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Sociodemographic Correlates of Childbirth Fear and Preventive Practices among Pregnant Women attending Healthcare Facilities in Nsukka Local Government Area, Enugu State

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Abstract

The study investigated sociodemographic correlates of childbirth fear and preventive practices among pregnant women attending healthcare facilities in Nsukka Local Government Area, Enugu State. Three specific objectives with three corresponding research questions and one null hypothesis guided the study. The correlational research design was adopted for the study. The population for the study consisted of 1,736 registered pregnant women attending healthcare facilities in Nsukka LGA, Enugu State. A total of 390 (97.5%) pregnant women who responded were drawn through a two-stage sampling procedure. The Sociodemographic Data Sheet (SDS), Childbirth Fear Questionnaire (CFQ), and Preventive Practices for Childbirth Fear Questionnaire (PPCFQ) were used for data collection. Data were analysed using frequencies and percentages, point-biserial (rbp) correlation, and multivariable logistic regression models. Overall, (37.4%) of pregnant women reported experiencing childbirth fear. Sociodemographic of age, educational level, and employment status (all p>.05) were not significant correlates of childbirth fear. Majority (69.9%) of pregnant women adopted appropriate preventive practices. The study concluded that pregnant women are actively employing informational, emotional, and faith-based approaches to cope with childbirth-related anxiety. It was recommended among others that healthcare providers should routinely screen pregnant women attending antenatal clinics for childbirth fear to enable early identification and appropriate support.

Keywords: Childbirth fear, Preventive practices, Sociodemographic correlates, Pregnant women, Maternal health, Antenatal care.

Introduction

Globally, childbirth fear has been increasingly recognized as a significant maternal health concern, with varying prevalence across countries. Studies indicate that approximately 20–25 per cent of pregnant women worldwide experience a high level of childbirth fear, with rates ranging from 6 per cent to 10 per cent in Northern Europe to as high as 25 per cent to 30 per cent in countries like Australia and the United States (Dai et al., 2020; O'Connell et al., 2019; Sanjari et al., 2022). In Ethiopia, a systematic review and meta-analysis reported a pooled prevalence of severe childbirth fear at 21 per cent, with notable regional variations with 24 per cent in the Southern Nations, Nationalities, and Peoples' Region (SNNPR), 25 per cent in Oromia, and 11 per cent in Addis Ababa (Assimamaw et al., 2024). Similarly, a recent study in Egypt showed that the prevalence of childbirth fear ranged from mild to severe, with 70.4 per cent of women displaying some degree of fear and 11.3 per cent exhibiting severe childbirth fear (Elsharkawy et al., 2024). A research conducted in Port Harcourt, Nigeria indicated that while severe perceived labour pain was widespread, childbirth fear was not very common; however, unemployment was identified as a

significant predictor of childbirth fear among birthing mothers (Eleke et al., 2020). Given the cultural and regional diversity within Nigeria, it is imperative to explore the correlates of childbirth fear and preventive practices in specific contexts, such as Nsukka LGA, Enugu State.

Childbirth fear is an increasingly acknowledged psychological and emotional concern affecting many pregnant women globally. According to Nilsson et al. (2018b), childbirth fear is a state of anxiety or dread about labour and birth, often associated with concerns about pain, complications, and the unknown. Childbirth fear is a complex and multifaceted experience that can arise from various psychological, physical, and social concerns. According to Fairbrother et al. (2022), these concerns may include fear of loss of sexual pleasure/attractiveness, fear of pain from a vaginal birth, fear of medical interventions, fear of embarrassment, fear of harm to baby, fear of caesarean birth, fear of mom or baby dying, fear of insufficient pain medication, and fear of body damage from a vaginal birth. Childbirth fear presents with a range of psychological, emotional, and physical symptoms that can significantly impact a woman's wellbeing during pregnancy and the birthing process. Common symptoms include persistent anxiety, panic attacks, sleep disturbances, intrusive thoughts about childbirth, and avoidance of discussions or environments related to birth (Nilsson et al., 2018a). These symptoms and outcomes show the critical importance of identifying and addressing childbirth fear early among pregnant women.

Pregnant women are individuals carrying a developing foetus within their uterus, beginning from the time of conception until childbirth. According to the World Health Organization (WHO, 2020), a pregnant woman is one who is undergoing a biological and physiological process marked by anatomical and hormonal changes in preparation for the birth of a child. There is need to include mental health in prenatal care as it ensures a holistic approach to maternal wellbeing, improves maternal-foetal bonding, and enhances birth outcomes (Naaz et al., 2023). This reflects the importance of exploring the correlates that influence psychological conditions such as childbirth fear among pregnant women.

Correlates are the various underlying factors that influence individuals' health behaviours and outcomes. Murray (2024) described correlates as the conditions in which people are born, live, work, and age, emphasizing that these factors collectively influence health disparities and access to care. In this study, correlates refer to factors which may influence childbirth fear among pregnant women. This study investigates the sociodemographic correlates of childbirth fear among pregnant women. Sociodemographic factors are the social and personal characteristics of individuals that influence their behaviours, experiences, and health outcomes. Sociodemographic factors capable of determining the occurrence of childbirth fear include age, educational level, and employment status. Alemu et al. (2024) reported that pregnant women aged 18 to 24 years showed a very high level of childbirth fear in Ethiopia. İsbir et al. (2024) reported that low education level was one of the factors causing childbirth fear among pregnant women in Turkey. Khwepeya et al. (2018) found that unemployed pregnant women in Malawi were more likely to report moderate to high levels of childbirth fear. Assessing these factors is essential for identifying appropriate preventive practices that can help reduce childbirth fear among pregnant women.

Preventive practices are actions taken to avoid, minimize, or manage potential health issues before they manifest or worsen. According to Sassen (2023), preventive practices are interventions that aim to reduce the risk of disease or health-related problems through lifestyle changes, education, and proactive healthcare. Preventive practices for childbirth fear can be categorized into primary,

secondary, and tertiary prevention, each playing a vital role in addressing the psychological challenges that arise during pregnancy. Primary prevention involves strategies aimed at reducing the risk of developing childbirth fear in the first place, such as providing antenatal education, stress management techniques, and promoting positive childbirth experiences through supportive care (Lebni et al., 2021). Secondary prevention focuses on early identification and intervention for women at risk of severe childbirth fear, including the use of screenings for anxiety and offering targeted counselling or therapy to help alleviate fears before they escalate (Webb et al., 2021). Tertiary prevention is centred on minimizing the negative effects of childbirth fear that has already developed, such as providing psychological support during labour, offering options for pain management, or facilitating a supportive birth environment that reduces anxiety (Nori et al., 2023). Adopting these prevention practices is crucial for improving maternal health outcomes and reducing the psychological burden of childbirth fear.

In an ideal maternal healthcare setting, pregnancy and childbirth are embraced as natural and positive life experiences. Pregnant women receive comprehensive, empathetic, and evidence-based care that addresses not only their physical needs but also their emotional and psychological well-being. They feel confident and supported throughout their pregnancy journey, with access to accurate information, skilled birth attendants, effective pain relief options, and strong social support systems. In such an environment, childbirth fear is minimal, and women are empowered to adopt preventive practices such as attending antenatal education sessions, engaging in relaxation techniques, seeking psychosocial support, and building trust in the healthcare system.

However, the reality in the present setting deviates significantly from this ideal. Many pregnant women experience significant fear about childbirth, driven by factors such as previous traumatic birth experiences, lack of knowledge, inadequate communication with healthcare providers, poor quality of care, and limited access to mental health support. Additionally, while preventive practices are known to reduce childbirth fear, their uptake remains low due to limited awareness, low self-efficacy, and perceived barriers such as stigma.

Despite increasing attention to childbirth fear globally, there is limited local evidence on its correlates and preventive practices among pregnant women. This gap in literature hinders the development of targeted, context-specific interventions to reduce childbirth fear and promote effective preventive practices in the region. Hence, this study assessed sociodemographic correlates of childbirth fear and preventive practices among pregnant women attending healthcare facilities in Nsukka LGA, Enugu State. However, the study sought to determine the prevalence of childbirth fear among pregnant women; relationship between childbirth fear and sociodemographic factors (age, education level, and employment status) among pregnant women; and preventive practices for childbirth fear adopted by pregnant women. Also, it was hypothesized that sociodemographic factors (age, educational level, and employment status) are not significant correlates of childbirth fear among pregnant women. Generally, this study is significant because it will contribute to improved maternal healthcare, evidence-based policy and practice, and future research on maternal mental health.

Methods

Study design and setting

The study utilized a correlational survey research design. Janse et al. (2021) defined correlational survey research design as a non-experimental method that examines the relationship between two or more variables to determine whether they are associated or correlated.

This study was conducted in Nsukka LGA of Enugu State. Nsukka LGA shares boundaries with Igbo-Eze South to the north, Uzo-Uwani to the west, Udenu to the east, and Igbo-Etiti to the south. It is predominantly inhabited by the Nsukka people, an Igbo-speaking ethnic group known for their rich cultural heritage, strong communal values, and traditional beliefs that significantly influence reproductive behaviours. Many cultural perceptions around childbirth, such as viewing labour pain as a rite of passage or expressing fear as a sign of weakness, persist within the community, potentially shaping women's attitudes toward childbirth. Nsukka LGA hosts several public and private healthcare facilities offering maternal health services; challenges such as limited access to skilled mental health support, inconsistent antenatal counselling, and socio-economic barriers remain prevalent. The combination of deep-rooted cultural norms, varying levels of healthcare access, and diverse maternal experiences makes the present location a suitable and relevant setting for studying the sociodemographic correlates of childbirth fear and preventive practices.

Population

The population for the study consisted of 1,736 registered pregnant women attending healthcare facilities in Nsukka LGA, Enugu State.

Sample size and sampling technique

The sample size for the study was 400 respondents. This was in line with the suggestion of Cohen et al. (2018), that when a population size is 1,500 and above at 95 per cent confidence level (5% interval), the sample size should be 306 or above. The sample size was increased to 400 in order to ensure greater representation of participants and make up for attrition (non-response) rate. A two-stage sampling procedure was used to draw the sample for the study. Stage one involved the use of simple random sampling of balloting without replacement to draw five secondary health facilities and five primary health facilities from the health facilities in Nsukka LGA. This gave a total of ten health facilities that were used for the study. Stage two involved convenience sampling to draw 40 pregnant women from each of the 10 health facilities drawn in stage two. Convenience in the sense that only pregnant women who agreed to participate in the study were selected. This gave a total of 400 pregnant women.

Data collection instruments

The Sociodemographic Data Sheet (SDS), Childbirth Fear Questionnaire (CFQ), and Preventive Practices for Childbirth Fear Questionnaire (PPCFQ) were used for data collection. The Sociodemographic Data Sheet (SDS) elicited data on sociodemographic factors (age, education level, and employment status). The appropriate response options were assigned to each item. The Childbirth Fear Questionnaire (CFQ), developed by Fairbrother et al. in 2022, is a comprehensive tool designed to assess various aspects of fear related to childbirth. It contains 40 items organized into nine subscales, along with an additional 7-item interference subscale that measures how

childbirth fear impacts daily functioning. The CFQ demonstrated excellent internal consistency, with high Cronbach's alpha values, and showed strong construct and convergent validity. The Preventive Practices for Childbirth Fear Questionnaire (PPCFQ) was designed by the researcher to assess the preventive practices pregnant women adopt to prevent childbirth fear. It is a 15-item questionnaire with dichotomous response options of "Yes or No". The instruments were validated by five experts: four experts from the Department of Human Kinetics and Health Education and one expert from the Department of Psychology, University of Nigeria, Nsukka. The reliabilities of the instruments were calculated using Cronbach's Alpha, Split-half method and Spearman-Brown Correlation Formula to determine the internal consistency. The reliability coefficients of the CFQ and PPCFQ were .955, and .909 respectively which were adjudged reliable for use in the present study.

Data collection procedure

In order to gain access to the respondents, a letter of introduction on fieldwork was obtained from the Head, Department of Human Kinetics and Health Education, University of Nigeria, Nsukka. This was presented to the Medical Directors of each of the health facilities selected for the study to seek permission and co-operation. The Medical Directors granted the researcher access to the pregnant women accessing antenatal care services in the health facilities. Four research assistants, who are CHEWs and JCHEWs, were briefed on the procedures for the administration of questionnaire and collection of the completed copies from the respondents. The researcher explained the objectives of the research to the participants and written informed consent were obtained from those who were willing to participate in the study. Copies of the instruments were administered directly to the pregnant women and every respondent given the questionnaire was encouraged to complete and return on the spot.

Data analysis

Out of the 400 questionnaires administered, only 390 (97.5) were duly filled and returned, and thus used for data analysis. The information from the duly filled out copies of the questionnaire were coded using the Statistical Package for Social Sciences (SPSS) version 26. Research questions one and three were answered using frequencies and percentages while point-biserial (rbp) correlation was used to answer research question two. Using Nwagu and Agbaje's (2017) recommendations for interpretation of correlation coefficients, 0.00 - ±.29 were interpreted as none (.00) to weak relationship (NR or WR), correlation coefficients of ±.30-.59 were interpreted as moderate relationship (MR), and correlation coefficients of ±.60-1.00 were interpreted as strong relationship (SR). Multivariable logistic regression model was used to test the null hypothesis at 0.05 level of significance.

Results

Table 1: **Prevalence of Childbirth Fear among Pregnant Women Attending Healthcare Facilities in Nsukka LGA, Enugu State (N=390)**

Category	N	%
No childbirth fear	244	62.6
Childbirth fear present	146	37.4

Key: CFQ Score < 83 = No childbirth fear; CFQ Score ≥ 83 = Childbirth fear; n = scores of categories; N = sample size; % = percentage sign

Source: Fairbrother et al. (2022)

Table 1 presents the prevalence of childbirth fear among pregnant women attending healthcare facilities in Nsukka LGA, Enugu State. The findings show that out of the 390 pregnant women studied, 244 respondents (62.6%) reported no childbirth fear, while 146 respondents (37.4%) were found to have childbirth fear present.

Table 2: **Point-Biserial Correlation between Childbirth Fear and Sociodemographic Factors among Pregnant Women Attending Healthcare Facilities in Nsukka LGA, Enugu State (N=390)**

S/N	Sociodemographic Factors	Childbirth Fear	
		Rpb	p-value
1.	Age	.012	.816
2.	Education level	.006	.903
3.	Employment status	.012	.818

Key for interpretation: ±.00 – ±.29 = None to weak relationship; ±.30 – ±.59 = Moderate relationship; ±.60 – ±.99 = Strong relationship; ± 1.00 = Perfect relationship.
Source: Nwagu and Agbaje (2017)

Table 2 presents the point-biserial correlation analysis showing the relationship between childbirth fear and sociodemographic factors among pregnant women attending healthcare facilities in Nsukka LGA, Enugu State. The findings revealed that age (rpb=.012, p=.816), educational level (rpb=.006, p=.903), and employment status (rpb=.012, p=.818) showed a very weak positive relationship with childbirth fear among pregnant women attending healthcare facilities in Nsukka LGA, Enugu State.

Table 3 **Preventive Practices for Childbirth Fear Adopted by Pregnant Women Attending Healthcare Facilities in Nsukka LGA, Enugu State (N=390)**

S/N	Preventive practices for childbirth fear	Yes n(%)	No n(%)
1.	I have taken time to learn about the childbirth process.	350(89.7)	40(10.3)
2.	I attend antenatal classes regularly to reduce my fear of childbirth.	276(70.8)	114(29.2)
3.	I have discussed my childbirth fears with a healthcare provider.	292(74.9)	98(25.1)
4.	I practice relaxation techniques (e.g., deep breathing, meditation) to manage childbirth fear.	273(70.0)	117(30.0)
5.	I seek emotional support from my partner, family, or friends when I feel anxious about childbirth.	287(73.6)	103(26.4)
6.	I avoid negative birth stories or disturbing media about childbirth.	275(70.5)	115(29.5)
7.	I have created a birth plan to feel more in control of my childbirth experience.	253(64.9)	137(35.1)
8.	I engage in exercises recommended for pregnant women to prepare for childbirth.	266(68.2)	124(31.8)
9.	I pray or engage in spiritual practices that help calm my fears about childbirth.	283(72.6)	107(27.4)
10.	I ask questions during antenatal visits to understand what to expect during labour.	260(66.7)	130(33.3)
11.	I have read books or articles about positive birth experiences.	257(65.9)	133(34.1)
12.	I talk with other women who have had positive childbirth experiences.	272(69.7)	118(30.3)
13.	I have considered hiring a birth companion (doula) to support me during childbirth.	227(58.2)	163(41.8)
14.	I make conscious efforts to stay optimistic about my childbirth journey.	270(69.2)	120(30.8)
15.	I have sought counselling or therapy to help manage my fear of childbirth.	247(63.3)	143(36.7)
	Overall %	**69.9**	**30.1**

Table 3 presents the preventive practices for childbirth fear adopted by pregnant women attending healthcare facilities in Nsukka LGA, Enugu State. The findings revealed that a majority of the respondents adopted various preventive practices aimed at reducing childbirth fear, as indicated by an overall 69.9% positive response compared to 30.1% negative response. Specifically, the most commonly adopted preventive practice was taking time to learn about the childbirth process (89.7%), followed by discussing childbirth fears with a healthcare provider (74.9%), seeking emotional support from partners, family, or friends (73.6%), and engaging in prayer or spiritual practices to calm fears (72.6%). Similarly, substantial proportions of the respondents reported attending antenatal classes regularly (70.8%), avoiding negative birth stories or disturbing media (70.5%), and practicing relaxation techniques such as deep breathing and meditation (70.0%) as measures for managing childbirth fear. Overall, the findings indicate that pregnant women in the study area generally adopted positive preventive practices to manage childbirth fear, with education

about childbirth, healthcare consultation, emotional support, and spiritual coping strategies emerging as the most commonly adopted preventive measures.

Table 4: **Multivariable Logistic Regression Showing Sociodemographic Factors are not Significant Correlates of Childbirth Fear among Pregnant Women Attending Healthcare Facilities in Nsukka LGA, Enugu State (*n*=390)**

Socio-demographic Factors	B	S.E	Wald	Df	p-value	OR	95% C.I. for Exp(B)	
							Lower	Upper
Age			.536	2	.765			
15 – 24 years[a]								
25 – 34 years	-.104	.236	.192	1	.661	.902	.567	1.433
35 years and above	.106	.311	.116	1	.733	1.112	.605	2.044
Education Level			.060	3	.996			
No formal education[b]								
Primary education	-.098	.422	.054	1	.816	.907	.396	2.074
Secondary education	-.021	.341	.004	1	.952	.980	.503	1.909
Tertiary education	-.026	.336	.006	1	.937	.974	.504	1.882
Employment Status			.163	2	.922			
Employed[c]								
Unemployed	-.057	.278	.042	1	.837	.945	.548	1.628
Self employed	.057	.249	.052	1	.819	1.059	.649	1.726
Constant	-.461	.326	2.000	1	.157	.630		

Cox & Snell R^2 =.002 CI= confidence Interval

$\chi^2(7)$ =0.815, p = .997 > .05 Predicted Classification Table Overall = 62.6%

Ref Groups: Age = 15–24 years[a]; Education Level = No Formal Education[b]; Employment Status= Employed[c]

Table 4 presents the results of a multivariable logistic regression analysis examining sociodemographic factors (age, education level, and employment status) as correlates of childbirth fear among pregnant women attending healthcare facilities in Nsukka LGA, Enugu State. The entire model was not statistically significant ($\chi^2(7) = 0.815$, $p = .997$), indicating that the sociodemographic variables collectively did not significantly contribute to the prediction of childbirth fear among pregnant women in the study area. The overall classification accuracy of the model was 62.6%, while the Cox and Snell R^2 value of .002 indicates that sociodemographic factors explained only 0.2% of the variation in childbirth fear. Findings further show that age (p>.05), educational level (p>.05), and employment status (p>.05) were not significant correlates of childbirth fear among pregnant women among pregnant women attending healthcare facilities in Nsukka LGA, Enugu State. Since the p-value for the overall model was greater than the 0.05 level of significance, the null hypothesis stating that sociodemographic factors are not significant correlates of childbirth fear among pregnant women is therefore accepted.

Discussion

Findings in Table 1 show that overall, less than half of pregnant women reported experiencing childbirth fear. This finding expected, considering that fear of childbirth is a recognized maternal health concern, but its occurrence often varies across populations depending on psychosocial support, access to antenatal education, and cultural perceptions surrounding childbirth (Kaya et al., 2025). Women who regularly attend healthcare facilities may benefit from professional guidance, counselling, and exposure to childbirth education, which could help reduce fear levels (AlKhunaizi et al., 2025). This finding aligns with the systematic review by Nilsson et al. (2018b), which reported that fear of childbirth occurs among a notable proportion of pregnant women globally, though prevalence differs widely depending on context and measurement approach, and with the Nigerian study by Eleke et al. (2023), which found that severe childbirth fear was not highly prevalent among birthing mothers. However, this finding contrasts with the findings on Alemu et al. (2024) who reported that among pregnant women in Dejen Woreda, East Gojjam Zone, Northwest Ethiopia, 23.8 per cent low fear of childbirth, 12 per cent moderate, 38.8 per cent had high, and 25.5 per cent had severe fear of childbirth. This difference in findings may be due to variations in study settings, sociocultural beliefs, fear measurement tools, and maternal health service utilization. This finding may be attributed to improved access to antenatal care services, childbirth education, and professional support, which help pregnant women develop confidence and reduce anxiety about childbirth. The finding implies that while childbirth fear may not be widespread, routine screening and appropriate psychological support should remain part of antenatal care to identify and assist women who experience significant fear.

Findings in Table 2 show that there was a very weak positive relationship between childbirth fear and age among pregnant women. The corresponding hypothesis in Table 4 show that age was not a significant correlate of childbirth fear among pregnant women. The findings are somewhat expected, as childbirth fear is often more strongly influenced by psychological, obstetric, and social experiences than chronological age alone. While age may shape pregnancy experiences to some extent, fear of childbirth can be experienced by both younger and older pregnant women depending on their personal beliefs, previous experiences, and available support systems (Zhou et al., 2021). This finding is consistent with the findings of Jing et al. (2025), who found that age was not significantly associated with trajectories of fear of childbirth among pregnant women, suggesting that maternal fear may be influenced more by childbirth-related experiences than age itself. Similarly, Alemu et al. (2024) reported that maternal age alone was not a major predictor of childbirth fear when other psychosocial and obstetric factors were considered. However, this finding contrasts with the report of Rashidi et al. (2025), who found age to be a significant predictor of fear of childbirth, with older maternal age associated with increased fear, possibly due to concerns about pregnancy complications and delivery outcomes. This difference in findings may be due to variations in study populations, cultural settings, parity distribution, and measurement tools used to assess childbirth fear. The finding may be attributed to the fact that childbirth fear is influenced more by psychological, obstetric, and social factors than by maternal age alone. This implies that interventions aimed at reducing childbirth fear should target all pregnant women regardless of age, with greater emphasis on addressing modifiable psychosocial and obstetric factors.

Furthermore, findings in Table 2 show that there was a very weak positive relationship between childbirth fear and educational level among pregnant women. Also, the corresponding hypothesis in

Table 4 shows that education level was not a significant correlate of childbirth fear among pregnant women among pregnant women. The findings are expected because educational level alone may not directly determine how a woman perceives childbirth, especially where fear is more strongly shaped by personal pregnancy experiences, psychological wellbeing, cultural beliefs, and the quality of maternal support available. Although education may improve health literacy and access to pregnancy-related information, it does not necessarily eliminate anxiety or fear associated with labour and childbirth (Athinaidou et al., 2024). This finding is consistent with the findings of O'Connell et al. (2019), who reported no significant relationship between maternal educational level and fear of childbirth. However, this finding contrast with Soysal and Işıkalan (2020) found that fear of childbirth increased as the education level increased. The finding also disagree with İsbir et al. (2024) who reported that low education level was one of the factors associated with childbirth fear among pregnant women in Turkey. These differences may have arisen due to variations in study settings, socio-cultural context, access to antenatal education, and differences in measurement tools used to assess childbirth fear. The finding may be attributed to the fact that childbirth fear is influenced more by psychosocial, cultural, and obstetric factors than by educational attainment alone. This implies that childbirth education and psychosocial support should be provided to all pregnant women irrespective of their educational level to effectively reduce childbirth fear.

More so, findings in Table 2 show that there was a very weak positive relationship between childbirth fear and employment status among pregnant women. Similarly, the corresponding hypothesis in Table 4 shows that employment status was not a significant correlate of childbirth fear among pregnant women. The findings are expected because employment on its own may not strongly determine childbirth fear. While employment may influence access to resources and healthcare, both employed and unemployed pregnant women can experience similar concerns about labour, pain, and childbirth outcomes (Grand-Guillaume-Perrenoud et al., 2022). This finding is consistent with the work of AlDardeir et al. (2025), who reported that employment status was not significantly associated with fear of childbirth among pregnant women. However, this finding contrast with Khwepeya et al. (2018) reported that pregnant women who were unemployed were more likely to report moderate and high fear in Malawi. The findings also disagree with the findings of İsbir et al. (2024) also reported that unemployment status was among the factors influencing fear of childbirth in pregnant women in Turkey. These differences may be due to variations in socioeconomic context, employment conditions, and healthcare access across study settings. The finding may be attributed to the fact that childbirth fear is influenced more by psychological, obstetric, and social support factors than by employment status alone. This implies that interventions to reduce childbirth fear should be made accessible to all pregnant women regardless of their employment status.

Findings in Table 3 show that majority of pregnant women adopted various preventive practices aimed at reducing childbirth fear. Specifically, the most commonly adopted preventive practice are: taking time to learn about the childbirth process; discussing childbirth fears with a healthcare provider; seeking emotional support from partners, family, or friends; and engaging in prayer or spiritual practices to calm fears. The findings were expected as pregnant women often employ both informational and emotional coping strategies to manage fear and uncertainty associated with childbirth. Increased knowledge about labour and delivery can reduce fear of the unknown, while communication with healthcare providers offers reassurance and clarification of concerns; similarly, social and spiritual support systems are well-established buffers against anxiety during pregnancy (Ramu et al., 2024). This finding is consistent with Kaya et al. (2025), who reported that antenatal

education and psychoeducational interventions significantly reduced fear of childbirth by improving women's understanding and coping capacity. Likewise, Seto et al. (2024) found that seeking support from healthcare professionals and close social networks was a common and effective strategy among women attempting to manage childbirth fear. The prominence of prayer and spiritual practices in this study also aligns with findings from Chehrazi et al. (2021), who noted that spiritual coping can play a meaningful role in reducing stress and promoting emotional wellbeing during pregnancy. The high adoption of these preventive practices may be attributed to increased awareness of childbirth preparation, regular antenatal care attendance, and the availability of social and spiritual support during pregnancy. This implies that healthcare providers should continue strengthening antenatal education, counselling, and support systems to encourage effective coping strategies that reduce childbirth fear.

Conclusion

The study established that childbirth fear exists among a substantial proportion of pregnant women, with more than one-third of the respondents reporting the presence of childbirth fear. Sociodemographic factors such as age, education level, and employment status showed very weak and non-significant relationships with childbirth fear. However, the majority of pregnant women reported adopting positive preventive practices aimed at managing childbirth fear, particularly through seeking childbirth-related knowledge, discussing concerns with healthcare providers, obtaining emotional support from significant others, and engaging in spiritual coping strategies. This demonstrates that pregnant women in the study area are actively employing informational, emotional, and faith-based approaches to cope with childbirth-related anxiety.

Recommendations

Based on the findings of the study, the following recommendations are made:

1. Healthcare providers should routinely screen pregnant women attending antenatal clinics for childbirth fear to enable early identification and appropriate support.

2. Public health educators and healthcare providers should intensify childbirth education for pregnant women through antenatal classes and regular health talks to improve their knowledge of the childbirth process and confidence in preparing for labour and delivery.

3. Healthcare providers should encourage pregnant women to continue positive preventive practices such as seeking information, discussing their fears, and adopting healthy coping strategies to reduce childbirth fear and promote positive childbirth experiences.

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