**KNOWLEDGE, PERCEPTIONS AND ACCEPTANCE OF CAESAREAN SECTION AMONG MEN: A COMMUNITY-BASED CROSS-SECTIONAL STUDY IN NORTHERN NIGERIA**

**Abstract**

**Background:** The involvement of male partners is essential to create better results for the health of mothers and children, as maternal health is crucial to family dynamics. The surgical birth of a newborn is known as a Caesarean section (CS). However, in regions with limited resources pregnant women and their partners often have differing opinions about this delivery method.

**Methods**: The study assessed men's knowledge, perceptions, and acceptance of CS in Chikun Local Government Area of Kaduna State. The sample of 290 males selected using a random sampling procedure who participated in the study was obtained with Cochran’s formula. Data were gathered with a paper-based, researcher-developed questionnaire from existing literature. Using descriptive and inferential statistics, data were analysed with the Statistical Package for Social Science (SPSS) version 24.

**Results:** Results showed that the majority of the respondents had good knowledge about CS (86.6%), a positive perception (68.6%) and a good level of acceptance of CS (99.3%). A statistically significant difference was found between respondents’ acceptance of CS and their educational levels (p= 0.018) and the number of children ever born (p = 0.005). Factors impacting acceptance include notions that CS is for unfaithful or lazy wives (p= 0.004) and inadequate availability and expertise of staff (p= 0.004).

**Conclusions:** men need to be provided with evidenced-based information about surgical birth to motivate them for active involvement in birth preparedness and emergency readiness to improve maternal health.

**KEYWORDS:** Knowledge, Perception, Acceptance, Men, Caesarean Section (CS)

**Background**

Caesarean section (CS) is a surgical operation in which the foetus is delivered by cutting through the mother’s abdomen and womb as opposed to the vaginal birth. CS is considered essential for averting poor outcomes of obstetric complications such as obstructed labour, prolonged labour, antepartum haemorrhage, foetal or maternal distress, pre-eclampsia and eclampsia (1,2). The World Health Organization (WHO) has recommended CS as part of quality comprehensive emergency obstetric services (3). It must be provided with adequate availability and accessibility when needed in developing countries like Nigeria where maternal, foetal and neonatal morbidity and mortality are still prevalent (4).

Maternal and child health has become a major global problem, particularly in middle- and low-income nations. Globally, 223 maternal deaths occurred in every 100,000 live births. (5), Sub-Saharan Africa was estimated to have up to 536 maternal deaths per 100,000 live births in 2020 while Nigeria recorded an alarming 1,047 maternal deaths per 100,000 live births in the same year (6). Although, the Sustainable Development Goals (SDGs) aimed to reduce the number of maternal deaths per 100,000 live births worldwide to less than 70 by 2030, numerous countries are still far from reaching the target.

In most communities, pregnancy, birth, and delivery are anticipated joys for women and family members, with spontaneous vaginal birth being the expectation of most women and family members (7). A spontaneous vaginal birth is more associated with positive short and long-term outcomes than a caesarean section (CS) in many developing countries (7,8). A systematic review and meta-analysis that assessed the associations between mode of delivery and maternal postpartum health-related quality-of-life reported that women who had vaginal births demontrated higher health-related quality of life scores in comparison with women who had CS (9). Studies from Nigeria (10), Burkina Faso (11) and Tanzania (12) reported conspicuous aversion for CS among women due to fear of complications and death, socio-cultural norms, high financial demand, having to undergo CS in subsequent pregnancies; stigmatisation from relatives and feeling of guilt for being a lazy or poor mother who is incapable of giving normal vaginal birth. However, CS might be indicated when there are potential complications or emergencies in which vaginal delivery is unfavourable or impossible to achieve positive health outcomes for the baby, mother, or both. Ensuring positive pregnancy outcomes in the maternal and perinatal domains is essential to the dynamics of a family, CS is found to be an important medical intervention reduce the risk of poor maternal and perinatal outcomes (13).

The CS rate globally ranged from 5% in sub-Saharan Africa to 42.8% in Latin America and the Caribbean. Even though Sub-Saharan Africa had a 3.6%-point increase from 1990–2018 (2), it is still the region with the lowest CS rate across the globe. This is not because there have been no instances where CS was needed to save the mother and child’s lives but because women and their partners have refused the procedure due to socio-cultural factors, misinformation, stereotypic gender roles, and religious ideologies (10,14). Studies among women and adults from different states in Nigeria displayed diverse perceptions, attitudes, and acceptance levels towards CS (15-17)

Male perception, attitude, and acceptance of CS still vary across different study settings and throughout different regions in Nigeria, some men held a negative attitude (15, 18), while others had a positive attitude with the willingness to accept CS as an option applicable to their wives’ condition antenatally and perinatally (15). Some socio-demographic factors like age, educational attainment and religion, residence and occupation were associated with men’s negative attitude toward CS (18). Furthermore, men as the major decision makers in health-related matters, male partners’ understanding of pregnancy-related care and acceptance of maternal healthcare interventions have been linked with positive outcomes (19), but there are still many gaps and only a few documentations exist on men’s knowledge and attitude to maternal and child health interventions like CS (20). In light of this, this study sought to evaluate men's knowledge, perceptions, acceptance of CS and identified factors attributable to men’s acceptance of CS in Chikun Local Government Area of Kaduna State, Northern Nigeria. The present study is guided by the Theory of Planned Behavior (TPB), a psychologically conceptualized theory that links beliefs to behaviour. It identifies three core concepts: attitude, subjective norms, and perceived behavioural control which collectively shapes an individual's behavioural intentions seen as a tenet of human social behaviour (21). It explains that behavioural intentions are influenced by the likelihood that the behaviour will yield the expected outcome and also by the subjective evaluation of the perceived risks and benefits of that outcome.

**Methods**

The study adopted a descriptive design to conduct the cross-sectional survey among adult men randomly selected from five out of the twelve political wards of the LGA, namely: Kujama, Sabon-Tasha, Chikun, Kakau and Kuriga political wards. The confidence interval was set at 95% (constant 1.96) with the addition of a 10% non-response rate the sample size obtained from Cochran’s formula (n= Z2pq/d2) was 290. The study was carried out in Chikun Local Government Area (LGA) of Kaduna State in the North-western region of Nigeria. It is the fourth largest and third most populous state in the country. It was nicknamed the ‘Centre of Learning’, owing to the presence of numerous educational institutions of importance within the state, such as Ahmadu Bello University, Greenfield University, NOK University, Franco British International University, College of Petroleum and Energy Studies, Kaduna State University, Kaduna State Polytechnic and many other tertiary institutions. The state is noted for its high commercial and agricultural contribution towards the national economic growth.

The Ethical approval was from the Ministry of Health in Kaduna State with no. MOH/ADM/744/VOL.1/1173. The informed consent was obtained from all respondents after giving them detailed information about the study. Their anonymity was assured and the confidentiality of all data obtained was also guaranteed. The acquired data were compiled, sorted and analyzed using the Statistical Package for Social Sciences (SPSS) version 24. Descriptive statistics were used to describe the data while Chi-squares, ANOVA and regression analyses were used for the inferential statistics.

**Data Analysis**

The knowledge variable was defined by assigning points based on the affirmative responses 'Yes' or 'No'. The maximum obtainable score for the 17 knowledge items is 17 points, while the minimum is 0 points. Using the cut-off of a 50% score, knowledge is graded as poor for a score of 1–8 points while a score of 9–17 denotes good knowledge. The perception was measured using 10 items that were scored based on a 4-point Likert scale as follows: 1: strongly agree (SA), 2: agree (A), 3: disagree (D), and 4: strongly disagree (SD) except three items which were scored in the reverse order. The maximum attainable score for perception is 40, and the minimum is 10. Therefore, perception is graded as follows: 1–19 for negative perception and 20-40 for positive perception. The level of acceptance of cesarean section was measured using 6 statements on acceptance rated on a 3-point Likert scale graded as follows: ‘will readily allow’ = 3 points; ‘if need be = 2 points’, and ‘not at all’ = 1 point. The maximum attainable score is 18 points, while the minimum is 6. Using a 50% cutoff point, a score of 1–8 points is adjudged poor acceptance, while a score of 9–18 was categorized as good acceptance of CS.

**Results**

**Sociodemographic Characteristics of Respondents**

Table 1 showed the details of the sociodemographic characteristics of respondents. The modal age range of the respondent was within the age brackets of 20 to 29 years (49.0%), the majority156 (53.8%) practised Islamic religion and were married 195 (67.2%). The biggest fraction was from the Hausa tribe 121 (41.7%), in a monogamous family setting 154 (53.1%).

**Table 1: Socio-demographic data of respondents**

|  |  |  |  |
| --- | --- | --- | --- |
| Variable | Classification | Frequency | Percentage |
| Age | 20-29 Years | 142 | 49.0 |
| 30-39 Years | 92 | 31.7 |
| 40-49 Years | 48 | 16.6 |
| >50 Years | 8 | 2.8 |
| Religion | Christianity | 120 | 41.4 |
| Islam | 156 | 53.8 |
| Traditional | 13 | 4.5 |
| Others  | 1 | 0.3 |
| Marital status | Single | 95 | 32.8 |
| Married | 195 | 67.2 |
| Education Level | Primary  | 85 | 29.3 |
| Secondary  | 44 | 15.2 |
| Diploma | 112 | 38.6 |
| Degree | 49 | 16.9 |
| Ethnicity | Yoruba | 72 | 24.8 |
| Igbo | 78 | 26.9 |
| Hausa | 121 | 41.7 |
| Others | 19 | 6.6 |
| Family setting | Monogamous | 154 | 53.1 |
| Polygamous | 136 | 46.9 |
| No. of Children ever born | 0 | 56 | 19.3 |
| 1 | 87 | 30.0 |
| 2 | 73 | 25.2 |
| 3 and above | 74 | 25.5 |
| Number of Children planning to have | 1 | 44 | 15.2 |
| 2 | 89 | 30.7 |
| 3 | 78 | 26.9 |
| 4 | 79 | 27.2 |

**Knowledge, Perception and Acceptance of Cesarean Section Delivery**

Figure 1 presents the descriptive analysis of the knowledge, perception and acceptance of Cesarean section delivery among the respondents. The majority 251 (86.6%) displayed good knowledge, 199 (68.6%) had a positive perception of this method of delivery while a vast majority 288 (99.3%) demonstrated a good level of acceptance.

**Figure 1: Knowledge, Perception and Acceptance of Cesarean among the Respondents**

**Association between respondents’ socio-demographic characteristics, their knowledge and acceptance of Caesarean Section**

The one-way analysis of variance revealed a statistically significant difference in the means of knowledge scores across the age groups (p = 0.005), religious beliefs (p = 0.0001) and the number of children ever born (p = 0.003). It also revealed a statistically significant difference in the mean score for acceptance across the respondents’ educational levels (p= 0.018) and the number of children ever born (p = 0.005) (Table 2).

**Table 2: One-way ANOVA result of association between respondents’ socio-demographic characteristics, their knowledge and acceptance of Caesarean Section**

|  |  |  |  |
| --- | --- | --- | --- |
| **Variables** | **Category** | **Knowledge of CS** | **Acceptance of CS** |
|  |  | Mean | F | P-value | Mean | F | P-value |
| **Age Group** | 20-29 Years | 11.59+2.30 | 4.41 | 0.005 | 12.73+1.74 | 2.56 | 0.056 |
| 30-39 Years | 11.88+2.63 |  |  | 13.16+1.76 |  |  |
| 40-49 Years | 11.33+2.78 |  |  | 13.33+1.29 |  |  |
| >50 Years | 8.63+1.19 |  |  | 13.63+1.69 |  |  |
|  |  |  |  |  |  |  |  |
| **Religion** | Christianity | 11.32+2.30 | 5.82 | 0.0001 | 13.11+1.72 | 1.97 | 0.119 |
| Islam | 11.94+2.61 |  |  | 12.82+1.68 |  |  |
| Traditional | 9.15+1.86 |  |  | 13.85+1.21 |  |  |
| Others | 12+0 |  |  | 14+0 |  |  |
|  |  |  |  |  |  |  |  |
| **Marital Status** | Single | 11.73+2.45 | 0.63 | 0.429 | 13.00+1.87 | 0.005 | 0.942 |
| Married | 11.8+2.55 |  |  | 12.98+1.60 |  |  |
|  |  |  |  |  |  |  |  |
| **Educational Level** | Primary  | 11.37+2.17 | 2.40 | 0.069 | 12.94+1.63 | 3.40 | 0.018 |
|  | Secondary  | 11.5+2.41 |  |  | 12.39+1.42 |  |  |
| Diploma | 12+2.66 |  |  | 13.31+1.76 |  |  |
| Degree | 10.92+2.72 |  |  | 12.88+1.75 |  |  |
|  |  |  |  |  |  |  |
| **Ethnicity** | Yoruba | 11.52+2.48 | 1.53 | 0.208 | 12.93+1.73 | 0.84 | 0.473 |
| Igbo | 11.12+2.52 |  |  | 12.99+1.68 |  |  |
| Hausa | 11.77+2.57 |  |  | 12.93+1.69 |  |  |
| Others | 12.21+2.12 |  |  | 13.57+1.61 |  |  |
|  |  |  |  |  |  |  |  |
| **No. of ever-born** | 0 | 11.71+2.54 | 4.86 | 0.003 | 13.27+2 | 4.32 | 0.005 |
| 1 | 11.10+2.33 |  |  | 12.57+1.63 |  |  |
| 2 | 11.11+2.53 |  |  | 12.82+1.74 |  |  |
| 3 and above | 12.42+2.52 |  |  | 13.43+1.30 |  |  |

**Impact of Knowledge on Respondents’ Perception towards Caesarean Section.**

From the regression result presented in Table 3, the opinion that indications for CS include twin pregnancy (p = 0.002), reasons for CS breech position birth (p = 0.002), vaginal delivery is often impossible after a CS (p = 0.011), and it is better to avoid CS in all circumstances (p = 0.0001) were statistically significant to the model. Overall, knowledge has an impact on men’s perception towards CS (F-statistic = 4.909; p = 0.001).

**Table 3: Impact of Knowledge on Men's Perception Towards Caesarean Section**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | B | T | p-value | Confidence Interval (CI) |
|  |  |  |  | Lower bound  | Upper bound |
| (Constant) | 17.392 | 7.431 | .000 | 12.784 | 22.000 |
| CS save lives | 3.003 | 1.437 | .152 | -1.110 | 7.116 |
| CS is performed when vaginal delivery is hazardous | .930 | 1.435 | .152 | -.346 | 2.206 |
| CS is carried out by trained traditional attendants | .294 | .418 | .676 | -1.089 | 1.676 |
| CS impacts womanhood negatively | -.896 | -1.393 | .165 | -2.163 | .370 |
| CS is carried out to remove the womb | -.378 | -.440 | .660 | -2.067 | 1.311 |
| CS occurs only in big hospitals | .567 | .839 | .402 | -.763 | 1.898 |
| CS is indicated for a twin pregnancy | -1.573 | -3.115 | .002 | -2.568 | -.579 |
| Maternal hypertension warrants CS  | -.102 | -.143 | .887 | -1.513 | 1.308 |
| Reasons for CS breech position birth | -2.198 | -3.078 | .002 | -3.604 | -.792 |
| CS may be needed to deliver a placenta | .469 | .839 | .402 | -.632 | 1.569 |
| Mother's organs are moved away from normal positions during CS | .258 | .447 | .655 | -.879 | 1.395 |
| Mothers will be given to sleep for days after CS | 1.176 | 1.902 | .058 | -.041 | 2.394 |
| Vaginal delivery is often impossible after a CS | 1.419 | 2.570 | .011 | .332 | 2.506 |
| The mother can hold her baby right away after the CS procedure | -1.000 | -1.930 | .055 | -2.021 | .020 |
| There is always a prolonged hospital stay after a CS | .758 | 1.337 | .182 | -.358 | 1.874 |
| It is better to avoid CS in all circumstances | 2.372 | 3.985 | .000 | 1.200 | 3.544 |
| R2 | 0.235 |  |  |  |  |
| F-statistic | 4.909 |  |  |  |  |
| F-statistic (Prob-value) | 0.0001 |  |  |  |  |

**Factors related to the acceptance of CS among the respondents**

A regression analysis shows the factors having statistically significant relationship with the acceptance of Caesarean Section among the respondents (Table 4). These factors include the notions that CS is for unfaithful or lazy wives (p= 0.004) and inadequate availability and expertise of staff (p= 0.004). The F-statistic was 2.178, with an F-statistic p-value = 0.016, indicating that the factors combined together may influence acceptance among the respondents.

**Table 4: Factors related to the acceptance of CS among the respondents**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | B | T | p-value | Confidence Interval (CI) |
|  |  |  |  | Lower bound | Upper bound |
| (Constant) | 12.827 | 27.942 | .000 | 11.923 | 13.730 |
| Caesarean section is too expensive | -.222 | -.597 | .551 | -.956 | .511 |
| CS is for unfaithful or lazy wives  | -.651 | -2.923 | .004 | -1.090 | -.213 |
| My religion accepts CS as a delivery method  | -.175 | -.560 | .576 | -.789 | .439 |
| CS is against the will of God  | -.126 | -.453 | .651 | -.673 | .421 |
| My culture accepts CS as a delivery method  | .059 | .209 | .835 | -.499 | .617 |
| My family accepts CS as a delivery method  | .520 | 1.936 | .054 | -.009 | 1.049 |
| The availability and expertise of staff are not adequate | .691 | 2.928 | .004 | .226 | 1.155 |
| Fear of death may hinder my acceptance of CS | -.161 | -.684 | .495 | -.623 | .302 |
| My wife has had a CS before | -.535 | -1.621 | .106 | -1.184 | .114 |
| R2 | 0.282 |  |  |  |  |
| F-statistic | 2.178 |  |  |  |  |
| F-statistic (Prob-value)s | 0.016 |  |  |  |  |

**Discussion**

The study examined men's knowledge, perception and acceptance of Cesarean Section as a method of child delivery in Chikun Local Government Area (LGA) in Kaduna State, Nigeria. The majority of men in the survey were young married men (ages 20-29 years) predominantly Muslims from the Hausa ethnic group and attained up to tertiary education. The majority (86.6%) of the respondents had good knowledge of CS. This high level of knowledge is expected to translate into increased awareness and a better attitude towards cesarean section delivery. Studies have found that men with greater levels of knowledge about reproductive health are more likely to be involved in their wives’ pregnancies and newborn care, thus leading to better health outcomes (20) (22).

Most of the men in the current study had attained tertiary education and demonstrated good knowledge and acceptance for CS delivery. This resonates with the fact that educational levels correlate with greater awareness and acceptance of modern medical practices including C-sections; however, this varies across different communities (23). Recent studies reported that male partners with a higher educational level are more likely to demonstrate a higher level of involvement in maternal health compared to those who had a lower educational level as reported in in Ghana (24), Ethiopia (25) and in Nigeria (26).

Men’s perception about CS was significantly influenced by their overall knowledge in the current study as they opined CS delivery will be beneficial for a woman carrying a multiple pregnancy and when is in a breech position at birth. However, the notions that vaginal delivery becomes impossible after a CS and that it is better to avoid CS in all circumstances should be corrected or else it translates to negative perception and low acceptance. Hence, community-based education initiatives aimed at increasing knowledge about reproductive health tailored towards birth preparedness and obstetric complication management can effectively improve the perceptions around surgical deliveries among male partners. It is crucial to point out that in many African societies a woman’s decision in the marital and similar context may be overruled by their male partners who take decisions for their women in all matters including their health (27). Men’s health literacy is therefore a top notch for them to take informed and wholesome decisions for themselves and their family members.

The understanding and perception of caesarean delivery among men is often linked not only to personal knowledge but also to socio-cultural dynamics within family settings. In the current study for example, age, religion and the number of children ever born were significant social factors influencing the knowledge of CS. The older men (50 years and above) and the traditional worshipers had a lower knowledge score. This may be due to the fact that older male adults might have limited exposure to formal education and information on modern healthcare services thus limiting their understanding of medical procedures like CS. A study in Ebonyi State, Nigeria suggested a lower health literacy and a higher level of adherence to traditional beliefs among older men impacted on their perceptions of CS and embracing of a natural method of childbirth (14). In the same vein, most traditional worshipers always disapprove modern medical practices because they do not align with their spiritual beliefs and this could hinder their acceptance of procedures like CS. These highlight the need to engage the community leaders and utilize targeted health education programmes designed with special consideration of cultural and religious sensitivity to improve the understanding and acceptance of CS.

This present study also revealed that men with no child and those with 3 or more children had a higher knowledge score as well as higher level of acceptance of CS than those with one or two children. This may be due to the fear and anxiety about child birth complications which may be nursed by those who are yet to have any child delivery experience while the previous experiences about maternal obstetric cases already gotten by those with higher number of children might make them accept CS method more readily.

Furthermore, the study found that about two-thirds (68.6%) of the men demonstrated positive perception of CS. This suggests a shift away from the traditional biases against surgical delivery methods reported by previous studies where serious aversion for CS were observed among men and women across various settings in Nigeria (2) (18) (28). Our study also indicates changing attitudes toward surgical births as Nigeria men are becoming more involved as fathers in maternal cares in the recent decades. Unlike previously, when mothers are presumed as the primary caregivers and the fathers as mere ‘helpers’ rather than parenthood being considered a shared responsibility, more men are closer to maternal care and are able to recognize the necessity of CS and its usefulness in averting complications and saving lives during complicated deliveries.

This present study was conducted in an urban setting where there existed higher access to health awareness or education through digital health campaigns, internet use and online platforms for telemedicine (28,29). This could have further aided better understanding of the roles of CS and increased acceptance as seen in this present study. Even though, just about two-thirds had a positive perception of CS, a remarkable majority (99.3%) demonstrated a good level of acceptance for the procedure. Compared with previous studies that reported lower acceptance levels due to entrenched socio-cultural and religious beliefs about CS as being abnormal childbirth (30,31) the variance in the present study may reflect a growing recognition among men about modern intervention in childbirth methods and their role in influencing women's choices regarding maternal health. When men understand the complexities involved in childbirth scenarios requiring surgical intervention, they are more supportive partners during pregnancy (32). Research findings affirmed that males who possess higher levels of awareness regarding sexual and reproductive health are more inclined to participate in their wives’ pregnancies and newborn care, thus leading to better health outcomes (33).

Almost all (99.3%) the men showed a good acceptance of CS because it helps to avert complications and preserve the mother and baby’s health. However, their major worries included fear of CS complications like maternal morbidity or death, and a potential inability to shoulder the financial cost of CS. In a related study in Nigeria, male partners embraced the choice of Caesarean section to lessen the woman's labor discomfort and they demonstrated a lesser aversion for CS post-delivery. However, they expressed concern about high financial demand (60.7%), fear of the procedure (48.0%), fear of complications (45.3%), longer hospital stay (44.0%), having fewer children in the future, (34.7%) and fear of repeat CS (34.0%) which they believed are the attending consequences of CS delivery (34).

Specifically, in the current study, CS was linked to unfaithfulness or laziness in wives while staff unavailability and poor expertise were highlighted as impacting on the acceptance. This is a reflection of deeply rooted cultural beliefs about gender roles and childbirth practices. This finding aligns with existing literature that explores how cultural perceptions and societal norms influence CS perception and acceptance and affects maternal health decisions in the society (35,36). Associating CS with negative judgments about women’s character may disapprove this medical intervention (37). Misconceptions surrounding CS as a result of misinformation within the communities having aversion for modern medical interventions has been noted to contribute to poor acceptance. Describing CS as ‘easy way out’ for mothers can be stigmatizing and discouraging for men who want their partners to prove motherhood capabilities by conforming to traditional norms of enduring childbirth pain (38,39).

The concern about poor availability and expertise of healthcare professionals in CS care, as seen in the current study, could misshape how men perceive this surgical birth most especially in low-resource settings where equipment and access to quality care are limited (40,41). Financial incapacitation and fear when given an indication for elective CS can discourage or cause a delay in consenting to surgical management among people with low socio-economic profile. This often result in late presentation of obstetric emergencies at the healthcare facility and may warrants unplanned caesarean sections which is often associated with high perinatal and maternal morbidity. Patients and their relatives could therefore have a bad impression of healthcare services in the absence of detailed information about their client’s condition and reasons for indicating the treatment options.

A Nigerian study highlighted how perceived deficiencies in healthcare services could deter both the acceptance and appropriate healthcare seeking in pregnancy (42). Hence, we need not just recommend adequate CS utilization but also adequate optimization to avoid its unnecessary use and the attendant complications. Health professionals should be trained on correct indication for CS, how to support pregnant women with obstetric complications and skillful exploration of other birthing alternatives before choosing a CS (43).

**Conclusions**

The majority of the men in Chikun Local Government Authority, Kaduna, Nigeria had good knowledge, positive perception and displayed good acceptance of Caesarean Section. Their overall knowledge of CS had a significant impact on their perceptions while the notion that CS is for lazy women, high cost of the procedure, fear of its complications, expertise and availability of professionals providing CS care may impact its acceptance as a delivery option. This finding aligns with existing literature that explored cultural perceptions, societal norms, and systemic healthcare issues regarding delivery options. Therefore, there is a need to integrate culturally sensitive messaging strategies into tailored educational interventions that not only improve factual understanding around CS but also challenge underlying societal attitudes toward surgical births and enhance men’s support for informed maternal health care.

**Declarations**

**Ethics approval and consent to participate**

The Ethical approval was from the Ministry of Health in Kaduna State with no. MOH/ADM/744/VOL.1/1173. The informed consent was obtained from all respondents after giving them detailed information about the study. Their anonymity was assured and the confidentiality of all data obtained was also guaranteed.

**Consent for publication**

**Availability of data and materials**

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

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