

Stigma, Cultural Belief, and Family Decision-Making in Emergency Caesarean Section: A Qualitative Study of Women in Southeast Nigeria

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ABSTRACT

Nigeria's national rate of caesarean section (CS) delivery has remained below 3% across successive rounds of the Nigeria Demographic and Health Survey, well short of the World Health Organisation's recommended minimum, and most CS deliveries that do occur happen only after an obstetric emergency has already developed. This study examined how stigma, cultural belief, and family decision-making authority shape women's acceptance of emergency CS in Southeast Nigeria. A qualitative, interpretivist design employing Interpretative Phenomenological Analysis was adopted. In-depth interviews and focus group discussions were conducted with 52 women aged 18 years and above who had undergone emergency CS in Enugu, Ebonyi, and Imo States, purposively sampled to achieve maximum variation in age, parity, education, and religious affiliation. Data were analysed through a case-by-case and then cross-case procedure, supported by a structured coding framework. Four inter-related patterns emerged. First, husbands, or in their absence other senior male relatives, occupied the primary practical decision-making role regarding CS, functioning as gatekeepers to care even when women themselves recognised the danger first, though mothers-in-law and sisters occupied a further, sometimes decisive, layer of influence. Second, CS was persistently framed as evidence of a failure of womanhood, most vividly through a "Hebrew woman" narrative idealising unaided vaginal delivery, producing post-operative stigma that some younger, urban, and more educated women actively resisted, while others, including women of high parity, described the stigma as compounding rather than easing with repeated childbearing. Third, traditional and spiritual explanatory frameworks, including ancestral and herbal interpretations of obstetric complications, at times delayed biomedical care before it was sought. Fourth, fear of death, distance from a capable facility, cost, and the woman's own health literacy shaped how the other three patterns played out in practice. In this sample, stigma, cultural belief, and family decision-making authority appeared to operate as an influential, and at times decisive, barrier to timely CS acceptance in Southeast Nigeria, concentrated chiefly at the point of family decision-making. Antenatal interventions aimed at improving the timeliness of CS acceptance in this setting may benefit from engaging husbands and family decision-makers directly, rather than addressing the pregnant woman alone.

Keywords: caesarean section, stigma, family decision-making, Nigeria, Interpretative Phenomenological Analysis

BACKGROUND

Caesarean section (CS) is among the most effective interventions available in modern obstetric care, capable of preventing maternal and neonatal death when performed for a genuine medical indication within a reasonable timeframe (Ugwu et al., 2011). Global CS utilisation has risen substantially over the past two decades, from approximately 12% of births in 2000 to 21% by 2019, with further increases projected (Betrán et al., 2021). The World Health Organisation has, since 2015, maintained that population-level CS rates below 10% are associated with unmet obstetric need, while rates above roughly 10 to 15% confer little additional benefit to maternal or newborn survival (World Health Organisation, 2015). This global picture, however, conceals sharply divergent regional dynamics: while CS overuse, driven by maternal preference, provider convenience, and medico-legal considerations, characterises many middle- and high-income settings, large parts of sub-Saharan Africa continue to record rates far below the minimum needed to avert preventable maternal death (Boerma et al., 2018). The consequence of this shortfall is measured in lives: sub-Saharan Africa accounts for a disproportionate share of the global maternal mortality burden, and inadequate access to timely CS is among the most consistently cited contributors to that burden (World Health Organisation et al., 2023).

Nigeria illustrates this shortfall starkly. Successive rounds of the Nigeria Demographic and Health Survey (NDHS) have placed national CS prevalence at approximately 2.1% in 2013 and 2.7% in 2018, figures that round to a widely cited 3% but that sit well below both the WHO's minimum threshold and the average recorded across West Africa (Boerma et al., 2018; National Population Commission [NPC] & ICF, 2019). What makes this shortfall especially concerning is not merely its magnitude but its composition: more than 75% of the CS deliveries that do occur in Nigeria happen only after labour has already become obstructed or otherwise complicated, rather than being planned in advance (Geidam et al., 2009; National Population Commission [NPC] & ICF, 2019; Onoh et al., 2015). In Southeast Nigeria specifically, where the present study is situated, this pattern has been documented directly: a mixed-methods study in a Southeast Nigerian community hospital found that 22% of maternity clients refused a recommended CS outright, and that more than 90% of the CS deliveries eventually performed at that facility were emergencies rather than planned procedures, a pattern the authors attributed to women arriving late after first seeking assistance elsewhere (Ugwu & de Kok, 2015). A systematic review and meta-analysis of Nigerian facility-based studies found a pooled intra-facility CS prevalence of 17.6%, a figure many times higher than the national population-based estimate, underscoring that even the CS which is accessed is concentrated among a comparatively advantaged minority of women who reach better-resourced facilities in the first place (Osayande et al., 2023).

A substantial body of Nigerian and West African literature has sought to explain why CS remains so persistently under-accessed, and so disproportionately delayed until an emergency, in this setting. Early studies in southern Nigeria documented widespread reluctance to accept CS even when medically indicated, citing fear of death during surgery, extended recovery time, and the social meaning attached to abdominal delivery as consistent barriers (Awoyinka et al., 2006; Aziken et al., 2007; Chigbu & Iloabachie, 2007; Sunday-Adeoye & Kalu, 2011). This social meaning has been most closely examined through the lens of stigma and cultural belief: women who are unable to deliver vaginally in many Southeast Nigerian communities are widely regarded as having fallen short of an idealised standard of womanhood, a framing sometimes expressed through reference to the biblical "Hebrew women", said to give birth with ease (Onwuka, 2024; Ugwu & de Kok, 2015). Comparable dynamics have been documented elsewhere in West Africa, with Ghanaian women reported to face ridicule and, in some cases, threats to their marriages founded on the belief that CS restricts subsequent childbearing (Gyaase et al., 2023), and Togolese women citing fear of death, a desire to regain physical autonomy quickly, and the belief that a need for CS signals spiritual weakness as the strongest drivers of reluctance to accept the procedure (Kpanake et al., 2024). That this pattern is not simply an artefact of resource scarcity is suggested by evidence from diaspora populations: an anthropological study of Somali women receiving care within Britain's well-resourced National Health Service found persistent fear and active avoidance of CS despite the substantial removal of facility-level and financial barriers (Essén et al., 2011), indicating that cultural conviction can operate as an independent barrier to CS acceptance regardless of the underlying health system's capacity.

Family decision-making dynamics, and the role of husbands in particular, have received comparatively less direct empirical attention than stigma and cultural belief, despite being frequently invoked as part of the same explanatory picture. A community-based survey of 400 male partners in Ebonyi State, one of the states in which the present study is situated, found that men widely believed CS to be a procedure reserved for women who are “not strong”, with clear implications for the pressure husbands may exert, consciously or otherwise, on their wives' decisions during an obstetric emergency (Elom et al., 2023). This finding is important, but it has a specific limitation: it measured men's stated beliefs about CS in the abstract, using a structured questionnaire administered outside the context of any actual obstetric emergency, rather than observing or eliciting accounts of how those beliefs translated into behaviour at the moment a real, high-stakes decision had to be made.

Taken together, this literature establishes with reasonable confidence that CS avoidance and delay in Southeast Nigeria is a socially patterned phenomenon, shaped by stigma, cultural belief, and, plausibly, by husbands' and family members' decision-making authority, and that this pattern is echoed across comparable West African settings. What it has not yet established is how these forces are actually negotiated, in real time, by women who have already lived through the specific crisis this literature describes: an emergency in which a CS became medically unavoidable. Existing Nigerian evidence on CS refusal is disproportionately drawn from single-facility, cross-sectional studies, evidence which, however individually rigorous, is each likely to under-represent the most severe cases of delay and to rely on retrospective self-report from women recruited on postnatal wards, a sampling approach that, for both ethical and practical reasons, excludes women whose delay resulted in the most catastrophic outcomes (National Population Commission [NPC] & ICF, 2019; Ugwu & de Kok, 2015). The Ebonyi State evidence on male partners' beliefs, meanwhile, documents attitudes in the abstract rather than behaviour during a lived emergency, and does not by itself reveal whether, or how, those beliefs actually shaped a specific decision when a specific woman's life was at risk (Elom et al., 2023).

This gap matters for reasons that extend beyond academic completeness. Theoretically, the widely applied three-delays framework for understanding preventable maternal death identifies the decision to seek care as the first, and often most consequential, point of delay, but the framework itself, as applied in comparable low-resource settings, has been shown to require adaptation to account for delay driven by active family or religious preference rather than by ignorance or resource constraint alone, a revision this study's own setting is well positioned to inform empirically rather than theoretically (Thaddeus & Maine, 1994). Clinically and in terms of policy, interventions designed to reduce the disproportionate burden of emergency CS in Nigeria have tended to focus on facility readiness, transport, and cost, addressing what the three-delays framework terms the second and third delays, while comparatively little attention has been paid to the first delay, the family decision-making process itself, precisely because so little first-hand evidence exists on how that process actually unfolds. An intervention built on the assumption that husbands are simply obstacles, rather than on evidence of how husbands actually reason and act under pressure, risks being poorly targeted, and a policy response that addresses only facility-level barriers while leaving the decision-making delay untouched is unlikely, on the evidence reviewed here, to substantially reduce the proportion of Nigerian CS deliveries that occur as emergencies.

The present study addresses this gap directly. It draws on in-depth, first-hand accounts from 52 women who have themselves undergone an emergency CS in Enugu, Ebonyi, and Imo States, Southeast Nigeria, eliciting not only their own experience of stigma and cultural expectation but the specific, real-time role their husbands and other family members played in the decision as it actually unfolded, rather than reconstructing that role from either the woman's own attitude alone or from a separate survey of men's abstract beliefs. In doing so, the study is positioned to move the existing literature from documenting that stigma, culture, and family authority matter toward showing, empirically and in participants' own words, how they are actually negotiated at the point where a woman's and her family's decision determines whether a life-threatening emergency is met with a timely, or a dangerously delayed, response. Specifically, this paper addresses two questions: first, what role do husbands and other family members play in the decision to accept an emergency CS, and how is that role exercised in practice; and second, how do stigma and cultural belief

about womanhood and childbirth shape women's own experience of, and response to, that decision, both before and after the procedure itself.

METHODS

Design

This study adopted a qualitative, exploratory design informed by Interpretative Phenomenological Analysis (IPA), an approach that combines a phenomenological concern with lived experience with an explicitly interpretative stance, treating the researcher's understanding of a participant's account as a "double hermeneutic" in which the researcher makes sense of the participant making sense of her own experience (Smith et al., 2009). IPA is idiographic, committed to understanding in detail how a phenomenon has been understood by particular people in a particular context before making broader claims, which suited a study concerned with the specific, culturally situated experience of Southeast Nigerian women rather than with producing a generalisable attitude measure. A methodological clarification is warranted here. Classic IPA studies are, by design, small: standard guidance recommends samples of three to fifteen participants to permit the sustained, line-by-line idiographic engagement with each individual account that the approach requires (Smith et al., 2009).

The present study's combined sample of 52 women is considerably larger than this norm, and this departure was a deliberate, justified adaptation rather than an oversight, made for two reasons. First, the study's explicitly comparative aim, examining whether and how decision-making patterns varied across three states with different urban-rural compositions, required a sample distributed widely enough to support that comparison, a rationale consistent with more recent methodological guidance on extending IPA to more complex, multi-site, and multi-perspectival designs beyond its original single-homogeneous-group template (Larkin et al., 2019). Second, the study adopted a two-tier analytic strategy, described fully in the Data Analysis section below, in which full idiographic, case-by-case engagement in the classic IPA sense was reserved for the 24 individual interview participants, while the 28 focus group participants contributed a complementary, group-level corroborating layer rather than being treated as 28 additional idiographic cases in their own right. This distinction, between idiographic case analysis and group-level thematic corroboration, is elaborated in the Data Analysis section, and is consistent with recent guidance on constructing Group Experiential Themes (GETs) from a body of Personal Experiential Themes (PETs) that is itself larger than the very smallest IPA studies typically comprise (Nizza et al., 2021). IPA and closely related phenomenological approaches have, in any case, been used previously to examine women's experience of emergency CS specifically, including a classic Swedish study interviewing women within days of an emergency CS (Ryding et al., 1998), a French study examining migrant women's experience of CS in a transcultural context (Rodriguez et al., 2023), and a Jordanian study of maternal perceptions of CS delivery (Bawadi et al., 2025), providing a methodological precedent for the broader design adopted here. The study was situated within an interpretivist paradigm, treating reality as multiple and socially constructed and the researcher and participant as jointly constructing the findings through their interaction (Guba & Lincoln, 1994).

Setting and Participants

The study was conducted in Enugu, Ebonyi, and Imo States, three of the five states comprising Nigeria's Southeast geopolitical zone. These three states were selected purposively rather than arbitrarily: each hosts at least one secondary or tertiary facility with documented capacity to provide comprehensive emergency obstetric care, a precondition for recruiting sufficient numbers of women with emergency CS experience within a feasible fieldwork period, and together they preserve meaningful variation in urban-rural composition, from Enugu's large urban teaching-hospital catchment to Ebonyi's more substantially rural hinterland. Participants were women aged 18 years and above who had undergone an emergency CS within the preceding 24 months. Purposive, maximum-variation sampling was used to capture women of varying age, parity, educational attainment, and religious affiliation (Patton, 2002), in order to elicit a range of ways in which stigma, cultural belief, and family decision-making might be experienced and narrated. A total of

52 women participated: 24 through individual in-depth interviews and 28 through focus group discussions across the three states, a sample size consistent with recommended thresholds for thematic and meaning saturation in relatively homogeneous qualitative samples, and with the concept of “information power”, whereby a narrowly focused study drawing on an established theoretical framework may achieve adequate analytic depth with a comparatively modest sample (Guest et al., 2006; Malterud et al., 2016).

Recruitment followed the same procedure at each of the three facilities. Nurses staffing the postnatal clinic reviewed daily attendance against the study’s inclusion criteria and identified women who had delivered by emergency CS within the preceding 24 months. Eligible women were then approached by a research assistant, given a full oral and written explanation of the study’s purpose and procedures in English or Igbo according to their preference, and invited to take part. Women who agreed were offered a choice between an individual interview and a focus group discussion, scheduled at a time and in a private space convenient to them within the facility, and written or witnessed verbal informed consent was obtained immediately before data collection began. This recruitment procedure was identical across the individual-interview and focus-group strands of the study; the two strands differ only in the format in which data were subsequently recorded, a distinction that bears directly on the completeness of the demographic information reported in Table 1 below. Full socio-demographic data, including parity, education, religious affiliation, and marital status, were recorded using a structured proforma for the 24 individual interview participants and for a subset of 6 focus group participants; for the remaining 22 focus group participants, demographic detail was limited to age and occupation, recorded during each group’s opening warm-up round rather than through the fuller structured proforma used elsewhere. This difference reflects a genuine limitation in how focus group data collection was documented across the study’s three sites, rather than missing responses, incomplete forms, or any deliberate exclusion of data by the authors, and it is addressed directly as a limitation in the Discussion.

Data Collection

Data were collected using a semi-structured interview guide covering participants’ general experience of the emergency, the decision-making process, and stigma and social impact; a fourth section addressing religious influence was also administered but is reported in a linked companion paper focused specifically on that theme, in order to give each dimension of the phenomenon the depth its own literature warrants rather than treating it superficially within a single, overloaded paper. Individual interviews lasted approximately 45–60 minutes and focus group discussions 60–90 minutes, conducted in English or Igbo according to participant preference, audio-recorded with consent, and transcribed verbatim, with bilingual transcripts checked against the original recording where translation was required.

Data Analysis

Transcripts from the 24 individual interviews were analysed following the classic IPA procedure of case-by-case reading, exploratory noting, and emergent-theme development (Smith et al., 2009). For each interview transcript in turn, the analyst first read and re-read the account to achieve familiarity with it as a whole, then developed exploratory notes attending to descriptive content, the participant’s own language, and more interpretative, conceptual observations, before developing these notes into emergent themes for that individual case, in keeping with the construction of Personal Experiential Themes (PETs) as set out in recent IPA guidance (Nizza et al., 2021). Only once this idiographic, case-by-case analysis had been completed for all 24 individual interviews did the analyst move to cross-case comparison, looking for convergence, divergence, and pattern across these PETs to develop a first set of candidate Group Experiential Themes (GETs) (Nizza et al., 2021).

The 28 focus group discussion transcripts were then examined against these candidate GETs, coded using the general principles of thematic analysis (Braun & Clarke, 2006) within the same structured, matrix-based coding framework, in order to check whether the patterns identified from the individual interviews were corroborated, extended, or complicated in a group setting. This second stage did not treat each focus group participant as an independent idiographic case in the full IPA sense; rather, focus group data functioned as a

triangulating, group-level layer of evidence, consistent with recognised practice for combining individual interviews with focus group discussions to enhance the richness and credibility of qualitative findings (Lambert & Loiselle, 2008). Where a pattern from the individual interviews was independently echoed by focus group participants, most importantly for the denominational and generational patterns discussed below, this was treated as strengthening confidence in that GET; where focus group accounts diverged from the individual-interview pattern, this divergence was itself retained and reported rather than smoothed over. Participant-level codes were cross-tabulated by state and data-collection method to support the comparative dimension of the analysis. Four themes relevant to this paper's focus on stigma, culture, and family decision-making were developed through this combined procedure; a fifth theme concerning religious ideology specifically was analysed using the same two-tier procedure and is reported in full in the companion paper referenced above, a division made so that each theme could be given the depth its own literature warrants rather than being treated superficially within a single, overloaded paper.

Trustworthiness

The study's credibility was supported through prolonged engagement with each participant's account and through triangulation of individual interviews with focus group discussions, which allowed patterns identified in one-to-one accounts to be checked against the ways women collectively discussed the same themes in a group setting (Lambert & Loiselle, 2008). Transferability was supported through thick, detailed description of the study setting and participants; dependability through detailed documentation of the data collection and analytic procedure, consistent with the Consolidated Criteria for Reporting Qualitative Research (Tong et al., 2007); and confirmability through a reflexive audit trail linking each reported theme to specific, identifiable extracts of the underlying data.

Ethical Considerations

Ethical approval was obtained from the participating health facilities' ethics committee, and the research was conducted in accordance with the ethical principles for medical research set out in the World Medical Association's Declaration of Helsinki. Written or witnessed verbal informed consent was obtained from all participants, who were free to decline any question or withdraw at any time without consequence for their clinical care. Given the sensitivity of the subject matter, researchers remained attentive to signs of distress during data collection and had arranged, in advance, a referral pathway to counselling support at each recruiting facility. Transcripts were anonymised, and quotations reviewed to prevent participant identification within her community.

Researcher Positionality and Reflexivity

Consistent with the interpretivist paradigm underpinning this study, the research team treated reflexivity as a methodological requirement rather than an optional addendum. The lead researcher is a Nigerian academic with professional, rather than personal, familiarity with the health facilities and communities studied, a position that afforded a degree of interpretive distance from participants' accounts while also requiring active effort to avoid importing untested assumptions, particularly regarding gender roles and religious practice, into the coding of emergent themes. A reflexive journal was maintained throughout data collection and analysis, recording the researchers' own reactions to each interview and the specific interpretive choices made in developing Personal Experiential Themes from ambiguous or emotionally difficult material, and this record was drawn upon directly in resolving disagreements during cross-case synthesis. Because data collection was conducted by two research assistants working across different states, the research team held regular debriefing discussions during fieldwork specifically to surface and discuss differences in interviewing style or emphasis between them, a step intended to limit the extent to which the resulting dataset reflected each research assistant's individual approach rather than participants' own accounts.

RESULTS

Participants ranged in age from 22 to 43 years (Table 1). Among the 30 participants for whom complete

socio-demographic data were available, parity ranged from one to six children, educational attainment spanned no formal education to postgraduate qualifications, and religious affiliation was predominantly Christian, with Catholic and Pentecostal denominations most common. Four inter-related themes are presented below.

Table 1: Selected Socio-Demographic Characteristics of Study Participants

Characteristic	Category	n	%
State (N=52)	Enugu / Ebonyi / Imo	17 / 18 / 17	32.7 / 34.6 / 32.7
Method (N=52)	Individual interview / Focus group	24 / 28	46.2 / 53.8
Age, years (N=52)	22–43 (range)	—	—
Parity (n=30)	1–6 children (range)	—	—
Religion (n=30)	Catholic / Pentecostal / Anglican / Other	11 / 10 / 5 / 4	36.7 / 33.3 / 16.7 / 13.3

Table 2 sets out the four themes presented below, together with their constituent sub-themes and working definitions, before the findings for each are presented in turn with supporting verbatim quotations.

Table 2: Main Themes and Sub-Themes with Definitions

Theme	Definition
Theme 1: Husbands and Family Members as Gatekeepers to Care	The husband functions as the formal signatory and final decision-maker for the CS, even where the woman herself first recognised the danger.
Theme 2: Caesarean Section as a Failure of Womanhood	The cultural idealisation of easy, unaided vaginal birth, explicitly invoking the biblical “Hebrew women” narrative.
Theme 3: Competing Explanatory Frameworks Before Biomedical Care	A traditional birth attendant or herbalist is consulted before, and instead of, biomedical care at the onset of complications.
Theme 4: The Acuity of the Emergency	The woman describes fear for her own life, her baby's life, or both, as the dominant emotional experience of the emergency.

Theme 1: Husbands and Family Members as Gatekeepers to Care

Across almost every account, formal authority to consent to the CS rested with the woman's husband, or, in his absence, with another senior male relative, even where the woman herself had already recognised the danger.

“My husband was in the room. He was hesitant at first, wanting us to wait another hour, but I told him point-blank that we were following the doctor's medical advice.” (EN-IDI-01)

Where the husband was unavailable, another male relative typically assumed this role, sometimes after a costly delay while he was located and briefed.

“My husband was not around; he works in Port Harcourt. My eldest brother-in-law was called. He hesitated because of the cost, but when the nurse showed him the blood I was losing, he gave consent.” (EN-IDI-03)

Mothers-in-law occupied a further, less formal but often decisive layer of authority. In some accounts this layer actively delayed consent; in others, once persuaded, the mother-in-law's own words became part of what moved the family toward acceptance.

“My mother-in-law resisted the doctor's advice at first, insisting I should be given another six hours to try. It was only when the doctor warned that both mother and child might die that my husband stepped in and overruled his mother to sign the consent form.” (IM-IDI-02)

“Husband and my mother-in-law. Doctor spoke to them. Husband agreed quickly. Mother-in-law said ‘It is better than losing both.’” (EB-IDI-04)

Several participants described their husband's consent as arriving not through deliberation but through a blunt recognition that no real alternative remained, a framing echoed by other family members present at the decision.

“The doctor asked husband to sign. Husband said ‘We have no choice.’ My sister cried but agreed.” (EN-IDI-06)

This pattern of husband-centred authority, tempered by mothers-in-law and other relatives, was corroborated independently in focus group discussion, where participants described it as a broadly shared community norm rather than a household-specific arrangement, alongside candid accounts of unqualified support.

“In my case it was mainly my husband and the doctor. But in our community the husband usually has the final say. Mother-in-law is called if she is close.” (EN-FGD-03)

“Support when the husband says ‘do whatever will save you.’” (EN-FGD-07)

“It took the intervention of my brother, who offered to pay part of the hospital bill, for consent to be granted.” (EB-FGD-01)

Caesarean Section as a Failure of Womanhood

The idealisation of unaided vaginal delivery, frequently expressed through a “Hebrew woman” narrative, recurred across interviews and focus groups in all three states.

“They call women who push ‘strong women like Hebrew women.’” (EN-IDI-05)

This framing produced tangible post-operative stigma for several participants, expressed through gossip, altered treatment within the family compound, or open mockery.

“When I returned to the village market, women were whispering, saying my hips were too weak and that I didn't pray well.” (EN-IDI-02)

Notably, this stigma did not diminish with parity; several higher-parity participants described it as compounding rather than easing across successive pregnancies, since a CS after multiple prior vaginal deliveries was read as an even sharper departure from expectation.

“I have born five before, why this one? [...] Village people talked. Some said I am no longer strong.” (EB-IDI-06)

“At this age I cannot push. [...] People say older women should know how to deliver.” (IM-IDI-06)

A smaller group of participants, generally younger, urban, and more educated, described actively resisting this framing rather than internalising it.

“In my social circles, the ‘Hebrew woman’ narrative still exists, but educated urban women are beginning to push back against it.” (EN-IDI-01) “I think the Hebrew women talk is outdated.” (IM-IDI-07)

Focus group participants reinforced that this stigma was collectively recognised, and that it operated relationally, through direct comparison with women who delivered vaginally. “They clap more for the woman who pushed. My neighbour told people I was not strong enough.” (EN-FGD-09)

Competing Explanatory Frameworks Before Biomedical Care

For a number of women, the obstructed labour that eventually necessitated CS was first interpreted and treated within a traditional or spiritual framework, delaying the point at which biomedical care was sought.

“The traditional midwife tried everything for two days, using local herbs. When I became weak and stopped moving, my husband carried me on a motorcycle to the Alex Ekwueme Federal University Teaching Hospital in Abakaliki.” (EB-IDI-01) “My bleeding refused to stop, so they brought me to Awgu Joint Hospital. I thought my ancestors were angry with me.” (EN-IDI-03)

Even where no specific traditional remedy was sought, a generalised cultural expectation that a woman should deliver by herself was described as a background pressure shaping the emotional texture of the decision, distinct from, though sometimes co-occurring with, the religious framing reported separately in the companion paper. “Culture says woman must deliver by herself.” (EN-IDI-06)

Several participants, particularly in more urban settings, described this expectation as gradually loosening across generations. “We are more open in town. [...] I think the old views are changing small by small.” (EB-IDI-07)

The Acuity of the Emergency

Underlying the three patterns above was the acute character of the emergency itself. Fear of death, for the woman, her baby, or both, was the single most frequently recurring element across the dataset. “Doctor in hospital said operation or we die. I cried plenty.” (IM-IDI-08) Distance and cost compounded this fear for several participants, particularly in more rural areas, a concern corroborated in focus group discussion as a widely shared community anxiety. “I was labouring in a riverside village near Oguta. Transporting me to the General Hospital took hours by boat and road.” (IM-IDI-03) “The cost. Many families fear the money for CS.” (EN-FGD-07)

By contrast, a small number of participants with a health-related occupation or background described a markedly faster, more self-directed path to acceptance, in which prior knowledge of CS attenuated rather than amplified their fear. “I had no big fear before because I read that CS can save lives.” (EN-IDI-07)

DISCUSSION

The most consistent pattern across this study’s accounts was that husbands and family elders occupied the primary practical decision-making role in whether, and how quickly, an emergency CS was accepted, even in instances where the woman herself appeared to have recognised the danger first. This pattern is broadly consistent with, and appears to extend, the Ebonyi State survey of male partners’ attitudes toward CS (Elom et al., 2023). That survey measured men’s stated beliefs about CS in the abstract; the present findings suggest, through women’s own accounts, one possible way those beliefs may translate into gatekeeping behaviour during a lived emergency, and point to a more differentiated picture than a single “husband as obstacle” narrative would suggest, one in which mothers-in-law, sisters, and brothers-in-law each appeared to occupy distinct, sometimes competing, positions of influence, and in which husbands themselves frequently arrived at consent not through settled conviction but through a stark recognition, articulated bluntly by one participant as having “no choice”, that the alternative was unacceptable.

A clarification is warranted regarding the language of “consent” used throughout this paper. Under Nigerian medical law and professional ethical guidance, the legal right to consent to a surgical procedure such as CS rests with the competent adult patient herself, not with her husband or any other family member; a woman’s own consent is what is clinically and legally required, and no family member holds a formal legal veto over that decision. What this study documents is therefore better understood as a socially and culturally patterned practice of family decision-making that operates alongside, and in practice often ahead of, the formal consent process, rather than a description of the legal requirement itself: participants’ accounts describe husbands and elders as the party whose agreement was practically sought, deferred to, or waited for before a woman’s own consent was acted upon, a social dynamic that can delay timely care even where it carries no formal legal standing. This distinction matters for how these findings should be read: the intervention implication that follows is not that family members should be given formal decision-making authority they do not currently hold, but that health workers and antenatal counselling should explicitly engage the family members who are, in practice, already shaping the pace of a woman’s own decision-making, so that her legally protected right to consent for herself is not, in effect, delayed by an informal family negotiation that formal consent procedures do not require.

The prominence of the “Hebrew woman” narrative corroborates the existing Nigerian literature on CS-related stigma (Onwuka, 2024; Ugwu & de Kok, 2015) and extends it in two respects. First, it documents the narrative operating as the specific language used by neighbours and community members to shame women after CS, rather than as an abstract cultural reference. Second, and less expected, it shows this stigma compounding rather than easing with parity, a pattern not previously documented in the Nigerian literature reviewed here and one that complicates any assumption that experienced mothers are somehow insulated from judgement; if anything, the present findings suggest higher-parity women may face a sharper version of the same scrutiny, precisely because a CS after several prior vaginal deliveries departs more visibly from what their community has come to expect of them specifically. This finding is broadly consistent with West African evidence that CS-related stigma persists across generations even as some women actively resist it (Gyaase et al., 2023; Kpanake et al., 2024), and the generational and educational gradient in resistance observed here offers a Southeast Nigeria-specific empirical anchor for that broader regional pattern.

The pattern of traditional or spiritual explanation preceding biomedical care is consistent with explanatory-model accounts of pluralistic health-seeking behaviour, in which family, professional, and traditional or spiritual sources of authority are negotiated simultaneously rather than sequentially (Kleinman, 1980; Treacy & Sagbakken, 2015). Read alongside the three-delays framework for understanding maternal mortality (Thaddeus & Maine, 1994), these findings situate stigma, cultural belief, and family decision-making authority squarely within the first, decision-making delay, the point at which intervention is most likely to prevent the downstream emergency this study’s participants ultimately experienced. That fear of death was nonetheless the single most consistently reported element across the dataset, regardless of how stigma or cultural belief was resolved in any individual case, suggests that acute maternal risk perception can, and in most of the accounts reviewed here eventually did, override cultural resistance once the danger became sufficiently unambiguous; the practical and policy question this raises is how to shift that recognition earlier, before an emergency has already developed, rather than relying on the crisis itself to force the decision.

These findings carry direct implications for practice. Antenatal counselling in this setting has typically been directed at the pregnant woman; the present findings suggest this is a structurally incomplete strategy, since the woman herself, in a majority of the accounts reviewed here, was not the party whose consent ultimately determined the timing of care. Counselling that explicitly and proactively engages husbands, and where feasible mothers-in-law, before any emergency arises, is likely to be better matched to where decision-making authority actually resides than counselling addressed to the woman alone.

This study has limitations. The qualitative design, while appropriate to its aim of eliciting lived experience in depth, does not permit statistical generalisation to Southeast Nigeria as a whole, and the 52 women in this sample cannot be assumed to represent the full range of experience across the region. Husbands’ and family members’ own reasoning is reconstructed through women’s narration rather than observed directly or elicited

through independent interview with those family members, a limitation that future research combining women's, husbands', and religious leaders' own accounts within a single design, as recommended below, could directly address. The sample, drawn from women well enough to be interviewed after their CS, cannot capture the experience of women whose delay resulted in the most severe outcomes, a survivorship consideration shared with much of the wider literature this study engages (National Population Commission [NPC] & ICF, 2019; Ugwu & de Kok, 2015).

Finally, the cross-sectional, retrospective nature of the interviews means that the temporal sequence between belief, family pressure, and eventual decision is reconstructed from memory rather than observed as it unfolded, though the relatively short recall window of 24 months was designed to mitigate this concern. A related limitation concerns the completeness of the socio-demographic data reported in Table 1: as explained in the Methods, full demographic detail was recorded for 30 of the 52 participants, comprising all individual interview participants and a subset of focus group participants, while the remaining focus group participants were profiled by age and occupation only, a consequence of how focus group data collection was documented rather than missing or excluded responses; this means the denominational, educational, and parity patterns discussed in this paper are based on the 30-participant sub-sample and should be interpreted with corresponding caution.

CONCLUSIONS

In the accounts examined here, stigma, cultural belief, and family decision-making dynamics appeared to operate as an influential, and at times decisive, barrier to timely CS acceptance among women in Southeast Nigeria, concentrated chiefly at the point of family decision-making rather than at the level of facility access alone. Husbands occupied the primary practical decision-making role in the great majority of cases documented here, though not the formal legal authority to consent, which under Nigerian medical law rests with the woman herself; that practical role was itself embedded within, and shaped by, a wider family and community field in which mothers-in-law, sisters, and neighbours all appeared to play a part, and within a stigma that persisted, and in some accounts appeared to intensify, regardless of a woman's age or parity.

These patterns suggest that interventions aimed at reducing the disproportionate burden of emergency, rather than planned, CS in this setting may benefit from engaging husbands and other family decision-makers directly during antenatal care, rather than addressing the pregnant woman alone, and from anticipating that fear of death, once an emergency becomes unambiguous, may be among the more reliable levers available to health workers for securing timely acceptance in the moment itself. Given the qualitative, single-study basis of these observations, they are offered as hypotheses warranting further, larger-scale investigation rather than as an established, generalisable causal account.

Declarations

Ethics Approval and Consent to Participate

Ethical approval was obtained from the participating health facilities' ethics committee, and the research was conducted in accordance with the ethical principles for medical research set out in the World Medical Association's Declaration of Helsinki.

Consent for Publication

Not applicable. All data are reported in anonymised, aggregated, or de-identified form.

Availability of Data and Materials

The anonymised datasets analysed during the current study are available from the corresponding author on reasonable request.

Competing Interests

The authors declare that they have no competing interests.

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Authors' Contributions

VUU conceived and designed the study, led data analysis, and drafted the manuscript. ICE, CEA, and VNU contributed to data collection, analysis, and critical revision of the manuscript. All authors read and approved the final manuscript.

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