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

**Abstract**

**Aims:** The surgical birth of a newborn, known as Cesarean section (CS), is perceived as unnatural by many people in the African setting. The study aims to evaluate men's knowledge, perception, and acceptance of CS, as well as the associated factors, in Northern Nigeria, where men are the primary providers and decision-makers in the family.

**Study design**: A cross-sectional descriptive study.

**Place and Duration of Study**: Chikun Local Government Area of Kaduna State, Nigeria. The study was conducted between September and November 2024.

**Methodology**: The study sample of 290 respondents was obtained using Cochran’s formula. Respondents were selected using systematic random sampling. The criteria for inclusion were individuals aged 18 and older who resided in the study area during the data collection period. Data were collected using a questionnaire developed by the researcher based on existing literature and analyzed with descriptive and inferential statistics using SPSS version 24.

**Results:** L**ess** than half of the respondents demonstrated good knowledge (47.6%), while slightly more than half had a positive perception (53.8%) and a good level of acceptance of CS (59.3%). Older ages (p= 0.005) and traditional religion practice (p= 0.0001) were associated with poor knowledge, while respondents’ level of education (p= 0.018) and previous childbirth experience (p= 0.0001) positively impacted their acceptance of CS. Factors associated with poor 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:** Poor knowledge of CS was prevalent, although a little above average, displayed good perception and acceptance. Culturally sensitive initiatives to enhance knowledge and acceptance of CS are essential for strategizing men’s active involvement in birth preparedness. Additionally, sufficient measures should be implemented to improve CS management. **KEYWORDS:** Knowledge, Perception, Acceptance, Men, Cesarean Section

1. **INTRODUCTION**

Cesarean 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 (Harrison & Goldenberg, 2016). The World Health Organization (WHO) has recommended CS as part of quality comprehensive emergency obstetric services, which 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 (Betran et al., 2016; Ajayi et al., 2023).

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 (World Health Organization et al., 2015). Sub-Saharan Africa was estimated to have up to 536 maternal deaths per 100,000 live births in 2020 while Nigeria recorded an alarming rate of 1,047 maternal deaths per 100,000 live births in the same year (WHO et al., 2023). Many countries are still far from reaching the Sustainable Development Goals (SDGs), targeting the reduction of the global rate of maternal deaths to fewer than 70 per 100,000 live births by 2030.

In many community settings, pregnancy, birth, and delivery are anticipated joys for women and family members, with spontaneous vaginal birth being the common expectation (Crossland et al., 2020). However, some women give birth through CS because of reasons that promote a positive outcome for the entire family. 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 demonstrated a higher health-related quality of life scores in comparison with women who had CS (Evans et al., 2021; Zeng et al., 2023). Studies from Nigeria (Ugwu & de Kok, 2015), Burkina Faso (Richard et al., 2014) and Tanzania (Litorp et al., 2015) reported conspicuous aversion for CS among women due to fear of complications and death, socio-cultural norms, high financial demand, thoughts of 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. Despite all the afore mentioned, CS might be essential to achieve positive health outcomes for the mother and the baby when there are potential complications or emergencies with vaginal delivery (Kibe et al., 2022).

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 (Betran et al., 2021), it is still the region with the lowest CS rate across the globe. This is not because there have been few 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 (Ugwu & de Kok, 2015; Elom et al., 2023) . Studies among women and adults from different states in Nigeria displayed diverse perceptions, attitudes, and acceptance levels towards CS (Babalola, 2022; Elom et al., 2023)

Male perception, attitude, and acceptance of CS still vary across different settings and regions in Nigeria with some men holding a negative attitude (Falade-Fatila & Adebayo, 2020) , while others having a positive attitude would only accept CS if it will ensure a positive outcome to avert a disruption to the family dynamics (Babalola, 2022). Some socio-demographic factors like age, educational attainment and religion, residence and occupation were associated with men’s attitude toward CS (Elom et al., 2023) . Furthermore, in many African countries, men mostly hold the position of decision-making and financial power in all household issues including healthcare seeking during pregnancy and delivery. Therefore, men’s shared responsibility and active involvement in responsible parenthood, as well as in maternal and child health, are imperative for promoting positive family dynamics.

Men’s understanding of pregnancy-related care and their acceptance of maternal healthcare interventions, such as cesarean section increases their support for their wives and have been associated with healthier decision-making regarding childbirth options by the woman and her spouse (Bam et al., 2021). However, there are still many gaps and only a few documentations exist on men’s acceptance of CS in Northern Nigeria, hence, this study sought to evaluate men's knowledge, perceptions and acceptance of CS and also to identify factors attributable to these in Chikun Local Government Area of Kaduna State, 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 shape an individual's behavioural intentions (Ajzen, 1991). It explains that the aims or plans of an individual to perform a behavior is influenced by the perception that the behavior will have a favorable consequence or an expected outcome. Implying that men’s subjective evaluation of the benefits and perceived risks of CS can influence their acceptance of the procedure.

1. **METHODS AND MATERIALS**
   1. **Study Design**

The study adopted a descriptive design for the cross-sectional survey to evaluate men's knowledge, perception and acceptance of CS and the associated factors in Northern Nigeria.

* 1. **Study setting**

The study was conducted in Chikun Local Government Area (LGA) of Kaduna State, 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 tertiary educational institutions and it is noted for its high commercial and agricultural contribution towards the national economic growth.

* 1. **Target Population**

The respondents were adult men of reproductive age group, married and unmarried. The inclusion criteria were ages of 18 years and above and they must be residing in the study area during the period of data collection while exclusion criteria are refusal to participate and physical or health challenges impairing hearing and speaking.

* 1. **Sampling Technique and Sample Size**

Using the rule of thumb, five of the twelve political wards (one-third) of the Local Government Area were randomly selected using a balloting method, namely: Kujama, Sabon-Tasha, Chikun, Kakau and Kuriga political wards. The streets and households in each ward were systematically selected and the male adults in the households were included in the study sample. The confidence interval was set at 95% (constant 1.96) and the sample size obtained from Cochran’s formula (n= Z2pq/d2) was 290 with the addition of 10% non-response rate.

* 1. **Instrument for data collection**

The semi-structured questionnaire was developed by the researcher from existing literature to address the study objectives. It comprises five sections namely: Sections A to E which respectively elicited information on socio-demographic variables, knowledge, perception, acceptance and factors influencing the acceptance of cesarean section. The validity of the instrument was ensured through a face and content review by experts while the reliability was obtained through a test-retest method in a pilot study conducted in a similar setting.

* 1. **Method of Data Collection**

The researcher with the help of two trained research assistants administered the questionnaires to the respondents in the selected households. Data collection took place in the evenings on daily basis for two weeks.

* 1. **Data analysis**

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 ANOVA and regression analyses were used for the inferential statistics. The knowledge variable was evaluated 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. Using the mean score (11.5 + 2.517), knowledge is graded as poor for a score below the mean while a score above the mean denotes good knowledge. The perception was determined using 10 items that were scored based on a 4-point Likert scale as follows: 1: strongly agree, 2: agree, 3: disagree and 4: strongly disagree except for three items which were scored in the reverse order. The maximum attainable score is 40, and the minimum is 10. The mean score obtained was 28.48 + 8.52, which also serves as the reference score. Hence, a score below the mean represents a negative perception while a score above the mean represents a positive perception. The level of acceptance of cesarean section was measured using 6 statements 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 the mean score of 12.98 + 1.694 as the cutoff score, a score below the mean is adjudged poor acceptance, while a score above it is categorized as good acceptance of CS.

1. **RESULTS**

**3.1 Sociodemographic Characteristics of Respondents**

Table 1 showed the details of the socio-demographic characteristics of respondents. The modal age range of the respondents was within the age brackets of 20 to 29 years (49.0%), the majority (53.8%) practised Islamic religion and were married (67.2%). The most significant fraction was from the Hausa tribe (41.7%), in monogamous family setting (53.1%).

**Table 1: Socio-demographic characteristics 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 |

**3.2 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 (52.4%) of the respondents had poor knowledge of CS while a little more than half (53.8%) shared a positive perception and a good level of acceptance (59.3%).

**Figure 1: Knowledge, perception and acceptance of Cesarean Sectioning among the respondents**

**3.3 Association between respondents’ socio-demographic characteristics, their knowledge and acceptance of cesarean section**

The one-way analysis of variance revealed a statistically significant difference in the means of knowledge scores across the age groups (p = .005), religious beliefs (p = .0001) and the number of children ever born (p = .003). It also revealed a statistically significant difference in the mean score for acceptance across the respondents’ educational levels (p= .018) and the number of children ever born (p = .005) (Table 2).

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

**3.4 Impact of knowledge on respondents’ perception towards cesarean section.**

From the regression result presented in Table 3, some opinions were statistically significant to the model. These include the opinion that indications for CS include twin pregnancy (p = .002) and baby’s breech position at birth (p = .002), that vaginal delivery is often impossible after a CS (p = .011), and it is better to avoid CS in all circumstances (p = .0001). Overall, knowledge has an impact on men’s perception towards CS (F-statistic = 4.909; p = .001).

**Table 3: Impact of Knowledge on men's perception towards Cesarean 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 (Probability-value) | 0.0001 |  |  |  |  |

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

A regression analysis shows the factors having statistically significant relationships with the acceptance of Cesarean Section among the respondents (Table 4). These factors include the notions that CS is for unfaithful or lazy wives (p= .004) and inadequate availability and expertise of staff (p= .004). The F-statistic was 2.178, with an F-statistic p-value = .016, indicating that these 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 |
| Cesarean section is too expensive for me | -.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 (Probability-value) | 0.016 |  |  |  |  |

1. **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 had attained up to tertiary education. These demographic characteristics reflect the socio-cultural composition of Northern Nigeria, where early marriage and religious doctrines could influence reproductive health decisions (Opara et al., 2024).

In this present study, less than half (47.6%) of the respondents had good knowledge of CS and this aligns with findings from similar studies conducted in Nigeria and other low-resource settings. For instance, a poor knowledge of CS was reported among men in Kano State which was found to be a significant barrier to its acceptance (Amole et al., 2023). Similarly, a mixed method study in Eastern Uganda highlighted that poor knowledge of CS was associated with misconceptions and poor acceptance of the procedure (Waniala et al., 2020).

The low knowledge level observed in the present study could be attributed to inadequate reproductive health education and prevalent cultural belief which embraces and prefers vaginal delivery to surgical method of delivery. Although, vast majority agreed that CS save lives, 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. It is also worthy of note, that the understanding and perception of cesarean delivery among men is most times not only linked to their personal knowledge but also to the socio-cultural dynamics within the 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 much lower knowledge scores. This findings corroborates a multi-level analysis of prevalence and factors associated with cesarean section in Nigeria which identified culture, ethnicity, religion and several community-level factors to be associated with CS utilisation in Nigeria (Ajayi et al., 2023).

A community-based education initiatives aimed at increasing knowledge and awareness about reproductive health tailored towards birth preparedness and obstetric complication management is therefore imperative to effectively improve the perceptions around surgical deliveries and acceptance among male partners especially the older ones. 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 (Osamor & Grady, 2018). Men’s health literacy is therefore a top-notch for them to make informed and wholesome decisions for themselves and their family members. Increasing awareness on male involvement on birth preparedness and complication readiness plan, as suggested by Yehualashet (2024), is vital to improving maternal and child health (Yehualashet et al., 2024).

A study in Ebonyi State, Nigeria suggested a lower health literacy and a higher level of adherence to traditional beliefs among older men had a negative impact on their perceptions of CS, hence, their significant preference for a natural method of childbirth (Elom et al., 2023). In the same vein, most traditional worshipers always disapprove modern medical practices because they do not align with their spiritual beliefs and could hinder their acceptance of modern procedures like CS. These highlight the need to engage the community and spiritual leaders and utilize targeted health education programmes designed with special consideration of cultural and religious sensitivity to improve the understanding and acceptance of CS (Ogunlaja et al., 2024). Men having 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.

Despite the poor knowledge of CS, a slight majority of respondents (53.8%) held a positive perception of the procedure. 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 (Betran et al., 2021; Elom et al., 2023; Adewuyi et al., 2024) . 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, men are closer to maternal care and are able to recognize the necessity of CS, its usefulness in averting complications and saving lives during complicated deliveries.

This findings of the present study contradicts some previous studies that reported predominantly negative perceptions due to increase financial implication, health complications as well as cultural and religious misconceptions (Oboijagbe, 2021; Ogunlaja et al., 2024). Same was reported in a Ghanian (Bam et al., 2021) and Zambian (Chongo et al., 2024) where poor acceptance of CS was attributed to and late presentation with complications when the women and her relatives could have tried all means to avert surgical deliveries but to no avail. However, this present study supports the notion that increased use of modern healthcare services may be gradually shifting attitudes towards CS in a positive direction (Adewuyi et al., 2024). This trend is crucial in addressing maternal and neonatal mortality associated with delays in accepting necessary obstetric interventions.

Most of the men in the current study had attained tertiary education and demonstrated positive perception and good acceptance for CS delivery resonating with the fact 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 Ghana (Craymah et al., 2017), Ethiopia (Mekonen et al., 2022) and in Nigeria (Okafor et al., 2022;Osayande et al., 2023).

The acceptance rate of CS was relatively high (59.3%) in this present study which may largely be due to the belief that it saves lives, suggesting a growing willingness to consider CS when men are aware that the benefits of CS is higher than the perceived risks inherent in the procedure. This finding is consistent with a the one that assessed inequalities between the rural and urban areas regarding uptake of CS and the associated factors in Nigeria, where husbands’ higher education and joint healthcare decisions increases the uptake (Adewuyi et al., 2024). It is also aligning with the findings in a comparative cross-sectional study conducted in Ogun State, Nigeria which reported that male involvement in maternal health decisions positively influences birth preparedness and uptake of maternal healthcare interventions (Adejoh et al., 2020). However, this study is at variance with the one conducted in Ibadan, southwestern Nigeria where majority had a fair knowledge but yet a negative attitude towards CS except for those with tertiary education. This disparity may be attributed to the predominance of Yoruba tribe and the ages of respondents who are more elderly (40-60 years) with low formal education and inadequate information about CS (Oboijagbe, 2021).

The significant relationship between acceptance of CS and respondents’ educational levels (p = 0.018) and number of children ever born (p = 0.005) supports the argument that higher education levels enhance health literacy, leading to better decision-making in reproductive health matters (Adewuyi et al., 2024) Furthermore, as men have more children, they may develop a better understanding of maternal health risks, thereby increasing their willingness to accept CS when necessary.

It is quite reassuring that the majority demonstrated a good acceptance of CS in the present study, however, the fear of CS complications like maternal morbidity or death, and a potential inability to shoulder the financial cost of CS were reasons for concern. In a related study in Nigeria, male partners embraced the choice of Cesarean Section to lessen the woman's labor discomfort but expressed their worries about high financial demand, fear of complications and fear of repeat CS (34.0%) which they believed are the attending consequences of CS delivery (Adeniran et al., 2021). Financial incapacitation and fear when given an indication for elective CS can discourage or cause a delay in consenting among people with low socio-economic profile. This often result in late presentation of obstetric emergencies at the healthcare facility and may warrants unplanned cesarean sections which is often associated with high perinatal and maternal morbidity.

Specifically, in the current study, CS was linked to the wives’ unfaithfulness or laziness. This is a reflection of deeply rooted cultural beliefs about gender roles and childbirth practices which associates CS with negative judgments about the women’s character. Other misconceptions include the description of CS as an ‘easy way out’ for lazy mothers which can be stigmatizing and discouraging for men who want their partners to prove motherhood capabilities by conforming to traditional norms of enduring childbirth pain (Michael et al., 2024) thus promoting aversion for and contributing to poor acceptance of CS (Kiruja et al., 2023). .

The concern about poor availability and expertise of healthcare professionals in providing CS care, as seen in the current study, could adversely influence how men perceive this surgical birth. Where equipment and access to skilled professionals and quality care are limited or detailed information about client’s condition and treatment options are not clearly provided, patients and their relatives could have a bad impression of healthcare services, reducing uptake of this intervention (Banke-Thomas et al., 2023).

A Nigerian study highlighted how perceived deficiencies in healthcare services could deter both the acceptance and appropriate healthcare seeking in pregnancy (Nwankwo et al., 2022). 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 (Banke-Thomas et al., 2023).

1. **CONCLUSION**

The majority of respondents had good knowledge, positive perception and displayed good acceptance of Cesarean 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. This study may be limited in scope because it is conducted in an urban area where access to media information and modern healthcare interventions are more prevalent than in the rural part of the state.

1. **RECOMMENDATIONS**

Based on the findings of this study, there is a need to improve the knowledge of men in this setting and also motivate their acceptance of CS when indicated to enhance maternal healthcare outcomes. Hence, the following recommendations are made:

1. A culturally sensitive messaging strategies be integrated into tailored educational interventions that not only improve factual understanding around CS but also reduce the misconceptions and negative societal attitudes toward the procedure.
2. Adequate equipment and skilled professionals who are competent in CS management should be provided
3. The cost of CS procedure should be subsidized for people with financial challenges.

**ETHICAL 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.

**COMPETING INTERESTS**

Authors hereby declared that no competing interests exist.

**DISCLAIMER (ARTIFICIAL INTELLIGENCE)**

Author(s) hereby declare that ChatGPT (Version GPT-4o) and QuillBot (Version 4.15.1) have been used during the editing of this manuscript.

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