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'It's Not a Weakness': Lived Experiences, Support Systems, and Emotional Wellbeing in Caesarean Birth among Postpartum Women in Nigeria.

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ABSTRACT

Background:
Caesarean section (CS) is an obstetric intervention for preventing maternal and neonatal complications. Despite its benefits, CS in Nigeria is influenced by cultural beliefs, stigma, and emotional responses, with limited research exploring how these factors affect women's experiences and mental well-being after surgery. This study examined the lived experiences of postpartum women who delivered by CS in selected Nigerian health facilities, focusing on emotional well-being and support systems.

Methods:
A qualitative phenomenological design was employed in four Local Government Areas of Ibadan, Oyo State. Data were collected through 11 in-depth interviews and two focus group discussions involving 24 women aged 22–49 years who had undergone CS within the previous five years. Purposive sampling was used to ensure variation in age, education, and residence. Audio-recorded interviews were transcribed and analyzed thematically with ATLAS.

Results:
Of the 24 participants, thirteen resided in urban areas while eleven resided in rural areas. Five major themes emerged: (1) Pathways to caesarean delivery, highlighting that decisions were largely driven by medical necessity and often involved joint decision-making with spouses; (2) Emotional responses and mental adjustment, ranging from fear and anxiety to calm acceptance influenced by clinical communication and faith; (3) Sociocultural interpretations and stigma, including narratives that associate CS with weakness or spiritual failure; (4) Support systems and recovery experiences, with strong spousal, family, and respectful healthcare support reported as central to recovery; and (5) Future preferences and advice to others, where many participants expressed willingness to undergo CS again, emphasizing the primacy of maternal and child safety.

Conclusions:
Caesarean birth is more than a clinical procedure; it is a deeply social and emotional experience.

Recommendation:
Supportive communication from healthcare professionals, family involvement, mental health and counselling, and efforts to dispel negative cultural myths around CS are essential to improving women's psychosocial outcomes.

Keywords: *Caesarean section, maternal health, lived experiences, stigma, mental wellbeing, Nigeria, qualitative study.*
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INTRODUCTION
Caesarean section (CS) is a critical life-saving obstetric intervention that reduces maternal and neonatal morbidity and mortality when complications arise during childbirth. Globally, CS rates have increased substantially in recent decades, rising from 7% in 1990 to over 21% in 2021, with projections suggesting that rates could reach nearly 29% by 2030 if current trends persist (Betrán et al., 2016; World Health Organization, 2021). While this growth reflects improved access to obstetric care, it has also been

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accompanied by persistent inequities, particularly in low- and middle-income countries where access to CS remains constrained for women who need it most (Angolile et al., 2023; World Health Organization, 2015).

In Nigeria, CS rates remain low compared to global averages. National estimates indicate that only 2–3% of deliveries in rural areas and approximately 13% in urban areas are performed by CS, reflecting both structural and sociocultural barriers (Ajayi et al., 2023; National Population Commission (NPC) [Nigeria] & ICF, 2019). Socioeconomic status, health system limitations, and poor communication between women and healthcare providers all influence the uptake and experience of CS (Anih et al., 2023; Asah-Opoku et al., 2023; Banke-Thomas et al., 2023). Previous research also shows that many Nigerian women desire vaginal births and resort to CS only when medically necessary due to complications such as malpresentation, prolonged labour, or life-threatening conditions like pre-eclampsia (Adeosun et al., 2022; Michael et al., 2024).

Beyond medical indications, CS carries a significant psychological and sociocultural dimension. The procedure is often associated with ambivalent emotions, including fear, relief, guilt, and a sense of failure, which can have lasting effects on postpartum mental health (Ma et al., 2025; Yesilçiçek Çalik & Durum, 2025). Studies from different contexts demonstrate that the experience of CS can be traumatic, particularly when decision-making is rushed or inadequately explained (LoPoni et al., 2025; Mao et al., 2023). Inadequate counselling and lack of emotional support have been linked to post-traumatic stress, anxiety, and negative recall of the birth experience (Bannister et al., 2025; Lai et al., 2025). These outcomes may also be compounded by limited access to respectful maternity care in some Nigerian health facilities, where evidence of verbal, physical, and emotional abuse has been documented (Olajide et al., 2025).

Sociocultural expectations around childbirth in Nigeria further shape the emotional impact of CS. Vaginal delivery is often valorized as a marker of strength and womanhood, whereas CS may be stigmatized as a sign of weakness, spiritual failure, or an unnecessary economic burden (Michael et al., 2024). Similar patterns of social judgment have been reported in other cultural settings (Fredriksson & Mattebo, 2025; Sharma et al., 2025). Consequently, women who undergo CS may experience internal conflict, anxiety, or social disapproval, potentially undermining their postnatal adjustment. Increasingly, research underscores the importance of holistic maternal care that integrates mental health support, birth debriefing, and family involvement to improve recovery outcomes (Saulnier et al., 2025; Sharma et al., 2025). Women's narratives indicate that strong social support from spouses, relatives, and healthcare professionals facilitates emotional resilience, while its absence can increase distress (Barnes et al., 2023; Donovan et al., 2023; LoPoni et al., 2025).

Despite these insights, there is a paucity of qualitative studies in Nigeria examining CS beyond its clinical outcomes. Few studies have focused on women's lived experiences, the emotional aftermath of CS, and the ways that support systems influence recovery and wellbeing. Existing Nigerian research on CS has mainly concentrated on prevalence, decision-making, and clinical outcomes (Adeyanju et al., 2023; Ajayi et al., 2023; Anih et al., 2023), leaving a gap in understanding the psychosocial aspects of CS as part of the childbirth continuum. This study addresses this gap by exploring the lived experiences of postpartum women who underwent caesarean deliveries in Ibadan, Nigeria. Drawing on perspectives from reproductive health, sociology, and mental health, the study examines (1) women's narratives of their CS experiences, (2) the emotional responses that accompany the procedure, (3) the role of sociocultural norms and stigma, and (4) the contribution of familial and institutional support systems to recovery. By focusing on the subjective realities of women, this study contributes to a more comprehensive understanding of CS in Nigeria and provides insights for designing interventions that integrate respectful maternity care and psychological support for postpartum women.

METHODOLOGY

Study Design and Setting

This qualitative study employed a phenomenological approach to explore the lived experiences, emotional well-being, and support systems of postpartum women who underwent caesarean delivery in selected health facilities in Ibadan, Oyo State, Nigeria. Ibadan is a major urban centre in Southwestern Nigeria, comprising both densely populated urban localities and peri-urban/rural settlements (Michael, 2024). The study sites included public and private health facilities, with names withheld for ethical purposes, across four Local Government Areas (LGAs): Ibadan North, Ibadan North-West, Ido, and Akinyele, representing a mix of urban and rural contexts.

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Study Population and Sampling Technique

The study population consisted of postpartum women who had delivered via caesarean section within the past five years and had accessed care from health facilities in the study areas. A purposive sampling technique was used to recruit participants who could provide rich, diverse accounts of their CS experiences. Participants were approached for face-to-face interview discussions.

Inclusion/Exclusion Criteria and Sample Size

Inclusion criteria were: (i) women aged 18 years and above, (ii) who had undergone at least one caesarean delivery, and (iii) who were willing and able to participate in an interview or group discussion. Women who had not undergone a caesarean section, or who experienced severe postnatal complications that impeded their ability to participate in an interview or focus group discussion, were excluded from the study. A total of 24 participants were recruited, comprising 11 individual in-depth interviews (IDIs) and two focus group discussions (FGDs) with 7 and 6 participants, respectively. Participants reflected a range of age groups (22–49 years), educational levels (none to post-secondary), and residential settings (urban and rural). The point of saturation, where no additional new information was obtained from additional interviews, determined the sample size.

Data Collection

Data were collected using semi-structured interview guides, developed in line with the study objectives and informed by relevant literature on maternal health and mental well-being. The guides captured topics such as decision-making processes around CS, emotional responses before and after the procedure, sociocultural beliefs and stigma, healthcare experiences, and sources of support. The IDIs and FGDs were conducted in Yoruba and/or English, depending on participants' preferences, and held in locations convenient and safe for the participants, without the presence of anyone else outside of the study participants and researchers, given the sensitivity of the discussion. This helped to protect the privacy of the participants. Two of the participants who initially agreed to participate in the study later dropped out because of health complications and a change of location. Interviews were audio-recorded with participants' consent and lasted between 30 and 60 minutes. Field notes were also taken to supplement the recordings and capture non-verbal cues. There were two repeated in-depth interviews conducted to fully capture relevant points from participants. Data collection occurred between 21 August and 6 November 2023.

Bias and Reflexivity

To minimize potential bias, a purposive sampling strategy was employed to ensure diversity in participants' age, residence, and educational background. Interview and FGD guides were pilot-tested to avoid leading questions, and data collection was conducted by trained qualitative researchers who were not part of the participants' healthcare teams to reduce social desirability bias. Triangulation of data sources (in-depth interviews and FGDs), independent coding by two researchers, and consensus discussions during thematic analysis further strengthened the credibility and trustworthiness of the findings (Creswell, 2014; Vaismoradi et al., 2013). On reflexivity, the research team approached the study with backgrounds in reproductive health, medical sociology, and mental health, which shaped the framing of the research questions and interpretation of findings. To reduce the influence of preconceptions, the researchers engaged in regular reflexive discussions and maintained analytic memos during data collection and analysis. These practices helped the team remain conscious of their positionality and its potential effect on participant interactions and theme development. This reflexive process contributed to ensuring that the women's voices were represented as authentically as possible, while also acknowledging the interpretive role of the researchers.

Trustworthiness and Rigor

To enhance the rigor of this qualitative study, some strategies were employed to ensure credibility, dependability, confirmability, and transferability. *Credibility:* Triangulation of data sources (focus group discussions and in-depth interviews) and independent coding by two researchers strengthened the credibility of findings. Member checking was used informally during interviews, where participants were asked to clarify or confirm their responses. *Dependability:* A detailed audit trail of methodological decisions, field notes, and data analysis steps was maintained, allowing the research process to be traceable. *Confirmability:* Reflexive journaling and consensus meetings during data analysis minimized the influence of researcher bias, ensuring that findings were grounded in participants' accounts rather than researchers' assumptions. *Transferability:* Rich, thick descriptions of participants' contexts and experiences were provided so that readers and other researchers can assess the applicability of

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the findings to similar settings (Castleberry & Nolen, 2018; Creswell, 2014; Vaismoradi et al., 2013).

Data Analysis

All interviews and FGDs were transcribed verbatim and, where necessary, translated into English. Thematic analysis was conducted using an inductive approach. Transcripts were reviewed multiple times to ensure familiarity with the content. A follow-up engagement was conducted with participants to review, correct, and confirm their responses. Coding was done manually by two researchers independently, and emergent codes were grouped into broader themes and sub-themes. The themes were derived from the data. Any discrepancies in coding were discussed and resolved collaboratively to enhance reliability. ATLAS.ti software was used to organize and manage the data during analysis.

Ethical Considerations

Ethical approval for the study was obtained from the College of Medicine and Health Sciences, Afe Babalola University Health Research Ethical Committee (HREC) (Protocol Number: ABUADHREC/26/07/2023/2006) on 26 July 2023. Informed consent was obtained from all participants before data collection. Participants were assured of confidentiality, voluntary participation, and their right to withdraw from the study at any point without consequences. Pseudonyms and anonymized IDs were used to protect identities in all transcriptions and reporting.

RESULTS

Participants' Characteristics

A total of 24 postpartum women who had undergone caesarean delivery participated in this study. As summarized in Table 1, the participants were drawn from both urban and rural local government areas (LGAs) in Ibadan, Oyo State. Two focus group discussions (FGDs) accounted for 13 participants (seven from Ibadan North-West (urban) and six from Ido (rural)), while 11 women were engaged individually through in-depth interviews (IDIs). Of those interviewed individually, six resided in the urban setting of Ibadan North and five in the rural LGA of Akinyele. Participants ranged in age from 22 to 49 years, with the majority in their late twenties to early forties. The group was diverse in terms of educational background, spanning from no formal education to post-secondary qualifications. Urban participants tended to have higher levels of formal education, whereas women from rural locations more often reported primary or secondary schooling as their highest attainment. This mix of settings and educational profiles provided rich and varied perspectives on the experiences and emotional well-being of women following caesarean birth.

Table 1. Profile of Study Participants by Interview Type, Location, and Demographic Characteristics (N = 24)

Data Collection Method	Local Government Area (LGA)	Residential Context	Number of Participants	Age Range (Years)	Educational Attainment
Focus Group Discussion 1	Ibadan North-West	Urban	7	22 – 49	Primary to Post-secondary
Focus Group Discussion 2	Ido	Rural	6	23 – 48	None to Secondary
In-depth Interviews (IDI 1–6)	Ibadan North	Urban	6	26 – 43	None to Post-secondary
In-depth Interviews (IDI 7–11)	Akinyele	Rural	5	22 – 40	None to Post-secondary

Table 2 presents key findings from the 11 in-depth interviews (IDIs) and two focus group discussions (FGDs) conducted with 24 postpartum women who had experienced CS deliveries. Thematic analysis of the data revealed five major themes, shown in Table 2 and subsequent thematic presentation.

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Table 2. Emergent Themes, Sub-Themes, and Illustrative Quotes from Participants

Main Theme	Sub-Themes	Illustrative Quotes
1. Pathways to caesarean delivery: from hope to necessity	- Medical indications (e.g., foetal position, prolonged labour) - Shared decision-making with spouse	*"I hoped to give birth naturally and never imagined needing a caesarean section… but when the baby was still in transverse position at eight months, we agreed with the doctor to proceed." (IDI 2, Urban)* *"After over 24 hours of labour and no progress, the doctor advised a CS. I had no choice because my previous delivery ended in stillbirth." (IDI 11, Rural)*
2. Emotional responses and mental adjustment	- Calm acceptance - Anxiety and distress - Role of faith and prayer	*"When I heard CS was needed, I was calm. I read about it, prayed, and prepared my mind for success." (IDI 4, Urban)* *"I felt distressed. I prayed and hoped for vaginal delivery, but memories of past complications haunted me." (IDI 11, Rural)*
3. Sociocultural interpretations and stigma	- Perceived stigma (e.g., laziness, weakness) - Resistance to societal beliefs - Religious misconceptions	*"Some people say CS means you're lazy or wasting your husband's money. But I don't pay attention to such talk." (IDI 6, Urban)* *"People believe giving birth through CS is against God's plan. I think that's ignorance." (FGD 2, Rural)*
4. Support systems and recovery experience	- Spousal and family support - Respectful health worker interaction - Inadequate follow-up care in some settings	*"My husband and mother-in-law supported me throughout. The nurses were respectful and explained everything." (IDI 5, Urban)* *"I had high blood pressure after the surgery, but the doctors didn't give proper guidance. That made recovery harder." (IDI 1, Urban)*
5. Reflections on future birth preferences and advice to others	- Willingness to undergo CS again - Emphasis on safety over stigma - Advice on financial preparedness and trust in professionals	*"CS is not a weakness. What matters is a healthy mother and baby. Trust your doctor and trust God." (FGD 1, Urban)* *"If it happens again, I'll do it. The pain is nothing compared to losing a child." (IDI 8, Rural)*

Theme 1: Pathways to Caesarean Delivery: From Hope to Necessity

Most participants initially hoped for vaginal delivery and considered CS only when complications arose. For many, medical conditions such as transverse foetal position, prolonged labour, or prior stillbirths influenced the decision. In several cases, the final decision was made jointly with spouses after receiving clinical advice.

"I hoped to give birth naturally and never imagined needing a caesarean section... but when the baby was still in transverse position at eight months, we agreed with the doctor to proceed." (IDI 2, Urban, 26 years)

"After over 24 hours of labour and no progress, the doctor advised a CS. I had no choice because my previous delivery ended in stillbirth." (IDI 11, Rural, 37 years)

Theme 2: Emotional Responses and Mental Adjustment

Women described varied emotional responses, ranging from calm acceptance and spiritual trust to anxiety, sadness, or disappointment. Despite initial fears, most participants reported feeling reassured after adequate explanations from medical staff and spiritual support from family.

"When I heard CS was needed, I was calm. I read about it, prayed, and prepared my mind for success." (IDI 4, Urban, 43 years)

"I felt distressed. I prayed and hoped for vaginal delivery, but memories of past complications haunted me." (IDI 11, Rural, 37 years)

Theme 3: Sociocultural Interpretations and Stigma

Participants reported encountering or hearing societal beliefs that frame caesarean birth as a sign of weakness, failure to endure labour, or waste of family resources. However, many women actively resisted these narratives and emphasized the primacy of safety over tradition.

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"Some people say CS means you're lazy or wasting your husband's money. But I don't pay attention to such talk." (IDI 6, Urban, 28 years)
"People believe giving birth through CS is against God's plan. I think that's ignorance." (FGD 2 Participant, Rural, 34 years)

Theme 4: Support Systems and Recovery Experience

Support from husbands, mothers, siblings, and friends was consistently cited as critical for emotional recovery and physical healing. Women with strong familial and institutional support reported faster recovery and better mental well-being. Respectful care from healthcare workers also played a positive role.
"My husband and mother-in-law supported me throughout. The nurses were respectful and explained everything." (IDI 5, Urban, 33 years)
"I had high blood pressure after the surgery, but the doctors didn't give proper guidance. That made recovery harder." (IDI 1, Urban, 32 years)

Theme 5: Reflections on Future Birth Preferences and Advice to Others

Most participants were open to CS in future deliveries, prioritizing maternal and child safety. They encouraged other women to be financially prepared, ignore societal pressure, and trust healthcare professionals.
"CS is not a weakness. What matters is a healthy mother and baby. Trust your doctor and trust God." (FGD 1 Participant, Urban, 29 years)
"If it happens again, I'll do it. The pain is nothing compared to losing a child." (IDI 8, Rural, 32 years)

DISCUSSION

This study explored the lived experiences, emotional well-being, and support systems of postpartum women who underwent CS in Ibadan, Nigeria. Five key themes emerged, providing important insights into how medical indications, cultural beliefs, emotional reactions, and support networks influence women's experiences. The findings both confirm and extend previous research from Nigeria and other countries. For instance, the finding that CS was largely driven by medical indications such as malpresentation, prolonged labour, and previous stillbirth rather than maternal request aligns with studies conducted in Nigeria, Uganda, Ghana, and Ethiopia (Adeosun et al., 2022; Asah-Opoku et al., 2023; Banke-Thomas et al., 2023; LoPoni et al., 2025). These authors similarly observed that CS is predominantly reactive in low-resource settings. However, this contrasts with findings from Sweden and Australia, where CS on maternal request and elective scheduling have become more common, often shaped by women's preferences and autonomy (Barnes et al., 2023; Fredriksson & Mattebo, 2025). Our results confirm that in Nigeria, male partners play a central role in decision-making, which agrees with findings from Ghana and Kenya showing that spousal involvement can both facilitate and delay CS decisions (Arunda et al., 2020; Asah-Opoku et al., 2023).
The range of emotional responses, from distress and fear to calm acceptance, observed in this study strongly agrees with evidence from China (Ma et al., 2025), Uganda (LoPoni et al., 2025), and India (Sharma et al., 2025), where women described CS as a stressful or even traumatic experience, particularly when it followed prolonged labor or when the reasons for surgery were not clearly communicated. In contrast, some participants in the current study emphasized that timely explanations from healthcare providers and reliance on religious faith played a calming role, a finding that also resonates with the Ugandan study, which noted reduced anxiety when health workers provide reassurance and clear information (LoPoni et al., 2025). These findings also corroborate Lai et al. (2025) in Canada, who demonstrated that emotional support and doula care mitigated post-traumatic stress after childbirth. However, this study's findings diverge slightly from those in China (Mao et al., 2023), where patients reported more significant emotional distress due to limited involvement in decision-making, suggesting that in this Nigerian sample study, joint decision-making with husbands acted as a partial buffer. Furthermore, while Saulnier et al. (2025) in the United States argue that obstetric quality of recovery tools do not capture psychological dimensions, this current study's findings confirm the need for emotional follow-up alongside physical recovery in Nigerian hospitals.
The belief that CS indicates weakness, laziness, or divine punishment, widely mentioned by the current study participants, is in agreement with earlier Nigerian research (Anih et al., 2023; Michael et al., 2024) and similar findings from India, Thailand, and Pakistan (Hassan et al., 2023; Nuampa et al., 2023; Sharma et al., 2025). These studies reported that cultural pressures frequently delay consent for CS and shape women's postnatal self-perceptions. However, the results from the current study participants revealed a noticeable resistance to these stigmatizing attitudes,

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emphasizing that delivery through CS is not a weakness. The participants of the current study also explicitly rejected the narratives that CS delivery is a weakness; rather, they advocated prioritizing maternal and infant health. This emerging resilience is consistent with studies in India (Sharma et al., 2025) and Thailand (Nuampa et al., 2023) that reported a gradual shift towards greater acceptance of CS as a safe, life-saving intervention.

Support systems were found to be central in shaping post-CS recovery. Similar to studies in Uganda and Ethiopia (Damtie et al., 2025; LoPoni et al., 2025), women in this study who received spousal, family, and health worker support reported faster psychological adjustment and better adherence to recovery recommendations. The calming influence of respectful maternity care also confirms findings from Canada (Lai et al., 2025) and India (Sharma et al., 2025), which show that supportive care reduces anxiety and post-traumatic stress. Conversely, some participants reported inadequate guidance after surgery, echoing the experiences documented in Nigeria (Olajide et al., 2025) and a recent scoping review of Sub-Saharan African hospitals (Musabeyezu et al., 2022). Such gaps in postnatal counselling remain a barrier to optimal maternal recovery and highlight an area where our findings agree with global concerns.

Generalizability

The findings are based on a relatively small sample of women in one Nigerian city, which limits the generalizability of the results to other regions.

CONCLUSION

This study provides compelling evidence that CS in Nigeria is not only a medical event but a deeply social and emotional experience shaped by cultural expectations, inadequate support systems, and gaps in respectful maternity care. The findings highlight that while caesarean delivery can save lives, the emotional cost, stigma, and insufficient postnatal support can have lasting impacts on women's mental health and overall well-being. The study is both timely and urgent because it addresses critical gaps in the current maternal health agenda at global, regional, and national levels. Despite the commitments of the Sustainable Development Goals (SDG 3) and the WHO Quality of Care Framework to improve maternal and newborn health, and Nigeria's adoption of strategies such as the National Reproductive, Maternal, Newborn, Child, Adolescent, and Elderly Health Plus Nutrition (RMNCAEH+N) policy, psychosocial care for women who undergo caesarean birth remains largely neglected. Without deliberate attention to the mental health, stigma, and support needs identified in this study, there is a risk of persistent maternal psychological distress, delayed recovery, poor bonding with infants, reluctance to seek facility-based care in future pregnancies, and, in extreme cases, avoidable maternal and neonatal morbidity and mortality.

Study Strengths

This study has several strengths. First, it draws on a qualitative phenomenological design that provides rich, in-depth insights into the lived experiences, emotions, and social contexts of women who delivered via caesarean section. The use of both in-depth interviews and focus group discussions enabled triangulation of perspectives, while including participants from both urban and rural local government areas ensured diversity in socio-demographic backgrounds. Additionally, the interdisciplinary approach, integrating reproductive health, sociology, and mental health, allowed for a holistic understanding of caesarean birth beyond clinical outcomes.

Study Limitations

The study has some limitations. As with many qualitative studies, the narratives are self-reported and influenced by recall bias or the social desirability of responses. Furthermore, the study did not include the perspectives of healthcare providers or male partners, which could provide additional dimensions to understanding decision-making, stigma, and support systems. To build on these findings. Future research with broader geographic coverage and the inclusion of other stakeholders is recommended.

Recommendations

The urgent implementation of this study's recommendations, particularly integrating psychosocial support into maternity care, strengthening respectful and family-inclusive care, and reducing stigma through community advocacy, is critical. Failure to act will perpetuate health inequities, particularly for vulnerable women in rural and low-income communities. Timely action is therefore essential to meet Nigeria's commitments to global maternal health targets, including reducing preventable maternal deaths to fewer than 70 per 100,000 live births by 2030. In conclusion, our findings call for immediate policy, practice, and research responses that elevate the emotional and social dimensions of caesarean

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birth to the same priority level as clinical safety. Doing so will protect the dignity and mental well-being of mothers, improve maternal and newborn outcomes, and accelerate Nigeria's progress toward global and regional health goals.

Implications for Policy, Practice, and Research

This study highlights key implications for improving maternal health outcomes and addressing the psychosocial dimensions of CS in Nigeria and similar low- and middle-income settings. On policy implications, national and state-level maternal health policies should explicitly include mental health services, such as postnatal counselling, debriefing sessions, and peer support groups, for women who undergo caesarean delivery, as recommended in other countries, including Uganda and India. Public health campaigns should promote accurate information about CS, positioning it as a safe, life-saving procedure rather than a marker of weakness, consistent with global best practices. Policymakers should reduce financial barriers, strengthen referral systems, and ensure that women in both rural and urban communities can access timely, safe, and affordable CS where medically indicated.

On practice implications, healthcare providers should prioritize effective communication, empathy, and patient involvement in decision-making, as this has been shown to reduce fear and psychological distress. Encouraging the involvement of husbands and family members during antenatal and postnatal care can strengthen support networks and improve both physical and emotional recovery. Structured follow-up visits, including clear discharge instructions and wound care guidance, should be standardized to address the gaps in continuity of care reported in Nigerian facilities.

Regarding research implications, future studies should include diverse regions in Nigeria and consider longitudinal designs to track mental health outcomes after CS. Research should integrate the voices of healthcare providers and male partners to better understand decision-making dynamics and barriers to care. Trials of culturally sensitive psychosocial interventions (e.g., birth debriefing, male-inclusive counselling) are needed to evaluate their impact on postnatal wellbeing, building on evidence from Canada, Australia, and Uganda (Lai et al., 2025; Tsakmakis et al., 2023).

List of Abbreviations

CS – Caesarean Section
FGD – Focus Group Discussion
IDI – In-depth Interview
LGA – Local Government Area
LMICs – Low- and Middle-Income Countries
NDHS – Nigeria Demographic and Health Survey
RMNCAEH+N – Reproductive, Maternal, Newborn, Child, Adolescent, and Elderly Health Plus Nutrition
SDG – Sustainable Development Goal
WHO – World Health Organization

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Authors' contributions:

Conceptualization: IM, TM; methodology: IM, TM; software: TM; validation: IM; formal analysis: TM; investigation: IM, TM; resources: IM, TM; data curation: IM, TM; writing—original draft preparation: IM, TM; writing—review and editing: IM, TM; visualization: IM; supervision: IM, TM; project administration: IM, TM. All authors have read and agreed to the published version of the manuscript.

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Conflicts of Interest:

The authors declare no conflicts of interest.

Data Availability Statement:

The qualitative datasets generated and analyzed during the current study consist of transcripts from interviews and focus group discussions. Due to the sensitive nature of the narratives and to protect participants' confidentiality, these data are not publicly available. De-identified excerpts relevant to the findings may be shared by the corresponding author upon reasonable request and with appropriate ethical approval.

Author Biography

Itoro T. Michael(BSc, PGDip) is a postgraduate student at the Centre for Child and Adolescent Mental Health, University of Ibadan, Nigeria. Her academic and professional interests focus on mental health promotion for

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children, adolescents, and mothers. She has experience in counselling, psychosocial interventions, and supporting families of children with special needs, with a growing research interest in perinatal mental health in low-resource settings.

Turnwait O. Michael (PhD) is a postdoctoral research fellow at the University of Johannesburg, specializing in reproductive health, demography, and medical sociology. His work focuses on women's maternal healthcare decision-making and the sociocultural dimensions of childbirth in Africa. Michael has published qualitative research on caesarean section perceptions and is active in promoting contextually informed maternal health interventions across sub-Saharan Africa.

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