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DIPLOMA PROGRAMMES

'THE KNOWLEDGE AND EXPERIENCES OF WOMEN WHO HAVE UNDERGONE CAESARIAN SECTION IN HOLY FAMILY HOSPITAL, BEREKUM IN THE BONO REGION OF GHANA'.

SUBMITTED BY:

AMISSAH ANN	**-**	**5171421**
KONAMAH JOSEPHINE	**-**	**5339021**
OSEI BONSU JOYCELYN	**-**	**5429421**

HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

AFFILIATED TO KNUST, KUMASI

AUGUST, 2022

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ABSTRACT

DECLARATION

This is to declare that, except for references and few quotations to the literature sources which have been acknowledged, this work was done originally by the under listed candidates of the Holy Family Nursing and Midwifery Training College, Berekum in partial fulfillment of the requirement for a Diploma Certificate in Registered Midwifery. It has neither been partly nor wholly presented elsewhere for another certificate.

AMISSAH ANN	....	03/03/2023
5171421	Signature	Date
KONAMAH JOSEPHINE	....	03/03/2023
5339021	Signature	Date
OSEI BONSU JOYCELYN	....	03/03/2023
5429421	Signature	Date

Certified by:

MARTHA KYEREMAA	....	....
(Supervisor)	Signature	Date
MONICA NKRUMAH	....	....
(Principal)	Signature	Date

Objectives: Childbirth remains a uniquely multifaceted, mental-cognitive and a major life experience to women. It is composed of a variety of psycho social and emotional aspects and creates memories, sometimes bad experiences and unmet expectations which leaves the mother with lasting scars. Therefore, this study aimed at exploring the knowledge and experiences of women who have undergone caesarian section in Holy Family Hospital, Berekum in the Bono Region of Ghana.

Methods: The study was a Cross sectional survey using quantitative methods. Questionnaires were distributed to the participants selected for the study. The respondents were obtained by convenient sampling which is a non – probability sampling technique. Subjects were selected because they were the easiest to recruit for the study. A structured questionnaire designed to assess the knowledge and experiences of women who have undergone caesarian section in Holy Family Hospital, Berekum in the Bono Region of Ghana. The questionnaire was administered to 60 women who seek medical care at Holy Family Hospital, Berekum in the Bono Region of Ghana by the researcher to after obtaining their consent.

Results: The findings of this study revealed that some participants were happy and satisfied with the quality of care and support given to them and without exception, these women recounted being grateful to the care givers for their survival and attributed it to the care that they have received. More than half of the respondents affirmed that they were warmly received at the labour whiles few of the respondents said they were neglected upon arriving at the labour. Also, the study showed that some participants were happy and satisfied with the quality of care and support given to them while some women were not motivated by some of the procedures and processes as they did not find what they were expecting from their healthcare providers.

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We are forever grateful.

God bless you all.

CHAPTER ONE

INTRODUCTION

1.0 BACKGROUND OF THE STUDY

Caesarean section (CS) is the most common surgical procedure performed worldwide (Ghotbi et al., 2015) and has contributed significantly to the reduction of maternal morbidity and mortality (Prah et al, 2017). It is essential to note that caesarean section is known to be related with increased risk of maternal and neonatal morbidity as well as high cost of healthcare than vaginal delivery (Koledoye et al, 2016). The term "caesarean" was derived from a decree in Roman law, which made it mandatory for children to be cut out of women who had died during childbirth. In fact, the term used at the time was 'Lex Caesarae' (Hall et al, 2015). A caesarean section denotes the use of surgery to deliver one or more babies from a mother's womb (Hinkle et al, 2016). This type of surgery has been in existence throughout medical history and has steadily progressed from being one that is totally fatal to one that is safe for both the mother and the foetus (Hall et al, 2015). Contrary to caesarean section, spontaneous vaginal delivery (SVD) is the most commonly accepted and widely used method for child delivery worldwide. It is the process through which childbirth naturally occurs through the birth canal (Hall et al, 2015).

The rate of CS in developed countries is rising as there has been a higher rate of acceptability over time while developing countries are struggling with the problems of non-acceptance of CS even in the face of eminent danger on pregnancy (Amiegheme et al, 2016). The rate of CS in developed countries is above the World Health Organization's (WHO) estimated target of 15% mark in many of the countries (WHO Human Reproduction Programme, 2015). High rates of caesarean sections (CS) are being recorded (WHO, Geneva, 2018), and globally the

rates increased from 6.7 % in 1990 to 19.1 % in 2014 with less developed countries having the largest increase from 6.3 % to 20.9 % (Betran el at, 2018).

Though the figure has increased, it is still below the WHO target of 15% of all deliveries. Although women's preferred mode of delivery vary widely between different countries (Kuan, 2015), a plethora of cross-sectional studies from Sub-Saharan Africa have revealed that the majority of women prefer vaginal birth over CS (Enabudoso et al, 2016) even though there might be pregnancy dangers. Some studies conducted in Ghana showed that an overwhelming majority of women had a preference for vaginal delivery over CS (Prah et al., 2017). In Ghana, an average of 12.8 % of deliveries is by CS (GSS, 2015). The increasing rates are being driven by medical and non-medical factors (Elnakib et al, 2019). Caesarean section is usually performed when vaginal birth is deemed hazardous either to the foetus or the mother (Ashimi et al, 2016). Major clinical indications for this include foetal distress, failure to progress in labour, previous caesarean sections, breech presentation, among others (WHO, Geneva, 2018).

The WHO in 2015 estimated that 298,000 women were dying from pregnancy and birth related causes globally (WHO, UNICEF, UNFPA, 2015). Most of these deaths occurred in developing countries and Sub-Saharan Africa alone accounted for 62% (179 000) of the global deaths due to various challenges impeding the delivery of quality healthcare services. Caesarean section is still being viewed as an abnormal means of delivery by some women in developing countries (Qazi et al, 2013). Although knowledge of women towards CS is changing, there is still a wide knowledge gap between the developed countries and the developing countries (Amiegheme et al., 2016).There is a broadly held belief and view that women in the West African sub-region have an aversion for caesarean section delivery (Adageba et al., 2018). Some sociocultural factors hinder the acceptance of CS. According to Chiamaka and Adetomi (2017), it is traditionally believed that achieving a vaginal delivery

portrays the woman's power and ability but a pregnant woman who delivers through CS is seen as being lazy. Women refuse CS for fear of being abandoned by their husbands and in-laws (Chiamaka & Adetomi, 2017) and are accused of being unfaithful (Mboho, 2015). This phenomenon leads to low acceptability of the procedure among African women, even in the face of obvious clinical justification. Many women perceive the process of not giving birth vaginally as a sign of 'failure'. A lot of them perceive vaginal birth as a right route of passage hence most of them crave for it (Robinson et al, 2017).

Panda and colleagues (Panda et al, 2018) in a systematic review of 34 studies identified from the clinician's point of view that the clinician's personal beliefs, health care systems and clinician's characteristics which includes confidence, skills and convenience influence their decisions to recommend a CS. Some women still react with fear and shock when informed about the need for CS and this can affect their decision-making (Litorp et al, 2015). Findings from studies in Nigeria and Ghana indicate that some traditional women are unwilling to have CS because of the general belief that abdominal delivery is reproductive failure on their part, and for fear of mockery (Lawani et al, 2019). Lawani and colleagues (2019) found in Nigeria that 5.5 % (24/344) of study participants at the antenatal clinic had declined CS due to perceptions of being seen by peers as reproductive failure. It is important that women receiving maternity care who need an elective CS are made aware of the benefits and risks so they can provide informed consent (Ashimi et al, 2016). The decision-making process for the woman involves a multiplicity of factors which include knowledge of the CS process, finances and family support Amiegheme et al, 2016). Osamor and Grady (Osamo et al, 2016) in an integrative literature review of studies in Africa, South and Central Asia observed that women's decision-making regarding their healthcare seems not to be fully autonomous. Their low decision-making power is attributed to sociocultural and gender norms (UNFPA, 2019)

and this can result in delays in accessing health care, which contributes to high maternal mortalities (Combs et al, 2015).

1.2: PROBLEM STATEMENT

Positive birth experiences lead to better postnatal functional and influence mode of delivery choice for subsequent pregnancies. Healthcare workers can influence birth experience through relevant support and care. Caesarean section (CS) rates are on the rise and elective caesarean section is being performed more often than it was a few decades ago (WHO, 2018) with very high rates of over 40% in some developed countries and 7.3% in Africa (Betran, 2016). Some factors responsible for the rise include high socioeconomic status, availability of service; psychological factors, perceptions of safety, socio-cultural influences, women's experience with previous Vaginal birth and advanced maternal age (Black et al, 2015). In Ghana, an average of 12.8% of deliveries is by caesarian section.

Caesarean section is now a common surgical operation around the world with many being aware of the existence of this medical procedure (Webb et al, 2016). The recent rates of delivery by caesarean section continue to rise worldwide, with reported rates of 12.5% in Western Europe, 32% in North America, and 41% in South America (Betran et al, 2016). Delivery by caesarian can minimize maternal and perinatal mortality and morbidity when there are maternal or fetal complications (Gibbons et al, 2017).

The knowledge of women about birth especially by caesarean section is important for most healthcare providers around the world (Hinkle et al, 2016). Considering the knowledge and experiences towards caesarean section, most pregnant women and their relations view their individual knowledge and experiences towards caesarean section delivery as one that is important in the decision-making process. Also, the experience women have at childbirth and their perceptions of that event can affect their feelings of satisfaction, strength, esteem and

the value they place on their achievement. For instance, there are many reported cases of women who have considered themselves to be sexually disadvantaged after a vaginal delivery, whiles others who have undergone a caesarean section consider as a disadvantage the distortion in their body image as a result of the surgical incision made (Zhao et al, 2016). With respect to developing countries (such as Ghana), the knowledge and experiences 24.5% in Western Europe, 32% in North America, and 41% in South America (Betran et al, 2016). Delivery by caesarean section can minimize maternal and perinatal mortality and morbidity when there are maternal or fetal complications (Gibbons et al, 2017).

With respect to developing countries (such as Ghana), the knowledge and experiences towards caesarean section delivery is still a major cause for concern (Eifedeyi et al, 2015). Although there are many who consider caesarean section to be either safe or unsafe, more costly than the normal vaginal delivery and more prone to complications than the SVD, there are some African women who perceive caesarean section to be a sign of female infidelity, a "curse," or a "failure of womanhood" (Clift et al, 2020). In fact, according to Clift-Mathews (2020), in developing countries, the negative experience of caesarean section has led to the underutilization of the procedure.

Interestingly, pregnant women's perception of caesarean section has been an essential consideration for providers of healthcare. One of the major reasons is because a positive perception can lead to an effective adaptation to the maternal role whiles a negative perception can leave women with a sense of failure, loss of control, personal disappointment and a cause to distrust their personal abilities as childbearing women, hence the need to promote positive perceptions in caesarean section related issues (Mboho et al, 2015). There are arguments in favour of the use of caesarean section birth to alleviate the pain and complications that arise during normal vaginal births (Gabbe et al, 2016). Some studies have also been conducted in an effort to further investigate various related issues about caesarean

section delivery. Prior studies have looked at the issue in developed jurisdictions (Clift et al, 2020), as well as developing countries (Ashimi et al, 2016). Few studies exist on the knowledge and experiences of pregnant women on caesarean section in Ghana (Afaya et al, 2017). This present study contributes to the literature by investigating pregnant +women's knowledge, and experiences towards caesarean section in Ghana. Specifically, the study first ascertains women's knowledge of caesarean section among obstetric unit attendants in Holy Family Hospital. Secondly, we investigate the experiences of women who undergone caesarian section at Holy Family Hospital, Berekum.

1.3 GENERAL OBJECTIVES

The main objective of the study is to assess the knowledge and experiences of women who have undergone caesarian section in Holy Family Hospital, Berekum in the Bono Region of Ghana.

1.4 SPECIFIC OBJECTIVES OF THE STUDY

The specific objectives of the study are to assess;

1. To determine puerperal women’s knowledge on caesarian section at Holy Family Hospital, Berekum.
2. To identify psychological situation prior to caesarian section
3. To ascertain the experiences of postnatal women who undergone caesarian section at Holy Family Hospital, Berekum.

1.5 OPERATIONAL DEFINITION OF TERMS

Caesarean-section delivery: Is a major surgical procedure by which a baby is delivered through a surgical incision in the abdominal wall and uterus. It may be done under general epidural or spinal anaesthesia (Dippenaar et al, 2016). In this study, a ‘caesarean-section

delivery' refers to the surgical operation by which babies were delivered to the mothers who will participate in this study.

Experiences: Refer to the events or facts that a person has encountered and observed that leave a lasting impression (Soanes et al 2018).

Mothers: Are female parents (Soanes et al 2016). For the purpose of this study, the term 'mother' refers to a woman who has given birth to a live baby via a caesarean section delivery.

Midwife: Is a person who, having been regularly admitted to a midwifery educational programme, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualification to be registered or legally licensed to practice midwifery (Sellers 2017). In the context of this study, a midwife shall refer to the registered nurse working in the postnatal ward, nursery or clinic and providing care and support to delivered women and neonates in the nursery.

Obstetric: Anything pertaining to pregnancy, labour and delivery.

Survive: Nearly died but continues to live due to care given or by chance. Severe: Very intense or harsh.

Obstetric complication – Any new pathological changes that are experienced by an obstetric patient with a worsening severity and the manifestations of higher number of signs and symptoms which are related to her state of pregnancy (Fiskin et al., 2017).

Labour / Childbirth: Is a physiologic process during which the fetus, membranes umbilical cord and placenta are expelled from the uterus.

Morbidity: The condition of suffering from a disease or medical condition

Mortality: The state of being subject to death.

Gestation: The process or period of developing inside the womb between conception and birth.

Participants: A person who takes part in something.

CHAPTER TWO

LITERATURE REVIEW

2.0 INTRODUCTION

This chapter provides an overview of previous research knowledge sharing and intranets. It introduces the framework for the study. It helps the researchers familiarize themselves with existing research prior to collecting their own data (Easterby – Smith, Thorpe & Lowe, 2002)

2.1 DEFINITION AND HISTORICAL OVERVIEW OF C-SECTION DELIVERY

C-section delivery has been part of human culture since ancient times and there are tales in both western and non-western cultures of this procedure (Lurie, 2015). According to Greek mythology, Apollo removed Asclepius, founder of the famous cult of religious medicine from his mother's abdomen. Again, several references to C-section deliveries appear in early Egyptian, Chinese, Hindu, Roman and other European folk tales (Sewell, 2015). However, the first written evidence of C-section birth dates to the era of Hammurabi from 1795 to 1750 BC, reporting the birth of a male child who was pulled out of the womb of a deceased woman. The name section Caesarea first appeared in print and was used by a French obstetrician Guillimeau in 1598, during which the operation was used to deliver live babies from dead mothers (Pallasmaa, 2018). Following his publication on midwifery, Guillimeau introduced the term "section" which led to the name of caesarean operation being changed to C-section (Sewell, 2015). However, literature suggests that there are three different accounts about the source of the name of the operation.

The first explanation was provided in 715 BC when a Roman King, Numa Pompilius ordered that all women who were destined to die by childbirth must be cut open to remove the baby hence, caesarean operation (Sewell, 2015). The second explanation indicated that Julius Caesar was delivered by C-section and given the name Caesar. This is considered unlikely

because his mother is known to have been alive during Julius Caesar's adulthood and during his reign about 100 BC, where no woman is known to have survived the operation (Todman, 2017). The third account which is the more plausible explanation to the origin of the name C-section is that, C-section is derived from two Latin words "caedere" and "seco" both meaning to cut (O'Sullivan, 2015). As both words mean to cut, most scholars believe that C-section which is a method of child delivery where birth is done through an incision on the abdomen is originated from Latin (Todman, 2017). Most of the earliest literature on C-section delivery is based on how to improve the operation, so in 460-377 BC, Hippocrates wrote about difficult labour and noted that the midwives were uneducated but worked based on experience.

In furtherance to this, few scholars wrote textbooks to educate the midwives on such difficult labour and how to go about them (O'Sullivan, 2015). However, there was no reference to C-section in any of these literature. Unfortunately, from the second to the sixteenth century, rational medicine gave way to superstition and the knowledge from these scholars were forgotten (Pallasmaa, 2018). However, after the sixteenth century, Vesalius published De Corporis Humani Fabrica in 1543, which gave a detailed description of the female anatomy and made the understanding of the female anatomy clearer. This formed the foundation of the operative obstetrics emerging in the 1700s and physicians became interested in obstetrics which led to reports of successful caesarean deliveries being performed in different countries across the globe (O'Sullivan, 2015). In Western society, the first reported case of C-section was performed in 1610 by Jeremias Trautmann of Wittenberg who operated on a woman who had difficult labour, the baby survived but the patient died few days after (O'Sullivan, 2015). The first known caesarean delivery in England, Britain and Italy, which the patients survived, were performed in 1793, 1815 and 1876 respectively (O'Sullivan, 2015). Later, key medical advancement in preventing maternal deaths due to C-section were introduced. Instances of

medical advancement were anaesthesia by Jackson and Morton in 1846, and antisepsis by Lister in 1867 (Todman, 2017).

Before the seventeenth century, C-section was done for the reasons of saving the baby after the death of the mother (Lurie, 2015). C-section at that time was sometimes performed for maternal reasons of obstructed and prolonged labour. By the early eighteenth century, C-section was done for reasons of placenta previa, eclampsia and difficult labour (Pallasmaa, 2018). From the late 20th century, the key reasons for performing C-section shifted to protracted labour, foetal distress, malpresentation of the foetus and placental abnormalities (Petersson et al, 2018). By the end of the 20th century, a new indication emerged which increased the rate of C-section globally. This indication is C-section without medical indication which led to controversies among gynaecologists and health policy makers with some accepting the policy and some not. Although there is evidence of higher maternal morbidity and even mortality related to C-section compared to vaginal delivery, many patients and gynaecologists consider it safe to be performed even without any medical indication (Josefsson et al, 2018). Since then, there has been growing C-section trends and levels globally with vast variations between and within countries (Betrán et al., 2016).

2.2 KNOWLEDGE OF WOMEN ABOUT CAESARIAN SECTION

Caesarean section is a surgical procedure which involves incisions made through a mother's abdomen (laparotomy) and uterus (hysterectomy) to deliver one or more babies or to remove a dead foetus. Compared to the consequences of, for example, an obstructed labour, CS is safe for both the mother and baby and it is the most commonly performed obstetric operation. There are some risks such as accidental damage to the woman's bladder or bowel and an increase in the incidence of breathing difficulties in the baby. These should be explained to the woman as part of preparation for surgery. While the experience of some women as it concerns pregnancy and delivery is very pleasant others have hazardous experiences (Eni et

al, 2015). Most of the deaths of pregnant women occur in low resource settings and are largely preventable (Aklema et al, 2016). It has been postulated that increased access of women to CS may decrease maternal mortality rate by as much as 92% (Hamilton et al, 2018). Nevertheless, the World Health Organization have noticed that the CS rate in many countries have continued to be on the rise despite the advice to keep the rates low (Rosenberg et al, 2017). Factors influencing the rise include safer anesthesia and fear of litigation.

In developing countries, women and those who make decisions for them such as husbands, mothers in law and local authority figures are reluctant to accept CS because of the traditional beliefs and sociocultural norms. Some women even see delivery by CS as reproductive failure on their part (Jeremiah et al, 2016). As a result of these they engage untrained and unskilled providers, they only report to the hospital when life threatening complications set in (Ilesanmi et al, 2018). A literature search revealed a positive correlation between CS rate and level of education of women. However, there is an aversion for CS among women (Adageba et al, 2018). Overall, women prefer vaginal delivery to CS (Molina et al, 2015). In a study in Ghana on the awareness, perception and attitudes of women towards CS, it was observed that 93.3% of clients preferred vaginal delivery to CS. Nevertheless, majority of these women (98.1%) wanted CS to be part of antenatal care education (Adageba et al, 2018). The knowledge of society surrounding CS may have a significant role in the decision making process of pregnant women accepting to undergo the procedure. The lack of knowledge about CS by women in the developing countries has led to underutilization of the procedure compared to the large burden of obstetric morbidity requiring resolution by CS (Qazi et al., 2016).

When clinicians make a decision on the need for elective caesarean section for a client, this will have to be accepted by the woman in order to ensure good health outcomes for the woman and baby, cooperation between the healthcare team, the client and family. The

decision-making process for the woman involves a multiplicity of factors which include knowledge of the CS process, finances and readily available family for children. Women's knowledge on caesarean section plays a significant role in the decision making procedure and there is a gap in knowledge between those in developed and the developing countries (Konlan et al, 2019). Findings from studies in Nigeria and Ghana indicate that some traditional women are unwilling to have caesarian section because of the general belief that abdominal delivery is reproductive failure on their part and others fear of mokery (Amiegheme et al, 2016).

2.3: COMMUNITY-LEVEL FACTORS DRIVING C-SECTION DELIVERIES IN GHANA.

Studies linking a population's health status and the community or neighbourhood characteristics in which the individual resides are not new (Adamba, 2013). Evidence suggests that residing in a deprived community is related to higher rates of adverse effects on the health of the people. In this study, key selected variables which could influence mode of child delivery, specifically C-section deliveries according to literature, were reviewed. Apart from place of residence, community-level factors influencing C-section delivery have not been well documented. Nevertheless, there is literature to show that such studies have been done in the areas of infant mortality, maternal health and contraceptive usage (Adedini, 2013; Belachew et al., 2016; Ejembi et al., 2015; Yebyo et al., 2014). Therefore, variables such as community-level female education, community-level poverty, region of residence and place of residence used in these studies were explored in the current study to add knowledge to C-section literature (Ejembi, Dahiru, & Aliyu, 2015). A study conducted in Nigeria with the aim of assessing the role of contextual factors on the use of modern contraceptives among 13,835 women suggests that community-level female education is a positive predictor of positive attitudes towards contraceptive usage (Ejembi et al., 2015). In a similar study to determine

the effect of individual and community-level factors on women's decision to deliver at home, community-level female poverty is reported to be associated with poor health behaviour such as higher proportion of home delivery (Yebyo, Gebreselassie, & Kahsay, 2014).

2.3.1 REGION OF RESIDENCE

Studies have explored the effect of region of residence on C-section deliveries and argued that region of residence significantly influences the rates of C-section births (Long et al., 2015; Maharouei Najmeh, Moalaee Mansoureh, Ajdari Saeed, Zarei Maasoumeh, 2012; Mancuso et al 2008; Nazir, 2015; Shabila, 2017). The study by Mancuso et al., (2008) to assess differences in women's motivations and in obstetricians' attitude in Italy found that C-section rates in southern regions of Italy were higher than rates in the northern regions. To buttress these findings, Long et al (2015) in Mozambique, and Shabila (2017) in Iraq support the finding that C-section rates were more common in the southern regions than in the northern regions due to socio-economic differences between the south and the north of these two countries.

2.3.2 PLACE OF RESIDENCE

Studies on the association between place of residence and mode of child delivery showed that there is a correlation between the two variables. In a study by Ghosh (2010), place of residence is seen to significantly correlate with mode of child delivery. Corroborating this finding, Ilyas (2013) conducted a retrospective cohort study among Argentinean women and concluded that urban living is associated with higher rates of C-section delivery than rural living.

Lending credence to this finding, Xing et al (2015) conducted a cross-sectional study among Chinese women and established that urban dwellers are more likely to give birth by C-section than their counterparts in the rural areas. Also Begum et al (2018), conducted a qualitative

study in Matlab in Bangladesh among women attending antenatal visit and those with recent caesarean births, and concluded that women from rural community had a strong preference for normal vaginal birth. Long et al (2015), in their population-based cross-sectional study among Mozambican women to determine the changes in C-section rates between 1995 and 2011 using DHS data, provided evidence that suggests that indeed, rural dwellers are less likely to have Csection births than urban dwellers. 2.9.3 Community-level Poverty Community-level poverty is another variable which has not been well documented in C-section research. Researchers believe that regardless of a woman's wealth status, the poverty-level of the community in which the woman resides could also determine her health behaviour. The poorer the community the more likely it is for the people living in the community to have poor health-seeking behaviour and to make less informed health choices (Adamba, 2013). Although researchers have ignored the influence of community-level poverty on C-section delivery rates, studies have established the association between wealth index of an individual and C-section deliveries. These studies argued that wealthier women are more likely to have C-section than their poorer women. For instance, recent studies conducted in middle- and low-income countries indicate that women from richer backgrounds are more likely to give birth by C-section than their poorer counterparts from less-endowed backgrounds (Faremi et al., 2014; Farghali et al., 2014; R. Khan et al., 2012). From this debate, it is expected that the richer a community is, the more likely is it to have a higher incidence of C-section deliveries compared to the poorer communities.

2.3.4 COMMUNITY-LEVEL FEMALE EDUCATION

As earlier stated, the relationship between community-level female education and C-section deliveries has not well been interrogated. However, studies at the individual level indicate that female education has a mixed effect on the rates of C-section globally. Several studies indicate that female education is inversely related to C-section delivery. These studies argued

that women with higher education are less likely to have C-section (Chung et al., 2014; Farghali, Rashed, Fathi, Moustafa, & Rahman, 2014; Kamal, 2013; Kottwitz, 2014; Roth & Henley, 2012). Few studies conducted mainly among African and Asian women have thought otherwise, indicating that female education is positively correlated with C-section deliveries (Azami-aghdash et al., 2014; Ghodrati et al., 2016; Long et al., 2015). Contrary, to this discourse, Akintayo et al (2014) and Xing Lin Feng et al (2015) found that there is no association between female education and Csection deliveries. From the above argument, female education is likely to have the same mixed effect on C-section deliveries at the community level. That is, women living in communities with higher female education may have greater odds of giving birth by C-section (Azami-aghdash et al., 2014; Ghodrati et al., 2016; Long et al., 2015) and those living in communities with lower female education may be less likely to give birth by C-section (Chung et al., 2014; Kottwitz, 2014). Similarly, community-level female education may have no effect on C-section deliveries as seen in the studies done at the individual level (Akintayo et al., 2014; Ji, Jiang, Yang, Qian, Tang, et al., 2015).

2.4 THE EXPERIENCE OF WOMEN FOLLOWING CAESAREAN SECTION

Improvement in the quality of health care delivery is an essential priority worldwide, and the aim of improving health care quality is to guarantee patient safety, and improve clinical outcomes thereby reducing disease burden (Sihonen, 2015). Provision of quality of care and ensuring patients' satisfaction has been a challenge faced by many healthcare facilities across the globe (Gishu et al, 2019). Exploring the quality of midwifery care from the patients' perspective is an important part of quality of health care assessment (Gishu et al, 2019). Ghana as a country has made several steps in improving health care delivery especially maternal and child health care. In 2003, delivery care fees were abolished in the northern part of Ghana (northern, upper east and west regions) and the central region. This was further

extended to the remaining six regions in 2005. In July 2008, the free maternal health care policy was implemented under the National Health Insurance Scheme (NHIS). The free maternal health care policy covers antenatal care, delivery services, postnatal care and 3 months' neonatal care under the mothers' NHIS card (Wang et al, 2017).

Childbirth is a sentinel event in a woman's life which she either treasures or abhors with disdain. It is composed of a variety of psychosocial and emotional aspects and creates memories, sometimes bad experiences and unmet expectations which may leave the mother with memories for life (Najafi et al, 2017). These experiences may influence their desire and attitude towards future pregnancy and delivery. Childbirth comes with excitement, however, for some women, this excitement is dampened as a result of physical pain, especially for those women who have had a caesarean delivery (Jikijela et al, 2017). It becomes more important with caesarean delivery as it has been reported of its negative correlation with childbirth experience (Hergugar et al, 2015). Maternal experience of childbirth influences her choice of health care in subsequent pregnancies Dzomeku et al, 2016, and as an average family size in Ghana was estimated to be 5.1 Dzomeku, 2016, it becomes important that caesarean section experience is evaluated. Assessment of maternal childbirth experience also helps in auditing the care provided as this enquiry X-rays the "tripod" of childbirth satisfaction (Abri et al, 2018).

Women who have had one previous caesarean section (CS) represent a significant proportion of all women presenting for antenatal care in pregnancy (Ryan et al, 2018). For the majority of such women, the option of having either a vaginal birth after caesarean (VBAC) or a repeat elective caesarean section (ELSCS) is a focus of major discussion in a subsequent pregnancy. Many factors influence this decision, including the reason for the original CS, other obstetric variables, views of the attending obstetrician and, finally and most importantly, the views of the mother and her partner (Bonzon et al, 2017). This discussion

includes attention to the risks and benefits of VBAC versus repeat ELSCS (Dodd et al, 2015). Apart from these clinical issues, there are many geographical, institutional, epidemiological and legal factors that influence VBAC rates worldwide (Knight et al, 2016). What is clear, however, is that VBAC attempt rates1 and VBAC rates have been declining significantly in recent years in developed countries (Ryan et al, 2018). Midwives are responsible for providing care and support to women during pregnancy, labour, and delivery. The quality and manner of providing midwifery care during the delivery process contribute to a positive or negative childbirth experience (Dzomeku et al, 2016). The role and responsibilities of midwives at this critical stage of a woman's life may lead to diverse outcomes ranging from life to death and from health to physical injuries, with significant effects on the mental, and emotional health of the mother and child (Sehhati et al, 2015). In low and middle-income countries, maternity care may be compromised by mistreatment during childbirth, including abusive, neglectful, or disrespectful care. Several studies have indicated that women may refuse to seek maternity care when they have previously been disrespected and may discourage other women from seeking maternity care even if the provider (midwife) is skilled in managing complications before and after delivery (Njuki et al, 2019).

The birth experiences of women are diverse, and largely influenced by outcome of the delivery, experience of pain, control, support and care during the process, as well as pre-existing expectations (Larkin et al, 2019). Birth "an individual life event, incorporating interrelated subjective psychological and physiological processes, influenced by social, environmental, organizational and policy contexts". Previous research suggests that birth experiences influence mode of delivery choice for subsequent pregnancies (Waldenstrom et al, 2016), and that positive birth experiences lead to better postnatal functioning (Michels et al, 2015). Conversely, negative birth experiences are associated with postnatal depression and post-traumatic stress symptoms (Bell et al, 2016). A meta-analysis of studies on women's

experiences with CS, highlighted that experiences with planned and emergency CS were similar (Puia, 2015). Studies of birth experiences following CS are mainly based on high income settings. Larkin (2019) determined that a focus on birth experiences began following the decrease in maternal and neonatal mortality. In low-income settings, a study revealed that women delivering by CS felt shame and guilt, and experienced lack of information about the need for the procedure (Quattara et al, 2016). Relatively few studies have been conducted on birth experiences following CS in Sub-Saharan Africa. To fill this gap of knowledge, this study aims to explore the birth experiences of women utilizing CS in Holy Family Hospital, Berekum.

CHAPTER THREE

MATERIALS AND METHOD

3.0 INTRODUCTION

This chapter describes the research methodology. Areas covered include the study location/area, type of study, study population, sampling procedure including the study participant's selection criteria, data collection tools and finally data management and data analysis.

Additionally, ethical considerations pertaining to the study, pretesting of the study instruments, data collection tools and study limitations are discussed in this chapter.

3.1 STUDY AREA

The research was conducted at the Holy Family Hospital, Berekum. Berekum hospital is a Catholic Diocesan Hospital which serves as the Municipal Hospital.

Holy Family Hospital, Berekum is a full-service hospital, delivering state-of-the-art emergency, acute inpatient and outpatient care. The range of services provided at the hospital include maternal and child health, general medical care, disease control and surveillance, dental, ear nose and throat, eye care, nutrition rehabilitation and other support services.

3.2 STUDY POPULATION

Creswell (2015) explains population as a group of people who are the focus of a research study and to which the results would apply. This is also the group on which the researcher would like to make inferences. The study population chosen were puerperal women who have undergone caesarian section at Holy Family Hospital, Berekum.

3.3 RESEARCH DESIGN

The study used the quantitative approach. This approach allows for flexibility in the collection of an array of perspectives from a number of participants in a study. In the quantitative method, there are prompting questions to explore objective data.

3.4 SAMPLING TECHNIQUE AND SIZE

The convenient sampling technique was used in selecting the sample for the study. The convenient sampling technique was used because the participants selected were deemed to have the characteristics considered appropriate for the study and from whom the needed data could be obtained.

To select the sample for the study, permission was obtained from the hospital authorities to conduct the study. The total sample size for the study consisted of sixty (60) respondents who were selected from the target population at the maternity ward.

3.5 DATA COLLECTION METHODS AND INSTRUMENTS

Data for the study was collected through interviewing the research participants. The researchers collected data through face-to-face interviews with respondents using a pre-coded structured questionnaire, after getting consent. The questionnaire had thirty - three (20) items under four sub-titles which included socio-demographic characteristics, knowledge of respondents on caesarian section, experiences of women who underwent caesarian section and psychological . The questionnaire was in a well understood language by all respondents that is English and translated to those who didn't understand English. The questionnaires were distributed to 60 patients who have undergone caesarian section at Holy Family Hospital, Berekum.

3.6 DATA ANALYSIS TECHNIQUES

Data was analyzed using Microsoft excel and results were presented using frequency distribution table because they are easy to read, understand by everybody and also make the data simpler, meaningful and easy to work with.

3.7 ETHICAL CONSIDERATION

Before the study was carried out, all necessary ethical issues were considered as outlined below:-

- A written permission was obtained from the administrator of Holy Family Hospital, Berekum.
- Informed consent was obtained from the study participants prior to data collection. Before taking consent, the research team explained to study participants what the study was all about, the processes involved during data collection, the associated risks and benefits of participating in the study. In addition, participants were offered the opportunity to ask questions before consent was obtained either by signing the consent form or providing a thumb print.
- If a participant was not able to read the consent form herself, a witness signed on the same consent form indicating that she or he was bearing witness that everything about the study was explained to the participant prior to getting the consent to participate in the study.
- Confidentiality and anonymity of the study participants' was also maintained by using identity numbers on the questionnaires other than participant's names.
- The respondents were informed of their right to refuse to participate in the study without any consequence. The right of each respondent was respected and their personal integrity safe-guarded.

- The study was also carried out with no physical or psychological harm on the respondents. They were assured of confidentiality of the information that was obtained from them hence names and addresses were omitted in the questionnaire.
- All respondents were made aware that participation was voluntary and they could withdraw from the study at any time.
- The respondents were made aware that there were no incentives but information provided will help to improve upon the attitudes of health care providers toward patient care.

3.8 LIMITATIONS OF THE STUDY

The major limitation of this study is that the sample size was small. A study as important as this one should have been done on a much larger scale with respondents drawn from all the communities in the Berekum Municipality to make the results highly representative, this could not be done because the researchers had financial constrained by time and money. These difficulties notwithstanding, the findings of this study offer valuable insights into the issue of the knowledge and experience of women on caesarian section at Holy Family Hospital, Berekum and also serve as a spring board for further study into this very important subject. In view of the small sample size the results should be interpreted with caution.

CHAPTER FOUR

DATA ANALYSIS AND DISCUSSIONS OF THE FINDINGS

4.0: INTRODUCTION

This chapter deals with analyzing data collected from the field. It is very important to analyze the data to determine it significant. The analysis was done using frequency distribution table. The analysis covers demographic characteristics of respondent, the knowledge of puerperal women who have under gone cesarian section, their perception and impression of woman who have under gone caesarian section.

4.1: SOCIO – DEMOGRAPHIC CHANRACTERISTICS OF RESPONDENTS

In trying to find the demographic background of respondents .Respondents were asked about their age , 35% (21) were between 26 – 30 years, , 22% (13) were between the ages of 21 - 25 years, 17% (10) were between the ages of 31-35, 15% (9) were between the ages of 16 – 20 years and 12% (7) of the respondent were between the ages of 36-40 Again about their marital status, 68% (41) were married, 20% (12) were cohabiting, 12% (7) were single and of the respondents was as follows 62%(37) were Christians, 30% (18) were Muslims and 8%(5) of the respondents were traditionalists. Again their educational background was enquired , 38% (23) attended Senior High School, 25% (15) attended Junior High School, 18% (11) attended Primary School, 12% (7) of the respondents had no formal education, and 7% (4) attended Tertiary. In obtaining their occupation 55% (33) were farmers 20% (12) were self – employed engaging in petty trading and other businesses , 17% (10) were students. (5) 8% of the respondents were civil servant. In trying to know their parity (35) 58% were of 0-2, (15) 25% were of 3-5 17% (10) were of 6 and above. As shown in the table below.

TABLE 4.1: SOCIO – DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

Characteristics	Frequency	Percentage (%)
Age		
16 – 20	9	15%
21 – 25	13	22 %
26 – 30	21	35%
31 – 35	10	16 .5%
36 - 40	7	11.5%
Religion		
Christian	37	62%
Muslim	18	30%
Traditionalist	5	8%
Marital status		
Single	7	12%
Married	41	68%
Divorced	0	0%
Cohabiting	12	20%

Level of education		
No formal education	7	12%
Primary	11	18%
J.H.S	15	25%
S.H.S	23	38%
Tertiary	4	7%
Occupation		
Student	10	17%
Farming	33	55%
Self – employed	12	20%
Civil servant	5	8%
	60	**100%**

TABLE 4.2: RESPONDENTS NUMBER OF CHILDREN

From table 2.0, 35 (58%) of the respondents have 0 -2 children, 15 (25%) have 3 – 5 children and 10 (17%) of the respondents have 6 children and above.

How many children do you have	Frequency	Percentage
0 – 2	35	58%
3 – 5	15	25%
6 and above	10	17%
Total	**60**	**100%**

4.2: KNOWLEDGE OF RESPONDENTS ABOUT CAESARIAN SECTION

This section throws light on the views of participants in Holy Family Hospital, Berekum about their knowledge on caesarian section. Below, some voices of participants have been presented to reflect participants' views.

4.2.1: UNDERSTANDING OF CAESARIAN SECTION

Delivery is one of the most important issues for human being and generation in the world. The process through which childbirth naturally occurs is called natural vaginal delivery whilst caesarean is delivery of child through incisions in abdominal wall (Laparotomy) or uterus (Histrotomy) Adeoye (2011). The rates of caesarean delivery in many developed and developing countries have risen higher than necessary for optimal maternal and neonatal health outcomes (Betran et al, 2017). Upward trends in caesarean delivery rates are not fully explained by changes in maternal characteristics or pregnancy complications (Stavrou et al, 2016). Caesarean rates may be affected by clinicians’ and women’s attitudes towards caesarean delivery, which may differ depending on how maternity services are delivered.

The participants were therefore asked about their knowledge their current caesarian section.35%(21) posited that caesarian section is scarry, 27% (16)of the participants said caesarian section is the easy way of delivery , 22% (13) indicates it prevent trauma and 16% (10) indicates weakness after birth. Again client were asked to share their views on vagina delivery after caesarian section, (50) 83% said vagina delivery is not possible after caesarian section, (10) 17% said is possible after caesarian section. In trying to review the responds of respondents on the indications of caesarian section, 38% (23) indicated big baby,25% (15) indicated post term, 22% (13) indicated fetal distress, 8% (5) indicated breech presentation, 7% (4) indicated two previous caesarian section. Clients were also asked about the health implication on caesarian section, 40% (24) indicated infection of the incisional area, 30% (18) bleeding from the vagina 17% (10) indicated headache, 13% (8) indicated difficulty in walking.

Variables	**Frequency (n)**	**Percentages (%)**
What they know before the current caesarian section		
Scary	21	35
Easy delivery	16	27
Prevent trauma	13	22
Weak after c/s	10	16
Thought of vagina delivery after c/s		

Variables	Frequency (n)	Percentages (%)
Possible	50	83
Not possible	10	17
Indication for c/s		
Big baby	23	38
Post term	15	25
Breech presentation	5	8
Two previous	4	7
Fetal distress	3	22

4.3.1PYSCOLOGICAL SITUATION OF WOMEN PRIOR TO CAESARIAN SECTION

In generating the psychological situation of the women prior to the caesarian section. The following ideas were reviewed, clients were asked on how they felt when they were told about the caesarian section. 43% (26) were anxious, 28% (17) indicates they were afraid, 14% (8) relieved, 8% (5) was depressed and 7% (4) was uncertainty. In reviewing clients expectation about caesarian section , 40% (24) alive baby, 25% (15) painless, 22% (13) healthy mother. 13% (8) healthy baby. In reviewing the likelihood outcome of the caesarian section, 45% (27) alive mother, 38% (33) alive baby, 13% (8) scar. , 3% (2) bleeding, 39% (23)relatives, 33% (20) midwife, 28% (17) doctor,

Variables	Frequency (n)	Percentage (%)
Feeling during c/s		
Anxious	26	43
Relieved	8	14
Afraid	17	28
Depressed	5	8
Uncertainty	4	7
Expectation about c/s		
Alive baby	24	40
Painless	15	25
Healthy baby	8	13
Healthy mother	13	22
Likelihood outcome on c/s		
Alive mother	27	45
Alive baby	23	38
Bleeding	2	3
Scar	8	13
Support on c/s		
Midwives	20	33
Doctor	17	28
Relatives	23	39

Variables	Frequency(n)	Percentage(%)
How they were received in the theatre room		
Warmly	42	70
Rudely	13	22
Neglected	5	8

Variables	Frequency (n)	Percentage(%)
Reinforcement of previous knowledge		
Yes	51	85
No	9	15
Companion, before during and		
after caesarian section		
Mother	36	60
Husband	5	8
Sister	13	22
Midwife	4	7
Doctor	2	3
Impression about the theatre team		
Good	57	95
Bad	3	5
Satisfied with mood of delivery		
Yes	54	90
No	6	10

4.3: EXPERIENCES OF RESPONDENTS ABOUT CAESARIAN SECTION

Provision of quality of care and ensuring patients' satisfaction has been a challenge faced by many healthcare facilities across the globe (Gishu et al, 2019). Exploring the quality of midwifery care from the patients' perspective is an important part of quality of health care assessment (Gishu et al, 2019). Midwives are responsible for providing care and support to women during pregnancy, labour, and delivery. The quality and manner of providing midwifery care during the delivery process contribute to a positive or negative childbirth experience (Dzomeku et al, 2016). The role and responsibilities of midwives at this critical stage of a woman's life may lead to diverse outcomes ranging from life to death and from health to physical injuries, with significant effects on the mental, and emotional health of the mother and child (Sehhati et al, 2015).

In finding out the experience of respondents on caesarian section, clients were asked to described how they were received in the theatre room, 70% (42) warmly, 22% (13) rudely, 8% (5) neglected. Also client were asked if information was given to reinforce their previous knowledge (51) 85% yes, (9) 15% no. Client was asked about their companion before, during and after caesarian section, 60% (36) mother,22% (13) sister, 8% (5) husband, 7% (4)midwife, 3% (2) doctor. Clients impression about the theatre team, 95% (57) good, 5% (3) bad. Client was asked about their satisfaction about mode of delivery, 90% (54) yes, 10% (6) no.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.0: INTRODUCTION

This chapter discusses the result of the study as related to the objectives. The study was aimed to assess the knowledge and experiences of women who have undergone caesarian section in Holy Family Hospital, Berekum in the Bono Region of Ghana. The chapter presents a summary of the findings, followed by conclusions drawn from the findings and recommendations for action

This was to make information available for policy makers to make informed decisions. The study is limited to the views of women who have undergone caesarian section in Holy Family Hospital, Berekum.

5.1: DISCUSSION

5.2: KNOWLEDGE OF RESPONDENTS ABOUT CAESARIAN SECTION

Caesarean section is a surgical procedure which involves incisions made through a mother's abdomen (laparotomy) and uterus (hysterectomy) to deliver one or more babies or to remove a dead fetus. Cesarean section is major surgery and can cause complications to pregnant women when compared to normal vaginal birth (Gallaher et al,2018)

The participants were therefore asked about their knowledge on caesarian section. It came out clearly that they have good knowledge on indication for caesarian section (key among them are big baby ,post term baby ,breech delivery, two previous caesarian section and fetal distress), health implication on caesarian section (bleeding and infection at the incisional

site) as well as knowledge on caesarian section prior to their experience(is easy way of delivery and prevent trauma).

PSCHCOLOGICAL SITUATION OF WOMAN PRIOR TO CAESARIAN SECTION

In generating the psychological situation of women prior to caesarian section, how the respondents were feeling was ascertain generally their psychological situation was about 86% unstable(anxiety 43%, afraid 28%. Depressed 8% and uncertainty 7%) Again their expectation about caesarian section was very low expecting alive baby 40%, health of the baby13% and health of the mother 22%. This lead to likelihood outcome on caesarian section alive baby 38%, alive mother 45% which all have psychological impact on the expectant mother. Finally the support they received were below expectation relatives 39% , midwives 33% and doctors 28%.

5.3.1 EXEPERIENCE OF RESPONDENTS ABOUT CAESARIAN SECTION

Collectively, respondents experience on caesarian section was very good. On how respondents were received in the theatre room 70% were warmly received at the theatre room and respondents impression of the theatre team was of a good one 95% since they had a positive caesarian section. Respondents were giving adequate information to reinforce their previous knowledge on caesarian section 85%. Mothers and sisters were the major companions of respondents, before, during and after caesarian section yet they couldn't give adequate psychological support maybe they lack the resource to do that. Respondents satisfaction was encouraging as a results of mothers having a successful caesarian section outcome.

5.4: CONCLUSION

Based on the findings of this study, it can be concluded that,

1. There was a good level of knowledge among puerperal women regarding caesarian section
2. Theater team attitude elicit positive effect on women during caesarian section
3. The psychological preparation wasn't good

5.4: RECOMMENDATIONS

Based on the findings of the study and the conclusions drawn from them, the following recommendations are being made for consideration:

1. The midwives and doctors are the professional and there is the need to improve the relationship with expectant mothers who are likely to have caesarian section.
2. Psychological support for expectant mother to have caesarian section should be mostly carried out by health care professionals
3. There should be further participant observation research on caesarian section and the theatre team maybe they were under the influence of anesthesia and for that matter they couldn't see much.

REFERENCES

Rosen, et al (2015). *Direct observation of respectful maternity care in five countries:* a cross-sectional study of health facilities in East and Southern Africa 15:306.

Janssen, P.A. (2007). *A Guide to a Health Birth*, United State of America, birth 34 (2), 140-147.

Lucia, D' Ambruoso (2005). *Midwives Attitudes to Women in Labour in Ghana Accra:* Mikono Publisher

Natukunda, C. (2007). *Midwifery Behaviour and Practice. Accra:* Mikono Publisher.

Abuya T, Warren CE, Miller N, et al (2015). *Exploring the Prevalence of Disrespect and Abuse during Childbirth in Kenya.* 10(4): e0123606.

Amroussia N. et al. (2017). *"Is the doctor God to punish me?"* An intersectional examination of disrespectful and abusive care during childbirth against single mothers in Tunisia. Reproductive Health; 14:32

Bohren MA, et al (2015). *The Mistreatment of Women during Childbirth in Health Facilities Globally:* A Mixed-Methods Systematic Review. PLOS Medicine; 12(6): e1001847.

Bohren MA, et al (2017). *Mistreatment of women during childbirth in Abuja, Nigeria:* a qualitative study on perceptions and experiences of women and healthcare providers. Reproductive Health. 14:9

Bowser D, Hill D. (2010). *Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth, Report of a Landscape Analysis.* USAID TRAction Project, Harvard School of Public Health.

Idris, S. H., Sambo, M. N. and Ibrahim, M. S. (2013). *Barriers to utilization of maternal health services in a semi-urban community in northern Nigeria:* The clients' perspective. Nigeria Medical Journal; 54 (1): 27 – 32

McMahon SA, George AS, Chebet JJ, et al (2014). *Experiences of and responses to disrespectful maternity care and abuse during childbirth;* a qualitative study with women and men in Morogoro Region , Tanzania. BMC Pregnancy and Childbirth; 14:268

APPENDICES

QUESTIONNAIRE

Dear Respondent,

We are students of Holy Family Nursing and Midwifery Training College, Berekum and as part of our diploma certification by Kwame Nkrumah University of Science and Technology [KNUST], we are conducting a survey that investigates **'The knowledge and experiences of women who have undergone caesarian section in Holy Family Hospital, Berekum in the Bono Region of Ghana'.**

We would appreciate it greatly if you could answer the following questions for us. Names or identity will not be needed. All information gathered is solely for academic purpose. We wish to assure you of confidentiality and privacy of this research study. Your sincere answers to the questions below will contribute to the success of this study.

Thank you.

PLEASE TICK [√] THE APPROPRIATE BOX WHERE APPLICABLE

SECTION A: [Background information of respondent]

Number	Questions	Responses
1.	What is your age?	1. 16 – 20 [ ] 2. 21 – 25 [ ] 3. 26 – 30 [ ] 4. 31 – 35 [ ] 5. 36 – 40 [ ]

2.	What is your marital status?	1. Married [ ] 2. Single [ ] 3. Divorced [ ] 4. Cohabiting [ ]
3.	What is your religion?	1. Christian [ ] 2. Islam [ ] 3. Traditional [ ] 4. Other [ ]
4.	What is your educational level?	1. Primary [ ] 2. Junior High School [ ] 3. Senior High School [ ] 4. Tertiary [ ] 5. None [ ]
5.	What is your occupation?	1. Trader/Business owner [ ] 2. Farmer [ ] 3. Student [ ] 4. Civil Servant [ ]
6.	What is your parity?	a. 0 – 2 [ ] b. 3 – 5 [ ] c. 6 and above [ ]

SECTION B: Knowledge of respondents About Caesarian Section

7. What did you know before the current caesarian section?

   …………….

8. Do you think vaginal delivery is possible after caesarian section?

   ……………………

9. State two indications of caesarian section?

   …………………………

10. What are the health implications on caesarian section?

    ....

SECTION C:Psychological situation of women prior to caesarian section

11. How did you feel when you were told about the caesarian section?

Anxious(……), Relieved (…..), Afraid(…….), Depressed(….). Uncertainty(……..)

12. What was your expectation about caesarian section?

………………………………

13. What are the likelihood outcome of the caesarian section?

………………………………

14. Where did you received support from?

Midwives(…), Doctors(……), Relatives(…)

SECTION D: Experiences of respondents About Caesarian Section

15 Describe how you were received in the theatre?

……………..

16. Were you given any information about your labour on admission to reinforce your previous knowledge?

…………………………

17 Who was your companion before ,during and after caesarian section?

Mother(…..), Husband(…), Sister(…), Midwife (…), Doctor(…)

18. Describe your impression on the theatre team?

……….

19.Were you satisfied with the mood of delivery.

THANK YOU

NATIONAL CATHOLIC HEALTH SERVICE (DIOCESE OF SUNYANI)

HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

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Error: IllegalTag
Operator: 0x1b
Position: 766

Our Ref. HFNMTC/GC/011/112122

Your Ref. ....

Date ....November 21, 2022....

The Administrator
Holy Family Hospital
Berekum

Dear Administrator

PERMISSION TO CONDUCT RESEARCH

I wish to introduce to you the under-listed names of final-year students of the College:

1. **Amissah Ann**
2. **Konamah Josephine**
3. **Osei-Bonsu Joycelyn**

As part of the pre-requisite for the award of Diploma in Midwifery, they are to conduct a research study, hence the data collection on **"The Knowledge and Experience of women who have undergone caesarian section in Holy Family Hospital, Berekum in Bono Region of Ghana."**

I would be grateful if you could assist them with any material or help they may need to accomplish this task.

Thank you.

Yours faithfully

ACADEMIC CO-ORDINATOR - MIDWIFERY
HOLY FAMILY NURSING & MIDWIFERY
TRAINING COLLEGE, BEREKUM

....
Martha Kyeremaa
Supervisor

For: Principal

Website: nmtcberekum.edu.gh **E-mail.** nmtcberekum@yahoo.com, nmtcberekum@gmail.com

HOLY FAMILY HOSPITAL,
BEREKUM, B/A

MEMO

To: Maternity Ward In-charge
From: Nursing Admin
Ref No:

Date: 22-11-2022
Cc:
Date:

SUBJECT APPROVAL FOR DATA COLLECTION

The bearer of this Memo has the approval from Management to collect data in your Department.

They are Students from NMTC Berekum.

Kindly give them the necessary support.

Thank you very much!

[signature]
Sr. Judith Magbity