) provided an in-depth perspective:

"The issue of culture and religious belief which works hand in hand has dealt with people from time immemorial, our people especially from this side of the world still has strong belief that women are still under men because the society upholds male dominance". Furthermore, Table 1, reveals that patriarchal/male dominance was identified as a prevalent cultural practice influencing the mode of delivery by 43.7% of the respondents, highlighting its significant role as a barrier. A male participant (40, married, business, Awka South) expressed a seemingly contradictory view on male dominance, stating If a woman is in the house and the house is burning, will she stay and wait for the husband to tell her to run away before she runs? So, any woman who has seen that her life or that of her baby is in danger and is waiting for the husband's approval before making life threatening decision is not informed, please women should be empowered to take decisions concerning safe motherhood as we live in an environment where people spent a lot of money on burial, so when people give the excuse of not having money for a CS, I always cringe. Nigeria is developing; no gynaecology surgeon will refuse to perform a CS for a pregnant woman. They will perform it and hold you in the hospital until the amount is raised and paid in full. There's organization who as well volunteer to help in clearing the debt.

This suggests a nuanced perspective, with some men advocating for women's autonomy in life-threatening situations related to childbirth.

Effects of Socio-cultural Barriers to Caesarean Mode of Childbirth on Safe Childbirth Choices

The study investigated how the identified socio-cultural barriers affect safe childbirth choices, with a particular focus on their implications for the utilization of CS as shown in table2.

Table 2: Effects of Barriers on CS and Safe Childbirth amongst Women of Reproductive Age

Outcome	Frequency	Percentage (%)
Increased Maternal and Neonatal Mortality	221	39.9
Underutilization of Postpartum Services	142	25.6
Birthing children with avoidable disabilities	86	15.5

Delayed Emergency Care	69	12.5
Stillbirths	28	5.1
I do not know	8	1.4
Total	554	100.0

Source: Fieldwork 2025

Table 2 presents the effects of these barriers on safe childbirth. A majority of respondents identified some negative to include "Increased Maternal and Neonatal Mortality," reported by 39.9% of respondents. "Underutilization of Postpartum Services" was identified by 25.6%, while "Birthing children with avoidable disabilities" and "Delayed Emergency Care" were cited by 15.5% and 12.5% respectively. "Stillbirths" accounted for 5.1% of the responses. These compelling findings imply that, among the various adverse consequences of unsuitable delivery choices, the heightened risk of maternal and neonatal mortality poses the most severe threat. Qualitative data strongly supported these findings. The inability to choose a preferred mode of childbirth due to socio-cultural barriers has significant implications for maternal and neonatal health. Women who face societal pressure to conform to traditional childbirth practices may be at increased risk of complications due to limited access to medical interventions when needed. For instance, a reluctance to undergo caesarean sections due to cultural stigma or misinformation can result in prolonged labour, birth injuries, or even maternal and infant mortality. Additionally, healthcare provider biases and gender norms may prevent women from making autonomous decisions, leading to adverse childbirth experiences and dissatisfaction with maternal healthcare services. Addressing these barriers is essential for improving childbirth safety and ensuring that women receive the care they need without cultural or social constraints

Strategies to Reduce Socio-cultural Barriers to Caesarean Mode of Childbirth and Promote Its Utilization

The study also investigated strategies to mitigate the socio-cultural barriers and promote safe childbirth choices, particularly concerning the appropriate utilization of CS as shown in table 3

Table 3: Measures to Reduce the Socio-cultural barriers on Caesarean Mode of Childbirth

Measure	Frequency	Percentage (%)
Increase women's knowledge of the benefits of safe delivery (VB/CS)	423	42.6
Provide functional health system/facilities and access	85	18.3
Improved socio-economic status of women	36	14.7
Eliminate cultural/religious practices affecting maternal health	10	10.9
Total	554	100.0

Source: Fieldwork 2025

Table 3 illustrates the specific measures identified. The most prominent strategy, cited by 42.6% of respondents, was to Increase women's knowledge of the benefits of safe delivery of either VB or CS," viewed as a panacea for improving women's decisions regarding the optimal choice for each child birthing. This was closely followed by "Provide functional health system/facilities and access to the health facility," identified by 18.3% of respondents as an important strategy for enhancing women's decision-making on delivery choices. Qualitative data strongly supported the emphasis on awareness and education. A female health worker (34, Awka South) advocated for Awareness creation through the media, markets, women's gathering locations, churches, and social groups to inform women about the danger of not attending antenatal clinics and adhering to doctors' prescribed mode of delivery either CS or VB what matters is the safety of mother and children. Encourage them to come for antenatal so they meet a doctor, and let them understand their medical history, they can never have the same history with another person or during each delivery. Every pregnant woman should understand that their life is important and once the person dies, their life is gone and cannot be replaced. Furthermore, a male participant (37, married, trader, Awka North) further stressed the broad reach required for such campaigns:

> Deliberate creation of awareness is very important to people of all ages, not just the pregnant women because if you focus your attention on only pregnant women, they will still be influenced by significant others who hold tight to whatever their belief system is. So, creating awareness on making informed decision on the particular mode of delivery suitable for birthing each baby is very important. Start with where men are gathering, go to the market, and teach market women, even in the August meeting. Make it a point of duty to reach out to every walk of life especially the men because the woman doesn't exist alone neither does she get herself pregnant. If proper education and adherence to the doctors prescribed mode of delivery is followed accordingly, maternal mortality will be curbed.

DISCUSSION

The findings of this study provide robust empirical evidence that deeply reinforces existing literature on the pervasive influence of socio-cultural factors on childbirth preferences and outcomes, particularly concerning Caesarean section (CS) utilization in a Nigerian context. This discussion will systematically explore how these findings address the study's three core objectives: investigating socio-cultural barriers to CS, examining their effects on safe childbirth choices, and identifying strategies for reduction and promotion of CS.

Regarding the first objective, the study's results found that deeply ingrained religious beliefs (39.9%) and pervasive cultural constraints (25.6%) stand as significant barriers to women's access to and acceptance of CS in Anambra State. This finding resonates strongly with prior research by Eke et al. (2021) and Imo (2022) who highlighted that women in various parts of Nigeria, including the Southeast, are frequently victimized and stigmatized for not undergoing a "natural" birth. The widespread belief among respondents (62.6%) that cultural factors exert a strong influence on the mode of childbirth further underscores the deep integration of traditional norms into health-seeking behaviours and birthing choices within the study area. The issue of culture and religious belief which work hand in hand has dealt with people in Nigeria. Nigerians people especially Igbo people still has strong belief that women are under men because the society upholds male dominance. In a study carried out by Amadi et al. (2021) on the topic: a five-year review of caesarean section at the Rivers State University Teaching Hospital, South-South, Nigeria. The study adopted mixed methods research design and

multistage sampling procedure. 250 women participated in the study. Analysis of data was done using descriptive statistics. The study focused on mothers and found that 1% of mothers reported that they once had a planned caesarean section knowing that there was no medical reason for it. The idea according to the respondents was to challenge the existing socio-cultural barriers such as stigma, isolation and victimization that tend to discourage caesarean section among childbearing women. Additionally, patriarchal structures were identified as a prevalent cultural practice influencing mode of delivery by 43.7% of respondents, with qualitative insights revealing that male approval for CS is often sought and typically granted only when severe medical abnormalities become evident. This directly reflects the socio-cultural barriers to CS utilization as articulated in the first objective.

Regarding the second objective on the effects of socio-cultural barriers on Caesarean Section mode of childbirth effects of these barriers on safe childbirth, a majority of respondents identified some negative to include "Increased Maternal and Neonatal Mortality," reported by 39.9% of respondents. "Underutilization of Postpartum Services" was identified by 25.6%, while "Birthing children with avoidable disabilities" and "Delayed Emergency Care" were cited by 15.5% and 12.5% respectively. "Stillbirths" accounted for 5.1% of the responses. These compelling findings imply that, among the various adverse consequences of unsuitable delivery choices, the heightened risk of maternal and neonatal mortality poses the most severe threat. Findings from Adedokun et al. (2023) who investigated determinants of partial and adequate maternal health services utilization in Ibadan, Oyo State, Nigeria found the effects of barriers to preferred childbirth among women of reproductive age to include negative health seeking behaviour, low utilization of antenatal care services in Ibadan, increased maternal and infant mortality, delayed access to emergency care, emotional distress, loss of autonomy (i.e., feelings of dissatisfaction by women) and promotion of harmful birth practices.

On measures to reduce the effects of the socio-cultural barriers on Caesarean mode of childbirth Similarly this study found that the 42.6% of the respondents identified increase of women's knowledge about the benefits of safe delivery of either VB or CS," as a panacea for improving women's decisions regarding the optimal choice for each child birthing. This was closely followed by "Provide functional health system/facilities and access to the health facility," identified by 18.3% of the respondents as an important strategy for enhancing women's decision-making on delivery choices. These finding align with Akokuwebe and Okafor (2015) who contended that, for there to be real sustainable transformation of Nigeria, the issue of maternal health should be accorded priority through reducing maternal mortality rate by government and other stakeholders. This could be achieved through massive enlightenment, sustainable education, poverty reduction, and adequate provision and funding of healthcare facilities in Nigeria

CONCLUSION

This study investigated the Socio-cultural barriers to Ccaesarean mode of childbirth among women of reproductive age in Anambra State, Nigeria. Findings show that deep-rooted religious beliefs, fear of stigmatization, and misconception significantly influence women's aversion to Caesarean Section(CS).Many women perceive CS as a failure of womanhood , a sign of weakness, often reinforced by family members, traditional birth attendants, and community norms. These barriers affect women's willingness to make informed and medically safe birth choices. The reluctance or delay in accepting CS when medically indicated contributes to maternal and neonatal mortality. The perception of CS as unnatural and undesirable continues to hinder its timely utilization, thereby threatening the goal of safe

motherhood. However, the study identified viable strategies to reduce these socio-cultural barriers including community based health education targeted sensitization campaigns and engagement with religious leaders.

Addressing the socio-cultural impediments to CS utilization through public health education, male and community engagement strengthened healthcare infrastructure, and policy interventions aimed at promoting gender equity and friendly maternity care are essential to improving maternal and child health outcomes in Anambra State. In other words, multifaceted and culturally sensitive approach is critical in promoting CS as a safe childbirth option in Anambra State, Nigeria.

RECOMMENDATIONS

Based on the findings of this study, the following recommendations are put forward to address the identified socio-cultural barriers on Caesarean Section (CS)to promote safer childbirth choices in the area of study:-

(1)Culturally Sensitive Community-Based Educational Programs to Address the Barriers: Given that religious beliefs (39.9%) and cultural constraints (25.6%) were identified as significant barriers to CS acceptance, and considering the high level of awareness regarding these barriers (85%), it is recommended that the government and relevant stakeholders initiate comprehensive, culturally sensitive awareness campaigns. These programs should leverage various media channels (radio, television) and community platforms (markets, women's gatherings, churches) to disseminate accurate information about the benefits and safety of medically indicated Caesarean section, explicitly designed to dispel prevailing myths, fears, and stigma associated with the procedure.

(2)Empower Women to Enhance Autonomy in CS Decisions and Combat Negative Effects: Recognizing that socio-cultural barriers lead to severe outcomes such as increased maternal and neonatal mortality (39.9%) and delayed emergency care (12.5%), and that educational attainment significantly influences CS acceptance, policy makers should develop and implement targeted initiatives. This empowerment should include promoting female education and fostering economic opportunities to strengthen women's autonomy and confidence in making informed, evidence-based decisions about their childbirth methods, including CS, free from undue external influence. Such empowerment directly addresses the effects of male-dominated decision-making and fosters an environment where women can make timely choices for safe childbirth.

(3)Strengthen Healthcare Infrastructure and Accessibility to Facilitate CS Utilization: Since access to healthcare facilities were identified as significant barriers influencing delivery preferences, it is recommended that hospital management, in strategic partnership with relevant stakeholders and community representatives, prioritize developing and equipping healthcare facilities, particularly in rural and underserved areas. The goal is to ensure that more women have timely, equitable, and accessible Caesarean section services. This involves a multi-pronged approach: upgrading existing healthcare infrastructure, ensuring the availability of well-equipped theaters and essential medical supplies, and enhancing emergency obstetric care capabilities. Furthermore, healthcare providers should receive cultural competence training to ensure respectful and non-discriminatory care, thereby building trust and encouraging greater utilization of institutional delivery services for CS when needed

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