UNIVERSITY OF CAPE COAST

PERSPECTIVES OF MOTHERS WITH BOTH EXPERIENCE OF CAESAREAN SECTION AND NATURAL BIRTH AND THEIR RELATIONSHIP WITH THEIR CHILDREN IN GHANA

A PHENOMENOLOGICAL INQUIRY

OPHELIA NYARKOAA BOATENG

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Thesis submitted to the Department of Education and Psychology of the Faculty of Educational Foundations, College of Education Studies, University of Cape Coast, in partial fulfillment of requirements for the award of Master of Philosophy degree in Clinical Health Psychology

JUNE 2022

DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature: …… Date: ……..

Name:……..……..

Supervisor's Declaration

I hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Supervisor's Signature: ……. Date: ……..

Name:……

ABSTRACT

Childbirth is a uniquely personal and unique experience for each woman. The birth is frequently associated with vivid and distinct memories of the journey. Many elements are thought to influence how people perceive their birth experience, the most important of which may be the type of delivery. The goal of the study was to look at the subjective knowledge of mothers who had both a caesarean section and a vaginal birth, as well as their relationship with their children, at the Cape Coast Teaching Hospital in Ghana's Central Region.

To grasp the participants' innermost thinking and psychological world, a phenomenological interpretative design was adopted. Data was acquired through an interview, painstakingly transcribed, and analysed using interpretative phenomenological analysis with a sample size of 15 women. According to the findings, mothers who had both caesarean and natural births experienced more severe pain on the side of the caesarean section than on the side of natural birth. They also experienced more severe psychological distress as a result of the Caesarean delivery than with a regular delivery. They showed sympathy for the caesarean babies because they lacked the same level of immunity as their natural-born children. They also received various types of support from family and friends, including physical, emotional, and esteem support. The research uncovered systematic flaws in the care of women who must have both a caesarean and a vaginal birth. Because of its holistic approach, the biopsychosocial approach to health and illness will be optimal in the management of all pregnant women.

KEY WORDS

Caesarean section

Natural birth

Relationship

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DEDICATION

To my husband, my children, late parents and all mothers.

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CHAPTER ONE

INTRODUCTION

Giving birth or bringing forth a new baby into the world is nature's own way of multiplying humanity. Natural birth is a normal way of bringing out a baby through the vagina whilst caesarean delivery is a surgical procedure in which incision is made through a mother's abdomen and through the womb. Just as all humans are unique in their own way both physical and psychological, giving birth is also unique to every woman no matter the status, whether educated, illiterate, fair or dark in complexion, race or tribe. This has an influence in the way mothers relate with such children. In view of this the study sought to find the perspectives of mothers with both experience of caesarean section and natural birth and their relationship with their children in Ghana at the Cape Coast teaching hospital in the central region of Ghana.

Background to the Study

Childbirth is a uniquely personal and unique experience for each woman. The birth is frequently associated with vivid and distinct memories of the journey. Many elements are thought to influence how people perceive their birth experience, the most important of which may be the type of delivery.

It is clear that the birth experience has a powerful impact on women, with the potential for long-term positive or negative consequences (Joy et at, 2020). Joy et at (2020) investigated women's long-term perceptions of their birth experience and discovered that fifteen to twenty years later, the women reported that their memories of their birth experience were vivid and deeply felt. Many of the women in this study felt that giving birth had given them a big accomplishment and that the experience had improved their self-

confidence and self-esteem. Others, on the other hand, had a bad time. Some of these women grew more aggressive, while others became enraged or had a bad self-image. Ranadheera and colleagues (2019) found that women's happiness with their birth experiences influenced their emotional well-being.

The goal is to create a country in which all pregnancies are desired, all deliveries are safe, all infants are healthy, and no woman dies during childbirth Cardenas et al, (2017). However, 358,000 women worldwide die each year as a result of pregnancy-related causes, with the bulk of these deaths occurring in Sub-Saharan Africa and Asia, with many more dying from obstetric complications, Tsakiridis et al (2020). Similarly, the number of deliveries attended by competent health providers increased internationally from 58 percent in 1990 to 68 percent in 2008, according to Cardenas et al (2017) but stayed around 50 percent in Africa.

In this sense, every woman, regardless of ethnicity, religion, political convictions, or economic or social circumstances, has a human right to the best possible care during pregnancy, birth, and the postpartum period in order to preserve her and her baby's lives (Nilsson,2017). Despite this, around eight million women face pregnancy and delivery-related issues each year, with more than half of them dying, despite the fact that these deaths are preventable Cardenas et al (2017). Rural areas are likewise more likely to have delivery issues in most low-income countries (Dankwah et al., 2019). This variation has an impact on the levels and quality of delivering results. Every death or long-term issue is a personal tragedy for the woman, her husband, her children, her family, and society.

'Vaginal Delivery,' or the natural way of giving birth, is widely regarded as the irrefutable mode of delivery all around the world. Caesarean Section (CS), on the other hand, which requires an operational medical incision, has been used as a method of birth, particularly among women with medical indications. In this way, Caesarean Section helps to reduce maternal morbidity and death from direct causes such as bleeding, infection, hypertensive disorders of pregnancy, and obstructed labor Cardenas et al (2017). Cephalopelvic disproportion, eclampsia, and pre-eclampsia were the most common reasons for an emergency caesarian section.

Vaginal birth has been natural to women since creation, so in the face of medical breakthroughs, many women still hold strong view about the importance of actively participating to achieve a vaginal birth because it is a normal delivery which is limited to no medical intervention. (Limaso et al ,2020), despite the hope of achieving vaginal birth, many pregnancies end up in a caesarean section due to health reasons and complications during birth. According to a survey conducted by Krol and colleagues (2018) involving 150 nations, caesarean sections were used in 18.6% of all births worldwide, ranging from 6% to 27% in the least developed to the most developed regions. The use of surgery to deliver babies is known as Caesarean section, commonly known as C-section or caesarean birth. When a vaginal delivery would put the baby or the mother in danger, a caesarean section is typically required. Obstructed labor, twin pregnancy, high blood pressure in the mother, breech birth, or issues with the placenta or umbilical cord are all possible causes.

Despite the fact that a caesarean section can save a mother's life, it is linked to both immediate and long-term maternal and neonatal hazards

(DiazMaitinez et al et al, 2020). According to Diaz-Martinez et al, Africa has an average caesarean section rate of 7.3 percent with a range of 1.4 to 5.8 percent, with Northern Africa having the highest rate of 2.8 percent and West Africa having an average of 2.3% and a range of 1.4 to 2.4 percent (2018).In Ghana ,the Ghana Statistical services report (2015) as well as Prah et al (2017) show that the national caesarean section rate is estimated at 13%.In some developing countries, they believe that if you deliver through caesarean section then it means you are a man and not a woman due to their cultural and social paradigm as a result of that, women reject caesarean section due to their beliefs (Chen & Tan, 2019).

Some researchers stated that even in the mist of danger most women still prefer vaginal delivery to caesarean section though there is a risk of the woman experiencing episiotomy during labor as a result of a problematic birth like the big size of the baby during the passage of the baby‟s head through the birth canal (Chiamaka and Adetomi (2017). Due to stress, anxiety, fear, depression and body image issues as well as such children‟s behavior, some women have also perceived caesarean section to be associated with psychological distress. Caesarean delivery is thought to be a stressful birth for the baby, with both immediate and long-term implications. The abrupt and rapid interruption of the physiologically designed vaginal delivery process makes a C-section a trauma. (Apanga et al., 2017).

Most women also feel restricted in most physical activities after delivery which brings them frustration and as a result have influence on the behavior of their children Krol et al, (2018). Due to the pain women go through after caesarean section, caring for the children becomes a little

difficult than the natural birth which also plays a part in the life of their children as well as their behavior Dankwah et al, (2019). The way a person is born and cared for has a significant impact on his or her life and conduct, as well as on the development of relationships. Human behavior, according to Hemakumara and colleagues in 2018, is the potential and expression of a mental, bodily, and social capacity of human individuals or groups to respond to internal and external stimuli throughout their lives. While many aspects of one's personality, temperament, and heredity may remain constant, other behaviors will alter as one progresses through life phases, such as childhood, adolescence, maturity, and, for example, motherhood and retirement. (Kagan and colleagues, 2020).

Thoughts and feelings influence behavior in part because they convey information about an individual's psychology, such as views and values. (Horsch, 2017) Psychological features influence human conduct, since personality types range from person to person, resulting in varied actions and behaviors. Verma et al (2020). Caesarean delivery rates are excessively high and rising in many regions of the world. In the United Kingdom, for example, around a quarter of newborns are delivered via caesarean section. The rate is one-third in the United States and one-half in Brazil. The World Health Organization WHO (2016) advises that caesarean sections be used for no more than 15% of deliveries. The Caesarean section was designed to be a surgical solution to difficulties linked with difficult childbirth, but it is now used without constraints. The number of Caesarean sections performed around the world has increased considerably as a result of its growing popularity. In the United Kingdom, the number of Caesarean sections performed went from 18%

in 1997 to 25% in 2010, while in the United States, the number of Caesarean sections performed increased from 27% in 1997 to 31.8 percent in 2011. Horsch et al (2017)

According to a World Health Organization survey, the average rate of Caesarean section deliveries in wealthy countries has risen to 25%, significantly higher than the WHO's recommended rate of 15%. Horsch et al., 2017, Pre-existing conditions such as diabetes, pelvic abnormalities, hypertension, and infectious diseases affect one out of every seven women in the United States during labor and delivery.

In addition, a number of medical disorders that occur during pregnancy (such as eclampsia and placenta previa) constitute surgical delivery indications. These issues can be life-threatening for both the mother and the infant, and in around 40% of cases, a caesarean section is the safest option. Almost a quarter of all newborns in the United States are currently delivered by caesarean section, compared to 982,000 in 1990. The caesarean section rate was at 5% in 1970; by 1988, it had risen to 12%. (24.7percent). It had declined slightly to 23.5 percent in 1990, owing to more women attempting vaginal births following caesarean procedures. The ratio is significantly higher in Asia. In Iran, Caesarean section operations account for about 40% of all surgeries, and in some locations, the figure is as high as 52.8 percent Chen et al (2019). In China, the rate has reached 34.9 percent (Tian, 2017), while it is significantly higher in some rural areas.

Natural delivery is an unavoidable physiological process of human reproduction with numerous benefits. For example, in spontaneous labor, the first touch between mother and child occurs fast, which is crucial for

establishing mother-infant coordination as well as the child's psychological development (Horsch et al., 2017). Caesarean section, on the other hand, is an unnatural method of delivery. A personal conversation with a woman who recently lost a baby told me that her fourth child was a still birth after going through a lot of procedures to keep the baby. According to her the first born was a normal birth but the other three were caesarean due to the fact that she was told the foetus normally are larger in size which always puts her through caesarean section. Though she was not in agreement of the procedure but she /agreed due to the health complications which was attached to those deliveries.

Effects of caesarean section on children and mothers

After two decades of clinical surveillance, Thompson et al (2017) discovered that neonates delivered via Caesarean section did not desire to be cuddled or caressed as much as newborns delivered vias natural childbirth. The neonates were stressed by their moms' physical contact. Mothers who give birth to their children via Caesarean section have significantly lower mother-infant bonds than mothers who give birth spontaneously, according to Karistrom (2017). Caesarean section, according to research, has a negative impact on the development of a secure parent-child attachment pattern, which has an effect on the child's behavior (Papadimitriou and friend (2017).

On a mother-child bonding scale, mothers who had a Caesarean section scored considerably lower than mothers who had a normal birth (Papadimitriou and friend (2017). Natural birth women were also shown to be more motivated to care for their newborns and to be less weary than mothers who had their babies via Caesarean section, who were more likely to fail in

their attempts to care for their babies (Singer et al, Bulled et al, Ostrach et al & Mendenhall et al (2017).

Statement of the Problem

Complications in labor and delivery have been linked to negative impressions of the birth experience, according to research by Hennein et al & Lowe et al. (2020). Benyamini, et al (2017), in a more recent investigation, backed up similar findings. Women who underwent an unanticipated caesarean delivery had a less favorable birth experience than women who gave birth vaginally, according to Benyamini and friends.

Other studies have found that unscheduled caesarean deliveries are not associated with unfavorable outcomes. Horsch et al, Vial et al, Harari et al, Watson et al & Holmes et al. (2017) however looked at postpartum depression, marital adjustment, and mother-infant interactions and found no significant differences between those who gave birth vaginally and those who gave birth by caesarean. The researchers hypothesized that because caesarean delivery is more common, parents may regard the technique as merely an alternative mode of delivery.

An unfavorable perspective of birth, according to by Hennein et al & Lowe et al. (2020). Could make it more difficult for mothers to fulfill their roles. Maternal role attainment is the process through which mothers gain competence in the mothering role by integrating their mothering behaviors into their existing responsibilities, allowing them to feel confident and at ease with their new identities (Atzaba-Poria, 2017). According to Atzaba-Poria, if a woman believes she does not perform as expected during childbirth, her ability in other mothering behaviors may be questioned. This was later

supported by research of Atzaba ‐ Poria and colleagues (2017) which discovered that selfesteem and mastery were consistent predictors of maternal competence, i.e., that a woman's acceptance of her overall self-image and perceived control over life events such as birth are critical to taking on the maternal role. Natural delivery has the advantage of allowing the mother to actively participate in labor and experience the actual moment of birth, rather than passively. The prenatal education course also gives women information about the birthing process, allowing them to feel more in control of the situation. Vaginal delivery remains the preferred method of labor. Still, there are times when a Caesarean section is warranted. Stalled Laborie the most common reason women go through C-sections. This refers to labor that has started but does not progress. Sometimes the cervix does not dilate enough, or the baby's head ceases to go through the birth canal.

Breech presentations, in which the baby enters the birth canal with the buttocks rather than the head, or when the lower part of the body enters the birth canal instead of the head, are two further situations that may necessitate a caesarean section. Second, if the baby is in a transverse position, or lying sideways in the birth canal, with an unusually large head, or if the heartbeat is slowing or there is a problem with oxygen delivery to the baby, or if the woman is giving birth to multiple babies and one of them is in an abnormal position, as proposed by. Thomson et al, Downe et al & Hall et al (2017). Gupta &Saini (2018).

However, if a baby has a birth defect that will make vaginal delivery unsafe, or when the woman is having health conditions like HIV, Open herpes lesions, or heart problems It may also result in caesarean section.

Also, medically a woman who experience thrice of caesarean section delivery will become physically weak which in the end puts the women at risk in terms of infection prevention which is detrimental to the health of the child as a result of that affect the behavior of such a child as compared to children born through natural birth. According to Karim et al (2020), The Caesarean section (CS) is the most common type of abdominal surgery performed on women around the world. Despite the fact that most industrialized countries have adopted the caesarean section, some women in poor countries still regard it as a unique method of delivery (Nilsson et al, 2017).

Many women in Ghana still regard not giving birth naturally (Vaginally) as a sign of failure, according to Adongo, Bam, Apiribi, and Afaya (2018), and are less ready to accept treatment even when they are in danger.

Despite a clear therapeutic reason, this incidence has resulted in a poor level of acceptance of the procedure among African women. According to Karlström, (2017), some women regard a caesarean section as a painful procedure that affects both the mother and the child. An emergency caesarean has been associated to post-partum depression (Dankwah et al, Zeng et al, & Farag et al (2019), as well as dominant sentiments of worry and anxiety about the surgery and its repercussions. Karlström, A. (2017). This suggest that there is a link between caesarean section delivery as well as natural birth and how women perceive it as pertaining to the psychological distress the women go through after delivery. Though most women prefer normal deliveries, certain class of people example those who call themselves carrier women also prefer caesarean section deliveries to natural birth with the view that there is a possibility of the woman experiencing incontinence after having three to four

children through the natural means as a result of episiotomy according to a personal conversation with a midwife.

Despite these, intervention have been geared towards reducing the only physical correlates without emphasizing on these psychological impacts. The study is therefore intended to help draw attention to the psychosocial correlate of women who have experienced both caesarean section delivery and that of natural birth and to inform changes in the intervention of women who undergo such procedures of caesarean section and natural birth and its impact on their children‟s behavior.

An extensive review of literature appears that much is known about the perception of post caesarean mothers as well as those who give birth through the normal (vaginal) means (Ghanbari-Homayi et al.,2019; Apanga et al., 2017; Adongo et al., 2018). However, these studies were conducted using a quantitative approach. Whereas the quantitative approach provided some understanding of the experiences and perception of post caesarean mothers, a qualitative approach will provide adequate and comprehensive understanding of the perspectives of mothers with both the experience of having caesarean section and natural birth children.

Purpose of the Study

The purpose of the study is to contribute to the general body of knowledge of perspectives of mothers with both experience of caesarean section and natural birth and their relationship with their children in Ghana.

Objectives of the study

General Objective

To investigate perspectives of mothers with both experience of caesarean section and natural birth and their relationship with their children in Ghana at Cape Coast Teaching Hospital in Cape Coast Metropolis.

Specific Objectives

The specific objectives of the study were to:

1. Explore the psychological preparation before the caesarean section and natural birth.
2. To know the best experiences in both the caesarean section and that of natural birth.
3. Evaluate their perception of caesarean section children.
4. To understand their perception of their natural birth children.

Research Questions

This research seeks to find answers to questions such as;

1. What psychological preparation do mothers who have both caesarean section and natural birth go through.
2. What are the best experiences mothers have with regard to both caesarean sections and natural birth children?
3. How do mothers who have the experience of both caesarean section and natural birth perceive their children?
4. What Social Support systems are available for mothers before during and after Caesarean Section and Natural Birth?

Significance of the Study

Delays in obstetric care, which are primarily clustered during labor, birth, and the early post-delivery period, have been linked to maternal and perinatal mortality. According to studies, there are many delays in giving consent for CS and a low number of pregnant women who accept it, which may be linked to an increase in unnecessary pregnancy complications such as obstructed labor and a high risk of neonatal and maternal mortality in various parts of Ghana. This research is significant since previous caesarean section studies in Ghana used a quantitative technique, which is limited. The quantitative approach has provided limited information about the experiences of mothers. Using the qualitative approach would provide firsthand and indepth information on the perspectives of mothers pertaining to having gone both caesarean section birth as well as natural birth.

Findings of the study will provide relevant information to practitioners to inform hospital policies as well as protocols concerning caesarean section and natural (vaginal) birth.

Findings of the study will help to expand the knowledge -base of the discipline of psychology.

Delimitations

This research focuses on the viewpoints of moms who have had both a caesarean section and a vaginal birth, as well as their psychological anguish and how they view their children. The study also looks at the social support networks they obtain as a result of their experiences. The study only included moms who had had both caesarean and natural births at the Cape Coast Teaching Hospital in Cape Coast Ghana's Central Region. Mothers who had

such children between one (1) year and five (5) years via planned, unplanned, or emergency caesarean section, as well as natural birth, are among the responses.

Limitations

The element of subjectivity present in qualitative studies is a limitation to the study. Another limitation is the difficult generalizability of the findings due to the smaller sample size, hence it not statistically representative.

Definition of Terms.

The following terms operationally defined in the study as follows:

- Caesarean birth: The surgical delivery of a baby through a cut (incision) made in the mother's abdomen and uterus.
- Natural birth: The process of giving using no medicines at all, instead using techniques such as relaxation and controlled breathing for pain.
- Relationship: The way in which two or more people or things are connected, or the state of being connected.

Organisation of the Study

The work was divided into five sections. The first chapter presented the study's fundamental introduction, which proposed the study's broad construction. It also supplied sufficient background information to allow the reader to comprehend the study's purpose and what the researcher hoped to achieve by conducting it. This chapter provided an overview of the entire research project. The work's second chapter analysed previous research on the research issue, with particular references to the research objectives. This study included excerpts from books, journals, and collected works that were useful in completing the project and justifying major conclusions and suggestions.

The third chapter dealt with the research technique. The population, sample size, sampling methodology, and data collection and analysis procedures were all explained. Chapter four summarized, concluded, drew recommendations, and made proposals for future research, whereas Chapter five summarized, concluded, drew recommendations, and made suggestions for future research.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter presented a review of the conceptual and empirical literature covering the main variables of the study. The chapter presented review of related and similar studies on perspectives of mothers with both experience of caesarean section and natural birth and their relationship with their children. It articulated and consolidated data from related studies and documents that were relevant to the study's aims and predicted outcomes, as well as any research or knowledge gaps that were identified. The research questions and objectives were used to organize this chapter. Theoretical and conceptual frameworks, mode of delivery among mothers at the time of birth, determinants of mode of delivery, effect of caesarean section on child-mother attachment, attachment, biological mechanisms in the mother during and after delivery, and effects of a caesarean section on mother and child were all reviewed and discussed. At the end of the chapter, a summary of the review's research gaps was offered.

Theoretical Framework

Biopsychosocial Theory

George Engel and John Romano established the biopsychosocial model in 1977. Traditional biomedical models of clinical medicine focus on pathological approaches to disease, whereas its approach highlighted the importance of understanding human health and illness in the broadest sense. When it comes to studying health, illness, and health care delivery, the biopsychosocial approach takes into account biological, psychological, social,

and spiritual components, as well as their numerous interactions. As a result, biological, psychological, and social elements exist along a collection of natural systems, and these aspects come into play when an individual is ill or healthy (Engel & Romano, 1977).

The biopsychosocial model theory also states that a disorder or an illness should be considered as resulting from the combination of the aforementioned determinants. The theory has provided a new conception of health and illness that has veered off the understanding of any illness condition solely from the physical point of view by the adaptation of a multiple approach. (Engel as cited by Krol et al, & Grossmann et al. (2018).

The development of this theory has acted as an alternative to the biological paradigm, which was born out of a mind–body divide and the necessity to comprehend patients' bodily complaints while ignoring their psychosocial symptoms. According to Woods (2019), the model emphasizes the psychosocial and biological components of human functioning, which should be addressed in a comprehensive health and wellbeing model. Engel, on the other hand also said the bio-medical eye centers on the abnormalities of physiological functioning associated with an illness, which results in social factors as well as psychological issues being methodically reduced or excluded which is physiologically conceptualized. Furthermore, He made it clear that this was an error and that to understand health in general, there should be a consideration of psychological, behavioral, and social dimensions of illness related events.

The Biopsychosocial model also deals with the review of issues like belief factors associated with healing which has to do with placebo effect and the social conceptions of disease and the socially constructed elements that justify policies and the behaviors of care workers and patients (Papadimitriou, 2017). Human beings‟ belief that there is another world in which people go after death, in as much as they belief there is an afterlife, women do not want to encounter that journey through labor.

With this in mind they result in trusting in a supreme being for protection and survival. The mechanism of biological makeup of a person makes it possible for a person to cope with genetical aspect of life where psychologically a person tries to cope with what the mind detects in order to overcome in terms of fright. What people believe in helps them to keep a stand in their daily aspect of life.

The treatment of the human body as a whole system and inclusiveness of different perspectives is based on the advantage of the biopsychosocial model. This model advocates for the importance of assessing and treating illness via a wholesome lens, in identifying the major role of social and behavioral factors in the overall human health example is the poor eating habits of individuals that brings about obesity, risk behavior factors like smoking, excessive drinking, war, that result in stress/anxiety/depression and its effect on physical health (Papadimitriou, 2017).

This model is significant to the study, because, it helps focus the lens on the possible relationship between current study objectives (social support and pain) and recovery following caesarean delivery as well as natural birth. Pain as well known, is identified to have a physical stand but also has

psychological factors. With regard to women who have been through both caesarean delivery and natural birth delivery, physical pain as a result of certain damage in the tissue through surgical incisions or tear due to natural birth, is a concrete representation. To understand this physical aspect of the procedure, this theory brings to mind the need to understand how other factors like anxiety, stress as well as unfulfilled expectations of mothers who go through both caesarean and natural birth have the ability of reducing the pain tolerance threshold. Also, there should be an emphasis on the need of considering all factors and not only the physical issues of discomfort when developing intervention plan for women who undergo both caesarean section and natural birth. Social support women receive, certain psychological distress and relationship issues should be considered because they have the ability to influence mothers‟ recovery. This gives a total approach to fully appreciating all aspects of possible distress and not only the physical impacts.

The Social Support Perspectives Theory

Social support has been observed to play an important role in the recovery of both post caesarean women as well as spontaneous or natural delivery women. (Singer et al, & Mendenhall et al (2017) defined it as the process of interplay in relationships which enhances belongingness, coping, esteem, and the abilities through which physical and psychological resources are anticipated or exchanged. It is also seen as a process of interaction between individuals, which is described as a network of individuals on whom one can rely for psychological or material support to cope with life changes and circumstances according to Krohne & Slangen, (2005).

Cohen claimed in 2004 that there are three sorts of resources in social support: instrumental, informational, and emotional resources. Instrumental social support entails the provision of material assistance, such as financial aid or assistance with everyday duties. Informational support is the supply of pertinent information to assist an individual in coping with current challenging situations. It usually takes the shape of advice or guidance in dealing with the issues. Emotional support focuses on expressing comfort, compassion, empathy, and trust, as well as providing outlets for emotional expression and venting.

Social assistance is viewed as fictitious and contingent. Perceived social support is the assistance that a person believes is accessible, regardless of whether it is truly available. The expectation of obtaining aid only after meeting some or all of a set of conditions is known as conditional social support. Social support is thought to have two effects on health: an indirect, buffering, or mediational influence, and a direct, main-effects one.

In stress-buffering hypothesis, it states that, the resources needed to cope with stressful events are supplied by the social network of the individual. Gellert et al, (2018) said social support tends to weaken the relationships between challenging life events and its associated physical or psychological difficulties, thus benefits of social support are only seen during stressful periods.

On the other hand, the main-effects hypothesis states that social support is beneficial whether one is going through a stressful event or not. The degree of social benefits of an individual has to do with the extent of an

individual's participation in the social network. Meaning, there is a link between social support in an individual's social network and well-being (Thompson et al, 2017).

A group of researchers have linked health outcomes to social support, these include improving physical and psychological health and better compliance with treatment regimen (Singer at al, 2017). With strong social support network mortality rates decline, health-related behaviours and maintenance of health behaviours are assured, decreased incision of depression and increased adherence to medical treatment is enhanced. (Kristrom, 2017). In addition to that, social support has been linked to both early post-surgical recovery and spontaneous delivery recovery that is patients who had social support network received lower doses of pain relievers, they were less anxious, and were discharged from the hospital earlier than individuals who had no type of social support according to Atzaba-Poria et al, (2017).

However, because the process of caesarean section is mostly not factored into the delivery planning, adequate resources are not mostly organized for the additional toll that the surgery might take on the woman. So specific support needs that might be as a result of the surgery may not necessarily be available when needed as compared to natural delivery (Hennein et al, 2020). It has been reported by Chen and Tan (2019) that unplanned caesarean section mostly is related to low social support as compared to that of natural birth.

Gate Control Theory of Pain

The gatekeeper's control in 1965, Melzack and Wall proposed the pain theory. According to nomenclature, pain and touch receptors synapse at two different places inside the dorsal horn of the spinal cord. According to the theory, nerve impulses from the peripheral nervous system undergo a sequence of changes in the spinal cord before they reach the dorsal horn, which are mediated by a "gatelike" mechanism (Melzack & Wall). It describes the psychological and sensory components of pain perception, as stated by Singer et al and Mendenhall, in addition to physiological challenges, cognition, and consequence (2017).

There are several fibres in the human body that transport pain signals; however, unlike a physical gate that opens and closes to allow items to pass through, the nerve gate in the spinal cord operates to differentiate pain signal fibres. According to Mendel, big nerve cells are blocked as a result of excitement as a result of neuron inhibition, however pain impulses that go through small nerve fibres are permitted to pass through when large fibre activity is greater than pain fibre activity, resulting in reduced pain (2017).

When there are more actions involving small fibres, the inhibitory neurons are inactivated, allowing pain signals to be sensed by the perception of pain, also known as nociception (Atzaba-Poria, Deater & Bell, 2017). Other activity from descending fibres that originate in supraspinal regions and project to the dorsal horn, according to Melzack and Wall, regulates this gate (1965).

Pain signals are transmitted to the spinal cord and then to the brain; in some circumstances, such as trauma or injury, the signals are carried along more quickly and the pain is felt more intensely, whereas the spinal cord reduces or prevents pain messages from reaching the brain (Papadimitriou ,2017). Studies have shown that thoughts, emotions, and expectations can change pain perception, according to Dankwah et al (2013). In other studies, pain has been found to modify and interact with motor systems (Horsch et al, 2017).

Conceptual Framework

The Adaptation Model was devised by Sister Callista Roy (1991). Roy was chosen to develop a conceptual framework for a research project on maternal adjustment during childbirth. A person is an adaptable system that must constantly adapt to changing external stimuli, according to the Roy Adaptation Model (Roy & Andrews, 1991). Focused, contextual, and residual stimuli are the three types of environmental stimuli. The stimuli that are directly in front of the person and demand their attention are known as focal stimuli. Contextual stimuli are other environmental cues that influence a person's behavior or the context of a situation.

The residual stimuli are imprecise, nonspecific cues that influence the individual's response to the initial stimulus. They include beliefs, attitudes, experiences, and expectations. Contextual stimuli are residual stimuli that have been shown to have a positive impact.

The birth of a child exposes a mother to a wide range of stimuli to which she must adapt. The physical and mental challenges of labor, whether vaginal or caesarean birth, are considered the key stimulus in this study.

Contextual stimuli are internal or external factors that influence the experience, such as the length of labor, kind of pain management, nursing interventions, and the presence of support persons. The residual stimuli include beliefs, attitudes, and expectations about the birth experience, which are merely theorized rather than measured. All three types of cues are important in the study of birth perception.

The individual uses two types of coping mechanisms to respond to internal and external environmental stimuli:

i. the regulator subsystem as identified as the biological response,
ii. the congenator subsystem which involves the cognitive-emotive processes of adaptation.

The two combined subsystems, or coping mechanisms, are manifested through coping behavior in the four adaptive or response modes (Roy & Andrews, 1991). The four adaptive modes include the:

1) physiological mode,
2) self-concept mode,
3) role function mode, and
4) interdependence mode.

The physiological mode is concerned with preserving the adaptive system's physiological integrity, which encompasses oxygenation, feeding, excretion, activity and rest, immunological processes and the integument, senses, fluids and electrolytes, neurological function, and endocrine function. Mental integrity, including self-consistency, self-ideal, and the moral-ethical spiritual self, as well as physical and personal self-perception, are all addressed by the self-concept mode. The role function mode is concerned with

social integrity and involves activities linked with the many roles that people acquire during their lives. Interdependence also promotes social integrity, emphasizing the behaviors required to form and maintain happy relationships with others (Karistrom,2017).

All four adaptive modalities must be altered significantly throughout pregnancy and childbirth. A woman's body adapts to the demands of childbirth physiologically, with each body system changing as a result. Her self-perception as a pregnant and mother woman evolves throughout the pregnancy. Through maternal role attainment, the pregnant woman finds harmony with her new identity by integrating her mothering behaviors into her established responsibilities (Dankwah et al, 2019). Finally, interdependence adaptation requires a woman to adjust to a new relationship with her child, as well as a new balance of dependency and independence with her partner.

Mode of delivery among mothers at time of birth

Vaginal and caesarean sections are the two most common birth techniques. Many mothers believe that a spontaneous vaginal delivery indicates a natural or normal birth and that they do not require medical help (Fatemeh, 2014). Despite the fact that caesarean sections are used 40 percent of the time, a study in South Korea found that most women prefer vaginal delivery to caesarean.

According to Abebe et al., only 10.6% of Ethiopian women who had a caesarean section said they wanted it (2012). 66% of Turkish women believe vaginal delivery is a natural and appropriate method of giving birth, according to Thompson et al. (2017). They believed that a caesarean section was a risky

procedure. As a result, there has been an increase in the number of residential deliveries.

According to Krol et al (2018), who did a study in India, mothers prefer to give birth at home, particularly in the Muslim community, because of the extra privacy that is not normally afforded in hospital deliveries. Many Muslim moms, for example, refuse to be assisted by male attendants, citing cultural beliefs and practices that encourage women to give birth at home. Many women skip the benefits of hospital-based deliveries, such as treatment for any infection related to the birth, professional newborn care counselling, and post-natal care assistance, because they want a normal birth, which they believe is possible at home. Due to a lack of early intervention therapy, this has been related to an increase in child mortality and morbidity (WHO, 2017).

The physical, mental, psychological, and emotional experience gained via spontaneous vaginal delivery gives mothers the strength to cope with childbirth while also giving them the assurance that the method is a natural process.

In a study conducted in South Africa Ghanbari-Homayi et al. (2019) discovered that it provides proof of feminine identity and strength for some mothers. As a result, women accept pain as a natural part of labor. Over time, it strengthens and loves their motherly attachment. This exchange is viewed as evidence of a mother's superior female role-playing abilities. They may even choose non-pharmacological pain relief approaches that require the least amount of assistance. Some of them do not require medicine, according to Gupta et al. (2018), putting the lives of both the newborn and the mother at

risk. Some women believe a Caesarean section is a superior way to give birth because it is associated with no labor pains (Lavender et al.,2021).

It gives mothers the peace of mind they need while giving birth. In today's context, they are also delighted with the procedure's safety. The quickness of the process, as well as the potential of a tubal ligation at the same time, are both benefits of this delivery method. Many people have praised the method for how effectively it works and how safe it is (Lavender et al. 2021). Mothers can choose from a range of delivery options. Some of the choices offered to mothers include aided breech deliveries, giving birth under water, assisted vacuum delivery, and scar trial (Gupta et al. 2010). All of these decisions have made childbirth more personal, resulting in a deeper sense of joy and fulfillment.

Determinants of Mode of Delivery

Prior to this investigation, no variables have been identified in Cape Coast Teaching Hospital to explain the exceptionally low caesarean section uptake rate as compared to natural birth.

Socio-Demographic Factors

The mother's socioeconomic status has a big influence on the delivery method she chooses. Maternal age is one of the characteristics that has been discovered to influence the mode of birth, with older moms preferring vaginal birth. In an Indian study, Dharmalingam et al. (2017) discovered that moms who had previously successful vaginal deliveries and those who had traditional birth experiences preferred vaginal birth to caesarean birth. Benyamini, Molcho, Gozian &Preis (2017) discovered that older Ethiopian women were apprehensive to have their babies delivered through caesarean

section.

According to studies conducted in Nigeria, young couples have a higher risk of vaginal delivery and prefer caesarean section over their older counterparts (Karim et al., 2013). This was the case because older women had greater delivery experience and younger women had fewer pregnancies.

Despite the fact that earlier studies have found no significant differences in manner of delivery between young and old women, the findings of a study in western Uganda revealed that young mothers' choice of birth was focused on cost rather than age (Nilsson et al 2017). This could be related to disparities in study environments and women's socioeconomic status in other nations. For example, reproductive health care and education are better in some nations, especially in the industrialized world, and are available to women at a younger age than in low-income countries. As a result, study outcomes may differ significantly.

It was discovered in China that educated women were more likely to have a caesarean section with the assistance of skilled medical personnel (Chen et al. 2019). Other components of mother care, like as prenatal and postnatal care, have also been linked to education. Women with more than a primary level of education are more likely to use prenatal care than women with little education, according to a study done in Nepal (Thompson and Hall, 2017). This was noted in Turkey as well (Verma, 2020).

Prenatal care can provide trustworthy knowledge and support, which can lead to better birth mode options and the establishment of a delivery plan at the time of delivery (Verma, 2020). This is due, in part, to a better understanding of present delivery systems and the benefits they give. These

women are more likely to embrace and adopt current methods of delivery since they have a positive attitude toward new and innovative medical breakthroughs. According to a 2011 Ethiopian Demographic Health Survey, 5% of uneducated moms chose caesarean birth compared to 30% of mothers with a secondary education (Central Statistical Agency and ICF Macro, 2011).

Rural Ethiopian and Nigerian women have indicated a desire to give birth vaginally (Tsegay et al., 2013). Due to a lack of infrastructure, such as roads and clinics, the use of caesarean sections by pregnant mothers is expected to be lower in rural parts of most African countries than in urban ones (Hajian et al., 2015). This is also likely in Wajir District, which has poor infrastructure, roads, and dispersed health facilities. However, no research has been done in Wajir District on the impact of this component on distribution methods. As a result, rural women had a 69 percent lower chance of having a caesarean section than urban ones (Horsch et al., 2017).

According to Thompson et al (2017), women in cities are substantially more likely than women in rural areas to choose caesarean birth over vaginal birth. City people may have a preference for caesarean procedures due to easier access to health professionals and more awareness about obstetric care. Furthermore, metropolitan regions have more government, commercial, and non-government medical facilities than rural areas in terms of pregnancy and child healthcare.

Married women have better access to maternal health care and are hence more likely than unmarried women to have a caesarean section. Dankwah (2019) discovered that the number of antenatal care visits was a function of marital status in her study of adolescents in western Uganda.

Prenatal care is more likely to be sought by married mothers than by unmarried mothers. This is because married women may count on their husbands for both financial and emotional assistance. Obtaining proper maternal health treatments may be difficult due to fiscal restrictions and a lack of social support networks.

In the delivery and utilization of health care, economic stability is critical. Regardless of the population's socioeconomic position, the international community and the national government have made accessible, high-quality maternal care a priority. However, socioeconomic constraints, particularly for the poor, continue to obstruct access around the world. Rich women accounted for more than 80% of caesarean deliveries due to expense and access to essential information, while poor women accounted for only 34%. (Joy et al., 2017). Gupta (2018) study in Ethiopia, which found a link between household wealth and the use of caesarean sections, supported up this theory.

When compared to women from poorer socioeconomic backgrounds, women from wealthier households can afford the higher cost of a caesarean birth (Aziato et al., 2011). According to Indian research, women with a medium or high quality of living had 1.4 times and 2.3 times the risk of having a caesarean section compared to those with a low standard of living, respectively (Ruckley et al., 2012). This emphasizes the significance of women's empowerment in terms of education and financial resources in society. This would enable them to make more informed judgments about delivery methods, leading to better mother and baby outcomes.

This is especially true in Muslim society, where a woman is stereotyped as a homemaker with limited educational opportunities, limiting her alternatives for child care and other life issues.

According to Chanza et al (2012), who conducted a study in Malawi on factors influencing the decision of home birth, housewives with little or no access to resources had trouble deciding mode of delivery selections. They are unable to make decisions in their married houses. They have little choice but to rely on their mothers' in-laws for pregnancy care and delivery methods. Although maternal care is offered free of charge, transportation is limited due to a shortage of funds. A well-known impediment to Caesarean section is a lack of funding.

The utilization of maternal health care services has also been linked to religion. Karim (2020) discovered that religious influence on mode of delivery was depending on one's beliefs in another study in Bangladesh on preferences for institutional birth and caesarean sections. Caesarean deliveries are not considered sinful by Christians if they are carried out on medical advice to save the mother or the unborn child's life.

Women who follow African traditional religion, on the other hand, are not allowed to have Caesarean sections; instead, traditional birth aids and regular vaginal delivery are praised. Muslims are intended to give birth naturally, according to God's plan. Even with medical counsel, a Caesarean section is not recommended. They argue that, even in life-threatening conditions, abortion should be avoided because the mother's life is God's will. They think that a Caesarean Section will not prevent the mother from dying if

it is God's will (Aziato et al, 2017). This explains why Muslim women are fearful of having a C-section.

Catholics, Muslims, and Protestants used more maternal health services than those who followed traditional beliefs, according to a study cited in an Ethiopian Demographic and Health Survey (Vasiljevic, 2019). Women with traditional views had a 50% lower likelihood of seeking antenatal care than those with Catholic beliefs, according to Vasiljevic (2019), resulting in more home deliveries and problems.

Furthermore, Muslim women requested less medical aid than non - Muslim mothers, according to Tsakiridis (2020). Firm religious convictions, cultural standards, and traditional habits that prioritize cultural practices over modern activities were attributed to this. Muslim males have been known to refuse to allow their wives to visit doctors or leave the house out of fear of disturbing their privacy.

When moms refuse to be examined by male health experts, choosing a delivery method becomes more difficult. Women in Bangladesh, for example, are apprehensive to be examined by male physicians and, in certain circumstances, unknown nurses in healthcare facilities due to socio-cultural hurdles. Unfortunately, Bangladesh's health facilities still lack sufficient female medical personnel Vasiljevic, (2019). Women's medical care provided by women is likewise in high demand. Although there is no official study to support this, it is possible that this is a major factor in Wajir's low rate of skilled births. User fees, in particular, have historically been demonstrated to disproportionately burden the poor. It inhibits people from receiving necessary healthcare, particularly maternal health services, reducing their chances of

benefiting from a caesarean delivery. Several reports have confirmed this, indicating that when user fees were implemented, service consumption decreased (Karim, 2020).

Cultural Factors

A society's culture and values have a significant impact on a community's and individual's decisions, activities, and behaviors. According to a workshop held in America by the society for maternal-fetal medicine and the American college of obstetricians and gynecologists, mothers value vaginal delivery because it is seen as a sign of femininity, strength, and ability to take on more challenging motherhood roles by the community. It's also regarded as a rite of passage into motherhood (Aziato et al., 2017), which has influenced community acceptance of modern delivery methods due to fears of scorn and stigma (Naa et al., 2019).s

Understanding socio-cultural interpretations in the delivery process is critical in assisting mothers in making the best decision, according to a study by Ugwu and de Kok (2015) on socio-cultural components, gender roles, and religious ideologies that contribute to Caesarean-section refusal in Nigeria. The role of gender norms and power dynamics in health-care delivery options is investigated in this study.

In some cases, moms seek faith healer counsel about caesarean section birth, and the healer may provide disputed and contradictory outcomes, even casting a curse hex if the mother chooses the wrong option. These healers believe that vaginal delivery is a "normal" and "natural" manner for a woman to give birth (Aziato et al., 2017). This was discovered in a study done in Kenya by Mokua (2014), owing to their lack of understanding and

underestimating of the underlying impacts, especially when pregnancy and delivery complications are a possibility. In this case, the risk of being perceived as a "failed" wife and mother is increased, leading to caesarean section refusal and strong justifications for vaginal birth despite the risks.

According to Aziato (2017), women's ideas and views regarding health problems influenced their selections of acceptable and meaningful treatments. On a cultural level many women, particularly those from countries where cultural norms and values are valued more highly, appear to choose alternative health approaches. According to participants in Aziato study, fear of pregnancy and birth was identified as a factor contributing to women seeking alternative health interventions, culminating in these women seeking protection from service providers such as traditional medicine men. Traditional service providers, for their part, encourage clients to choose normal delivery, thinking that the spirit will protect them and ensure a safe delivery. Traditional and religious values, on the other hand, are skillfully weaved into modern health care. Due to a lack of relevant knowledge and community engagement, debunking the beliefs, values, and myths remains a challenge. In addition, some cultural and religious preferences are exceedingly strong, needing gradual change. However, there is no relevant material on the impact of cultural factors on women's choice of delivery procedures at Cape Coast Teaching Hospital.

Hospital Related Factors

Hospitalizations and skilled birth attendance have increased globally, including in Kenya, as a result of health-care reforms and escalating concerns in obstetric treatment and care outcomes. According to Victoria et al., the

perceived quality and capacity of a health institution influence mothers' decisions on service consumption, such as mode of delivery (2011). Health care service delivery features, according to Limaso et al. (2020), have a considerable impact on maternal mode of birth choices, particularly Cesarean section. This is because mothers want to know that the clinic has the experience and resources necessary to perform the surgery safely and successfully.

According to Diaz et al. (2020), who conducted a study in Argentina on birth preferences, women complained about unnecessary caesarean sections being performed in private health institutions with the goal of accelerating deliveries to make beds for new admissions. Mothers are looking for a place that understands their "ideology," "desire," and "style," and is willing to work with them to form a bond. Once the mother has selected the correct service provider, she may rest assured that rational professional decisions will be made in her care, with the alternative delivery method being employed only as a last resort, much to the satisfaction of the mother.

According to Aziato (2017), moms at public health facilities are unable to choose their service providers, even if they have reservations about them owing to low care quality. They also believe that nurses and doctors often underestimate their patients' pain and suffering. Women's objections and requests were allegedly ignored, according to attendees. This resulted in a slew of issues, many of which were long-term and resulted in serious harm to the newborn or the mother. As a result, future moms will prefer to give birth at home rather than go to a public health facility, assuming the risks that entails.

In a study conducted in Tanzania, Mrisho et al. (2017) discovered that negative attitudes among health-care workers and poor treatment experiences, such as a lack of privacy in health-care facilities, discouraged women from giving birth in hospitals, leading to a preference for vaginal birth at home. Naa Ghandau et al (2019) found that rural Ghanaian women were unsatisfied with the quality of maternity care in health facilities in a cross- sectional study. Alternatively, giving birth at home or even at a health facility may cause you to overlook the importance of giving birth to your following children in a health facility.

According to a study conducted in Kenya's Nyanza district, lower-level health institutions are judged to deliver lower-quality maternity care than higher-level health facilities (Kitui et al. 2013). Mothers who give birth in less ideal conditions are more likely to attribute the rise in home births on their poor health. Government facilities have also been linked to regular shortages of critical drugs, leading to the assumption that they lack the capacity to give high-quality treatments.

Prenatal and postnatal health education may improve the delivery facility's knowledge, perceptions, and assessments. Improvements in delivery services, sensitivity to mothers' needs, and the quality of care given to women throughout labor and delivery will all help moms make better choices (Barnabas, 2019). If impediments to service delivery are addressed, maternal health seeking behavior will improve. For example, a facility known for having highly competent health care professionals encourages mothers to give birth there without worry of unfavorable maternal outcomes or the delivery method recommended.

Despite the presence of well-trained and experienced delivery attendants, 60.4 percent of deliveries in Wareng District, Uasin Gishu District, Kenya, were Caesarean sections (Mokua, 2014). These moms were more likely than 44 percent of Kenyan mothers and 33 percent of Rift Valley mothers to have a caesarean section (NCAPD et al. 2011). Mothers who visit health facilities frequently and are satisfied with the competency of health workers are more likely to have the correct mode of birth than those who get care from incompetent health workers.

According to a study conducted by Mokua in Kenya, the perceived comprehensiveness of a health facility's offers influences how pregnant moms give birth (2014). The majority of women in Mokua's study gave birth at Moi Teaching and Referral Hospital, for example. Despite the presence of a district hospital in the catchment region, more mothers picked Moi Teaching Referral Hospital for their childbirth due to its superior services. Any difficulties could have been handled more efficiently there than at lower-level facilities, they claimed.

The mothers' delivery method has also been linked to the availability of professional nurses and doctors to advise and guide expectant women. According to Bannabas, women with high-risk pregnancies and difficulties were more likely to be counseled about the need for additional consultations and investigations (2019). Increased use of ANC services encourages moms to seek medical attention more frequently, allowing them to better grasp the optimum delivery approach. You're more likely to consider and accept a caesarean section as a result of this. Teenagers who frequent the clinic for

prenatal care on a regular basis are more likely than those who do not to have a caesarean section (Gama et al. 2016).

As a result, having more interactions with medical specialists may give you a better chance of persuading the patient to use the optimum delivery method. The presence of professional service providers for counseling and other service-delivery needs, as well as effective antenatal care, may thereby encourage institutional birth.

Certain personality features have a strong negative link with cesarean birth, increasing the desire for a vaginal birth. The availability of neonatal intensive care units, birth volumes, maternal-fetal medicine subspecialists, obstetricians and gynecologists, and neonatal intensive care units are all contributors. According to study, living in a city, having a family physician, and having a 24-hour anesthetist all increase the chance of a caesarean delivery (Naa Ghandau et al., 2019). While having enough operating rooms with on-call nurses, anesthetists, and medical officers influences how pregnant women are born in hospitals, the hospital may become overcrowded and refer mothers to other hospitals, limiting their options (Banabas et al., 2019).

Knowledge, Attitude and Practice Factors

Mothers' opinions and perceptions differ depending on the style of delivery. According to research conducted by Alaei and Motamedi in Kerman, 66.7 percent of women believe vaginal birth is a natural and appropriate method of giving birth (Yazdizadeh et al., 2011). A study in South Korea confirmed this, indicating that, despite the 40% chance of CS, the majority of women preferred vaginal birth to CS. Vaginal birth is a physiological method that allows mothers to be in a more comfortable position during giving birth

and requires less interventions. The availability of suitable medical equipment and services to support mothers who deliver vaginally has been linked to a higher percentage of women who have a positive attitude toward vaginal birth (Lavender et al., 2012).

According to Shiferaw et al. (2013), in uncomplicated pregnancies, the rate of CS at the mother's request is increasing to 22%. According to the data, mother requests accounted for 21% of all cesarean births in public and private hospitals. Fear of pain was the most common reason for CD maternal requests (35.5 percent) (Fatemeh et al., 2014). Increased maternal understanding of pain-relieving treatments during labor, as well as technology and skilled staff to maximize obstetrical anesthesia, may reduce maternal pain concerns and encourage more moms to choose vaginal birth in both public and private institutions (Yuen et al., 2014)

According to Klemetti et al. (2010), who conducted Cesarean section deliveries among primiparous women in rural China, women's fear of labor pains encourages them to choose a Cesarean section. Fear has a bad impact on pregnant women's emotional health and increases the likelihood of a caesarian section (Garcia et al, 2015). According to another study, cesarean sections were performed in 43 percent of deliveries in Iran. The bulk of these were caused by the discomfort of birth (Etghayi et al., 2010). According to Etghayi's research, 81 percent of women feared vaginal deliveries.

This study emphasizes the need for more regular and intensive monitoring of pregnant women during their pregnancies, as well as emotional support, to ensure that delivery decisions are taken in accordance with the mother's desires. Women who sought a selected caesarian section did not

anticipate to have the surgery performed, according to Mokua (2014). Rather, they desired assistance in becoming emotionally prepared to give birth vaginally.

Women's attitudes, actions, and practices around various types of delivery procedures are influenced by their community's and individual women's knowledge and understanding of reproductive health issues and delivery methods. Clients must be informed in order to have a favorable attitude regarding a treatment strategy or predicted outcome (Ruckley et al., 2012). According to Fatemeh et al. (2014), there was no significant difference in knowledge of different types of births among mothers who gave birth in private and public hospitals in Iran, and only a small percentage of mothers had a thorough understanding.

A higher degree of education does not appear to be associated with greater reproductive knowledge. It's possible that this is due to a lack of information about reproductive health. Only 2.4 percent of pregnant women receiving prenatal care in Nigeria were aware of their right to a Caesarean Section, according to research. Long-term infertility, recurrent losses, and a high maternal age at first pregnancy were the reasons for this request.

Due to labor difficulty, previous bad delivering experiences, and concerns about possible rectal and urinary system harm, cesarean sections are linked to a fear of vaginal birth. These bad effects may prevent mothers from going through the agony of a vaginal birth (Ecker, 2013). Low self-esteem, which was connected to their fear of labor, was another reason for moms' inability to deliver vaginally (Khorsandi et al., 2012). It's vital to identify

pregnant women who are terrified of giving birth vaginally so that appropriate counseling and therapy can be given to them.

Persuasion words and the providing of pertinent data to support their conclusions may boost their confidence. Another poll found that 86 percent of women had their caesarian section requests canceled in favor of vaginal birth. To reduce the number of needless primary caesarean sections, an educational intervention may be effective. According to studies, pregnant women who have a good attitude toward pregnancy and discomfort do not view the experience as dreadful (Khorsandi et al., 2012). This lessens their apprehension of giving delivery vaginally. As a result, providing pregnant women with counseling sessions to help them better prepare for delivery is critical in assisting mothers in making educated decisions. As a result, people's perceptions of delivery have transformed from negative to favorable.

Women who want caesarian sections should be counseled in hospitals and clinics, given the high occurrence of them in different countries and the important variables that influence them, such as fear of vaginal birth (Arikan et al., 2011). Obstetricians and midwives should provide prenatal education and support to pregnant women. According to Ijadunola et al. (2010), 15% of pregnant women in Nigeria getting prenatal care were aware of their entitlement to request a caesarian section. Only 2.4 percent of those who sought it received it in the end. Long-term infertility, frequent miscarriages, and a high maternal age at first pregnancy were the reasons for this request.

The majority of the women in the study believed that the doctor should have entire control over the delivery technique, demonstrating a lack of necessary knowledge and comprehension of patient rights in terms of birth

mode. Women did not insist for caesarian sections for a variety of reasons, including physician understanding of the dangers, family worry of problems, fear of negative medical answers, and lack of awareness of their own rights for asking for one.

Women who have only one kid are regarded to be more resistive to caesarian sections than women who have a large family (Lassi et al., 2014). This conclusion could be the result of a misunderstanding about the likelihood of being unable to give birth after surgery. Caesarian birth perceptions have a vital role in the decision-making process during childbirth.

Some women choose caesarean sections for non-medical reasons such as fear of labor pain, concerns about traditionally considered auspicious dates or times of birth, and the belief that caesarean section delivery preserves the baby's brain. These results differ from earlier studies, which could be attributed to changes in study settings such as demography, socioeconomic circumstances, and literacy levels (knowledge and awareness) within the study population.

Effect of Caesarean Section on Attachment Child to Mother

Around the world, 18.5 million children are born via caesarean section each year. In 2012, caesarean sections were used to deliver 13.5 percent of all children born in the Netherlands (Gibbons et al., 2012). A caesarean section is a type of birth in which a surgeon creates incisions in the mother's abdomen and uterus and removes the baby through these incisions (Belsky, 2010). A vaginal delivery, on the other hand, occurs when the baby is born through the birth canal. A vaginal delivery is the most common method of giving birth (Widmaier, Raff, & Strang, 2011).

A caesarean section might be one of two types. The first is when the woman or the doctor understands ahead of time that she will not be able to give birth vaginally, either due to medical reasons or because she does not want to. This is known as a primary caesarean section, and there is no trial of labor in this case. This is in contrast to the second type, in which there is a trial of labor but it is decided to give delivery by caesarean section due to difficulties that put mother and child in danger (Belsky, 2010). A secondary caesarean section is what this is known as (Roumen, & Luyben, 1991).

A caesarean section can have a variety of psychological effects on both the mother and the baby. Lower childbirth satisfaction, increased concern about their child's condition, increased fear during delivery, maternal depression, less favorable looks at the child, different caretaking, less intimate play (Lobel & DeLuca, 20017), and different attachment of the mother to her child (Annagur, Herguner, & Ors, 2014) are just a few examples of these consequences. The current research looked at the impact of a caesarean section on the child's bond to its mother.

Attachment

Attachment is defined as a strong link formed between two people, in this case a mother and her child (Belsky, 2010). Attachment, according to Bowlby (1969), is essential for a child's healthy growth. He outlined the many stages of a child's attachment to his or her mother. The first phase, which lasts from zero to three months, is the pre-attachment phase. During this stage, the youngster shows no genuine affection for his or her mother. The child's attachment to its mother begins to grow at the age of four months. The child displays a modest preference for his or her caregiver throughout this time.

Children are in the clear-cut attachment phase from the age of seven or eight months to toddlerhood.

During this stage, children become extremely connected to their caregiver, dislike being touched by persons other than their caregiver, and become distressed when their caregiver is not physically there. Children reach the working model period at the age of three. Children recall that even if they do not see their caregiver, they are aware that he or she exists and that their caregiver will return during this phase (Belsky, 2010).

In terms of connection to their career, children can be divided into several types. The Strange Situation Test for one-year-olds is frequently used to categorize children (Ainsworth, 1970). When the caregiver leaves the room, the child's reaction is observed in this test. A child's attachment to their caregiver might be stable or insecure. Children that are emotionally attached to their caregiver may be unhappy when they leave, but they will be overjoyed when their caregiver returns. Insecurely attached children, on the other hand, can have a variety of reactions. There are three subcategories of insecure attachment. The avoidant category is the first one.

An avoidant attached child does not appear to have any happy or negative sensations in response to the caregiver's leave or return. The anxiousambivalent attached child, on the other hand, is unduly connected to the caregiver, may be distressed when the caregiver goes, and may react angrily when the caregiver returns. The disorganized attachment is the last type of insecure attachment. When the caregiver leaves and returns, the children in this group will behave in an unpredictable and unusual manner.

They can react in a variety of ways, such as freezing or racing about (Belsky, 2010).

The type of attachment a child has can have a significant impact on his or her life. Insecure attachment has a variety of consequences, including social functioning, coping, stress response, psychological well-being, health behavior, and morbidity (Ravitz, Maunder, Hunter, Sthankiya, & Lancee, 2010). The majority of these consequences are negative. An insecure attachment, for example, can lead to an insecure coping technique (Schmidt, Nachtigall, Wuethrich-Martone, & Strauss, 2002). These impacts and the sort of relationship can last throughout adulthood (Zayas, Mischel, Shoda, & Lawrence Aber, 2011). Physical sickness might also result from this form of relationship. People who are insecurely attached, for example, will suffer from more inflammation-related illnesses, have more non-specific symptoms, and be sick more frequently than those who are firmly attached (Puig, Englund, Simpson, Collins, & 2013).

Biological Mechanisms in the Mother During and After Delivery

Several biochemical systems in the mother are activated during vaginal delivery, which affect the mother's attachment to the kid. To begin with, Keverne, Levy, Poindron, and Lindsay (1983) discovered that stimulation of the vaginal and cervix during delivery is critical for the mother's attachment to the infant in sheep. This stimulus activates the mother's olfactory learning system, which is critical for the child's recognition. Despite the fact that this impact has been discovered in animal studies, it has not been studied in humans.

Second, Takeda, Kiwabara, and Mizuno (1985) discovered that oxytocin levels in the mother's brain, specifically in the cerebrospinal fluid, are higher during and after delivery. The hormone oxytocin, which is released following delivery, is discovered to signal the commencement of mother care in rodents (Bosch & Neumann, 2012). During pregnancy and the first few months following delivery, oxytocin is linked to the mother's attachment to her child as well as maternal behavior, such as attachment-related thoughts, affectionate contact, and checking on the infant's well-being (Feldman, Weller, Zagoory-Sharon, & Levine, 2007). A caesarean section is linked to reduced oxytocin levels (Nissen, et al., 1996). This could lead to the mother's relationship to the kid becoming less stable.

Cortisol, a third crucial hormone for maternal behavior and connection to the kid, is another important hormone. During birth, cortisol levels rise. Animal studies with rats have discovered that when cortisol levels are high, the mother exhibits higher maternal behavior and memory. Maternal memory is defined as a mother's maternal behavior toward her child after a period of not seeing the child (Benyamini et al 2017). In the postpartum phase, a higher level of cortisol is connected to a stronger liking for smell and a better recognition of the newborn. These behaviors indicate a more stable relationship between the mother and her pup (Benyamini et al 2017). Shortly after delivery, a caesarean section is linked to a reduced level of cortisol (Aziato et al 2017). This could lead to less maternal behavior and a decreased affinity for the child's scent. These lower levels of maternal behavior could lead to the mother's kid developing a less stable bond.

Biological Mechanisms in the Child During and After Delivery

Not only does the mother's body go through a lot of changes during and after delivery, but the child's body goes through a lot of changes as well. Noradrenaline is one of the earliest hormones to be released. During uterine contractions, noradrenaline levels rise. When newborns are born, the smell of their mother is often the first thing they smell, and this first smell is critical for the formation of the child's relationship to the mother.

Children will be more attracted to this smell because of the noradrenaline. Because they do not experience the influence of the contractions, children born by primary caesarean section do not experience this increase in noradrenaline and become less attracted to the fragrance of their mother (Naa et al 2019).

Oxytocin is the second hormone that surges in the kid during delivery. It is unknown whether this hormone is produced by the child or is conveyed from the mother and enters the placenta (Thompson, et al., 2017). Studies on the influence of oxytocin on attachment have shown conflicting results, and additional research is needed to have a better understanding. A caesarean delivery was linked to a reduced level of fetal oxytocin, according to (Aziato et al 2017).

A caesarean section has a significant impact on the mother. Reduced oxytocin and cortisol secretion (Diaz-Martinez et al., 1985) may result in a less secure attachment between the mother and her child (Krol et al 2018) Furthermore, brain studies show that two to four weeks following a caesarean section, mothers who had a caesarean section were less reactive to their children's weeping. Mothers who gave birth vaginally were more attentive to

their child's cries (Krol &Grossman., 2018). Because mother and kid influence each other, the child's attachment to the mother is likely to be less solid when the mother is insecure in her relationship with her child.

A caesarean section has an impact on the infant as well. The levels of noradrenaline in a child born through caesarean section will be lower (Limaso &Dangisso 2020). Because noradrenaline is vital for a child's attitude toward their mother's smell, this could have an impact on the child's connection to the mother (Cardenas, et al., 2017). At preschool age, children born by caesarean section are more likely to develop anxiety, depression, sleeping problems, and internalizing problems. When separated from their mother, children born by caesarean section cry less than children born vaginally. This could indicate a change in the child's attachment behavior to its mother (Vasiljevic, 2019).

The distinct maternal views a mother has when her child is born by caesarean section could explain these effects (Limaso et al ,2020).

All of these factors have the potential to alter mother-child behavior and bonding. This could have a significant impact on the child's life, as an insecure attachment can have severe implications later in life, such as physical disease (Aziato, et al., 2017) and an insecure coping style (Aziato, et al., 2017). (Tsakiridis, et al., 2020).

Although several of the studies described above focused solely on animals, the results of these studies may not be applicable to people. All of the earlier research looked into the attachment that occurs quickly after delivery. When a child is older, the effects of a caesarean section may alter. As a result, the current research looks into the viewpoints of moms who have had both a caesarean section and a normal birth, as well as their relationships with their

children. Few studies have looked into a child's attachment to his or her mother, despite the fact that it is critical for the child's development and that an insecure attachment can lead to medical and psychological disorders (Aziato, et al., 2017; Krol, et al., 2018).

Gaps in Literature Review

The research provided enough context and groundwork for the examination, as well as a solid platform for identifying gaps in the current body of knowledge. Vaginal delivery (VD) is the most prevalent delivery method, according to the report, while Caesarean delivery (CD) is growing more popular, especially in wealthier countries.

Due to a variety of challenges ranging from cultural hurdles to a lack of information regarding delivery methods, the usage of Caesarean Delivery (CD) is still low in developing nations.

Despite the abundance of studies that provide useful insight on delivery modal preferences elsewhere, the majority of these studies are conducted in affluent countries, with little or no publishing in developing countries, particularly in Sub-Saharan Africa.

Few studies have been conducted on the perspectives of mothers who have had both caesarean section and natural birth experiences, as well as their relationships with their children, in Ghana, which faces unique challenges such as poor health care infrastructure, roads, resource limitations, cultural and religious barriers to formal health care, and limited health care delivery points.

CHAPTER THREE

RESEARCH METHODS

Introduction

Research methodology is an approach through which research is undertaken. The research methodology will include research design, data collection methods and approach, sampling techniques, data collection as well as analysis of data.

Research Approach

The study was conducted utilizing a qualitative research approach and a phenomenology research design. According to (Smith & Osborn, 2007), phenomenological research design is used to investigate in depth how people make sense of specific experiences, happenings, or states. The method is phenomenological in that it entails a thorough examination of the participant's lifeworld; it aims to elucidate personal experiences and is concerned with a person's own assessment of an object or event (Smith, Larkin & Flowers, 2009). The researcher used a qualitative technique because she wanted to learn about the opinions of moms who had both a caesarean section and a vaginal birth, as well as their relationship with their children.

In addition, the qualitative approach was chosen for this study because of its theoretical underpinnings in terms of individual perceptions and uniqueness in understanding occurrences (Mushi, 2012). The qualitative technique is holistic, and it provides a contextual knowledge of the participants' lived experience (BrockUtne, 2006). Furthermore, it is more persuasive and appealing than statistical power, generalized, and replicated results (Patton, 2012). Qualitative research provided the researcher with more

proof, solid, and convincing information. This kind will assist in the exploration of social phenomena in natural settings, as well as the organization of data into categories and the establishment of patterns (relationships) among other categories (Mcmillan & Schumacher, 1993). (Teherani, et al, 2017).

It does not deal with numerical representations, and it is better suited to phenomena that are difficult to quantify. However, this design has some flaws, including generalizability issues, time constraints, and difficulty showing cause and effect (Queirós, Faria, & Almeida, 2017).

Research Design

The phenomenological design (Teherani et al, 2015) was used to characterize the essence of a phenomenon from the perspective of people who experienced it in order to comprehend the meaning participants attach to it. The design was chosen because it is a more psychologically oriented approach and a better way to communicate the experiences of women who have had both caesarean and vaginal deliveries. It gives participants the freedom to express themselves in any way they see fit. In comparison to data collection procedures such as questionnaires and inventories, it also aided the researcher in gathering in-depth information and interpreting a coherent narrative about the event (Pietkiewicz & Smith, 2012).

Target Population

The population was mothers who gave birth at the Cape Coast Teaching Hospital, because caesarean section and natural birth are mostly unplanned with diverse means of delivery.

The eligibility criteria included admission as well as postnatal conditions, those willing to participate and those who have the capacity to respond to the interview questions being asked.

The targeted population of the study comprised mothers who have both the experience of caesarean section and that of natural birth between 1 month to 5 years at the Cape Coast Teaching Hospital in the Central Region of Ghana.

Those excluded from this study were individuals who might have had diagnosed psychological issues not related to the phenomenon under study and those who might have identifiable physical and emotional issues such as; recent loss of a relative or neurological problem.

Inclusion Criteria

1. Mothers who have had both the experience of having caesarean section and natural birth either through planned or unplanned.
2. Mothers who have had both the experience of caesarean section and natural birth for the first time.
3. Mothers who have both experience of caesarean section and natural birth within the age of one to five years.
4. Mothers who meet the above criteria and were willing to participate in the study.

Exclusion Criteria

1. Women who have had only caesarean section.
2. Women who have had only natural birth.

Sample and Sampling Procedure

The study sample comprised of 15 women who have had both the experience of caesarean section and that of natural birth at Cape Coast Teaching Hospital, they were selected as suggested by Creswell (1998) and Mason (2010) who recommended that sample size be between 5 - 25 or Morse (1994), at least six participants can be considered ideal.

As a key to getting reliable non-repetitive information in qualitative research, element of saturation is duly considered (Vasileiou, Barnett, Thorpe & Young, 2018). Sandelowski (1995), buttresses and expands this approach and advices the determination of sample size in research like this to look at a size that is not too small to support claims of having achieved either informational redundancy or theoretical saturation, or too large to permit the deep, case-oriented analysis.

Based on the above suggestions above, 15 participants were used for the purpose of this research. The convenience sampling method was used to select these participants. Convenience sampling, a type of nonprobability or non-random sampling, affords the researcher the opportunity in targeting population that meet certain practical criteria, such as easy accessibility, geographical proximity, availability at a given time, or the willingness to participate are included for the purpose of the study (Dornyei, 2007).

Data Collection Procedure

As a requirement for conducting this research, an introductory letter was sought from the Department of Education and Psychology to the facility for this research with ethical clearance being sought from both the University and the Hospital.

During data collection, purpose of this research was explained to participants and also, they were assured of their right to decline response before or during interview which will in no way affect any treatment outcome of their infant.

The confidentiality of the information they shared was ensured. Data collection period is estimated in between 1-2 months. Data was collected with the use of a un- structured interview, within the hospital or at a location of choice. An interview guide was used to arrive at the desire data for this research.

The study employed unstructured questions that seek to elicit responses in the various domains understudy. The instrument used in data collection is the interview guide. The interview was designed along the themes in line with the study (Adams, 2015).

Data Processing and Analysis

Collected data from interview were analysed using the Interpretative Phenomenological Analysis (IPA). It produced an account of lived experience in its own terms rather than one prescribed by pre-existing theoretical preconceptions and also, particularly useful for examining topics which are complex, ambiguous and emotionally laden (Smith & Osborn, 2015).

Data Reliability

In ensuring the reliability of data collected, Guba and Lincoln (1994), criterion, „reliability" was used. It includes four elements that are; credibility, transferability, dependability and confirmability.

To ensure credibility (The confidence that can be placed in the truth of the research findings), member checking was used whilst in ensuring

transferability (The degree to which the results of qualitative research can be transferred to other contexts or settings with other respondents), thick description which describes both the behaviour and context was used (Korstjens & Moser, 2018).

Also, in ensuring dependability (The stability of findings over time) and confirmability (The degree to which the findings of the research study could be confirmed by other researchers), audit trail where records of the research path are kept throughout the study was employed (Korstjens & Moser).

Ethical Consideration

Client were briefed on the tenets of confidentiality in relation to this research; anonymity, research being used for sole explained purpose and data protection. Permission to digitally record interview sessions were obtained by the researcher.

Again, since issues of labor experiences could be severely distressful, individuals who might experience prominent emotional reaction to variables under study were linked with the Psychology Unit of the facility.

Introductory letter from department of education and psychology UCC was be sought, Confidentiality, anonymity, right to withdraw, right to decline was given.

To ensure anonymity, recorded responses were ascribed pseudo names. Data protection was achieved through the safe and secure digital storage by employing personal password only known to researcher.

Data Collection Instrument and Procedure

The study made use of primary data sources to produce information that was used to answer the research questions from the primary sources. The research instrument used in this study was the self–administered questionnaires, involving both structured and unstructured question items. The structured items allowed the researcher to tabulate and analyze data with easiness, while the unstructured ones was set to facilitate in-depth responses and opinions beyond the researcher‟s scope of understandability. Selfadministered questionnaires are a suitable method in a survey study since they avoid subjectivity due to absence of interviewers‟ influence. Also, they allow respondents sufficient time on items that will require consultation before response (Kothari, 2004). The researcher visited and distributed questionnaires to the respondents in their respective work places. The task was scheduled on appointments with the respondents with the intention of allowing respondents to have adequate time to answer research questions.

CHAPTER FOUR

RESULTS AND DISCUSSION

The purpose of the study is to explore perspectives of mothers with both experience of caesarean section and natural birth and their relationship with their children in Ghana. The study used the qualitative approach with the interpretative phenomenological design and the interpretative phenomenological analysis (IPA) was used to analyze data collected. The sample comprised of 15 mothers who gave birth at the Cape Coast Teaching Hospital through caesarean section and natural birth which are unplanned with diverse means of delivery or without pre-planning. Pseudo names were used to identify the clients.

Socio-demographic Characteristics of Participants

Interviews were conducted with 15 participants. All 15 participants were Ghanaians within the ages of 18 and 40 years. Seven of the participants were tertiary level educated, three were senior high school graduate, three were uneducated while three had an unstructured education. All participants except one were married, this same person was the youngest among all the respondents.

Table 1: Socio-demographic Characteristics of Participants

Pseudonyms	Age	Parity in natural birth	Parity in caesarean birth	'=- Educational level	Marital Status	Religion	Profession	Duration after natural births	Duration after caesarean section birth	Indication for caesarean section	Indication for natural birth
Kay	24	2	1	Non-structured uneducated	Married	Islam	Trader	4 years 9 5months	2 years	Breech presentation	Due date
Nana	39	4	1	Uneducated	Married	Christian	Fishmonger	2 years 7 months	1 year,2 months	Delayed 2nd stage of labour	Fast labour process
Dee	34	2	2	Tertiary	Married	Christian	Accountant	5 years	3 years	Insufficient amniotic fluid	Due date
Feli	23	2	1	SHS	Married	Christian	Trader	4 years	1 year,10 months	Foetal distress	Expected date of delivery
Tina	26	2	1	Uneducated	Married	Christian	Fishmonger	4 years	2 years	Ante-natal complication	Due date
Sanny	39	3	1	Tertiary	Married	Christian	Ward aid	5 years	3 years	Pregnancy	Normal

Table 1: Continue

									induced hypertension	form
Ghani	32	2	1	Tertiary	Married	Christian	Health promotion officer	5 years	2 years	Post- date distress	Expected date of delivery
Kandi	30	2	1	Tertiary	Married	Christian	Teacher	2years, 11 months	1year, two months	Insufficient amniotic fluid	Due date
Tifia	37	3	2	Non-structured uneducated	Married	Islam	Trader	3 years 8 months	1 years 8 months	Foetal distress	Sharp spontaneous delivery
Tata	37	3	1	Tertiary	Married	Christian	gynecologist	3 years 10 months	1 year, 9 months		Due date
Gee	30	2	2	Tertiary	Married	Christians	Accountant	4 years 8 months	2 years	Delayed 2nd stage of labor	Due date
Jenny	27	1	2	SHS	Married	Christian	Trader	5 years	3 years	Breech presentation	Due date
Pat	26	1	2	Uneducated	Married	Christian	Fishmonger	3 years 2 months	1 year, 7 months	Foetal large size	Expected date of delivery
Yaa	31	2	1	Tertiary	Married	None	Security officer	4 years 3 months	2 years	Delayed in second stage	Due date
Araba	20	1	1	SHS	Not married	Christian	Student	1year, 8months	1year, 8months	Difficulties in pushing	Due date

At the point of data collection, all participants were found in the postnatal unit where mothers immunized their children from zero month to the fifth year. Participants had various forms of jobs; three were health care workers, three were fishmongers, two were accountants, a police officer, four were trading in various commodities, a teacher, and the last one being a student. For the purpose of anonymity, participants were assigned the following names: Kay, Nana, Dee, Feli, Tina, Sanny, Ghani, Kandi, Tifia, Tata, Gee, Jenny, Pat, Yaa and, Araba.

Main Results

The findings are presented based on the research questions that were raised in the study. The analysis answered the questions on the subjective perspectives of mothers who have had the experience of both caesarean and natural delivery. The researcher attempted to learn about their psychological world through the narration. These research questions guided the presentations of the findings.

Research Question 1

What perception do mothers who have both caesarean section and natural birth have regarding pain?

This research question examined the views and perceptions of the participants concerning the experience of pain they encountered. The findings on this research question are put under 3 major themes: (1) perceptions of both Caesarean Section and natural delivery (2) Attributions, and (3) Relationship with the children. Several sub-themes emerged including; Knowledge of both Caesarean Section and natural delivery, pain experiences before, during and

after experiencing both Caesarean Section and natural delivery, pain management, relationship with the children, breastfeeding, spirituality, and recommendations of both Caesarean Section and natural delivery as a choice of birth.

Major Theme 1: PERCEPTIONS.

The first theme highlights difficulties of mothers who have undergone both Caesarean Section and natural birth and how they perceived both experiences before encountering the procedure. These were influenced by subordinate en delving into the analysis of Experience, the researcher found subtopics related to knowledge about having gone through both Caesarean Section and natural birth, experience of pain before, during and after Caesarean Section and natural birth, as well as pain assessment and management.

Sub-theme 1: Knowledge about both Caesarean Section (CS) and Natural Birth (NB).

The participants‟ understanding of the advantages of vaginal delivery and the few associated complications was among the most important positive perceptions about vaginal delivery while having negative perceptions about caesarean section delivery. The participants believed that vaginal delivery resulted in minor complications and was unrelated to Caesarean-section complications such as back pain, infection, irritation or itching at the incision site, forgetfulness, death, or anesthesia-related complications, as well as having a negative body image or disfigure shape. As one participant pointed out:

"Caesarean-section may cause foot pain, back pain, digestive problems, asthma, abdominal pain, or back pain; but these complications do not happen in vaginal delivery. Also, your legs get swelled up after the surgery unlike the vaginal birth which the legs swell during pregnancy and gets away few days after delivery." (**Kay**)

The respondents in this study demonstrated some understanding of Caesarean Section and the level of understanding was distinguished by the level of education. Tertiary educated participants (seven), described Caesarean Section as a surgical procedure which is done when there is a complication occurring in childbirth. Two of the quotes from respondents are as follows;

1: „"I know doctors request it when the life of the mother or child or both is at stake. I heard it during my teenage. Sometimes, others opt for it because they want to save their vaginas from widening. Sometimes too, when the baby dies before it is born, Caesarean Section is done and you will have to spend more days at the hospital before going home."" but with vaginal birth, you only need to be strong in mind to accept the suturing of the tear of the vagina after delivery that is if you are not lucky, and you experience a tear and you are good to go home even on that same day few hours after delivery (**Tata**)

"what I know is that women who have been pregnant for 40 weeks and above without any sign of labour have to undergo Caesarean Section" until I had my second born with whom I

fell from a chair that was not good to carry me and started bleeding at seven months, the doctor took me through caesarean section to save me and my baby and I believe it was the cause of me having another caesarean birth for my third born. With my first born I also experienced a tear which made them to suture my vagina hmmm,

"emidze mafena oo""(as for me I have really suffered oo) **(Jenny)**

One participant with no educational background commented that:

I do not know anything about it...I knew some people had to be cut before a baby is born but I did not know why or how. And I have had 4 children all through vaginal births so I did not even care about Caesarean Section until I had this boy, that was when I realise it might be because the baby is bigger than those four children I already have. **(Nana)**

As some of the participants acknowledged, vaginal delivery was accompanied by fast recovery. As an interviewee said:

"After natural delivery, I was able to do my daily tasks. I recovered pretty fast and helped others but with the caesarean child I have to spend more days at the hospital before going home, even that I depended on others for a long time before recovering fully. (**Tina**,)

"In C-section, the baby is delivered while I"m under anesthesia. What"s the point? The pain starts after childbirth.

But in vaginal delivery, pain is only before and during the delivery." (**Jenny**)

Sub-theme 2: Pre - Caesarean Section and Natural Birth experience

All 15 participants who were interviewed by the researcher, 10 had pre-Caesarean Section experiences. Events like high blood pressure, low level maternal haemoglobin or weak foetal heart rate were some common denominators among participants.

As participants pointed out, vaginal delivery is a safe mode of delivery since it ensures the health of both mother and child and helps improve the health of the family and community. One of the pregnant women who have had both experiences before stated that vaginal delivery detoxifies the body, and the body can regain its health:

"Vaginal delivery is difficult, but all the toxins get out of your body, which is a good thing but caesarean section you feel the toxins are still in your system because your body get swelled up especially your feet and defecation also becomes very difficult." (**Kandi)**

Another participant when sharing her experience said,

I went to the antenatal clinic till 9months. The midwife told me I needed blood and so I sent people to give 2 units of blood to be on standby. At my next visit, the doctor told me that my blood was low so I should get 2 extra units at standby... I was asked to go for a scan, the results showed that my baby"s head was up instead of it being down, so I was told I needed to be

sent to the theatre since the baby was not in a normal position meanwhile, previous children were born through vaginal birth and there was nothing like blood demand (**Tina**).

Yaa also stated that;

At 36 weeks, I went for a scan and was told that the amniotic fluid was insufficient, if I don"t go for the baby to be induced, he will die. Ei, in my head, I was like what! How could you give me such news so dry like that? So I went, they induced labour, I was in severe pain for more than 24hours but no show so eventually the Doctor said I have to be cut to bring the baby out because, I was in distress meanwhile my first born was a normal vaginal birth with no complications as this girl oo hmm (**Yaa**).

All but one of the participants admitted being in a considerable amount of pain before undergoing the Caesarean Section. On her general experience before the Caesarean Section, she said;

"*for that, I did not feel any pain but in my natural birth, madam stop the pain was unbearable, because I could not sleep, stand, sit, or do anything before labour. The most dangerous part was that I was feeling sleepy during labour"* ***(*Sanny**).

From the analysis of the pre-Caesarean Section and natural birth experience of mothers who underwent the procedure, they reported having the Caesarean

Section done because it was the only option as instructed by the health professionals.

Although their experiences before the operation were not all the same as seen from the extracts, the post-Caesarean Section experience was very much the same for all participants as well as the natural birth.

Sub-theme 3: Post Caesarean Section and Natural Birth Experience

A small percentage of respondents felt that vaginal birth causes pelvic floor dysfunction, perineal relaxation, menstrual cycle alterations, and orgasmic disorders; this information came from their families, particularly those whose husbands were involved in the interview. Vaginal delivery, on the other hand, was seen as a safe and relatively uncomplicated form of delivery by these individuals. According to one participant, a gynecologist who favored vaginal delivery to Caesarean section for non-medical reasons acknowledged the negative effects of pregnancy on pelvic floor muscles as well as the impact of pregnancy and hormonal changes on pelvic floor muscle relaxation..:

> "*People think that vaginal delivery causes pelvic floor disorders, unlike cesarean section. I always tell mothers that pregnancy and its hormonal changes cause pelvic problems, regardless of the mode of delivery but vaginal birth is the normal one design by nature and healing takes place faster and is appropriate to go through the natural process than the artificial delivery which is not nature"s design; this is why I prefer vaginal delivery.”* (A gynecologist, 37 years old, 10

years of working experience on both Vaginal and Caesarean Delivery).

One word recurred through the accounts of all participants. The word „pain", was constantly used when describing their experiences after each procedure. Aside verbalising their pain, the facial expression of agony was visible on the faces of participants as they described their experiences. **Tifia,** agonisingly said;

"*hmmm. Let no one tell you that it is not painful because it is extremely painful whether caesarean section or natural birth, but for caesarean it is not easy (changes facial expression to that of pain).*"

Dee also recounted her story saying:

After the anaesthetic had left my system, I started feeling severe pain around the operation site. I could not walk. Eiiii stop, stop. (laughs hysterically) I tried to sit up by putting my hands on the site to ease the pain in order to sit up but it did not work., unlike the natural birth which I was able to eat my favourite food few minutes after delivery.

Further, participants described the transition from no pain to extreme pain: *...immediately after the caesarean section delivery, there was no pain but the dawn leading to the following day, that was when it started. It was very painful (snaps her fingers, several times). I could not walk, sit, lie, turn. Every attempt to do anything was so painful, as for me my*

pain was unbearable because I experienced both natural and caesarean delivery the same day, my sister I will never forget that day.so sometimes I don"t want to even remember it at all if not for you and your work (**Araba**)

To get a full understanding of their level of pain, the researcher probed and asked participants to rate their level of pain on a scale of 1-10 (1 being the least representation of pain whilst 10 symbolised the highest form of pain). The lowest degree of pain was 7 as reported by **Kandi**: "*I will say 7/10" for caesarean and 3/10 for natural birth.* Three participants expressed the degree of pain at 10 for caesarean and 5 for natural while the other participants ranged between 8 to 10 for caesarean and 4/10 for natural birth.

Sub-theme 4: Pain Management

Just as the experience of Post Caesarean Section and Natural Birth pain, pain assessment and management were similar across all participants. Pain assessments varied…. two of the participants went through regular form of assessment as quoted

I went through several assessments, every 30 minutes. I think this was because I am a staff of the hospital because the other Natural birth, I was sharing room with other patients where I was not being assessed as often as I was in the caesarean section. They frequently came to my bedside to ask "how are you feeling" has the pain reduced"? And they also came to my bedside as soon as they hear me moaning in pain." **(Tata)**

Given the mother's quick recovery and the few problems connected with vaginal birth, she will be able to care for her child and resume her maternal role. As a result, she will be able to form an emotional bond with her child and ensure his or her mental and social well-being in the future. Only by completing vaginal delivery and suffering this arduous and exhausting experience, the participants believed, could one grasp the moms' agony and enormous value. One participant put it this way: "*The moment I gave birth to my baby through the natural process,*

> *I appreciated my mother. In that very moment, I found out how great mothers are. This is why we can never repay what they have done for us and with the caesarean birth hmm it was hell on earth"* (**Tifia)**

Another participant also said

> *..."" the health professionals usually came to assess without me calling them and at one midnight, when the pain was severe, they went to the pharmacy to get Intravenous (IV) pain reliever for me. That, I was impressed but vaginal delivery was not like that after the injection they gave me on my thigh after delivery that was all""* (Gee).

Here are other views

> *...sometimes I will call them and call before they give the pain medication. There is nothing like taking the initiative to check on me or the other mothers on the vaginal delivery room but with caesarean section sometimes they listen to you a little.".*

"Sometimes I had to force to sleep with the pain. Because if I complained, they will say, "ahh Hajia, you worry us a lot but with the caesarean section a little sign that you are in pain and the health professional are around you" (**Tifia**)

Some participants felt that they were asked to bear the pain and not complain since an incision in any part of the body comes with pain, so the need for pain medication was not something to be encouraged because pain was expected; "they said it was normal to feel pains after operation. **Pat** stated that,

*sometimes I woke up at 12 or 1 am in pain and they will not give me anything till the next morning in my caesarean section birth but the normal birth they gave me injection and other drugs which helped me a lot**" Ghani** also said in Vaginal birth you won"t even need that waking up attitude, but the caesarean it is like the time has been set because of you. Sleeping will not even come.*

All of the respondents also expressed their views about the medications and the efficacy of the medications that were provided by the health professionals. However, none of the participants reported any side effects of the medications. All the participants reported being given pain medications, with a number of them being IVs and suppositories. One respondent commented saying;

"*Sometimes I was given Intravenous (IV) drugs; other times it was suppositories"* stated **Gee**. Another also stated:

I started screaming and the nurses gave me a drug and I felt better, but after a few hours it returned. Sometimes they gave me drugs when I called them, other times, they didn"t mind me...I was in so much pain and I walked without my heel touching the ground just to reduce the pain" in the caesarean section but with the vaginal it was the exact opposite. (**Tina**).

Other participants also had their say:

As for the pain, it doesn"t come and go, it comes and did not leave till they gave me drugs. The drugs helped me somehow but they did not always give it.

Sometimes they will say that I was getting addicted so they won"t give me or they will say it"s not time or they will say that it"s normal so I should sleep like that but the natural delivery you won"t even need pain killers like that, and you can also sleep comfortably just that you feel the pain in case they give you episiotomy as they call it her epis at the department. (Yaa).

Araba said because of the severity of the pain after the caesarean section, I was moaning1

***in pain, So, my mother called the nurse and she gave me drugs through my hands (points to a vein) and it was okay. But the next morning it came again. I could not walk well; I was walking on my toes so I stopped moving but this did not happen in the natural birth.*

It was clear from the analysis of data that none of the participants opted out of the use of medication to treat or ease the pain. Some participants went on to use non pharmacological means to manage the pain since the medications did not suffice.

Take, for example, the case of **Jenny,** who voiced that *"my mother gave me cloth soaked in hot water, which she squeezes the water out so that I put on the plaster*". All 10 out of the 15 participants complained of recurrent pain at the incision site months after the operation and wound heal.

Sub-theme 5: Recommendation of Caesarean Section and Natural Birth as a choice of birth

Mothers were asked on what Caesarean Section and Natural Birth means to them and if they will be willing to undergo the procedure again as well as recommend it to a friend or family. Out of the 15 sample, 13 stated emphatically that if they have their own way they will not go through caesarean delivery again due to the traumatic experiences, neither will they recommend it to another woman even though they admit that they may have lost their lives or their babies had they not had the procedure. "*Never, never"* **Jenny** said. **Tina** believed she will recommend Caesarean Section to another person only if the person"s life was at stake.

> *"If you are not careful, you can lose your mind in the process, no I will never recommend it"* **Tifia**. For **Gee**, *in fact, my own experience has disproven all my negative perception of Caesarean Section. I may opt for it in my next delivery (laughs loudly).* **Pat** believes Caesarean Section is not a normal way of

delivery and so "*doctors should allow women to try giving birth before they force them to operate".*

Major theme 2: ATTRIBUTIONS

The second main theme brings out two predominant reasons for having to undergo Caesarean Section and Natural Birth. Sub-themes such as Spirituality and envy were pointed out as the reasons why some participants had to undergo Caesarean Section and Natural Birth.

Sub-theme 1: Spirituality

All but three of the participants of the study attributed their unavoidable need for caesarean delivery to spiritual reasons. Interestingly, some of these participants who expressed adequate knowledge about why Caesarean Section and Natural

Birth is performed still attributed their „predicament" of having to undergo caesarean delivery to spiritual forces engineered by people. Another said; (believing someone is the cause)

"*to be honest yes. Sometimes I can"t stop thinking about it. I have had 3 natural births so why should I have operations with just one child. Hmmm*" **Sanny**.

Mothers actively participate in vaginal delivery and give birth after enduring tremendous agony, according to participants. As a result, giving birth naturally heightens maternal sentiments. As one participant remarked:

"When you hug your baby, it feels like God has given you an angel; a baby that you have given birth to." But with the

caesarean birth, sometimes you overdo things. (**Tina,** Fishmonger)

Jenny also said: *"Yes. Sometimes; I think so but I don"t have proof. Because why did I have normal birth the first time and the two suddenly turns to be caesarean?*

I leave it to God. Maybe someone wanted to kill me".

All participants, however, did not attribute their indication for Natural Birth to any spiritual causes:

"I don"t think so. If it were so, then my baby and I would not have survived. That person would have killed us" **Dee Gee**, who had expressed adequate knowledge about Caesarean Section shared a view on attributions*;*

"no, it is just my body system that couldn"t handle all the stress of pregnancy and labour".

Sub-theme 2: Envy

The need to attribute blame to an external force was evident in the opinions of envy. Some participants believed rivals who envied their success were to blame for their quandary. One participant talking about envy commented thus;

"the leader at the „garden" said my competitors at the seashore don"t like me". (**Pat**).

Another with the view that an envious rival engineered this said*;*

"it could be. I think about it strongly. We fishmongers, we argue a lot and people curse people and I am also part. I also had an

argument with my husband"s girlfriend while pregnant. Maybe she is responsible for what happened" (**Tina**)

Major Theme 3: RELATIONSHIP WITH THEIR CHILDREN

This theme reflects the struggles the new mothers faced while attempting to create a maternal bond with their children, Subthemes of bonding, breastfeeding and living with them, were generated.

Sub-theme 1: Bonding

For some participants, there was the challenge of having a relationship with the new-born after months of pregnancy with the caesarean birth but with the natural birth it was easy. The subtheme of bonding and breastfeeding were generated to help better understand the relationship mothers formed with their babies after birth. Bonding, is closely related to Bowlby"s attachment theory, as many mothers complained that because of the complications in caesarean delivery, they could not have easy access to their babies and this stalled the initial bonding process as compared to the natural birth where the baby is given to you few minutes after delivery.

One mother said;

"*Because the caesarean section was not my plan for my delivery. I felt interrupted my chance to bond early with the baby during the early stages, but the normal birth it was all joy to hold her in my arms"* (**Sanny**).

According to the findings of this study, vaginal delivery is a symbol of joy in childbirth. Labor pain differs from other types of pain in that it has a joyful finish, making vaginal birth more

tolerable. As one interviewee put it: "*Vaginal delivery is giving birth, with happiness and comfort. Although you feel so much pain, in the end, the pain ends in happiness. Vaginal delivery means birth; it is a good feeling and you see your baby earlier than the caesarean births."* (**Feli**)

For some, the caesarean babies had to be placed in neonatal intensive care units and as a result, this was a barrier for the mothers who have just undergone the surgical procedure to bond with their children. Mothers who had this setback gloomily described the experience with much anguish.

"my baby was admitted at the Neonatal Intensive Care Unit (NICU) because of jaundice, right after delivery that is the caesarean section. And since I couldn"t walk for the first 3 days, I couldn"t go see her till the next 3 days. it wasn"t easy for me. I was always worried. I had to depend on the nurses bringing the baby to me, whenever they decide to unlike the natural birth, my baby was placed on my belly immediately she came out of my womb" (**Ghani**)

Another added; *"We didn"t have much chance to bond...I wasn"t happy when I had to go to my ward and leave him there. He was under phototherapy" but the natural birth my baby was brought in a cort to me few hours after delivery* (**kandi**)

This was the prevalent narrative when participants described their relationship with their babies.

Sub-theme 2: Breastfeeding

The second subtheme was that of breastfeeding the babies and how it affected relationships between the babies and the mothers. A participant expressed her views saying;

> "*I had difficulty breastfeeding; the milk was not flowing, the baby was always crying, sometimes picking up the baby to feed was a problem. I kept asking myself… "so is this me?". I couldn"t bond with my baby and it worried me so much but I was so helpless" but the normal birth, I was able to breastfeed her immediately they brought her to me* (**Gee**)

One participant, however, had a different experience from her cohorts. Her approach to Caesarean Section was that of understanding and acceptance and she appeared to have a better outcome than those who did not have a positive outlook on Caesarean Section. Talking about her relationship with her child, she described bonding as being immediate.

> "*mmm, it was easy for me. (laughs). I am a very positive person and couldn"t wait to mother my baby so I was looking forward to it. And for breastfeeding she recounted saying; I was lucky. It started flowing at the hospital so I started feeding him and bonding with him right at the hospital just like the natural baby but the difference was that the natural birth I saw my baby and*

could touch her immediately but this one they only showed him to me but I could not touch him" (**Dee**).

Sub theme 3: Living with the children.

The third subtheme has to do with living with the children from birth till they get to age five and how the relationship with the caesarean children different from the natural birth children. Here are the views of the mothers.

> ***Tina*** *said my natural birth child is more caring than the caesarean one oo, hmmm with the caesarean child you will call for more than three times before he responds even though he has heard you. He is also stubborn and without care you will beat him and regret.*

This is what **Tifia** also said:

> *as for me the only caesarean among them is this one with me here, even coming to this post-natal at the two years of his age is a problem, madam we are even coming for vitamin A without injection oo but, I have to run after him before he came to bath unlike the natural ones, they are even happy if you tell them you are going for weighing at age two.*
>
> **Tata** *also said her natural birth is calm than the caesarean one, also the caesarean child is bold and does not fear anything, he is somehow violent than the other, saying sorry is something he would not want to do. The natural one shows remorse each time he is reprimanded.*

Research Question 2

What psychological distress do mothers go through before, during and after both caesarean section birth and natural birth

This research question examined the psychological distress experienced by mothers who have undergone an unplanned Caesarean Section and Natural Birth. The presentations of findings on this research question are put under 2 major themes; Psychological reactions and Coping.

Major theme 4: PSYCHOLOGICAL REACTION

Psychological state has to do with the state of mind in which mothers were before, during and after both Caesarean Section and natural birth. Subthemes of Stress, Fear and Postpartum depression, lack of psychological attention and negative reactions to Caesarean Section and natural birth were identified.

The majority of women believed that vaginal delivery is a natural, physiological process that requires no interventions. They saw it as a symbol of oneness with nature and God's creations, and they believed that God would assist them during childbirth. One participant put it this way:

> *"Vaginal delivery is birth of a baby in the way that God intended to."'"* (**Feli**). *Some of the participants considered that vaginal birth could assist women in achieving a comfortable condition. In reality, compared to caesarean delivery, which requires a lot of compromises, including your body form, this sensation boosts maternal satisfaction with vaginal delivery. This point can be summed up in the following statement from*

an interviewee:"After the pain goes away, I feel happy for having passed this stage." (**Tina**)

Sub-theme 1: Fear

One of the most consistent acknowledgements of feelings of all mothers was that of fear. They expressed their fears and anxieties right from their knowledge of what Natural Birth is and when they were informed about having to undergo the procedure of pushing the baby out. One participant said;

"*As for my emotions, they were not easy, I didn"t want to do it, I was scared" I was very, very fearful, I feared getting complications of not being able to push for the first time which could result in death. But with the caesarean birth my fear was with wound healing or losing this baby too because I was told the amniotic fluid was insufficient for my baby. I was panicking. I told the doctor and he tried to calm me but I was still anxious* (**Pat**).

Another Participant said;

„Before the Caesarean Section I was not scared, because I had gone through

"push, push, push" and the baby was just not coming. I was fed up with the situation and I was afraid the baby will die. So had no option to accept. It was after I got to the theatre that I started feeling cold and very scared. I was scared that something will happen to me and the baby. I had heard of complications after Caesarean Section and it made me anxious

and very fearful. I told the nurses and they said, nothing will happen" but with the natural birth of my previous children I just breath through my mouth and the fear is the pushing aspect because that has to do with faith and stength. (**Ghani**)

Also, another participant voiced:

"I was very scared. And anxious. I was afraid that I will die or we will both die. So, I told the doctor to take me through the caesarean. Section.by then my husband was there so he told me, my Blood Pressure (BP) was very high and he allowed my husband to hug me and started singing with me including all the nurses, as they prepared me for the theatre. They even played music on the phone. After I calmed down, I was taken to the theatre and was given an injection in the spine which made me lose all sensation in my legs and abdomen" but with the natural birth I was asked to hold my knee and push it did not work and I was asked to hold the labour bed very tight and put my chin on my chest and push after I did that the baby came so there was no fear it only demands great courage and strength. (**Kandi**)

Interestingly, mothers" account of fear was partially for themselves as they mostly expressed fear for the lives of their babies or what fate would befall their babies if they (mothers) lost their lives as a result of both procedures. A 30-year-old mother said;

You see, that"s my first operation. You know Caesarean Section is more or less a death sentence in Ghana. Initially I was ok, but when they started preparing me to the theatre, I started getting anxious. my thoughts were; what if I don"t return, what if some harm come to my baby. With the natural birth delivery, I heard of a neighbour who lost her life during labour a day before I went to deliver, so the fear of death was with me because I was attending anti-natal clinic with her so you can imagine (**kandi**)

Another said *I was very scared;*

I could feel my heart beating in my throat

...because I was thinking, what if my baby dies? What if I don"t wake up? Unlike the natural birth which you only go through suturing of a tear you will have (**Jenny**).

Sub-theme 2: Stress

All 15 participants of the study admitted going through stressful periods in the course of both procedures and after being discharged home. The discomfort that accompanied the restrictions ordered by the health workers was a source of stress to all participants in the study. One commented saying;

"I was advised to withhold bathing, which made me very uncomfortable and discouraged me from letting people get too close after the caesarean section. That particular advice "really worried me". And so many instructions I had to adhere to were really a bother. Don"t do this, don"t do that etc. the physical restrictions. it was difficult to walk in the beginning but I was

able to walk on the 3rd day. I wanted to bath my baby myself but I could not hold her for long. I was only able to perform activities of daily living after my discharge. The wound also starts to pain me with the least movement, even movements in bed" and with the natural

birth I could not sit well because of the tear they sutured, the only thing I could do was to lie down for a week after it healed but that I could bath anytime I want, but could not lie on your back but rather side by side always till after the healing (Sanny)

Another participant said:

"Restrictions on bathing was uncomfortable for me. Sometimes when I wanted to go for my baby, it was a struggle plus the intermittent pain was quite stressful… initially I could not do anything. I had to depend on others for both my baby and I. I felt something that I could not explain anytime I had to ask for help. This is my first time of giving birth through caesarean section so it is very stressful but my natural birth I had no tear which other women talk about so I could even wash my own clothes the next morning because I went home the same day, even some of them I delivered them at home (**Nana**)

In the case of another participant called **Tata**, she narrated her ordeal, saying:

initially I could not do anything for myself. I had to depend on others for both my baby and I. I felt something that I could not

explain anytime I had to ask for help. And I had to withhold bathing till the wound was healed. Living with operation from birth, after 2 children through normal deliveries is very difficult. Everything is confusing for me and my sister… I think there are so many instructions on things not to do. And it is disturbing to me. I had to stop working which is not normal for me after birth. Usually by second week, I go back to work. Now I am very "broke" and totally depend on my husband who is not getting much money because he can"t go on the sea due to the new disease. That is very worrying to me".

According to the 20years old mother;

"the ward, the visitors of other people will say, poor girl, you will suffer before you recover, even adults are going through stress how much more a child. And they will look at me with pity some will also insult me that I am a bad girl. It didn"t feel nice. Also, I did not want to go out, I was shy but I had to go for wound dressing every 3days. I was tired and shy and people will keep looking at me. And my mother will call that the twins were crying so I should hurry and come. Sometimes I beg the people I went to meet at the hospital to let me do my dressing before them. It was too stressful for me because one (Panyin) was natural birth but the little one (Kakra) was the caesarean birth because I was very tied and could not push again my pain was double since they did episiotomy for the first one so I have to lie

down in a taxi each time I was coming to dress the caesarean wound, the fact is I could not also sit. Madam I have suffered oooo" (**Araba**)

Dee, describes her experience as follows*:*

"I had difficulty breastfeeding; the milk was not flowing, the baby was always crying, sometimes picking up the baby to feed was a problem. I kept asking myself… "so is this me?". I couldn"t bond with my baby and it worried me so much but I was so helpless. And then I had to perform personal hygiene without bathing. I wrap a big towel around myself and bath without getting water on the plaster. I did not bath well; I was always worried that water will get in and the wound will not heal and I will be sent back to the theatre. Normal delivery doesn"t have that problem, you can even eat what you want after going through all the pain at the hospital but if care is not taken you will vomit".

For **Yaa**, stress came in the form of wound infection and a second surgical procedure.

After discharge, the wound got infected, even though I did my best not to infect it. Some weeks later, I was told that the thread that was to dissolve did not. I had to be sent back to the theatre and cut. I was left with half-opened wound for some days. I now had to go for daily dressing at the hospital instead of 3rd day dressing that I was going initially. My sister, that was mentally and physically stressful, till later I was stitched again and continued

dressing till wound healed in my second month. Talking about the natural birth I disobeyed the nurses and sat on hot water not knowing the thread was melting so I had to go back for another suturing ooo, hmmm it was the reason why I decided, not to give birth again,""Awo dze onda fom oo" (delivery is not easy) (**Nana**).

Sub-theme 3: Postpartum Depression

Vaginal delivery is a symbol of joy and birth, according to the findings of this study. The joyful conclusion of labor pain sets it apart from other types of pain, making vaginal birth more tolerable. As an interviewee said:

"*Vaginal delivery is happiness and comfort. Although you feel so much pain, in the end, the pain ends in happiness. Vaginal delivery means birth; it is a good feeling. unlike caesarean section which makes life a living hell after a week of delivery"* (**kay**)

Sadness after the operation was another recurrent theme that was pointed out by most of the participants.

"I heard about it and read more after the birth. This is because I was always crying and not taking care of my baby. I kept asking "why me?" and I was always sad. It felt like I had lost something. And friends made matters worse by making me feel that I didn"t try enough to push the baby out. So, my husband went to buy books and downloaded so many materials on Caesarean Section and read them to me. And informed the doctor. The doctor told me that

sometimes women who do not expect to go through caesarean section get depressed when they are informed but after delivery, they don"t experience it again. (**Kandi**)

Although not all participants experienced postpartum depression, some admitted to being sad, avoid visitors and don"t feel like eating. The following are some excerpts from some of the participants:

"Whenever it comes to mind, I feel sad. It still happens sometimes. I feel I am not grown enough for it. But it comes and goes. I remember the beginning and the end and I cry and I always tell myself that I will never do it again but with the natural birth I was so glued to my baby and didn"t want anybody to touch her". (**Kay**)

"Yes. I have had 2 operations to give birth and I did not understand. It is not common at the place we live. Some even give birth at home. As for me, hmmm. So, when I was discharged, I did not come out for 3 weeks, except to go and dress the wound. ...All these disturb me when I think about it, with the natural birth at first, I did not want to mind the baby when he is crying because I was saying he made me suffer too much before he came during the pregnancy period till birth. I will always vomit anything I eat out" (**Tifia**)

"I was very sad. I couldn"t see my child. So finally, when I could go to her, I broke down crying. To be honest to God, I had regrets. Also, whenever my husband comes to visit and is

leaving, I increase the crying a lot. I had no hope, I had no appetite and I was always sad with the caesarean section unlike the natural birth my baby like crying a lot so I was always confused and became stuck in one particular chair each time I pick him and was always talking". (**Dee**)

*"After my birth, I was crying a lot. Every minute I will cry. When you leave me alone, you"d come back to find me crying. I cried all the time. My sister is a midwife and educated me about it. She said it usually comes with unfulfilled expectations. She understood me. I did not know why I was crying, but I kept on crying even after discharge" but with the natural birth I felt ashamed of myself each time I go for anti-natal because the nurses and midwifes who were there will remind me of my behaviuor during labour and I even changed my anti- natal clinic facility (**Ghani**)*

Sub-theme 4: Disappointment

The findings of this study revealed that vaginal delivery is a normal part of a woman's life. The straightforward end of labor discomfort distinguishes it from other types of pain, making vaginal birth preferred to caesarean section delivery. As one interviewee put it:

"*Vaginal delivery is an expected way of giving birth, so when it happens it is no news. But rather brings joy happiness and comfort to the entire household."* (**Tata**)

Another negative emotional reaction observed among the participants during the post-operative period was disappointment.

> *"I will describe it as a disappointment rather. I was disappointed that I couldn"t get to feel vaginal birth. I wanted to give birth like the Hebrew women as my first born but this one took a new turn"* (**Sanny**).
>
> *(she avoided my gaze) "yes. I still don"t understand and don"t want to go through it ever again. Again, I was not even given time to prepare and accept it in my heart. I was forced to accept because of my baby who decided to come with the buttocks... Everywoman should push as God created us. So, if you are asked to go through it, it means, someone is behind it. And it is painful. The nurse lied to me"* (**Tata**).

Sub-theme 5: Lack of psychological support

Although 11 out of 15 participants reported experiencing at least one aspect of psychological distress, none was given psychological attention either through a psychologist or a psychiatrist. Though some reported how low in mood they felt to the health workers, these participants had to go through it with the support and encouragement of family members who have experience in what they are going through. Others had to keep it to themselves for fear of being judged and looking weak.

> ***Kandi*** *recounted her experience as "no, I was not given any psychological attention. It lasted about 2-3weeks. But my husband and mother were very*

helpful. I felt better"

"No, the nurse said sometimes it is normal to be sad after birth. I will say for almost a month" (**Star**), *Ghani also said, "No, but the doctor kept telling me I will be alright"*

For **Pat**, *the fear of her husband as well as being gossiped by the community people kept her from expressing her emotions to anyone except her mother and sister and warned them to keep quiet about.*

Research Question 3

How do mothers who have the experience of both caesarean section and natural birth perceive their children?

Caesarean Section as a procedure involves cutting of the skin and underlying tissues and this leaves behind some scars which makes mothers more concerned about such children. Unlike the natural birth children. Mothers are required to withhold tying the abdomen as is normally done in Ghana and other parts of Africa but the natural birth you can tie the stomach in order to maintain your normal shape. Because of sometimes the end result of what they go through they attribute it to the children which has a great impact on how they perceive them.

From the analysis, it was evident that mothers wished they had all their children through natural birth. However, this was not possible which made them feel so much attached to the natural birth children more than that of the caesarean children when they grow from two years till five years but they seem more attached to them from zero to the eleventh month (0- 23rd month).

It was discovered that mothers were somehow violent to the caesarean children in terms of verbal abuse when they grow up from two years till the fifth year which as a result makes the caesarean children retaliate. Sub-themes of Appearance and Acceptance were generated from the analysis.

Major-theme 5: APPEARANCE OF BOTH CAESAREAN AND NATURAL CHILDREN.

To the mothers, the natural birth children are good looking and attractive than the caesarean children. They admitted it is because they spend more time at the hospital than the normal birth which makes caring and massaging the head to delay and take a rough shape at the hospital before getting home. However, the natural birth children seem stronger than the caesarean children.

Sub theme 1: Structure

With the views of all the 15 mothers, 10 of them talked about the thick and attractive structure of the normal birth children as compared to that of the caesarean children when they grow up from the fourth year to the fifth year and how they can resist infection as compared to the caesarean birth. The normal children look more attractive when it come to the shape of the head than the caesarean children with the type of head they carry, their height, their stature and they are strong in immunity than the caesarean children.

Tina in her submission *said "my normal birth children are nice looking than this one in terms of their head, madam you just look, at the head but this one too is fat as compared to the*

normal child is tough and fat with a thick head ha! ha! ha! she laughed".

Kay also said *she feels proud when walking with the normal birth children than the caesarean child. she stated that the caesarean child head is too long but the normal birth child has normal size. with the caesarean he is too heavy to carry all the time.*

Tata emphatically stated that *"my natural birth girl is more beautiful than that of my caesarean girl, the natural one has round head but the caesarean one if you see the head you will laugh. She is like someone who is sick but is not sick oo, my mother said she will be okay and look more beautiful than the other when she grows, but when kai I don"t believe her:"*

Yaa's version goes *like "Asem yin a abo do yi, okyina mewu (you have said what shouldn"t have been said ,I will die tomorrow) that is the name I call my normal child she is thin and if you see the legs it looks like it will break when she walks, but with the caesarean child, she looks good and if you see her you will like her ,the caesarean child is always violent but he is strong in decision making and very bright, he understands things easily than the natural one.*

*As for me my natural birth is looking fresh and healthy with a good stature, but the caesarean child I have name koo nkasei (mr. bones) he easily gets sick**"(Pat)***

Sub theme 2: ATTITUDE

It was discovered from 11 mothers out of the 15 that, the attitude of both children were different from each other, with the normal birth children they seem more obedient, respectful, caring and generous as compared to the caesarean children who do not have feelings for your pain, all they care about is themselves which makes them more selfish. They, are also overambitious but rather lazy and also more disorganized than the natural birth children who are well organised and stick to instructions.

Some of them shared their views

Nana "*my caesarean child hmmm, always he has a frowned face because he knows you will send him. He is just five years but can tell you he won"t go on the errand like take this or that for me but the little sister who is three will run for it for me. he throws his things always and if you try to correct him, he will refuse to listen ", ombu adze kakraba po" (he doesn"t have an iota of respect at all)"*

"As for me the normal child is older than the caesarean one but the way the small one fights with the elder hmmm, he is strong and forceful with no sign of remorse. he has the bossy attitude but dislike to be instructed. does not give a denm to what you think is important to you. The only good thing about him is that he is a good caretaker and would not allow anybody to destroy what belongs to him but if is for someone he does not care" ***(Ghani)***

Jenny on the other hand stated *that my natural birth child is more caring than that of the caesarean child, she is also hardworking though she is a child but the caesarean child is lazy and always ascribing everything to her homework. Even, eating she would want someone to feed her whilst the natural child will eat by herself*

Sub theme 3: CAPABILITIES.

This has to do with the ability and strength of both the caesarean children and the natural birth how both of them are able to perform a task, things they can do and the urgency with which they achieve such task. It was discovered that the caesarean section children are smart in performing a task provided they decide to do it. They are smart when it comes to something that has to do with brain, their approach to certain things makes them more brilliant than the natural birth. However, Caesarean Section children are more prone to infections as compared to the natural birth children who are strong in immunity.

Nana gave her submission pointing to the fact that "*the caesarean child likes learning than household chores, he easily understands things and always tries to find his own way of solving problems, he also does not give up easily, but the natural birth normally seek for help with her books and have the attitude of I can"t do It"*

Tifia *shared her story "It might be because the caesarean child falls sick with the slightest infection that is why he is lazy*

and always want to watch cartoons and memorized them. He can stay without me for a long time but the natural one cannot stay without seeing me".

Pat *made it clear that if you ask "the caesarean child to close a bottle he will not hesitate to do it because he likes destroying things without feeling but, sometimes he feels reluctant in doing things since he hates to be instructed. He does things according to his instinct. He also does not accept defeat and would never give up but the natural birth child normally compromises.".*

Tata *says when it comes to food my natural birth will eat anything and that makes him stronger than the caesarean section child when it comes to infections the natural birth child is stronger in immunity than the caesarean child.*

Ghani *also says her caesarean section child does not eat so he is not able to fight infections and overcome it unless he is admitted at the hospital but the natural child will defeat sickness in no time with the taking of only paracetamol.*

Jenny *said "with my caesarean child he will need assistance in everything he does from waking up to going to bed, but the natural birth can handle her own affairs when it comes to personal hygiene.*

Research Question 4

What Social Support systems are available for mothers before during and after Caesarean Section and Natural Birth?

This research question sought to find out the support systems available for mothers who have undergone both Caesarean Section and Natural Birth. From immediate social environment like family, church, friends and other social groups. Participants reported that they got emotional support from their families and friends. They reported that the inspiration and words of motivation from friends and family have greatly influenced their recoveries. Themes such as Family Support, Negative feedback and Health staff attitude were realised.

Major theme 6: SOCIAL SUPPORT.

The support of family is vital in recovery and healing. From the analysis, all of the mothers relied on support from their families and close friends as sources of support. The following are some excerpts from the interviews conducted:

"My work colleagues visited at the hospital, friends called and wished me well and comforted me. Family members mostly helped in physical care of the baby and I. My mother in-law moved in to stay with me. Church members also gave money and other gifts...It made me feel important. I felt that people cared about me and I was not alone" (**Jenny**).

"My sister and my sister in- law have moved to stay with me, my nieces visit often to help me out. I don"t do anything

stressful. I don"t even ask for help and they offer it. Friends also visit and even bring gifts...I couldn"t have survived without them" (**Fati)**

"My sister, my mother and my mother"s friend **...***because they saw that I was sad, they did everything for me so that I won"t suffer much. They help before I ask*" (**Pat**)

Spousal support as a part of family support also stood out during the analysis. Some of the women spoke about how helpful their spouses have been through the process.

"I received lots of support from family, my husband. Everyone helps to care for the baby. I could not have done it without them. In-laws as well. I get time to rest for faster recovery. (**Ghani**)

I would say mostly, my husband, my mother and my grandmother. He has been very supportive. He is my rock. My mother takes care of my baby without me asking. When I was so low and couldn"t do anything for the baby, they took turns to care for him even at night. Sometimes grandma also visits and helps. (**Kay**) One participant, however, was not so fortunate to receive such support.

"If I am speaking the truth, I hate it. My husband is not happy and he was complaining that I always make him waste his money on me when I am ready to deliver with the exception of the first born. He will go for a new wife who can push by

herself (. I wish I had not done it" (**Dee**). However, she was lucky enough to receive support from other members of the family; "*my sister, my mother and my mother"s friend ...because they saw that I was sad, they did everything for me so that I won"t suffer much. They help before I ask"* (**Feli**)

Tina recounted the lack of emotional support from friends with the following words *"friends think I should have insisted and given birth because in our village, everyone gives birth by themselves. When they say these things, I feel sad but I don"t say anything. I just try to avoid visitors".*

Major theme 7: HEALTH PROFESSIONALS

The seventh major theme was their experiences with health professionals. Despite the differences in techniques used by the professionals in relating to mothers who have undergone Caesarean Section and Natural Birth, the effect produced seems to be equivalent. Sub-themes such as Information delivery, and attitudes of health workers were identified.

Sub-theme 1: Information delivery.

In health-related issues, quality information and manner of delivery is essential to the wellbeing of the patient. Majority of the participants in this study (11) reported that information regarding the health of themselves and their babies was not adequately delivered. Regarding how information was delivered, a participant expressed her dissatisfaction saying;

"*At 36 weeks, I went for a scan and was told that the amniotic fluid was insufficient, so if I don"t go for the baby to be*

induced, he will die. Eiiiii. In my head, I was like what! How do you give me such news so dry like that? But I went through caesarean section instead of induction ooo, so sometimes they lie to us"

(**Yaa**)

Other participants had concerns over how difficult it was to get information from health workers.

"I always asked. When my breastmilk was not flowing, when in pain, when I could be discharged. At a time, the nurse forced me to walk around without explaining why. So, I refused until another came to explain the importance of walking after Caesarean Section so the way they will talk to you, you will not feel comfortable at all but some of them are good and they have patience" (**Tina**)

"As for the staff, they don"t say anything if I don"t ask, not just with me but with everyone else" (**Pat**)

"I always asked. When my breastmilk was not flowing, when in pain, when I could be discharged. They don"t give any information if I don"t ask" (**Jenny**).

Very similar remarks were made by **Tifia**;

Although the majority seemed to have had challenges with the dissemination of useful information, one participant who was a health staff admitted to being adequately informed from health professionals. It was discovered that there were some preferences and bias as to how she was being

treated because she was a staff herself and a gynaecologist at the same hospital where the research took place.

"Yes, I received information about my health as well as that of baby"s health, even without asking" (**Tata**)

Sub-theme 2: Attitudes of Health Workers

Another sub-theme generated was the attitudes exhibited by health workers towards the mothers. Again, 13 out of 15 participants complained about the attitudes of the nurses towards themselves and other mothers. Interestingly, mothers who have received favourable treatments commented about the harsh treatment nurses give to other mothers. They complained about their insensitivity to the pain of mothers who had undergone Natural birth but rather show more concern with those who go through caesarean section and were in a considerable amount of pain.

A mother who had affiliations with staff at the hospital commented;

"*The nurses were amazing. Extra kind, I feel it is because my sister was a staff of the hospital. They even call from home to check up on me. I never asked, they always volunteered information*. (**Ghani**),

Others said:

It felt nice… however, she added *some of the health workers treat those they are not affiliated to roughly. They forget that the woman is already emotionally stressed and need all the support. I saw how they treated others and it was not nice. We were all helpless and needed love and care"* (**Sanny**)

"Sometimes, not all the time. Some of them are very nice, others frown, they talk loudly and interrupt the babies as well as our sleep. And they didn"t care" (**Tina**).

"I think health workers should stop verbally abusing women who refuse Caesarean Section at first. It isn"t good news to be told that" (**Yaa**).

Major theme 8: Coping

The main theme is coping strategies employed by Caesarean Section and Natural Birth mothers. Results from this study revealed that coping mechanisms included: spiritual coping, and inspiration from significant others. Majority of the participants used more than one coping strategy but almost all reported using spiritual coping. Some also dwelt more on their individual strength

Sub-theme 1: Spiritual coping

This was the common coping strategy participants used in coping with their diagnosis. Most resorted to believing or faith in God, and also prayer. The major elements in religious coping are the use of prayer and reading the word of God (Bible) or Quran or any other source of inspirational words as a means of diverting their worrying thoughts. Some participants responded;

"I accepted it because of my previous Caesarean Section when I had my second born. It felt that Caesarean Section was inevitable, also the doctor took time to educate me. Also, I read my Bible and believed that God won"t let any harm come to me" (**Dee**)

"Yes. In Africa, we are suspicious about people harming our pregnancies. We hide our babies. So, I know that God was on my side and I prayed" (**Ghani**) The results of this study showed that vaginal delivery is a symbol of joy but caesarean birth is a source of stress. What distinguishes labor pain from other types of pain is the outcome, which makes vaginal delivery more enjoyable. As an interviewee said: "*Vaginal delivery is giving birth, is happiness and comfort. Although you feel so much pain, in the end, the pain ends in happiness. Vaginal delivery means birth; it is a good feeling."* (**Feli**)

The majority of women believed that vaginal delivery is a natural, physiological process that requires no interventions. They saw it as a symbol of union with nature and God's creations, and they believed that God would assist them during labor, as opposed to a caesarean birth, which is an artificial and interrupted labor that is unbearable for both the mother and the child from the first three months to the fifth year, as the researcher discovered. One participant put it this way:

"*Vaginal delivery is birth of a baby in the way that God want it but caesarean birth is man- made which will leave you a permanent damage of the whole body."* **(Ghani)**

Some participants believed that vaginal delivery could help women attain a state of comfort. In fact, this feeling increases maternal satisfaction with vaginal delivery but no woman will be bold enough to tell you caesarean section gives satisfaction.

This point can be summarized in an interviewee‟s statement:

"*After the pain goes away, I feel happy for having passed the stage of natural birth because I have my normal shape back unlike caesarean section which will disfigure you completely.”* (**Sanny**)

Sub-theme 2: Inspiration from Significant Others

Other participants also drew some form of motivation from family, particularly spouses. According to them, their families motivate them and are a source of strength to them. Some participants responded;

“I depend on family support a lot, I also got encouragement from the doctor when I was depressed and my faith in God always makes me feel better, eventually about any bad situation. I didn"t want the caesarean section but rather Natural Birth always. But my faith in God, family support and the doctor helped me to come to an acceptance and finally, I had peace in my heart”. (**Kany**).

“hmmm, I prayed, and depended on my husband for support. My husband is my support” **(Tifia)**

“I pray. I also seek help from my family members when I needed help, sometimes, they also say nice things to make me feel better” (**Tina**).

Sub-theme 3: Personal survival efforts

Some participants also dwelt more on their strength and combined it with other coping forms such as prayer. They reported being positive about the condition and trying not to think about it. One participant said;

"*self-encouragement and prayers. I am very religious so I pray*" **(Gee)**

One participant whose family members have gone through Caesarean Section drew inspiration from their survival. Her response was;

"*Because my mother and auntie did Caesarean Section, I know that I will be fine, just like them. I always considered my mother and auntie who were living their normal lives after Caesarean Section and cheered myself up. I knew that with time, me too I will be fine"* (**Araba).**

SUMMARY OF KEY QUALITATIVE FINDINGS (N=15)

The findings of this study have been summarised in Table 2.

Table 2: Summary of Results

Major Theme	Sub-theme	Findings Caesarean section birth	Findings Natural or Vaginal Birth
Perceptions	Knowledge about Caesarean Section and Natural Birth	Inadequate knowledge on Caesarean Section and illinformed Negative body image (disfigured shape)	• Much knowledge on natural birth • Normal shape recovery.
	Pre-Caesarean Section and Natural Birth	• Severe Pain • Negative attitude towards the caesarean section	Normal pain Positive attitude towards Natural birth
	Post Caesarean Section and Natural Birth Pain assessment and Management	• Severity of pain for Caesarean Section • Poor/ no pain assessment Intravenous (IV) pain reliever • Suppositories	• Normal expected pain for natural birth No\poor pain assessment Injection on the thigh • Suppositories
	Recommendations of Caesarean Section and Natural Birth	• Not willing to recommend • Caesarean • Section to other women was poor Recommend only at the expense of life	Willingness to recommend to all women
Attributions	Spirituality	• Some believe that external forces are responsible for having Caesarean • Section	God is behind every process that has to do with natural birth

Table 2: Continue

	Envy	▯ Jealous rivals use spiritual means to attack their pregnancy	▯ Jealousy sets in when in-laws are not in agreement with the marriage
Relationship with the children	Bonding	▯ Difficulty transitioning into motherhood	▯ Easy bonding as well as transitioning into motherhood
	Breastfeeding	▯ Reliance on supplementary feeding	▯ Early breastfeeding
Psychological reaction	Stress	▯ The procedure, restriction and complications after Caesarean Section was a source of stress for mothers	▯ The labor process of pushing and sometimes suturing of the vaginal tear is the source of stress
	Fear	▯ Fear of loss of life of both mother and baby	▯ Fear of loss of life of both mother and baby during pushing
	Postpartum depression	▯ Experiences of sadness after birth	▯ Experience of joy after birth
	Disappointment	▯ Failure to have a normal delivery	▯ Joy of experiencing normal delivery
	Lack of psychological support	Psychological reactions were managed without professionals	Psychological reactions were managed with family without professionals

Table 2: Continue

Appearance of both caesarean section and natural birth children.	Appearance	Not that attractive with disfigured head	•More attractive and nice looking.
	Capabilities	More prone to infections Reluctant to respond to calls Very intelligent but not sympathetic	•Not prone to infections. •Responds to calls with urgency •Very intelligent and sympathetic
Social Support	Family Support	Physical, self-esteem, and emotional	Physical, self-esteem and emotional support
Health professionals	Information delivery	support from families and friends Poor information delivery leading to low	from families and fiends Information delivery leads to informational support
	Attitude of health workers	informational support Negative and insensitive attitude of nurses	Negative and insensitive as well as poor attitude of health staff
Coping	Spiritual coping	Use of prayer and faith in God as a form of coping	Prayer and faith in God as a form of coping
	Personal survival efforts	Use the experience of others as a coping strategy Positive emotions	Use of experience of others as a coping strategy Positive emotions

Discussions

The study aimed to explore perspectives of mothers with both experience of caesarean section and natural birth and their relationship with their children in Ghana. The study will help to fill the literature gap in the qualitative research approach to the experience of Ghanaian women who have had such experience. Pain experience, psychological distress, body image perception, and social support were explored with the Interpretative Phenomenological design and analysis. The study identified eight themes. The themes include: 1) Perceptions 2) Attributions 3) Relationship with the children 4) psychological reaction 5) Appearance of both caesarean section and natural birth children 6) Social support 7) Health professionals 8) Coping.

Perceptions of Mothers Regarding Delivery through Caesarean Section and Natural Birth

According to the data, the most striking event following a surgical procedure was pain, which all 15 individuals experienced in varied degrees.

Because no interventions were required in this study, the interviewees saw vaginal birth as a normal occurrence. Other research found that women described vaginal birth as a normal process, and that if they were unable to do so, they felt disappointed. Nilsson et al (2017).

According to the conclusions of this study, practically all women prefer vaginal delivery due to its unique nature and physical, psychological, and social benefits over caesarean section, which they have as a result of medical intervention. According to the interviewees‟ statements, one of the

reasons for mothers‟ tendency towards vaginal delivery was their belief in the superiority of vaginal delivery, due to its positive outcomes for both mother and infant due to the fact that it is nature oriented; the results were consistent with the findings of Benyamini et al. (2019). In some previous studies, participants believed that vaginal delivery was necessary for the baby‟s lung development, improvement of mother-child emotional relationship, reduction of medication usage Gupta, (2009) and other interventions such as epidurals and labor induction, and eliminating adverse labor-related outcomes; generally, they believed that vaginal delivery was less risky than caesarean section.

The severity of pain ratings (1-10, with one being mildest and 10 being very severe) ranged from 7 -10 on the subjective unit of distress scale, with three participants choosing 10. Pain sites included the surgical incision site and the lower back. 11 of the participants described vaginal birth history and described a sharp contrast between vaginal birth pain and caesarean birth pain. Pain intensity served as interference with engaging in activities of daily living and care of the new-born.

Pain assessment involves intensity, duration, description, factors that influence the perception of pain, and effectiveness of intervention (Main, 2016); were reported to be inadequate during pain management. This was demonstrated when seven participants rated satisfaction with pain assessment and management at 5, three others rated at 6, three of the participants rated at 8, while the remaining two rated at 9 on the subjective unit of distress scale (1-10).

Participants‟ dissatisfaction was expressed on the lack of initiative in pain assessment and management. Mothers felt that chronic pain is disabling and should not be ignored after surgery which doubles as a mode of childbirth since the woman is the primary caretaker of the child.

Participants who rated satisfaction with pain management at 9 believe they were paid special attention to because they were affiliated to the hospital. The remaining participants described how they often engaged in a struggle to manage pain and sleep simultaneously, due to the absence of pain medications. Seven participants reported being asked to sleep with the pain sensation as it was “normal” after surgery as well as helps to fight against possible addiction to pain medications. This went against their expectations of pain management. None of the participants reported being offered non-pharmacologic management of pain as an option.

All clients experienced pain between one to six months after the surgery, but with natural birth they recover within the third month since it is a natural process and they do not need to be on pain management medications as in the caesarean section. This finding is similar to Ranadheera et al (2019), a study on pain relief following caesarean section, where at 3 months, 56% of all responders with pain reported pain in and around the surgical site and 32% of those with pain reported pain on several locations. In the same study, 25% of the responders reported pain at 6 months after the procedure.

Joy et al (2020) reported similar results, with moms who had a caesarean birth showing a very delayed recovery in their quality of life due to long-term pain. A research to assess the incidence of persistent pain after

caesarean delivery found that pain was 15% after two months, but was reduced to 4% at 12 months. Overall, the pain was acute after surgery but became modest after a few weeks, with an estimated 8% of patients reporting consistent or daily pain at two months, dropping to 1% at twelve months. At two months, less than 5% were using analgesics, and at 12 months, less than 1% were (Liu, Raju, Boesel, Cyna, & Tan, 2013).

These findings have implications for proper pain management. It addresses the reality of post caesarean pain and concerns on pain assessment protocols at the regional hospital, knowing that lack of proper assessment by medical and nursing staff led to poor interventions and outcomes as well as reduced quality of life during the post-partum period. The pain threshold varies from person to person and each woman‟s pain complaints must be respected and

evaluated.

Positive attitudes after birth are usually dependent on women's expectations before birth and the ability to manage one‟s expectations after birth. Though Caesarean Section is widely accepted in the western world, it is approached with some level of hesitancy in Africa and Ghana (Prah, Kudom, Afrifa & Abdulai, 2017).

Participants were asked to state their willingness to engage in caesarean section birth, if need be, in the future. The majority emphatically expressed their displeasure with the procedure, absence of desire to have the procedure, and unwillingness to recommend it to another person. Only one participant was comfortable with the outcome of the birth experience and

expressed her likelihood to request for it in her next delivery. Two participants were willing to undergo it again if meant saving lives. This revealed that a previous history of

Caesarean Section does not provide a more positive attitude to news of another Caesarean Section.

A study by Afaya, Bam, Apiribu, Atia, and Afaya. (2018) found that the majority of women (92 percent) would prefer vaginal delivery over Caesarean section delivery as their preferred mode of delivery, even among those who had previously undergone a Caesarean Section. Despite the fact that the Caesarean Section may have saved their lives, the participants felt it is not the best technique of birth and would not choose it again. The traumatic experience contributed to the negative attitude of mothers to caesarean delivery. This finding reflects the seeming disconnection of the mother from the birth process and the loss of personally working with one‟s own body to achieve birthing of babies.

Referring to the cause or indications of a caesarean delivery instead of vaginal births. Causal reasons for undergoing caesarean delivery differed among participants. From the participant‟s perspective, spiritual factors and envy played a role in their caesarean births. Majority (nine) of the participants attributed their cause of Caesarean Section birth to paranormal manipulations caused by jealous people in their social settings. One participant who had earlier demonstrated adequate knowledge on indications of a caesarean birth also reinforced this belief, she however admitted that she had no proof to support her belief.

This blame was centered around rival envy and jealous business colleagues. There was the general belief about such persons wanting to hurt them and get them out of the way; and since pregnancy comes with its associated complications and vulnerabilities, and morbidities it provided the best avenues to execute their objectives.

This finding raises concerns on the knowledge on caesarean section among Ghanaian women. The findings were contrary to previously given reasons on why a woman would have a Caesarean Section birth instead of vaginal birth. It reveals that though some participants know that physiological causes can prevent a woman from achieving a vaginal birth (Asare & Danquah, 2017)., they are more inclined to think along certain spiritual lines, as far as causes are concerned, when confronted with the situation. This is further demonstrated by 2 participants actively praying, fasting, and visiting prayer centers to cancel the impending procedure. Though some attributed it to the inability of the bodies to endure stresses till the end of labour, the overwhelming belief of most participants was that their bodies cannot have any anomaly and that any mishap is caused by

external factors.

The sort for external causal attributes, especially in the area of spiritual attributions, is something that has been reported among the Ghanaian population. The Ghanaian belief system is supernatural which is deeply embedded in the Ghanaian culture, where spiritual involvement is considered in illness and healthcare. Ghanaians believe that spiritual powers invoked by others, can cause physical and mental anomalies on other individuals. Though

the specific practice may differ from culture to culture, it has similarities across and it helped in influencing the perceptions of participants on their need for a surgical birth (Asare & Danquah, 2017).

This differs from Nilsson (2017), a study on perceptions and experiences in Caesarean Section, where the majority (70.8%) of the respondents had a positive perception about caesarean birth and agreed that Caesarean Section was justifiable in them for medical reasons they still preferred to have gone through the natural birth.

After childbirth, another sensitive phase of the woman is the transitioning into motherhood. Aside the mode of delivery no woman was born a mother but you turn into one whether you like it or not immediately after delivering a new baby, every woman has the expectation of mothering and bonding with their children right after the baby is delivered. A mother‟s relationship with her child is beneficial to both mother and child, and it is recommended by experts in the medical field to begin as soon as the baby is born whether caesarean or natural. As revealed in the study, Caesarean birth comes with certain limitations which include difficulty initiating breastfeeding and bonding with the new-born. For 8 out of 15 mothers, the desire to breastfeed their babies was met with difficulties in the first 2 days, since their breastmilk started flowing on the third day after the surgery as well as the natural birth. Only 6 had milk flowing for their babies on the first day even those women had those babies through the natural birth not their caesarean ones.

The delay in the initiation of breastfeeding, the physical restrictions, and reduced mobility including pain after birth were the reasons in delaying the bonding process of mother and child with the caesarean section birth which is not so in the natural birth where bonding starts immediately after the baby comes out of the womb. Eight out of fifteen women stated that there was no bonding due to the challenges encountered in their recovery after the caesarean section but with the natural birth bonding was real. Babies were being cared for by family members and midwives which was not so with the natural birth where she was able to touch and feel her baby after she was taken to the recovery room.

It was evident that some of the mothers felt that their failures to form a relationship with the child right from the onset gave the other caregivers the chance to bond with the child instead of them in the case of the caesarean children which is the cause of their attitude towards them as mothers. This is confirmed by

Bowlby‟s evolutionary theory of attachment (1969), which suggests that children come into the world biologically pre-programmed to form attachments with others, to aid their survival. Therefore, in the absence of the mother, an instinctive attachment can be formed with any caregiver.

The physiology of breastfeeding is regulated by hormones and can be impacted by the physiological stressors and other emotional reactions encountered during the peri-operative period. This could account for the delay in milk production. These unfulfilled expectations of early motherhood are similar to Krol &Grossman (2018) study which revealed that there were

delayed first breastfeeding and a lower rate of breastfeeding up to six months associated with Caesarean Section which the women confirmed buts is not so in the natural birth.

Limaso et al (2020) also had such results in their study on breastfeeding after caesarean delivery. They found out that initiation of breastfeeding and Expressed breast milk is often delayed after Caesarean Section and more breastfeeding problems occur after Caesarean Section as compared to vaginal delivery which breastfeeding starts as soon as the baby is born. This breastfeeding process of the new born aids in the passing out of the babies first faecal matter called the colostrum that aids in cleansing of the baby‟s system from unwanted materials or substances.

Breastfeeding after birth is the preferred method of feeding the child as recommended by the Ghana Health Service. According to Ghanaian practice, it can be achieved by latching the infant‟s mouth unto the breast, expressing the milk manually or through a breast pump and subsequently spoon feeding the newborn with it. In cases where the new mother is unable to initiate breastfeeding, Benyamini et al (2017), report that lactation is induced by engaging a female relative who has not delivered to act as a wet nurse to breast feed the baby, or a mother who is already breastfeeding her own baby is tasked to co- feed both babies until the new mother is able to establish breastfeeding on her own.

Psychological Distresses of Mothers who have gone through both Caesarean Section and Natural Birth

Vaginal delivery was incorporated in the current study as a symbol of women's power and ability to play the maternal role.

The current study's findings looked at vaginal delivery as a trigger for maternal emotions. The findings matched those of Fenwick and colleagues, who cited maternal/fetal health, mother-child communication, and the adjustment to motherhood as benefits of vaginal delivery (Cardenas, Beckers & Vanelslander 2017). Unplanned surgeries come with emotional reactions. These emotional reactions are heightened during labor when maternal hormones are in a surge with varied expectations. The woman has little control over the emotions and becomes vulnerable to changes in the environment. From the study, it was evidenced that emotional reactions like fear and anxiety, stress, postpartum depression, and disappointment were dominant among the participants.

For 13 out of the fifteen women, the news of an impending caesarean delivery was recounted with a sense of panic and anxiety. According to these 13 participants, they felt extreme fear and were scared. An attempt at rationalizing the anxiety-provoking situation was done by asking questions and suggesting to the doctors to give them a chance to push. Some handled it by praying and rejecting the news unlike the natural birth which does not put much pressure on the woman when the due date is approaching.

In the present study, vaginal delivery was introduced as a manifestation of women‟s power and ability to play the maternal role.

On the other hand, one of the problems, the women stated with the cesarean experience was mothers‟ inability to care for the child and fit the maternal role; the results were in accordance with those of (Ranadheera,2019).

Thoughts that raced through their minds were fear of possible harm to self and baby, fear of the unknown, negative perceptions from friends, and family which was not so in their Natural Birth delivery process. A participant with a history of four vaginal births recounted her attempt to push on the fifth one which was caesarean birth which was met with a warning to discharge if attempted since it has to do with the larger size of the baby.

Participants felt rushed, forced, denied any attempt to further process the news, and make meaning out of it. These feelings are considered valid as the mothers felt a loss of autonomy in making their birth decisions. Joy (2020), reported similar findings; the agonizing experience encountered by all of the mothers during the caesarean delivery was expressed as feelings of anxiety, anguish, and panic. In Joy‟s report, seven out of ten mothers experienced the uncertainty and great concern about whether their babies were going to survive the procedure.

The findings of this study showed that vaginal delivery is a symbol of birth and womanhood, as well as a key to a woman's satisfaction after giving birth. Childbirth pain is distinguished from other types of pain by the fact that it is linked to favorable results. Manthata's study implicitly validated this finding, as most participants saw labor pain as a normal and necessary aspect of pregnancy. In the current research, participants considered vaginal delivery as a natural process and experience with a happy ending, while Caesarean

section was known as an artificial procedure, accompanied by anesthesia with stressful ending. The difference is the variation in the pain which is severely experienced before vaginal birth and after Caesarean birth. According to one participant, dread of labor discomfort was one of the key reasons for choosing Caesarean Section. Nilsson and colleagues (2017) found that women's choice for Caesarean Section is based on their irrational fear of pain during vaginal delivery, as well as misconceptions about their incapacity to deliver vaginally and the episiotomy they will face if there is a tear.

The idea that mothers with previous Caesarean Section experience have a more positive attitude to Caesarean Section was not reflected in the study but rather they chose to have a natural birth if they have their own way. There were expressions of fear and anxiety among all the 15 mothers with the previous history of caesarean delivery but they have no such attitudes towards natural birth They recounted their experience as negative and unwanted, emphasizing how unpleasant the previous experience of caesarean section delivery is as compared to that of natural birth. Only two out of the 15 participants experienced no anxiety but relief when given the news. The outcome of this findings is that, clearly, in this research area, mothers had not overcome their negative emotional experiences in Caesarean Section delivery which greatly affected how they perceived the next one should in case they will give birth again. The difficulty in overcoming previous negative emotional experience could be understood in the lack of psychological interventions for such individuals in the Ghanaian setting.

Eleven (11) participants related how frustrating and stressful the postoperative period was to them. For these mothers, they doubled as convalescing patients as well as new mothers, tasked with the responsibility of caring for themselves and babies who were entirely dependent on them which was not so in the natural birth. Mothers felt battered, always worried, and helpless. Relevant sources of stress included: delay in initiating breastfeeding, separation from baby, wound infection, daily or alternate day trips to the hospital for wound dressing after discharge from the hospital to the house, fear of judgement by society, physical restrictions impeding activities of daily living, and pain. Reduced mobility and loss of income were also a source of worry for the new mothers. Lack of adequate knowledge on possible complications was also observed to be a stressor on the mothers, the majority of mothers were clueless and confused with the whole postoperative experience leading to adjustment difficulties which they never experience in the natural delivery period.

Participants recalled that the stressors gradually reduced over time as they recovered in both type of delivery but in natural birth it heals faster than the caesarean birth. The sense of independence and the chance to make certain decisions for self and baby increased the positive emotions in mothers during the vaginal birth period than the caesarean section period. They began to worry less and spent much time enjoying motherhood. Findings relating to stress coincide with Karim et al (2020), where they realized that; many women are unprepared for the implications of birth by caesarean, and were overwhelmed and frustrated. They described the struggles as they tried to fill

into the expected roles. These accounts signify a lack of information on the expected consequences of caesarean delivery from the health care providers to mothers, and mothers had to depend on unofficial sources of information to get by.

According to the DSM-5, A blending of physical, emotional, and behavioral changes that affect a number of women after childbirth is postpartum depression, it occurs within the first 4 weeks after delivery which is attributed to withdrawal of maternal hormones. Nine participants had dominant feelings of depression as they recounted their experience. But in the case of normal birth there was nothing like depression. These mothers related how miserable they felt and went on weeping all day unprovoked. The accounts included neglect of baby, self, anger, and psychomotor retardation spanning from a minimum of 10 days to 4 weeks. These emotional and behavioural changes marred the early motherhood period for the participants. Recalling her experience, one participant talked about how her baby kept crying each time she wept, which lead her to change her sad mood to becoming happy consciously but with difficulty, it was unhealthy for a new-born to witness its mother crying all the time as told by her mother and mother in-law.

Pregnant mothers anticipate the arrival of their babies with joy but the situation was different for these nine mothers with the arrival of the babies through caesarean section which is the exact opposite of their normal birth. Another participant regretted having the baby and even having a uterus after the caesarean birth. For her to adjust emotionally, she encountered a lot of

complications like, new responsibilities, unfulfilled expectations, traumatic birth experience, physical changes and having intimacy with the husband even after the sixth month of her birth. On the other hand, she was able to share intimacy with the husband after the third month with no fear of wound opening.

For some participants, the sense of loss and failure to engage in a natural experience of childbirth was overwhelming not even after being able to have a child through natural means before. Especially women who were from communities where women who go through caesarean delivery are perceived as „„ not true mothers" who cannot boast of full womanhood. Such perceptions took their toll on the women who are pressured and feel manipulated by societal constructs, i.e.to deliver by vaginal births even at the expense of their lives. This emotional reaction has deeply affected participants" negative perceptions of caesarean deliveries and will take a lot to undo that belief. Contrary to the nine, six mothers did not experience sadness nor grief after going through the caesarean procedure as well as that of the natural birth, they only seem to be concern with the severity of the pain after both experiences

These findings are consistent with a study by Tonei (2019), where he found a positive and significant association between unplanned caesarean delivery and postnatal depression. The extent of the emotional toll on the participants was observed as six participants were between various stages of tearfulness and actually tearing up as they recounted their experiences in the caesarean section birth but were cool with the natural birth. All participants depended on family, friends, nurses, and midwives for support without the

involvement of psychologist or psychiatrist who manages psychological and emotional problems.

Ten participants recounted their experience of disappointment. For these women, childbirth meant carrying the baby and pushing the baby out of the body with all the woman"s strength which is a natural phenomenon. They have already been able to go through that already so what is the point in changing the style of birth by the health professional for them. Anything else was not-normal, leading to their disappointment. For some of the women it was disappointment but others it was sad news. Four participants felt only disappointment but no sadness. Five felt disappointed and depressed in the caesarean birth but the natural birth was no more news. Feelings of not doing enough during the antenatal period, not insisting on pushing and even regrets, failure to seek a second opinion from another hospital before giving consent to the surgery. The study suggests disappointments were seen to be stemming from not getting their normal birth experience but had to go through a different process. It was found out that 14 of them had their natural birth procedure before encountering the caesarean section which made them still have a reason to believe it is spiritual with the exception of one who had twins with the first natural and the second one caesarean which was at the same time her first born.

On the psychological reactions, six participants experienced all reactions; that is, fear, stress, postpartum depression, and disappointment, four experienced fear, stress, and depression without disappointment. three participant experienced fear and stress one experienced fear and

disappointment and one client had no negative emotional reaction. One very striking about these psychological reactions was that, none of the fifteen participants was given psychological attention nor support, before, during or after the procedure. Though participants mostly reported their feelings to the health care workers, there were no psychologist referrals made.

Participants had to depend on personal coping efforts, family, and friends for support. This highlights the deficiencies in the psychological management of the woman going for an unplanned surgery which doubles as a method of childbirth and with natural birth is no different. Though the emotional reactions waned off as they recovered, some still experience mild feelings of sadness and regret as in having gone through the caesarean birth. These emotions, however, mild and inconsistent, set in them an unresolved conflict requiring professional intervention which they lack.

Reasons for this conflict may include, stigma and discrimination surrounding a surgical birth. This discrimination is fueled by societal expectations likening the strength and resilience of a woman to her ability to experience vaginal birth, while women unable to achieve this are forced to associate negative images about themselves even though they have some of the children through the natural means.

Social Support Systems Available for Caesarean Section and Natural Birth Mothers

Among the study participants, 14 of them were married and staying with spouses. All participants reported receiving support from family members right from receiving the news until recovery. In both caesarean birth

and natural birth. Family members spent the admission period with them as much as allowed by the health care workers. Support provided was in the form of both physical and emotional

Physical support included assistance with hygiene practices, feeding, and care of the baby as well as themselves. Participants recall how family, usually females, took over the care of the babies from them and gave them opportunities to rest in the case of the caesarean birth till the sixth month but with the natural birth such support ends at the third month. The majority of the participants recounted how helpful the spouses were in offering support. Emotional support was given by both spouses and other relations with reassurances and spiritual support through prayers. Informational support in the form of reading materials, videos on Caesarean Section were given. Participants without much education and technological know-how had family and friends sharing their own experiences and tips on recoveries to them.

Family support greatly influenced participants‟ recovery and emotional wellbeing by inducing confidence and positive emotions in them, thereby increasing their quality of life. Participants knew there was an unspoken help waiting to be accessed when necessary. One out of the ten participants‟ accounts included physical and emotional support from her husband in the operating room this was because she is a health professional unlike the rest whose husbands were not allowed in the theatre.

The overwhelming effect of an unplanned surgery which doubles as a form of birth was mitigated by the readily available support provided. The positive reactions by the family, reveal that, Caesarean Section, though not

readily accepted in the community is seen as a major event not only in the woman's life, but in the family as well as compared to natural birth. Family members recognize that its effect is in a magnitude that cannot be borne by one woman alone. This support is explained by Dankwah (2019) in the Stress Buffering hypothesis, which suggests that social support provided to individuals helps them to cope with stress by mediating the stress–illness link. This mediation is achieved by cushioning the individual from the stressor and its harsh impacts. The presence of other people and the support they give influences the individual's evaluation of a stressor and enables them to choose which identity or role to accept as a result of a stressful event.

Contrary to this finding is a study by Karim et al (2020), where women described how they strived to get time to rest in order to avoid pain, fatigue, and wound complications, while giving the most care to the newborn and other children as well as home maintenance in the period following caesarean delivery. Three participants, though received support from family, recounted experiencing negative comments from friends after the discharge from the hospital. These friends passed inappropriate comments that reflected negatively on their status as women.

Though in the minority, this finding reveals that a section of community members still considers Caesarean Section as divergent means of delivery which save life but still avoidable if the woman wishes to avoid it. Women who go through it are thought to be lazy and failures as women without considering whether you have had a natural birth before or not. Similarly, Gupta (2018), found out some men were also reluctant to give their

consent for Caesarean Section provided the woman have already had a child through vaginal means, because it was perceived as a mark of reproductive failure and the belief that it would have negative consequences for the rest of her pregnancies and also reduces the number of children you would want to have. Social relationships have an impact on mothers after the caesarean section procedure. The most important sources of support for participants were female relatives and husbands and must be included in the management of the mother involved in a caesarean delivery.

The majority of the participants (eleven), reported on poor health worker attitudes towards them. Reports centered on negative attitude towards the poor, rude responses, impatience, lack of empathy, and absence of relevant information. Participants recalled receiving inadequate information on expectations during and after the procedure. Informational support involves providing formal, up to date information in a timely manner to clients on admission. Participants' expectations included sympathetic words, therapeutic touches, timely administration of drugs, privacy, and respect from health professionals. A participant who experienced 3weeks of postpartum sadness reported on how some midwives increased her emotional vulnerability by invalidating her feelings.

For these participants, health care workers enjoyed seeing them in pain hence their constant refusal to give them pain medications until determined to be necessary by the worker. Their replies to participants were always „it is normal to be in pain", so after the first 24- 48hrs after the surgery, the administration of pain medications was infrequent. Participants felt their

feelings were disregarded as pain is subjective and cannot be tangibly proven. Some were even ascribing the cause of their pain to the health staff which one said, “some of the health staff are witches and agents of destruction.”

Lack of health worker support was also evident in responses given by some participants who had a delay in initiating breastfeeding. To the first - time mothers of Caesarean Section delivery, health care workers were better placed to give detailed information on occurrences to be anticipated, but their hopes were dashed. Two participants felt the doctors rushed them into signing the consent without proper education nor time to process their feelings. Participants felt certain information threatens the peace of mind so must be given in a way that reduces the negative emotional impact. Four clients had only positive responses for the health care workers; to them, it could have been so because they worked at the hospital so had and with a lot of clients within a day based on her personal observation. Also, they have some information on the right of clients pertaining to information.

Some participants had no idea of their right to client information and took whatever was given them with gratitude. These findings reflect the gap in information management as well as the client-health worker relationship. Health care workers may be overwhelmed with work hence the neglect in that aspect of health delivery as in taking care of mothers with newborns or it could also be attributed to some Ghanaian health workers behavior of not valuing the words of the client in the sense that the staff “know more than the client” rule and the expectation that the client must accept whatever is given them with humility without question. Surprisingly, Health professionals were

unaware of the effect of their behavior and actions on their clients so they did not take the opportunity to change as well as impacting them in a positive way. The staff did not take into consideration the values of clients that goes beyond decision making as well as ill health. As a result of the negative experiences of these mothers their perception towards caesarean section is not good as compared to the normal delivery since Caesarean births come with longer hospital stays than vaginal births, with the poor health care worker-client relationships, participants felt stressed the longer they stayed in the hospital while being treated as "something without value and with no feeling".

Support from loved ones and health care workers had a remarkable impact on mothers‟ health post-operatively. Researchers have identified the role of supportive care, to a positive evaluation of childbirth (Tahan, Koyuncu, Yilmaz and Sever, 2017).

Coping Strategies of Caesarean Section and Natural birth Mothers

In the current research, participants considered vaginal delivery as a painful and fearful experience though it is a natural means which every woman must go through when the time is due, while Caesarean-section birth was known as a pain-free, simple procedure, accompanied by anesthesia which is the artificial means which comes with a reason like life threatening as well as death of either the mother of child and even both. Besides, 1caesarean section brings a lot of pain after delivery which has to do with, walking, turning in bed inability to do things on their own (being dependent). Therefore, one of the main reasons for selecting

Caesarean-section was to save their life and that of their babies. The study of Poikkeus (2010) also showed that women‟s preference for elective Caesareansection is based on their unrealistic fear of pain during vaginal delivery and Misconceptions about their inability to perform vaginal delivery

For 12 participants, faith in God enhanced the stages involved in refusing Caesarean Section outrightly in accepting to go through it when mention to them but they accept the natural birth without asking questions or trying to get more information as to how the process works and the stages involve. These participants reported that, their faith, prayers and believing that their object of worship will let no harm come to them nor their children strengthened them. One participant who experienced no negative emotional reaction after going through caesarean section birth voiced out her positive attitude to life and all events that comes with it. four participants described encouraging themselves with positive self-talk as well as prayers. A participant stated that, her encouragement was gotten from positive experiences from her female relatives who had had the experience of caesarean section before. To her, Caesarean Section mothers are just like any other mother and the only participant who did not relate it to

religiosity.

Participants were inspired with positive experiences of mothers with Caesarean Section history and that was what kept them going during their own turn, combining it with personal survival efforts as well as spirituality made it possible for them to go through. This same attitude has been extended to their

natural birth procedure. These coping strategies provided an avenue to rationalize the situation, make sense out of it, and hope for the best.

Similar to these, are studies by Reenen and van Rensburg (2015); Crowther and Hall (2018), on exploration of mothers‟ coping strategies in managing emergency caesarean deliveries. Mothers‟ experiences of traumatic births were impacted by their perceived faith, strengths, hope, and religiosity when adjusting to the negative consequences of both caesarean birth and natural
birth.

The outcome of this research has given credence to several theories that seek to explain health, distress, perception and relationship. Taking for example, as explained by Bowlby‟s attachment theory, not only does the child seek gratification from feeding but also, considers warmth as a major determinant of how a child attaches to the mother which builds up a relationship. Somehow, mothers knew that the more a baby stayed away from them, the less they will relate with their children. The worry of being unable to immediately attend fully to their infant also generated into several described distress scenarios. So, in this situation, their thought about the implication, impacted how „ok‟ they were. Postoperative events (staff care, social support) also added to how mothers handled the aftermath of their Caesarean Section birth and the natural one. This phenomenon is a central tenet held by the biopsychosocial approach which tends to advocate for the consideration of psychological and social factors in treatment formulations that can help accomplish holistic healthcare delivery. Relationship with their children was a

major issue with the pathway to distress mainly being in the form of „comparison" mothers made with other individuals who have had only one of the procedures like either caesarean section birth or natural birth and did not go through similar ordeals. Comparison is explained by the Higgin"s selfdiscrepancy theory. The theory helped understand the mechanism of distress by knowing the standard guides that these women held and expected to fulfil.

Inability to fulfil therefore created a discrepancy and less acceptance, increasing distress levels. Despite the relevance of these elements, only a few studies have looked into cultural ideas about Caesarean sections and natural birth, and even fewer have tested their impact experimentally. As a result, more research is needed to determine the direct association between cultural views and the predisposition to both caesarean–section and vaginal birth (given the fear of labor pain).

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This chapter presents the summary, conclusion and recommendations in relation to findings of the study. Findings of the study are to provide guidance for policy direction and hospital practice.

Summary

The study sought to investigate perspectives of mothers with both experience of caesarean section and natural birth and their relationship with their children in Ghana at Cape Coast Teaching Hospital in Cape Coast Metropolis. In an attempt to attain its purpose, the study:

1. Investigated the perception of mothers who have both caesarean section and natural birth have regarding pain.
2. Assessed psychological distress mothers, go through before, during and after having both the experience of caesarean section and natural birth children.
3. Explored how mothers who have both the experience of caesarean section and natural birth perceive their children.
4. Examined the social support systems received by mothers with both experience of caesarean section and natural birth before, during and after both Caesarean Section and natural birth procedure.

The phenomenological interpretative design was used because it presents the most suitable method of representing the useful experiences of both caesarean delivery and natural birth delivery. It is participant-oriented and provides an avenue to understand the innermost deliberations and the

psychological world of the participants. A sample size of 15 women were conveniently sampled, with their ages ranging from 18-40years. The instrument for collecting data was unstructured interview guide, data was collected through an interview and manually transcribed and analyzed through the interpretative phenomenological analysis. Ethical considerations were given before data was collected.

Key Findings

Findings from the study confirmed and also contradicted previously reported findings in the various literature revealed in the study. Major findings included:

1. The synthesis of the studies analyzed reveals the production of scientific knowledge that reflects the experience of a woman's role playing, among the positive aspects discovered regarding caesarean section and vaginal birth. This role-playing was associated with emotional and socio-cultural aspects described as a unique and relevant experience beyond the physical experience, which lead to personal growth, to building a new identity, and the status of being a mother. These factors are associated with the emotion of the first meeting with the child, and bring greater satisfaction with a natural birth. Among the positive physical aspects highlighted in the natural birth, the study found lower levels of postpartum pain, faster recovery and quicker return to their daily activities was better with the natural birth than the caesarean birth.

2. Pain assessment and management which is an integral part of any postoperative management was inadequate at the regional facility as mothers were expected to feel it as a consequence of a caesarean birth. It revealed the gaps in the efficient management of post-operative pain after caesarean deliveries and post-natal in the natural birth.
3. 3.There were no considerations given to nonpharmacological management of pain. Mothers who go through caesarean deliveries experienced severity of pain, with ratings ranging from 7-10, unlike the natural birth which rated 3-5 on the subjective unit of distress scale. There was also little to poor assessment of pain which led to poor pain management.
4. The participants stated that labor pain deepens the mother-child bond and enhances maternal sentiments. Furthermore, vaginal delivery was regarded as a physiological process as well as a symbol of birth and joy. Two participants, on the other hand, who had good attitudes of Caesarean-section and prioritized this style of delivery, saw it as a painless and safe method of delivery that preserved the beauty of the reproductive organs since vaginal delivery sometimes result in incontinence as a result of the tear or stretch of the vaginal wall. Mothers, who delivered through caesarean sections unplanned, went through various psychological distresses (cognitive, emotional and behavioral), ranging from fear, anxiety, postpartum sadness and disappointment. These negative emotional reactions were experienced before the procedure and lasted for weeks to months in the

postoperative period. These distressing reactions negatively influenced their quality of lives and delayed the recovery process as well as having effect on the relationship with the children. Again, though all clients verbalized their negative emotions to health care professionals, none was given any psychological attention as required.

5. Participants in the current study thought caesarean section was a difficult and frightening event with complicated anaesthetic issues, whereas vaginal delivery was thought to be a painless, As a result, one of the main reasons for Caesarean section was the fear of death of both the mother and child or one of them, (saving lives). The study suggested that mothers after an unplanned caesarean delivery demonstrated negative poor self-acceptance after a caesarean delivery which was not so in the natural birth where women express boldness and confidence after the procedure.
6. Newborns were cared for by female family members while the new mothers were encouraged to recover, Recovery is faster in the natural birth than the caesarean birth which mitigated the negative birth experiences of caesarean sections. However, the study finding also observed deficiencies in health care worker support, spanning from lack of empathy, rude responses and lack of information. It suggested health care workers seem to be unaware of their unique position and hence do not take advantage to positively impacting the lives of their clients. Social support is an important factor in the community and mothers received all forms of support: physical, emotional and self -

esteem supports mostly from family members and friends. Spouses were observed to play important supportive roles in the periods before the surgeries and predominantly during post-operation and the anti-natal and postnatal state in natural birth.

Conclusion

Several studies have been conducted into caesarean section deliveries and natural birth deliveries but are limited when it comes to the subjective experiences of mothers who have had both experiences in Ghana as well as Africa as a whole.

This study delved into what it means to have both experience of caesarean and natural birth and their relationship with their children and revealed the systematic gaps in the management of the women who have undergone both procedures. Majority of participants had positive perceptions about vaginal delivery but their perceptions on caesarean section was negative except in the case of life risk. Vaginal delivery was considered a safe method which is not associated with complications like what occurs due to Caesarean-section. They also believe that natural birth has many benefits for the mother and baby.

Labor discomfort, according to the participants, boosts maternal sentiments and strengthens the mother-child bond. Furthermore, vaginal delivery was regarded as a physiological process as well as a symbol of birth and joy. Few participants, on the other hand, who had positive perceptions of Caesarean-section and prioritized this mode of delivery, saw it as a painless and safe mode of delivery that preserves the beauty of the reproductive organs,

but it is more stressful and does not improve the early relationship with the child when compared to natural birth. Majority of participants had negative perceptions about the procedure and were unaware of expected consequences following it. Psychological management of the woman who has to be operated to give birth is limited in the health care delivery as mothers had to depend on personal coping skills, religiosity, as well as previous experiences of family and friends to navigate through the confusing recovery period. Adoption of the biopsychosocial approach of health and illness will be ideal in the management of all pregnant women from conception to delivery, since it is client inclined and holistic in its approach.

Awareness must be developed in many ways, and current myths must be rectified, in order to build a favorable cultural and religious attitude regarding vaginal delivery. Encourage people to use vaginal birth as a form of delivery that enhances fetal/maternal health, increases women's awareness of maternal identity, increases their comfort, and changes the mode of delivery decision by modifying current beliefs and attitudes about safe delivery. However, mothers need to be gentle on their caesarean section children in terms of their attitude as they do with the natural birth children. There is the need to refrain from abusive words which they ascribe to their caesarean section children. Mothers should be more patient and take keen interest in the health of the caesarean children and must not consider them as those who invite sickness to themselves but rather consider them vulnerable to certain environmental conditions due to the mode of their delivery.

Recommendations

The following are recommended based on the findings:

1. Psychological management of clients who go through both caesarean delivery and natural birth should be included in the whole intervention of a either natural or caesarean delivery by the Ministry of Health and enforced by the Ghana health Service. Preoperative psychological care would help to mitigate pre caesarean anxiety and fear experienced with the news of an impending surgery, since psychologists are better placed to break seemingly unpleasant news. Caesarean delivery comes with various cognitive and emotional reactions, thereby requiring psychological care. As such, clinical health psychologists will help clients to manage the negative emotional reactions, induce positive emotions, come to an acceptance and increase the quality of life in the recovery process of both natural and caesarean delivery.
2. The Ghana Health Service must have extensive health education policies on pregnancy, vaginal delivery and caesarean sections outcomes. This can be achieved through the various forms of print and electronic media. Pictorial, audio and video means of education can be employed to disseminate such information to the general population. Antenatal clinics should also have frequent ongoing education on the indications of both vaginal and caesarean births and demystify the myths surrounding the procedures. The education should include the benefits as well as the expected complications of both procedures especially to new expectant mothers and measures put in place to

ensure a smooth recovery. Target population should include both the educated and uneducated as the finding revealed a knowledge deficit of caesarean section among all participants including the tertiary educated ones.

3. Health care professionals will benefit from a sensitization through seminars on their role in the lives of their clients. It will be expedient for such professionals to go on frequent conferences and seminars to. .9 update their knowledge on customer care and put it into practice. Consciously, health professionals should employ empathy, understanding, patience, and supportive attitude in the delivery of care. Delivery of timely information is a supportive measure to clients and helps to make informed choices, clients will prefer to be given an opportunity in making decisions instead of being expected to accept whatever is given to them when it is deemed necessary by doctors and nurses. Health care workers must understand that clients handle issues better when they are informed and given the autonomy to make a choice in any situation.
4. The health care team in the management of both vaginal and caesarean births should adopt the biopsychosocial-spiritual model of health and illness. Pregnancy and childbirth is a remarkable occurrence in a woman's life and women who have to depend on surgery to give birth would need to be managed by a multi-disciplinary team in the hospital. This will ensure that all factors that interplay to ensure health, including relevant professionals are included to ensure a smooth

intervention and recovery. Family members are an integral part of clients‟ lives and must be included in the care as per the client‟ preference. Also, health-seeking behaviours of Ghanaian clients include religious coping, thus belief system of the clients should be respected and considered in the management of both vaginal and caesarean delivery.

5. The Teaching Hospital in Cape Coast Metropolis must have an existing protocol on pain assessment and management. This protocol must cover all forms of deliveries and surgeries, especially surgeries that double as a means of birth and be updated as per new study findings on pain assessment and interventions. Pain interventions should be directed towards an individual's perception of pain as recommended by standards. Health care workers must be encouraged to acknowledge the individuality of pain experience and intervene as such. Effective pain management influences coping during the post-operative and mothers must be assisted in such vulnerable moments.

Suggestions for Further Research

1. There should be further studies on pain assessment after both caesarean and natural delivery. Such studies should adopt a mixed method approach to include both quantitative and qualitative methods to get in-depth experience as well as allow for generalization of the findings to help inform practice.
2. Although this study verified the positive roles of physiologic delivery in the mother-infant attachment, no knowledge is available about these

mechanisms and more research should be done accordingly. The evaluation of this subject could consider a research design for comparing the attachment of siblings, who were born by a vaginal delivery and a Caesarean-section delivery to their mothers. The present study had some limitations such as including small sample size, which is related to the cross-sectional study, not measuring hormones levels, and altering the attachment behavior at the presence of the observer.

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APPENDICES

APPENDIX A

INTERVIEW GUIDE

UNIVERSITY OF CAPE COAST: PERSPECTIVES OF MOTHERS WITH BOTH EXPERIENCE OF CAESAREAN SECTION AND NATURAL BIRTH AND THEIR RELATIONSHIP WITH THEIR CHILDREN IN GHANA.

In-depth interview guide for mothers who have both the experience of caesarean section and that of natural birth between one (1) month to five (5) years at the Cape Coast Teaching Hospital in the Central Region of Ghana.

Introduction

As I have mentioned, I am conducting a research study on *PERSPECTIVES OF MOTHERS WITH BOTH EXPERIENCE OF CAESAREAN SECTION AND NATURAL BIRTH AND THEIR RELATIONSHIP WITH THEIR CHILDREN IN GHANA*. The information that you provide will help inform future reproductive health care services and programs. I would like to ask you some questions to find out what your thoughts and experiences are with regards to experience of caesarean section and natural birth and your relationship with your child or children. Please note that there are no right or wrong answers, I am interested in your thoughts and opinions on the subject matter.

We can discontinue the interview at any time should you so require.

1. Could you tell me a little about you?
2. How many caesarean and natural births have you had?
3. Was your last birth caesarean section or natural birth?
4. In the absence of medical necessity, what is your preferred mode of birth (vaginal, or caesarean)?
5. In the future, do you plan on delivering through the same methods that you plan on delivering your first child?
6. Could you describe the kinds of relationship you have with both your caesarean and natural birth children?
7. What perception do you have about both caesarean section and natural birth regarding to pain?
8. What psychological distresses did you go through before, during and after having both the experience of caesarean section and natural birth?
9. How do you perceive both caesarean section and natural birth children?
10. What social support systems were available for you with both the experience of caesarean section and natural birth before during and after the procedure?
11. Do you have any other comments, suggestions or questions that you would like to tell or ask me?
12. What is your overall perspectives of caesarean section and natural birth and your relationship with your child or children?

We have come to the end of the interview. I would like to thank you for your time and participation.

UNSTRUCTURED INTERVIEW GUIDE

PERSPECTIVES OF MOTHERS WITH THE EXPERIENCE OF BOTH CAESAREAN SECTION AND THAT OF NATURAL BIRTH AND THEIR RELATIONSHIP WITH THE IR CHILDREN.

SECTION I – SOCIO-DEMOGRAPHICS

a. **Age**
b. Level of education
c. Marital status
d. Religion
e. Occupation

SECTION II – MAJOR QUESTIONS

1. EXPERIENCES

Probes

a. Positive relationship with others
b. Mastery of care of child
c. Unpleasant and Pleasant affect
d. Satisfaction with self and hospital process

2. Emotional experiences

I. Stress in handling situation

Probes

a. Demanding more than you can handle
b. restlessness
c. agitations
d. sleep

e. Others

II. Anxiety and or Fear

Probes

a. Baby's survival

b. Personal survival

c. Ability to care for child post admission

d. Ability to bond with child

e. Societal expectations

III. Depression

Probes

a. Sadness in relation to event

b. Self-blame and Self-loathing

c. Sleep and appetite

3. Psychosocial support

I. Type of social support available and how they support

Probes

a. Family

b. Health worker

c. Work

d. Friends

e. Church

II. Type of psychological support available

Probe

a. Referral to a professional pre-admission

b. Referral during admission

c. Emotional needs being tackled by staff

4. Impact of support on emotional experience

Probe

a. Reduction or increase on emotional experience

b. Type of support/lack of and emotional experience

c. Is there anything else you would like to tell me?

5. Impact of psychosocial support on relationship with child. Probe

How psychosocial support impact:

a. Positive relationship with others

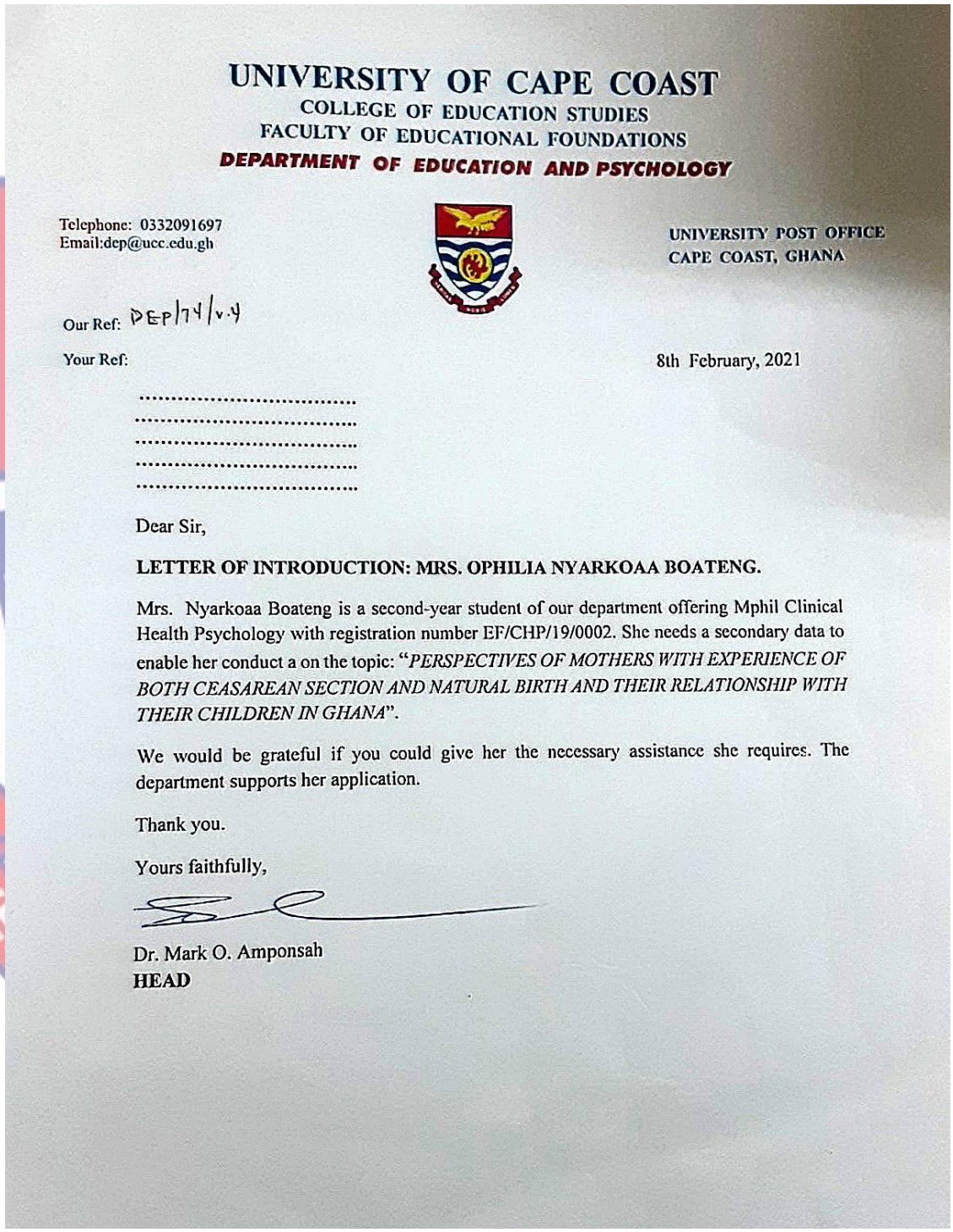
b. Mastery of care of child

c. Unpleasant and Pleasant affect

d. Satisfaction with self and events.

APPENDIX B

INTRODUCTORY LETTER



UNIVERSITY OF CAPE COAST
COLLEGE OF EDUCATION STUDIES
FACULTY OF EDUCATIONAL FOUNDATIONS
DEPARTMENT OF EDUCATION AND PSYCHOLOGY

Telephone: 0332091697
Email:dep@ucc.edu.gh

UNIVERSITY POST OFFICE
CAPE COAST, GHANA

Our Ref: DEP/74/V.4

Your Ref:

8th February, 2021

.....
.....
.....
.....
.....

Dear Sir,

LETTER OF INTRODUCTION: MRS. OPHILIA NYARKOAA BOATENG.

Mrs. Nyarkoaa Boateng is a second-year student of our department offering Mphil Clinical Health Psychology with registration number EF/CHP/19/0002. She needs a secondary data to enable her conduct a on the topic: "*PERSPECTIVES OF MOTHERS WITH EXPERIENCE OF BOTH CEASAREAN SECTION AND NATURAL BIRTH AND THEIR RELATIONSHIP WITH THEIR CHILDREN IN GHANA*".

We would be grateful if you could give her the necessary assistance she requires. The department supports her application.

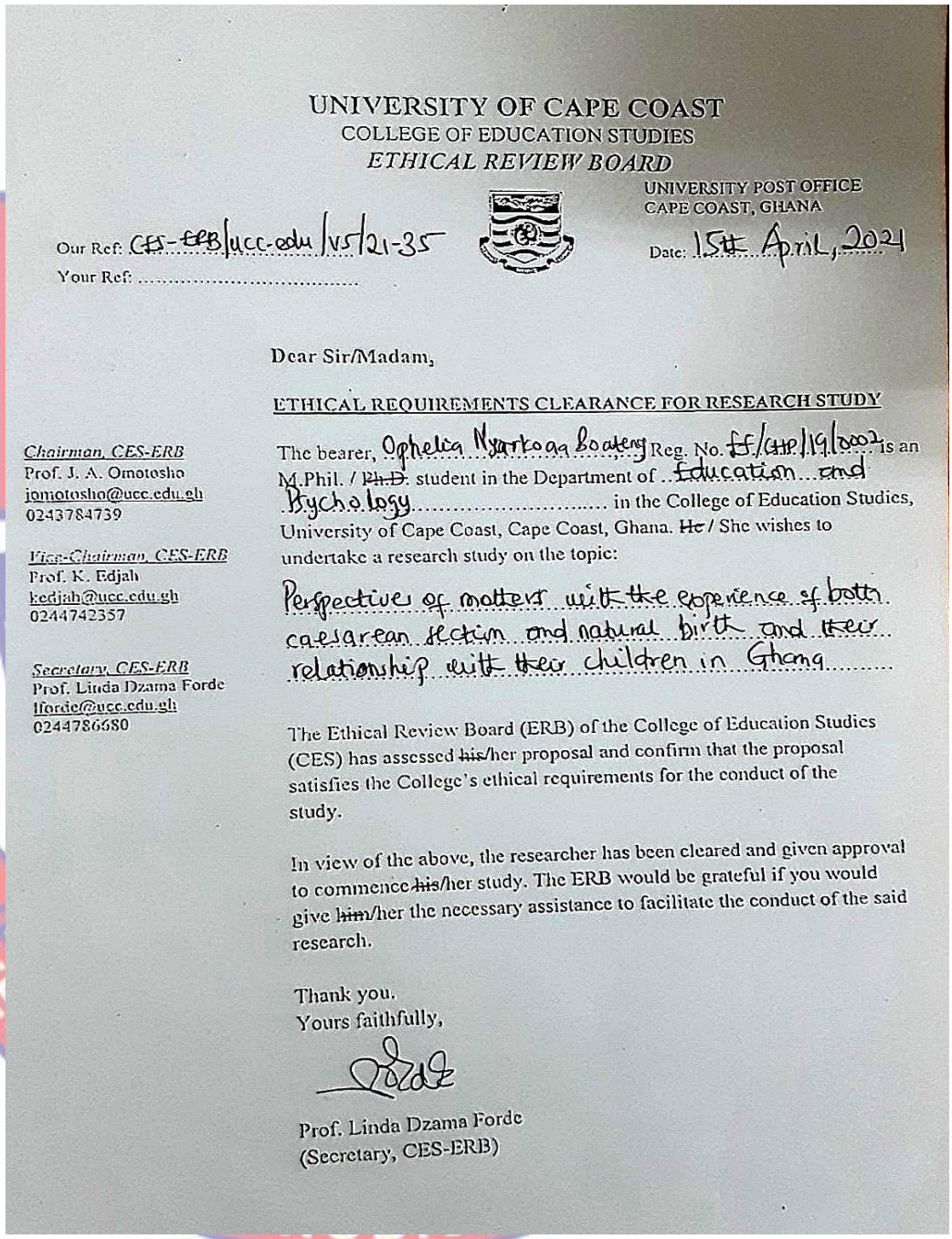
Thank you.

Yours faithfully,

Dr. Mark O. Amponsah
HEAD

APPENDIX C

ETHICAL CLEARANCE UCC ERB



UNIVERSITY OF CAPE COAST
COLLEGE OF EDUCATION STUDIES
ETHICAL REVIEW BOARD

UNIVERSITY POST OFFICE
CAPE COAST, GHANA

Our Ref: CES-~~ERB~~/ucc-edu/vs/21-35
Your Ref: .....
Date: 15th April, 2024

Dear Sir/Madam,

ETHICAL REQUIREMENTS CLEARANCE FOR RESEARCH STUDY

Chairman, CES-ERB
Prof. J. A. Omotosho
jomotosho@ucc.edu.gh
0243784739

Vice-Chairman, CES-ERB
Prof. K. Edjah
kedjah@ucc.edu.gh
0244742357

Secretary, CES-ERB
Prof. Linda Dzama Forde
lforde@ucc.edu.gh
0244786680

The bearer, Ophelia Nyarkoaa Boateng Reg. No. ~~ES~~/CHE/19/0002 is an M.Phil. / ~~Ph.D.~~ student in the Department of Education and Psychology in the College of Education Studies, University of Cape Coast, Cape Coast, Ghana. ~~He~~ / She wishes to undertake a research study on the topic:

Perspectives of mothers with the experience of both caesarean section and natural birth and their relationship with their children in Ghana

The Ethical Review Board (ERB) of the College of Education Studies (CES) has assessed ~~his~~/her proposal and confirm that the proposal satisfies the College's ethical requirements for the conduct of the study.

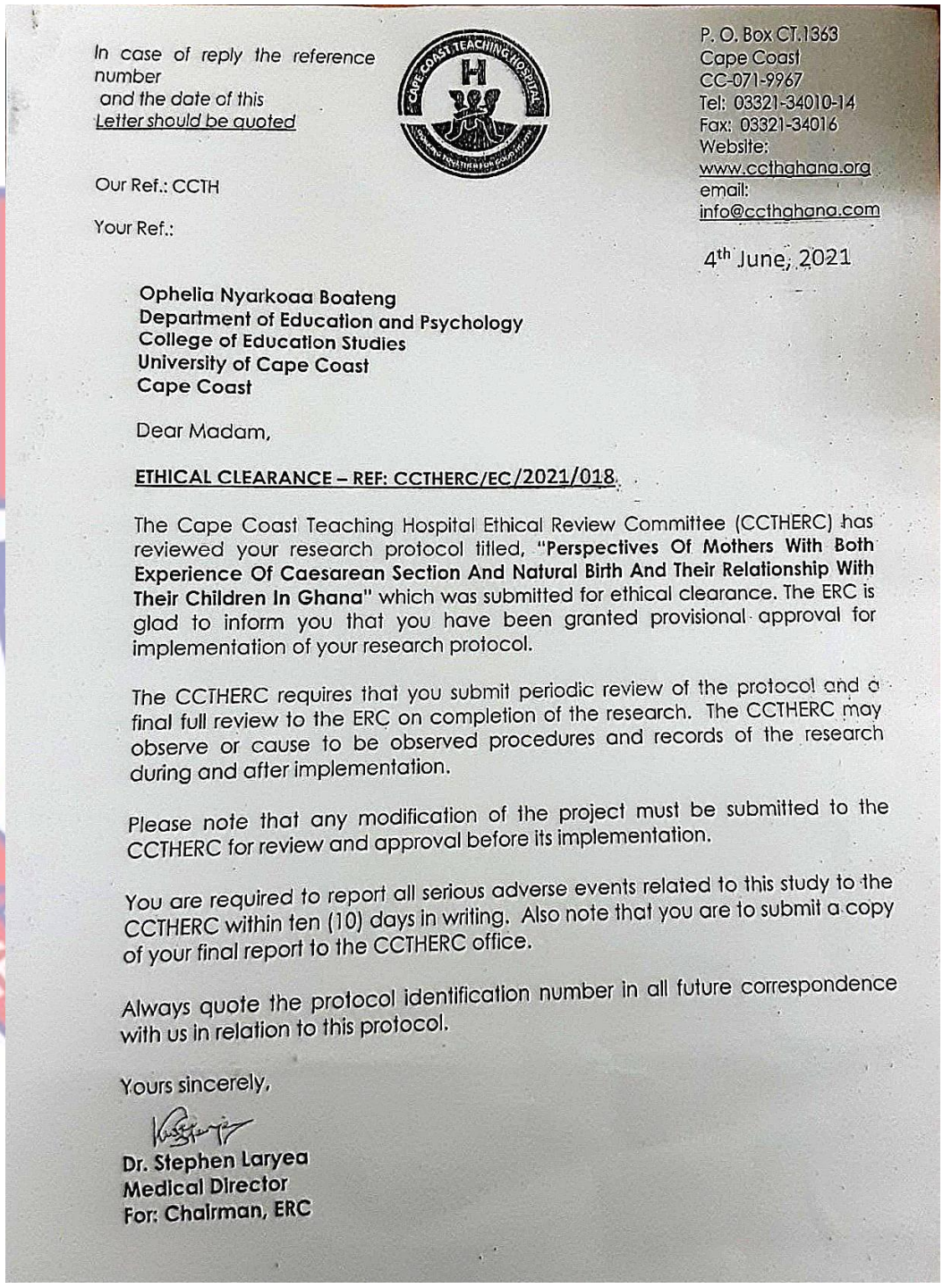
In view of the above, the researcher has been cleared and given approval to commence ~~his~~/her study. The ERB would be grateful if you would give ~~him~~/her the necessary assistance to facilitate the conduct of the said research.

Thank you.
Yours faithfully,

Prof. Linda Dzama Forde
(Secretary, CES-ERB)

APPENDIX D

ETHICAL CLEARANCE CCTH



In case of reply the reference number and the date of this Letter should be quoted

P. O. Box CT.1363
Cape Coast
CC-071-9967
Tel: 03321-34010-14
Fax: 03321-34016
Website:
www.ccthghana.org
email:
info@ccthghana.com

Our Ref.: CCTH

Your Ref.:

4th June, 2021

Ophelia Nyarkoaa Boateng
Department of Education and Psychology
College of Education Studies
University of Cape Coast
Cape Coast

Dear Madam,

ETHICAL CLEARANCE – REF: CCTHERC/EC/2021/018.

The Cape Coast Teaching Hospital Ethical Review Committee (CCTHERC) has reviewed your research protocol titled, **"Perspectives Of Mothers With Both Experience Of Caesarean Section And Natural Birth And Their Relationship With Their Children In Ghana"** which was submitted for ethical clearance. The ERC is glad to inform you that you have been granted provisional approval for implementation of your research protocol.

The CCTHERC requires that you submit periodic review of the protocol and a final full review to the ERC on completion of the research. The CCTHERC may observe or cause to be observed procedures and records of the research during and after implementation.

Please note that any modification of the project must be submitted to the CCTHERC for review and approval before its implementation.

You are required to report all serious adverse events related to this study to the CCTHERC within ten (10) days in writing. Also note that you are to submit a copy of your final report to the CCTHERC office.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol.

Yours sincerely,

Dr. Stephen Laryea
Medical Director
For: Chairman, ERC

APPENDIX E

INFORMED CONSENT FOR RESEARCH

Title: Perspectives of mothers with both experience of caesarean section and natural birth and their relationship with their children in Ghana at the Cape Coast Teaching Hospital

Principal Investigator: Ophelia Nyarkoaa Boateng

Department of Education and Psychology University of Cape Coast onyarkoaa@gmail.com, 0208297570

PURPOSE OF STUDY

The purpose of this study is to explore the perspective of mothers with both experience of caesarean section birth and natural birth and their relationship with their children.

Possible Benefits

There may be no direct physical benefit for your participation. However, Results of the study will provide in-depth information on the subjective experiences of individuals living with both experience of caesarean section birth and natural birth and their relationship with their children and to draw attention to the potential psychosocial correlates of having both caesarean deliveries and natural deliveries.

Findings of the study will also provide relevant information to practitioners to inform hospital protocols concerning what mothers go through before, during and after experiencing both caesarean section birth and natural birth and how it could be Manage. Furthermore, findings of the study will help to expand the knowledge-base of the discipline of psychology.

Confidentiality

- Your responses to this survey will be anonymous. Every information about you will be protected and you will not be named in any reports or journal or magazine. Effort will be made by the researcher to preserve anonymity including:
- assigning pseudo names for participants to be used on all research notes and documents
- Keeping notes, interview transcriptions, and any other identifying material in the personal possession of the researcher.

Data will be safeguarded and kept confidential except in certain circumstances where the researcher is legally obligated to report specific incidents. These incidents include, but may not be limited to, incidents of abuse and suicide risk.

Contacts for Additional Information

If you have questions at any point in time about this research, you may contact the researcher whose contact information is provided on the first page. If you have questions regarding your rights as a research participant, or if problems arise which you do not think you can discuss with the Primary Investigator, please contact the following people for further information about the research. Dr. Kofi Krafona 0541078770.

Voluntary Participation

Your participation in this study is voluntary. If you decide to take part in this study, you will be asked to sign a consent form. After the consent form has been signed, you have the right to withdraw at any point in time and without

giving a reason. Withdrawal from participating will not affect the relationship with the researcher, if any. Your data will be returned to you or destroyed if consent is withdrawn before data collection and processing is completed.

Consent

I have read and understand the provided information and have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost. I also understand that every information given will be held in strict confidence. I understand that I will be given a copy of this consent form. I voluntarily agree to take part in this study.

Participant"s signature _____ Date _____

Investigator's signature _____ Date _____

APPENDIX F

SAMPLE OF TRANSCRIBED INTERVIEW

Participant 6 (C.S. 4years 8months, N.B. 2 years)

Age: 30years

Level of education: Tertiary

Marital status: Married

Religious affiliation: Christian

Occupation: Accountant

Number of Caesarean births: 2

Number of Natural births: 2

Knowledge on Caesarean Section

Interviewer: please can you tell me what you knew about caesarean delivery?

Participant: I knew that when the normal delivery becomes very difficult that is when the Doctors will take you through the caesarean section. by yourself, I had 2 children through the normal means so I never thought I would have operation but when it got to the extent that my life was at stake, I had no choice go through the caesarean section twice.

Knowledge on Natural birth

Interviewer: please can you tell me what you knew about natural birth?

Participant: As for natural birth I knew it is something made for all women. It is a way the vagina opens by itself for the baby to come out on their own with a little push by the woman.

Experience

Interviewer: can you tell me about your experience with both the Caesarean Section and natural birth? What made them suggest that as a means of delivery?

Participant: I did not know I will have one. When I was due for delivery, I had a delayed in my second stage of labour, so I was rushed to the theatre for my safety to deliver my baby. But, the normal birth I felt the edge to push at a faster pace and I did.

Interviewer: when you were given the news, what went through your mind? How did you feel and behave?

Participant: I was very worried because I had no intention of going through caesarean section, but I later made up my mind for the safety of my child and myself. Whilst the normal delivery I was determined to push my baby out.

Interviewer: were you taken to see a psychologist since you were afraid and worried?

Participant: never not even after the operation.

Interviewer: let‟s talk about the pain experiences. Were you in pain before the operation?

Participant: very much

Interviewer: what about after the CS?

Participant: immediately after it, there was no pain but some hours later I was in very severe pain. Madam, ‟emidze yaw no na onye easy oo’’. I was only able to walk after the 3rd day. I just couldn’t walk. Every part of my stomach ached so much and that made me more anxious. But they gave me drugs

through my veins 3x a day for the first 3 days. Then later they gave me suppository for pain. Sometimes I still felt pain even after using the pain suppository but I was told that it will go so I kept quiet and wept silently.

Interviewer: can you rate your pain experience from 1-10, one being the mildest, 10 being very severe?

Participant: I will say 10 for the caesarean and 5 for the natural birth.

Interviewer: apart from drugs, were you told or given other means of managing pain?

Participant: My sister with both the caesarean and natural nothing of that sort was done.

Interviewer: in your opinion, do you think the pain was managed well?

Participant: absolutely not. sometimes I had to force to sleep with the pain. Sometimes when I complained, they will say, "ah ehaw adwen" (you are disturbing) with the caesarean but with the natural birth, the pain was less.

Interviewer: can you rate the pain management on a scale of 1-10, where one means not well and 10 means very well?

Participant: with the caesarean 7/10, and 3/10 for the natural birth.

Interviewer: after both Caesarean Section and natural birth, did you go through stress?

Participant: yes, a lot. (Her expression was changed). I was readmitted again because the pain was unbearable, unlike the natural birth I was not admitted. I also had to always struggle and go for wound dressing every 3 days till after 21 days when it healed but with the natural, I only sat on hot water and after few weeks I was good to go.

Interviewer: were you able to perform activities of daily living after both the caesarean and natural birth?

Participant: no**.** my relatives assisted me with the caesarean but the natural I was able to do things on my own after few weeks.

Interviewer: what about your relationship with the children?

Participant: my caesarean child is more prone to infections which make me get closer more than the natural when it comes to their health matters. On the other hand the natural birth is more capable in so many things than the other so I always do my best to satisfy them both**.**

Interviewer: what about breastfeeding? Was it normal?

Participant: it didn‟t flow for the 3 days that I couldn‟t work, and I was told that the baby was always crying. So they had to buy Nan 1 for her on the part of caesarean child but the natural one the breast milk was flowing few hours after I put the breast in the baby‟s mouth.

Interviewer: have you heard of postnatal depression?

Participant: yes

Interviewer: Were you sad?

Participant: I was very sad. I couldn‟t see my child on the caesarean side but the natural my baby was put on my belly immediately she came out of my belly

I wasn‟t prepared for Caesarean Section and I was also asking myself why me? Because I was the only one in my family to have a Caesarean Section. But with the normal delivery, I was not sad at all it was all joy to see the face of my baby.

Interviewer: were you referred to a psychologist?

Participant: no, the nurse said sometimes it is normal to be sad after birth with caesarean section but with natural birth after taking pain killer the pain subsides.

Interviewer: how long did it last?

Participant: I will say for almost a month for the caesarean section for the natural birth it was two weeks.

Interviewer: how do your friends and family relate to you after both Caesarean Section and natural birth?

Participant: my family members encourage me to be strong, I will be fine. But my neighbours looked at me strangely. They asked me why I had to do a Caesarean Section when I could have insisted and pushed**,** unlike the natural birth where they were wishing me pleasantries

Interviewer: were you disappointed that you went through Caesarean Section and natural birth?

Participant: yes, I was fed up with the caesarean section and just tired. Now I am ok but I wish I had been told how to avoid Caesarean Section. Talking of natural birth, I will never be fed up with that.

Interviewer: do you think someone is responsible for you having both Caesarean Section and natural birth?

Participant: yes. though I don"t have anybody in mind but how could I have surgery after giving birth twice naturally.

Interviewer: have you accepted what you went through before during and after both caesarean and natural birth?

Participant: yes. I think so. But I think I have lost the desire to have sex. I keep on reminding myself that it will take time but I don‟t really know.

Interviewer: what about vaginal bleeding? Six weeks after birth of both caesarean section and natural birth?

Participant: I have seen that it takes longer as compared to vaginal birth.

Interviewer: how many days did it take for the wound to get healed in both caesarean section and natural birth?

Participant: it took 21 days for it to heal with the caesarean section and two 14 days with the natural birth.

Interviewer: can you tell me about the people who supported you at home?

Participant: my husband, my sister and my mother moved to stay with me, my nieces visit often to help me out. I didn‟t do anything stressful. I didn‟t even ask for help before they offer it. Friends also visit and even bring gifts it was the same as the natural birth when it was my first time of giving birth with the natural one.

Interviewer: do you think their support had influence on your recovery?

Participant: laughs, yes. I couldn‟t have survived without them especially the caesarean delivery.

Interviewer: when you were at the hospital, how was information given? Did you always have to ask or was it given you without you asking?

Participant: I always asked. When my breastmilk was not flowing, when in pain, when I could be discharged. They don‟t give any information if I don‟t ask.

Interviewer: were you at any point made to feel like you matter or you are important while on admission?

Participant: sometimes, not all the time. Right after the operation they paid much attention, afterwards it reduced. When the breastmilk was not flowing, and I kept asking them what to do, some were rude. One of them kept telling me "Ebaadze ehaw adwen dodo." (what is it you like disturbing). And she gave me an injection that wasn"t mine so that I will stop bothering her on both deliveries.

Interviewer: what coping strategies did you employ during those periods?

Participant: hmmm I prayed, and depended on my husband for support. My husband was my support.

Interviewer: six weeks after Caesarean Section and natural birth, did you feel same as you felt before and some days after it?

Participant: no, it got much better after six weeks.

Interviewer: what does Caesarean Section and natural birth mean to you?

Participant: it is not a normal way of delivery, especially if you have given birth normally before. And if you are not careful, you can lose your mind in the process. Hmmm it is not easy. Natural birth is a normal process that brings joy in the end.

Interviewer: is there anything you would like to talk about that I haven"t asked?

Participant: health staff especially nurses should be nicer to people who have Caesarean Section. It is not easy. The doctors try a lot during the process of labour. I appreciate them.

Interviewer: Will you recommend Caesarean Section and natural birth to another person?

Participant: I will always recommend natural birth, but with caesarean section I will say capital NO.

Interviewer: thank you so much for your time and attention as well as participation, we will end here. God richly bless you.