SOCIAL CONSTRUCTION OF CAESARIAN SECTION AMONG
WOMEN AFTER SURGICAL INTERVENTION
IN THE TAMALE METROPOLIS

BY

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I, Millicent Kala, hereby declare that this thesis is the result of a research undertaken towards the award of a Master of Philosophy in Nursing Degree in the School of Nursing and Midwifery, University of Ghana, Legon. This research has been duly guided and supervised by Dr. Florence Naab, School of Nursing and Midwifery, University of Ghana, Legon and Dr. Michael Wombeogo, School of Allied Health Sciences, University for Development Studies, Tamale. The undersigned supervisors certify that they have read the thesis and have recommended it to the School of Nursing and Midwifery for acceptance.

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(CO-SUPERVISOR) Signature Date
DEDICATION

I dedicate this thesis to my dear father and siblings for their constant interest in my educational achievements, encouragement, and support in diverse ways to enable me succeed academically. To my husband, my mother in-law, and my kids for their support, understanding, and sacrifice throughout the period of my course. Finally, to Dr. and Mrs. Sulemana for accommodating me and showing interest in my work.
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My profound gratitude goes to all the lecturers of the School of Nursing and Midwifery, Legon, who imparted the appropriate knowledge of Research in Nursing to enable me undertake this project.

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<tr>
<td>CS</td>
<td>Caesarian Section</td>
</tr>
<tr>
<td>SSS</td>
<td>Senior Secondary School</td>
</tr>
<tr>
<td>GSS</td>
<td>Ghana Statistical Service</td>
</tr>
<tr>
<td>LI</td>
<td>Legislative Instrument</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<td>HCP</td>
<td>Health Care Providers</td>
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<td>ANC</td>
<td>Antenatal Clinic</td>
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<tr>
<td>TCA</td>
<td>Thematic Content Analysis</td>
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<tr>
<td>ECG</td>
<td>Electrocardiogram</td>
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<tr>
<td>CT Scan</td>
<td>Computerized Tomography Scan</td>
</tr>
<tr>
<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
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<tr>
<td>CBR</td>
<td>Crude Birth Rate</td>
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<tr>
<td>BLF</td>
<td>Belief</td>
</tr>
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<td>SOP</td>
<td>Sources of Perception</td>
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<tr>
<td>PCC</td>
<td>Post Caesarian Section Consequence</td>
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<tr>
<td>POS</td>
<td>Perceives Order of Socialisation</td>
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<tr>
<td>Emo</td>
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ABSTRACT

Caesarian Section is chosen as a birth method particularly when difficulties arise during delivery. Despite this, women are not willing to take up caesarian section as a birth method because they are afraid of what their significant others will say about them. However, literature on how women construct Caesarian section in Ghana is scanty. This study therefore focused on understanding the meaning given to caesarian section among women after surgical intervention in the Tamale Metropolis. A qualitative exploratory descriptive design was employed in the study. Data was collected through in-depth interviews of twelve (12) purposively selected women who underwent CS within six months to one year and were aged 18 years and above. Interviews were audio taped and later transcribed verbatim and analysed using thematic content analysis. Five (5) themes were identified and described as follows: Social construction of CS, Sources of perception about CS, Perceived order of socialisation about CS, emotions associated with CS and Post CS consequences. The study found that, participants had varied beliefs about CS. The sources of perception of CS as mentioned by the women include social media and significant others. Social perception of womanhood emerged strongly as an order of socialization. The study revealed that the women were anxious, depressed while others expressed positive emotions towards CS. Following the incidence of CS, the women suffered from marital and social consequences. The findings of this study have implications for nursing practice, nursing research and policy formulation.
CHAPTER ONE
INTRODUCTION

This chapter comprises of the background of the study, problem statement, purpose and objectives of the study, significance of the study and operational definitions of key terms.

1.1 Background of the study

Among the challenges women face during childbearing years is the choice of the mode of delivering a baby and its acceptability in their social context (Boz, Teskereci, & Akman, 2016). Choosing between spontaneous vaginal delivery and delivery through surgery becomes a crucial moment especially when women are nearer to the time of delivery (Shahoei, Rezaei, Ranaei, Khosravy, & Zaheri, 2014). Different reasons are given for choosing one birth method over another.

Women will prefer Caesarian Section over normal birth because it relieves them of the pain in normal vaginal delivery and their lives and that of the babies are protected from danger as well (Ajeet, Jaydeep, Nandkishore, & Nisha, 2011; Fenwick, Staff, Gamble, Creedy, & Bayes, 2010; Sahlin, Carlander-Klint, Hildingsson, & Wiklund, 2013). On the other hand, vaginal delivery is regarded as a choice of birth that creates a bond between the mother and the baby from the moment the baby is delivered. It is easier for mothers to get back to their daily routine of work and it frees them from the danger that is associated with caesarian delivery (Faremi, Ibitye, Olatubi, Koledoye, & Ogbeye, 2014; Rishworth, Bisung, & Luginaah, 2016; Shahoei et al., 2014; Torloni et al., 2013).
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In a study by Abbaspoor, Moghaddam-Banaem, Ahmadi, & Kazemnejad (2014), financial capability as well as views from significant others influenced Iranian women’s choice on a particular mode of delivery. Similarly, a study among Canadian women indicated that women’s concern about their ability to assume satisfactory sexual relationships influenced their decision making on the method of birth (Stoll, Hall, Janssen, & Carty, 2014). According to Shahoei et al., (2014), in Iran, women made their delivery choices based on the positive information they obtained from their care providers regarding one method as better than the other. That aside, birth experiences shared by women’s significant others and through the social networks, served as a guide to women in taking decisions with regard to the mode of delivery (Boz, Teskereci, & Akman, 2016; Shahoei et al., 2014; Stoll et al., 2014).

Caesarian section is a procedure used by surgeons to deliver a baby when it is impossible for the expectant mother to do so by herself based on health reasons or difficulties encountered during childbirth. It is also chosen by some expectant mothers and their significant others because they regard it as an excellent way to bring forth a child (Souza et al., 2015). Also, mothers who do not abide by the belief that delivery should necessarily be through the vagina as prescribed by society may opt for caesarian section (Fenwick, Staff, Gamble, Creedy, & Bayes, 2010; Haines, Rubertsson, Pallant, & Hildingsson, 2012).

Research has indicated an increased demand for Caesarean Section globally among high and low income countries (Rishworth, Bisung, & Luginaah, 2016; Souza et al., 2015; Subhashini & Uma, 2015). This is as a result of several Caesarian Sections being performed (Phuong, 2015; Subhashini & Uma, 2015). With reference to existing
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statistics from 150 countries, presently 18.6% of childbirth results in surgical birth, 6% from less industrialized countries and 27.2% from industrialized countries respectively. Latin America and the Caribbean region presents a greater score of (40.5%), Northern America (32.3%), Oceania (31.1%), Europe (25%), Asia (19.2%) and Africa (7.3%) (Betrán et al., 2016). In addition, scores from 121 countries showed that within the period of 1990 and 2014, worldwide, there has been a rise in CS statistics by 12.4% (from 6.7% to 19.1%) with an average annual rate of increase of 4.4% (Betran et al., 2016).

According to Betran and colleagues (2016), in Africa, there has been a rise in CS from 2.9% to 7.4%.

Across countries, Caesarian Section is performed based on the following medical indications; transverse or breech presentation, failure in the progress of labour, foetal abnormalities, foetal macrosomia, ill health of the mother, placenta previa, bleeding in pregnancy (Gao et al., 2013; Tita, 2012; Ugwu & De Kok, 2015). Besides, maternal attributes such as age, number of previous deliveries, weight of the mother, a mother with a narrow pelvis contributes to the conduction of Caesarian Section (Buyukbayrak et al., 2010; Qazi, Akhtar, Khan, & Khan, 2013)

That notwithstanding, in the absence of any form of medical indication Caesarian Section is performed base on maternal request (Buyukbayrak et al., 2010). In a study conducted among six countries namely: Bangladesh, Colombia, Dominican Republic, Egypt, Morocco and Vietnam, utilization of caesarian section as a mode of delivery is common among elite women with good financial background who go for regular antenatal services while women of low economic stands who tend to access health information through socialization may not choose this method as a delivery option.
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(Leone, Padmadas, & Matthews, 2008). Also, women opt for Caesarian Section because they are afraid to give birth vaginally, to escape the discomfort associated with normal birth and to enable them undertake tubal ligation (Boz et al., 2016; Buyukbayrak et al., 2010; Lewis et al., 2014; Sahlin, Carlander-Klint, Hildingsson, & Wiklund, 2013).

Studies have also shown that there is underutilization of surgical birth as a means of delivery in sub-Saharan Africa. This is evident in the findings from ten countries in sub-Saharan Africa indicating scores less than 2% except for five countries – Ghana, Kenya, Lesotho, Rwanda and Uganda with surgical birth rates exceeding 5% (Cavallaro, Cresswell, França, Victora, & Barros, 2015).

Regardless of the benefits Caesarian Section offer to mothers and their newborn babies, it is not without effects. These may include bleeding, fetal growth restriction, delivery before term, and possible stillbirth. Long term maternal illnesses may include pelvic pain and adhesions. It is a believe that Caesarian Section causes a decline in the number of children one intends to have and heightens a couple susceptibility to unintentional pregnancy loss and ectopic pregnancy (Clark & Silver, 2011; Saeedi, Tabatabaie, Moudi, Vedadhir, & Navidian, 2013). Rise in newborn illness and death are linked with surgical birth in low income countries in addition to risk of being admitted to neonatal intensive care unit (Lumbiganon et al., 2010; Macdorman, Declercq, Menacker, & Malloy, 2010).

The underutilization of Caesarian Section as a mode of childbirth in sub-saharan Africa may stem from societal understanding of the basic factors raised above and other misconceptions they may hold about natural deliveries as against assisted delivery. With reference to a study carried out by Qazi et al., (2013) and Ugwu and Kok, (2015), it
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became obvious that most expectant mothers are against Caesarian Section as a result of the social context within which they find themselves. In most sub-Saharan African countries, women are not willing to accept caesarian Section as a mode of delivery, influencing factors include Caesarian Section being seen as a form of punishment to an adulterous woman, a procedure carried on women without strength, it is also perceived as a failure to womanhood in their social context (Mboho, 2013b; Sunday-Adeoye & Kalu, 2011; Ugwu & Kok, 2015).

To regard an event or idea as socially constructed is to stress on the meaning and beliefs individuals and groups together assign to a concept. “Social Constructionism or the social construction of reality is a theory of knowledge of sociology and communication that examines the development of jointly constructed understanding of the world. Social constructionism may be defined as a perspective which believes that a great deal of human life exists as it does due to social and interpersonal influences” (Berger & Luckmann, 1966; Gergen, 1985, p. 265). It also means that the believe or meaning would not have come to being if society did not create it (Boghossian, 2001). The description that is assigned to an event or a thing becomes a real characteristic given by society (Diaz-Leon, 2013). Socially constructed ideas determine how society classifies individuals and events making some more important than others (Flores, 2012).

According to Hacking (1999) the meaning ascribed to the event originated from humans, transmitted through history which could have been differently described.

It is therefore obvious that society cannot exist without culture. Our cultural beliefs and practices, to a larger extend, directs how we perceive and react to situations. Culture describes what is acceptable, deemed a common practice in any given society,
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and should be adhered to by the inhabitants (Greider & Garkovich, 1994). Decisions individuals make on their health issues with regard to self-medications, and the need to seek for medical attention, largely depend on the individual belief about health and illnesses. The belief the individual holds about illness is influenced by the culture and acquired through interaction with significant others. This has an influence on how those afflicted are accepted in their social settings and to a larger extend, affect how they live with the condition (Conrad & Barker, 2010a; Hjelm & Beebwa, 2013). Individuals give meaning to an illness when they tend to behave in a way that is in line with what society says the illness is rather than of biological origin (Conrad & Barker, 2010b; Greider & Garkovich, 1994). It is, therefore obvious that women’s significant others, social media, culture and the like as mentioned above serve increasingly as powerful determinants of delivery preferences among women.

Findings from research conducted among North American women indicated that women had increased desire for Caesarian Section because it is considered as a way of giving standardized care to the new born (Stoll et al., 2014). However, according to Ugwu and Kok (2015), in Nigeria and other African countries women assign different meanings to CS. Thus, it is seen as a procedure performed for an expectant woman who is not strong enough to deliver through the vagina, it is spiritual and punishment from the Gods to an adulterous woman. This stands to reason that women’s perceptions about Caesarian Section are to some extent, influenced by culture which invariably affect their decision to choose Caesarian Section as a method of delivery. This study is proposing to use the theory of social construction to understand the social construction of CS among women after surgical intervention in Tamale Metropolis.
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1.2 Problem statement

Worldwide about 20 million women give birth through surgical intervention and as such it is placed first among operative cases in most hospitals. Little is known about how this method of delivery affects the psychosocial health of the mothers and that of the baby. Yet the rate keeps on increasing among high and low income nations (Torloni et al., 2013).

Despite the knowledge mothers have on the role Caesarian Section plays in saving them from difficult deliveries, they are much particular about its negative effects on them and their families (Rishworth et al., 2016). Research has shown that 71% and 25% of women in northern Ghana deliver either at home or in a health facility respectively (Dako-gyeke, Aikins, Aryeetey, Mccough, & Adongo, 2013). It therefore stands to reason that with the high percentage of 71% of home deliveries, a lot of factors might have contributed to this, one of which might be to avoid Caesarian Section.

In this part of the world and most importantly the study area, people are so much bound to their immediate environment of their society and tend to hold it in high esteem to the extent that they do not appreciate the assistance of a health professional at birth (Gumanga, Kolbila, Gandau, Munkaila, & Malechi, 2015). Majority of women are particular about the extended period of stay in the hospital after surgical birth, the difficulty they encounter in carrying out their daily activities especially engaging in economic ventures to be self-sufficient and other roles they are unable to play (Litorp, Mgaya, Mbekenga, et al., 2015; Rishworth et al., 2016). It is obvious that Caesarian Section serves as a barrier preventing them from carrying out their expected
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Responsibilities. That aside, it is believed that caesarian section tends to impose some negative emotional experiences in the postpartum period (Kabakian-khasholian, 2013).

Assisted birth in some societies is seen as a sign of adultery on the part of the woman and for that matter a punishment from the gods ((Mboho, 2013a; Qazi et al., 2013). This myth cannot be proven scientifically, yet it is of clinical significance as women who receive assistance during delivery, may receive criticism from society in the context of engaging in adultery (Mboho, 2013b; Qazi et al., 2013). Society may not regard women who have undergone Caesarian Section as complete women, as some see natural deliveries as a sign to ensure a complete womanhood (Faremi, Ibitoye, Olatubi, Koledoye, & Ogbeye, 2014).

The social criticism may also stem out of the fact that Caesarian Section limits the number of deliveries that a woman can engage in (Mboho, 2013a). The ideas and beliefs each woman has regarding their preferred mode of delivery is as a result of cultural and societal influence (Kuan, 2014; Litorp, Mgaya, Kidanto, Johnsdotter, & Essén, 2015). For this reason, the choice of mode of delivery must be tackled and appreciated within women’s world view (Bohren, Hunter, Munthe-kaas, Souza, & Vogel, 2014). This is of worry in the social context as family size is of much relevance in many rural homes in the study area.

The undesirable, different views of social origin about Caesarian Section may jeopardize the fight against maternal and neonatal deaths because it can lead to underutilization of surgical birth in low income countries as an alternate means of childbirth when complications do occur (Mboho, 2013a; Qazi et al., 2013). The undesirable views about CS by women’s significant others can also hinder attempts to
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refer women in instances where there are complications during delivery that require surgical interventions. This is because undergoing Caesarian Section is seen as a reproductive defeat (Ugwu & de Kok, 2015).

Based on the researcher’s own experience, observation, and anecdotal evidence, within the study area, most women refuse to undergo caesarian section even when there are obvious medical indications, most of which results in infant deaths and maternal morbidities. For most of the women who have experienced CS, the wish for vaginal delivery is all they desire in their subsequent deliveries. In the study area, CS is viewed with hatred, misconstruction, anxiety, quilt, misery and anger. Women are not willing to opt for CS due to the negative perception of the procedure. As a result, this study explored the meaning of CS among women who have undergone CS in the Tamale Metropolis.

1.3. Purpose of the study

The purpose of this study was to explore the meaning of Caesarian Section among women who have undergone Caesarian Section, using the theory of social construction as an organizing framework.

1.4 Specific objectives

The specific objectives of the study are to;

1. Describe the social construction of Caesarian Section among women in the Tamale Metropolis.

2. Identify the sources by which women perceive Caesarian Section as a birth strategy.
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3. Describe the perceived order of socialization about Caesarian Section.

1.5 Specific Research Questions

1. How is Caesarian Section socially constructed among women in Tamale Metropolis?

2. What are the sources through which women perceive CS as a birth strategy?

3. What is the perceived order of socialization about Caesarian Section in the Tamale metropolis?

1.6 Significance of the study

It is important for nurses to have better understanding of what meanings women give to Caesarian Section. For this reason, the findings of this research would equip nurses and midwives with knowledge on the meaning, beliefs and behavior of women towards Caesarian Section. This will enable them give better education to women antenatally on the indications for Caesarian Section which will lead to the acceptability of the procedure when medically indicated. Moreover, nurses and midwives will be able to reduce fear for women who are undergoing Caesarian Section. Finally, nurses and midwives who work in labor and delivery rooms will be able to assess and respond to their patients’ feelings and concerns about Caesarian Section before and after the procedure.

1.7 Operational definitions

**Caesarian Section:** The process whereby an incision is made on the abdomen to remove a baby.
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Social construction: The beliefs and meaning society attach to a thing or an event or a situation.

Assisted birth: Giving birth with the help of medical intervention rather than normal vaginal delivery.

Significant others: This refers to friends, relatives, religious leaders, husbands, siblings
CHAPTER TWO

2.0. THEORETICAL FRAMEWORK / LITERATURE REVIEW

This chapter presents the theoretical framework for the study and the review of empirical literature on social construction of Caesarian Section.

2.1 Theoretical framework of the study: The social construction theory

The social construction of reality theory seeks to describe how ideas, beliefs and values in a given society are created by its inhabitants and tend to influence how they perceive, act and react to situations in their everyday lives. In social construction, the main tenets of the theory is on how meaning is given to an event or situation which is not a real characteristic of it but one ascribed to by society (Galbin, 2014). It also emphasizes on the belief that what an individual acquires as knowledge is dependent on socialization within the social network. Thus, the way an individual view and embraces situations in life to a larger extend, is as a result of how the social context perceives and accepts it (Coljocaru, 2010; Galbin, 2014).

The social construction theory was originally proposed by Berger and Luckman (1966). There are three major means through which reality is generated: externalization, objectivation and internalization.

2.1.1 Externalization

In the context of the model, new practices emerge when individuals share their beliefs, norms and principles with significant others that become socially acceptable with time. Beliefs and labels that are assigned to events and situations by individuals through
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socialization, informs what is considered appropriate and meaningful in a social context (Berger & Luckman, 1966).

2.1.2 Objectivation

According to Berger and Luckman (1966) human beings are born into an environment that is both natural and of human kind. The individual thus, grows biologically yet his life is being shaped through his constant association and interaction with significant others who create realities and are being governed by them (values, believes, rules). Naively, the individual interact with the societal norms, believes and practices and with time conforms to them as the ethics of the society. Thus, the beliefs the individual holds about an event, situation is influenced by the culture and acquired through interaction with significant others.

2.1.3 Internalization

Internalization as used in the model seeks to explain the process of practicing what others have practiced before; their objectified norms, values and beliefs that directs how things are done in the society. Berger and Luckman, (1966) emphasized that once reality exist in any given society, individuals are seen as members of a society only when they are able to identify with their neighbours and society, by believing and engaging in their practices. Once the individual becomes conscious of these predetermined realities it becomes part and parcel of his life. This is achieved through the individual interaction with significant others and through role modelling. Subsequently, the inherited reality influences how the individual behaves, act and identify with significant others in emotional ways (Berger & Luckman, 1966).
The social construction of reality theory as postulated by Berger and Luckman has been found suitable for this study because, the women’s conception of CS as a reality stemmed from their beliefs as gathered from the society, that an ideal woman is someone who gives birth vaginally (externalization).
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These norms or beliefs are obtained from significant others through the socialization process (objectivation). These beliefs manifest in the need for everywoman to deliver vaginally as a reality so as to be regarded as a “woman” in their social context. This pre-ordered arrangement may make women want to deliver through the vagina, such that women may not prefer CS even if there is the need (internalization).

2.2 Concept of social construction explained

Social construction seeks to explain how individuals and groups assign meaning, views, concept to situations, events which is accepted as standards in the society. It means that the idea only came to being because society created it to serve a purpose. This implies that a different meaning could be assigned to society’s events at any time base on society’s interest. It also means that the constructed view and meaning can be discarded once it does not meet societal needs (Boghossian, 2001). The meaning given to the event or situation forms part of societal principles and is being adhered to and practiced by members of the society.

However, this same meaning, notion placed on the event or situation cannot be replicated in another environment. It only pertains to the society in which it was constructed. The jointly developed ideology is transmitted and made meaningful through language during our daily interaction as human beings (Berger & Luckman, 1966).

2.3 Literature review

In this section of the chapter, related literature on social construction of caesarian section was reviewed. Sources of data includes internet, books, published data, journals, grey literature. Databases accessed include; HINARI, PUBMED, Cihnal, Sage, Science
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direct, Medline, google scholar. Key words and phrases used include, social construction, caesarian section, attitude of women, behavior of women, environmental factors, meaning women give to Cesarian Section, beliefs about caesarian section, and societal perception on illness. The literature reviewed will be organized according to the objectives of the study.

2.3.1 Overview of caesarian section

Caesarian Section refers to a procedure in which a baby is removed from the mother’s womb through an incision made on the mother’s abdomen. It is a procedure mostly carried out when the mother is unable to deliver through the vagina either due to maternal factors such as ill health, age, parity or foetal factors such as big babies, foetal distress and abnormalities among others (Sunday-Adeoye & Kalu, 2011; Ugwu & De Kok, 2015; Verdult, 2009).

Records have proven that the first CS performed can be traced to the time of Hammurabi (1795-1750 BC), re-counting the delivery of a baby boy removed from the womb of a dead woman (Lurie, 2005). A French obstetrician Guillimeau is known to have invented the name ‘sectio caesarea’ in 1598. It was a method used to bring forth a child especially when the pregnant woman dies (O’Sullivan, 1990). There are three different explanations about the origin of the name of the operation. In 715 BC, the King of Rome, Numa Pompilius, organized the Roman laws. According to the law, it was illegal to dispose off a dead pregnant woman without removing the baby. If a baby boy was removed it was called a “caeson”. This law, Lex Caesaris or Lex Caesarea, is assumed to be the origin for the name of the procedure “cesarean section” (O’Sullivan, 1990; Todman, 2007).
2.4 Social construction of caesarian section

In a study conducted by Aziken, Omo-agojha, and Okonofua, (2007) on Perceptions and attitude of pregnant women towards caesarian section in Nigeria, the study revealed that, all participants in the study were well informed on the essence of CS and how the procedure is been done. They all mentioned that CS involves the surgical removal of a baby from the womb through the abdomen. Loke, Davies, and Li, (2015) recorded that CS was seen as a much easier and comfortable mode of delivery among the study participants and gives the mother adequate time to prepare for delivery.

A study conducted in Sweden to find out caregivers and women perspective of CS in low resource settings with increasing CS revealed that, women held the belief that CS could only be done only if the woman agrees to be killed during the procedure (Litorp, Mgaya, Kidanto, et al., 2015).

Several number of research works have indicated that, most women hold the belief that vaginal delivery is God’s ordained way of giving birth and as such God frowns at Caesarian Section as an initiative by man to alter what is considered natural (Abbaspoor et al., 2014; Mboho, 2013a). Available literature, however, points to the fact that women assign different reasons for a planned Caesarian Section. Among them are: a way of escaping death during delivery, to be relieved of pain, to maintain their self-worth and to protect their babies from stress (Ajeet et al., 2011; Buyukbayrak et al., 2010; J. Fenwick et al., 2010; Karlstrom, Nystedt, Johansson, & Hildingsson, 2011; Sahlin et al., 2013). This was particularly evident in the work of Ajeet, Jaydeep, Nandkishore, and Nisha, (2011), where 91.5% of the respondents were in favour of vaginal delivery as their preferred mode of delivery with the above reasons assigned for the choice. The
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studies also indicated that, women opt for Caesarian Section because of the expert attention coupled with a relax atmosphere they experience from health facilities. They also found out that most (68.5%) of the study participants will embrace CS as their preferred mode of delivery because it frees them of the pain associated with childbirth. In the contrary, 44% of these mothers felt CS rather inflicts more pain on the mother.

In a study conducted in Kurdistan, the findings portrayed that with CS one cannot be assured of safe delivery and a baby in that, one misses the first cry of the newborn which is a revelation of the state of the baby at birth. Thus, women in the study frowned at the procedure (Shahoei et al., 2014). In research findings from qualitative studies, women were of the view that, any woman who give birth through surgery is weak and unfaithful to the husband. For these women, CS is also a form of punishment to a disrespectful woman by her immediate associates and a curse from the ancestors (Mboho, 2013 a; Qazi et al., 2013; Sahlin et al., 2013; Ugwu & De Kok, 2015; Ugwu & Kok, 2015). However, in (Litorp, Mgaya, Kidanto, et al., 2015; Rahnama, Mohammadi, & Montazeri, 2017) study, a cross section of the study participants held the belief that the experience of CS was God’s plan.

The belief that with CS one cannot attain the ideal family size in most African settings which necessitate the need for a rival to prove her worth to the husband as custom demands serves as a basis to the rejection of Caesarian Section as a mode of delivery (Qazi et al., 2013; Ugwu & Kok, 2015). In the contrary, other studies revealed that women will prefer small number of children resulting from CS in order to give them better care (Litorp, Mgaya, Kidanto, et al., 2015). It is also a belief that Caesarian Section heightens a couple’s susceptibility to unintentional pregnancy loss and ectopic
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Studies have found out that women concern about the preservation of their genital organ as well as their ability to assume satisfactory sexual relationships after CS, influenced their choice of CS as a birth method instead of normal vaginal delivery (Abbaspoor et al., 2014; Latifnejad Roudsari, Zakerihamidi, & Merghati Khoei, 2015; Stoll et al., 2014).

Research work carried out by Fenwick, Holloway, and Alexander (2009) revealed that women consider caesarian section as a reproductive defeat once they were not able to deliver as planned by their maker. According to Mboho, (2013a) in a qualitative study in Nigeria, women who gave birth through surgery are referred to as men until they prove their worth by giving birth vaginally. Their children even try to deny them as their biological mothers once they get to realise a scar on their abdomen because for them children are not born through the abdomen.

Several qualitative studies have indicated that women are against CS because they spend more days at the hospital after delivery. This prevents them from carrying out their daily activities at home and engaging in economic ventures (Rishworth et al., 2016; Shahoei et al., 2014). However, in Stoll et al., (2014) study, women regarded CS as a way of giving good care to the baby. Findings from Susan, Immy, & Jo, (2009) study reported that the women in the study expressed that delivery through the vagina was considered the best for them, reasons been that, they will be able to carry on with their works at home immediately after a vaginal delivery.
Furthermore, some studies indicate that most women describe CS as a disease and will not want to die or suffer from any disability which will affect them for the rest of their lives (Qazi et al., 2013; Rishworth et al., 2016). For instance, in a descriptive review study by Quazi et al., (2013), it was observed that 36.1% of the research participants associated CS to death while (23.1%) believed that CS comes with impairment.

According to findings from a study conducted by Fenwick et al., (2010), fourteen (14) of the study participants suffered from one effect of CS to the other ranging from wound infections, uncontrolled vomiting and complications resulting from the anesthesia that was administered on them. Similarly, in a study conducted by Ghotbi et al., (2014) in Tehran, 26.4% of mothers who had Caesarian delivery indicated that, they agreed to undergo CS because they had no knowledge on the possible effect CS could have on them.

In other studies, women have the believe that some residue from childbirth are retained in the womb after CS but are expelled when a woman undergoes vaginal delivery (Boz et al., 2016; Latifnejad Roudsari et al., 2015; Rahnama, Mohammadi, & Montazeri, 2016). For fear of this, some women are against CS as a birth strategy. Similar authors also came out with the findings that, women have the belief that, the beauty of a woman is boosted after a vaginal delivery since the sweat produced during delivery ensures a smooth skin as it removes and clears all spots on the face. Apart from the above, women equally are of the view that God responds to their needs better when they deliver through the vagina which is not the case in CS delivery (Boz et al., 2016). In Boz et al., (2016) study, shared experiences such as women not been able to conceive immediately after CS, difficulty women encounter in shedding belly fat as a result of
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scars acquired through CS, and the pain felt on the abdomen during the cold whether influence women’s unwillingness to accept CS as a birth strategy.

2.5 The sources through which women perceive cs as a birth strategy

In Iran, there has been an upsurge in the use of surgical intervention as a means of childbirth to the extent that it has become a common appreciable procedure by all. This has led to the description of the intervention as one to show off and a current trend in delivery in Iranian society. Thus, the procedure is considered safe for mothers and their babies (Abbaspoor et al., 2014). Shahoei et al., (2014) study in Iran concerning Kurdish women preference on mode of birth, established that most of the research participants mentioned that information they received from significant others portrayed CS as a dangerous procedure which does not ensure the wellbeing of the baby. Based on the information they received, their quest for CS decreased and they showed interest in vaginal delivery. Similarly, 10 respondents in a study by Ameresekere et al., (2011) revealed that their preference for CS diminished because they were deterred from the information they received from their significant others on CS.

Alternatively, researchers have reported findings attesting to the fact that CS was considered as the desirable means of delivery based on information respondents gathered from their significant others, the social networks, books, magazines, television and role models (Fenwick et al., 2010; Munro, Kornelsen, & Hutton, 2009). This was obvious in a study conducted by Ajeet, Jaydeep, Nandkishore, and Nisha, (2011) on women knowledge, perception and potential demand towards CS. The findings indicated that, 54.7% heard of CS from significant others, 24.5% from the social network and lastly 20.8% from health care providers making women significant others the most accessible
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means through which they obtained information on CS. Similar studies conducted by Ajeet et al., (2011) revealed that most (54.7%) of the study participants obtained information on CS from very close associates which the study believed could not be credible.

From a study conducted by Ameresekere et al., (2011) in the United States of America, 17 of the respondents claimed that their CS choice was largely dependent on information they received from their health care providers as the best means to deliver their babies. Studies have reported that about 71% of CS births that took place in health facilities, the idea for CS was first initiated and heard from a medical officer (Ajeet et al., 2011).

For instance, in a quantitative study by Qazi et al., (2013) the findings indicated that among 41 women in the North West of Pakistan in Children and Women Teaching Hospital who have experienced CS, 12.2% of them upon discharge felt bad about the procedure because they were rejected by their immediate family members while 87.8% were received well by their relatives after undergoing the procedure. A good percentage (8.7%) of the respondents were not willing to be operated upon and explained that in their social context CS was a curse.

That aside, in settings where pregnant women seek for the help of other birth attendants first or still expressed a belief in the powers of these people while in a health facility in order to overcome CS, indicates the extent to which their practices have influenced the way women construct CS (Ugwu & Kok, 2015).
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2.6 Perceived order of socialization about caesarian section

Studies by (Ajeet et al., 2011; Ghotbi et al., 2014; Rahnama et al., 2016, 2017; Ugwu & Kok, 2015) have documented that, women adored vaginal delivery based on information given by significant others. In their social context one could only be recognized as a mother only if she can share the experience of delivering through the birth canal. That aside, the importance attach to a child largely depends on its mode of delivery. Children delivered vaginally were more valued, which women wanted for their kids. Thus, a cross section of the study participants wanted to fulfill their role as mothers by ensuring that their babies were delivered through the vagina. Also in Ugwu & Kok, (2015) study, the women mentioned that they tend to lose their positions in society once they are unable to give birth to many children as a result of the CS they underwent.

In Litorp, Mgaya, Kidanto, et al., 2015; Ugwu & Kok, 2015) studies, it was revealed that, women are against CS because, seeing significant others in the past deliver without any form of assistance informed their belief that their deliveries take that same form.

Ceasarian delivery is considered as an abnormal way of bringing forth a child in some communities. Women who underwent CS in such communities felt they were less of a woman after the procedure (Ghotbi et al., 2014; Litorp, Mgaya, Kidanto, et al., 2015). In Ghotbi et al., (2014) study, among six public and private health facilities in Tehran, 44% of the participants strongly agreed that vaginal birth was one ordained by God and should be adhered to by all. These findings were in line with similar findings by (Karlström, Engström-Olofsson, Nystedt, Thomas, & Hildingsson, 2009; Rahnama et al., 2017).
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Studies have indicated that women who have undergone Caesarian Section are not complete women, as women see natural deliveries as a sign to ensure a complete womanhood. Thus, women prefer vaginal delivery in order to be seen as real women (Faremi et al., 2014; Rahnama et al., 2017; Ugwu & Kok, 2015).

Studies have shown that women will react negatively to this surgical intervention because, in the social context in which they find themselves coupled with their religious denominations, delivery is best executed when done through the vagina and not any other means which makes one to be accepted in her immediate environment as a woman (Mboho, 2013a; Qazi et al., 2013; Ugwu & Kok, 2015).

2.7 Emotions associated with caesarian section

In south west of England, Fenwick, Holloway and Alexander (2009) conducted a study aimed at exploring the experiences of women after Caesarian Section. The study was based on the fact that there has been an increased patronage of surgery as a means of childbirth in the study area. The study findings portrayed that, all the research participants frowned at CS, most of whom feel they lost that control over the birthing process. For some of these women, the experience of CS put them in a state of doubt, surprise, and sadness. Findings from this same study explained that for most of the women who delivered through CS they continue to battle with unpleasant memories for long until they give birth through the vagina to prove their worth as women.

Research points to the fact that some women will run away from the hospital after they have been booked for the procedure only to resort to their religious leaders for divine interventions (Mboho, 2013a; Ugwu & Kok, 2015). This was especially evident in the
work of Boz, Teskereci, and Akman, (2016) where four women absconded from the hospital after they were informed of the planned procedure to deliver their babies. In a study conducted by Ameresekere et al., (2011) in the United States of America, 8 women of African descent complained bitterly and felt frustrated when they were faced with CS as a choice of delivery. From their previous deliveries, they were sure of vaginal birth given the needed support and time. The findings from the same study portrayed that women expressed fear when they were informed of a planned CS delivery especially for those encountering it for the first time. Findings from a study conducted by Ghotbi et al., (2014) in Iran, revealed that 26.4% of mothers who had surgical birth lamented for accepting the procedure because of its associated problems.

On the other hand, women embraced CS when the option was discussed with them because they felt the procedure was sufficient enough to relieve them of stress and discomfort, it was a way of maintaining their integrity as women and sure way of having a healthy baby (Ajeet, Jaydeep, Nandkishore, & Nisha, 2011; Buyukbayrak et al., 2010; Fenwick, Staff, Gamble, Creedy, & Bayes, 2010; Sahlin et al., 2013). This was evident in a study conducted by Ajeet et al., (2011) where 68.5% of the respondents out of 247 respondents testified that the procedure was less stressful and offered a better delivery outcome.

A study in Canada found out that women suffer from postpartum depression after they had unplanned surgical deliveries (Habel, Feeley, Hayton, Bell, & Zelkowitz, 2015). In the contrary, in Phuong, (2015) study, women showed interest in CS because they wanted to give birth on a particular day and time hence it was more exciting to hear of CS.
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Choice is severely limited at any given time and is shaped by informal orders and social practices that often privilege the interests of one particular group over those of the individual (Buyukbayrak et al., 2010).

2.8 Post CS consequences

Caesarian Section though a lifesaving procedure, victims of CS suffer from one social consequence to another ranging from marital to social consequences. In a mixed method study conducted by Ugwu & Kok, (2015) in Nigeria, the qualitative findings reported that women suffered in their marital homes after they underwent CS in that, they had to either share their husbands with other women who the family believed would give birth to other children to keep their lineage going. In other instances, women had to leave their marital homes to give way for other competent women to build the family lineage. CS to them, limits a woman ability to give birth to many children. They further reported that women who underwent CS were being maltreated in the community they live in either by their rivals, friends or immediate associates. These women were being teased at and as such those yet to be operated refused to undertake CS as a birth strategy. In other studies like that conducted by Mboho,( 2013a) in Nigeria, women show their dislike for CS after seeing how other women have been maltreated in the past in their social groups for undertaking CS as a birth strategy.

Summary of literature review

In summary, studies reviewed so far have shown that women have different meanings and views that they assign to CS. Notably among them is that, CS is regarded as a procedure performed on a woman who had indulged in extra marital affairs, a
procedure for women not strong enough to push her baby out of the birth canal and a form of punishment from the gods to a disobedient woman (Mboho, 2013a; Sahlin et al., 2013; Ugwu & de Kok, 2015). Several studies have identified women considerations for a planned CS ranging from pain control, avoidance of death, the best way to guarantee the safety of the baby and mother (Ajeet et al., 2011; Fenwick et al., 2010; Karlström et al., 2009).

The literature search also revealed that, women insights on CS as a birth strategy was largely dependent on the following sources; women social context, culture, their religious denomination, health professionals, the social media, and women significant others (Boz et al., 2016; Fenwick et al., 2010; Ugwu & Kok, 2015).

Studies have also reported that, in some societies, childbirth is best done when a woman delivers through the vagina. Also, the importance attached to a child largely depends on its mode of delivery which women want for their kids. For these reasons, women will want to undergo normal vaginal delivery after CS (Ajeet et al., 2011; Ghotbi et al., 2014; Rahnama et al., 2016, 2017; Ugwu & Kok, 2015). In some instances, a woman is recognized in her social context based on the number of children she has. Women felt CS restricted them from having their ideal family size and the recognition due them (Ugwu & Kok, 2015).

Based on the information women received from their significant others, women showed varied behaviours toward CS. While others embraced it as a procedure to protect them and their babies from harm, to avoid pain and to have satisfactory sexual intercourse and an opportunity to fix the birth date of their babies, some others were in a state of depression and shock after the procedure and others absconded from the hospital.
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hearing they were to be operated upon (Ajeet et al., 2011; Habel, Feeley, Hayton, Bell, & Zelkowitz, 2015; Mboho, 2013a; Susan et al., 2009). However, literature in this area is limited in scope.

Following the incidence of CS, some women had to share their husbands with other women who will give birth to more children to keep the family lineage (Ugwu & Kok, 2015). For some others they were maltreated in the society (Mboho, 2013a).

The literature reviewed revealed that most of the studies were done abroad especially in the western world with few studies conducted in Africa. Even though studies have been done to find out women perception on CS even in Ghana, none of the studies applied the social construction model as a framework to guide their work. Also, the studies generated their findings from women who were either pregnant or not, but not from women after caesarian section. It is therefore obvious that no studies have been conducted in Ghana on social construction of CS and therefore in the Northern region of Ghana.
CHAPTER THREE

METHODOLOGY

This chapter presents an overview of the methodology employed in the thesis. The chapter reports the research design, the research setting, sampling technique employed to recruit the study participants, data collection techniques, data management and analysis. A rationale for choice of the study design and data collection approaches are reported. The chapter also discussed the strategies utilized to ensure data trustworthiness and rigour. An overview of the ethical principles which guided the conduct of the research is also presented.

3.1 Research design

Sound scientific enquiries are underpinned by a research design. A research design according to key research methodologists guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal (Hanson, Creswell, Clark, Petska, & Creswell, 2005). In this study, a qualitative exploratory descriptive design was employed as this design was considered as the most appropriate to obtaining answers on how women give meaning to caesarian section after the procedure. The qualitative exploratory descriptive design is highly favored for research enquiries which seek to get an in-depth understanding of a situation, to generate new ideas based on participants responses and to have a better insight to a phenomenon (Creswell, 2007; Patton & Cochran, 2002). As a result, this approach was deemed fit in the quest to obtain first-hand information and a contextually rich understanding on how women construct CS in this part of the country and to give better understanding of the phenomenon.
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3.2 Research setting

The study was conducted in the Tamale Metropolis. The Tamale Metropolitan Assembly was established by legislative instrument (LI, 2068) which elevated the then Municipal Assembly into a Metropolis in 2004. Within the Northern sector, Tamale is the only region among the three regions namely; Upper East, Upper West and Northern regions that has assumed a Metropolitan status adding up to make six Metropolitan Assemblies in the country. Tamale is the Metropolitan capital city as well as the regional capital of the Northern Region (Ghana Statistical Service, 2014).

The Tamale Metropolis is positioned in the central part of the Region and shares borders with the Sagnarigu District to the west and north, Mion District to the east, East Gonja to the south and Central Gonja to the south-west. The Metropolis has a total projected land size of 646.90180 sqkm (GSS-2014). Geographically, the Metropolis lies between latitude 9º16 and 9º 34 North and longitudes 0º 36 and 0º 57 West. Tamale is strategically situated in the Northern Region and by this strategic location, it serves as a point where most farm produce from the nearby districts are brought for sale. Based on the location of the Metropolis within the region, the area stands to benefit from markets within the West African region from countries such as Burkina Faso, Niger, Mali and the northern part of Togo and also en-route through the area to the southern part of Ghana (GSS, 2014).

With reference to the 2010 Population and Housing Census, the population of Tamale Metropolis is 233,252 representing 9.4 percent of the region’s population. Thus 49.7% males and females represent 50.3 percent. Majority of the inhabitants (80%) are living within the town while 19.1% reside in rural areas of the Metropolis. The
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The metropolis has a sex ratio of 99.1. The youth are the majority in the metropolis (almost 36.4% of the population is below 15 years) depicting a broad base population pyramid which tapers off with a small number of elderly persons (60 years and older) representing 5.1 percent. The total age dependency ratio for the district is 69.4, the age dependency ratio for rural localities is higher (86.5) than that of urban localities (65.7) (GSS, 2014).

The metropolis has a total of 219,971 families. Averagely, each family has a household size of 6.3 persons, majority of whom are children representing 40.4 percent and the elderly make-up 16.1 percent of the household population. Spouses form about 9.4 percent while significant others form 12.9 percent of the population. The extended family system structure is mostly seen within the Metropolis (head, spouse (s), children and head’s relatives) which represents a greater proportion of (46.1%) than that of any other type of household structure. Only a small percentage (19.5%) of the nuclear family structure (head, spouse (s) and children) is seen in the metropolis (GSS, 2014).

Within the Tamale Metropolis, delivery of health care is done at multiple levels. Health care is provided in private health facilities, public health facilities, traditional and herbal medical practice, faith-based healthcare delivery systems. However, at the public health care delivery point, the Tamale Teaching Hospital, the Tamale Central and Tamale West Hospitals are notable. The Tamale Teaching Hospital is the main referral center for the entire northern sector. It is equipped with state of the art and modern health care delivery services such as ECG, CT scan, MRI, carry out major surgical procedures. The Moshie Zongo Clinic, The Seventh Day Adventist Hospital (SDA), JAG’s Clinical Laboratory Limited and Kabsad Scientific Hospital, Habana among others are key leading private healthcare delivery centers.
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In terms of educational facilities, the Metropolis is blessed with both private and government schools comprising Secondary, Junior, Primary and Kindergarten Schools in the metropolis. Most of the residents are educated making 60.1 percent and 39.9 percent are non-literates. Males (69.2%) are educated as compared to their counterparts who form (51.1%) of the educated group (GSS, 2014). Commonly experienced diseases among the inhabitants are, liver cirrhosis, elevated cholesterol, diabetes, sexual weakness, hypertension, pregnancy induced hypertension, and hepatitis among others in the Tamale Metropolis and Ghana as a whole (GSS, 2014).

The entire fertility rate for the metropolis is 2.8 which is less than of the regional fertility rate of 3.5. The Overall Fertility Rate is 79.9 births per 1000 women aged 15-49 years. The Crude Birth Rate (CBR) is 21.2 per 1000 population. The crude death rate for the metropolis is 5.6 deaths per 1000. Contributory factors to death within the Metropolis are accident, violence homicide, suicide which are responsible for 9.6 percent of all deaths while other causes contribute to 90.5 percent of deaths. Majority of migrants (54.9 percent) living in the metropolis were born elsewhere in the region while 45.1 percent were born elsewhere in another region. For migrants born elsewhere in another region, those born in Northern region have the highest proportion (19.6%) followed by those who were born in the Upper East 18.7% (GSS, 2014).

3.3 Target population

The study population comprised of all women who underwent Caesarian Section and were residing within the Tamale Metropolis at the time of the study.
3.4 Inclusion criteria

The study involved all women aged 18 years and above, who underwent C/S within the last six months to one year prior to the data collection who lived within the Tamale Metropolis. Only women who were willing to participant in the study were recruited.

3.5 Exclusion criteria

Women who needed emergency care at the time of the data collection were not eligible.

Where medical or clinical evidence suggested a potential participant was mentally retarded or emotionally imbalanced, they were excluded from the study.

3.6 Sampling technique and sampling size

The study employed purposive sampling technique to recruit participants for the interviews. In this technique, participants with knowledge and experience about the particular topic under study is sampled (Tongco, 2007). In other words, the researcher to decide on the type of participants needed for the study and go in search for them. This sampling method ensured that the researcher selected women who have undergone caesarian section to share meanings and experiences after the procedure.

Classical of qualitative research design, the sample size for the study was not predetermined. Rather, the number of research participants was determined when the researcher noticed that there was repetition in the responses and no new information or responses was emerging. In simple terms, data saturation in qualitative research describes
a point in time during data collection where no new information is generated after interviewing a good number of participants. (Francis et al., 2010; Fusch & Ness, 2015).

3.7 Data collection tool

A semi-structured interview guide with only open-ended questions was used in this study to collect the primary data involving in-depth face to face interview. The semi-structured interview guide was designed in line with the study objectives which were developed from the constructs of the model serving as the framework for this study.

The interview guide was pre-tested using three women who met the inclusion criteria from Tamale West Hospital. The pretesting was done to obtain firsthand information on the feasibility of using the topic guide, comprehensibility of the questions by participants and to ensure flow and coherence in the flow of questions. All ambiguous questions were noted and reviewed at this stage. Following the pre-test exercise, the interview guide was then revised, restructured and the necessary corrections were made before the actual field work was carried out. To avoid false information during the actual field study, women that were used for the pre-test were excluded from those that were used for the actual study.

3.8 Procedure for Data Collection

Ethical approval to conduct the study was obtained from the Institutional Review Board of Noguchi Memorial Institute for Medical Research University of Ghana, Legon. Permission was obtained through formal writing from the chief executive of the Tamale Teaching Hospital through the research and monitoring unit of the hospital with an
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introductory letter from the School of Nursing and Midwifery, indicating the purpose of the study.

In recruiting participants for the study, the researcher identified potential participants from the maternity unit records of the Tamale Teaching Hospital where their addresses and contact numbers were retrieved. Each participant was made to thumbprint or sign two consent forms to indicate her willingness to take part in the study. The participant kept one consent form while the researcher kept the second for future reference and as part of an audit trial. This was done after the essence of the study was explained to them by the researcher. Data for this study was collected from women who experienced CS and were 18 years and above. Privacy was ensured during the interview session by avoiding crowded environment.

During the interview session, the researcher communicated with the participants in the language both parties could understand. The researcher equally trained a translator to obtain information from participants especially in Dagbani the most spoken language among inhabitants in the metropolis. The information was then transcribed to English by the same translator. All data that was gathered was audiotaped using a digital audio-recorder in addition to written field notes. On average, the interview lasted for about forty minutes.

3.9 Data management and analysis

All interviews were transcribed verbatim and cross-checked for accuracy and completeness by replaying the audiotaped information and comparing with transcribed data at hand severally. This was aimed at ensuring that the researcher identifies sections that
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needed to be modified to be probed subsequently for the desired results. For easy reference to each respondent’s responses, the transcribed data was assigned unique codes in the order in which they were recorded and saved in a folder that was created by the researcher on her computer with a password known to her alone.

Pseudonyms were assigned to individual files for easy identification of each participant. All written materials on the study were treated as confidential by filing them and keeping in a reliable and secured cabinet where only the researcher and the supervisor can have access to. Following the study, all documents, research findings were secured in a locked cabinet preferably for five years and made accessible only to the researcher and her supervisor.

To analyze the data, thematic content analysis was used to analyze the data. Thematic Content Analysis (TCA) is a descriptive presentation of qualitative data (Anderson, 2007). This method of data analyses involves an organized coding and classification method employed to discover huge volumes of written information to identify similar ideas, words and phrases that appeared in the text, their frequency, their association that emerged in each data unit (Vaismoradi, Turunen, Bondas, Turunen, & van Teijlingen, 2013). It includes looking across all the data to identify the main themes that summarize all the views you have collected (Anderson, 2007; Vaismoradi et al., 2013). The process involves critical reading of the various transcribed data at hand severally and attentively to help familiarize oneself with the data and to identify the common phrases, expressions, that will emerge in each data unit (Vaismoradi et al., 2013). Codes were generated out of this. Comparable codes were put to groups to form themes, and linked themes were grouped to form categories. The researcher then reviewed the themes.
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generated by checking to ensure that the themes have a connection with the coded abstracts and the whole of the data at hand. All categories of themes recognized were labelled with descriptive sub headings in a file. Each transcript was handled in this same manner. During the process of categorization, new themes that emerged was added on until all the transcripts were analyzed.

Each major theme identified was put in a labelled file. The researcher then identified and grouped the data units or statements under the predetermined themes which were based on the constructs of the model guiding the study using different colour fonts to help in easy identification of the participants.

A report was then created out of the emerging themes. The themes were refined based on the constructs of the model to come out with final themes and through content analysis new themes were obtained from the study. Lastly conclusion and interpretation of the findings will be done (Vaismoradi et al., 2013). At this stage, the researcher revisited the research questions and the theoretical framework to compare and draw conclusion on individual data unit.

3.10 Methodological Rigour (Trustworthiness)

Trustworthiness in qualitative research is a means through which the researcher is able to convince the public that information obtained from the study units and the interpretation made are truly what the participants provided (Shenton, 2004). Shenton, (2004) described the following ways of ensuring trustworthiness in qualitative studies (credibility, transferability, dependability, and confirmability) and suggested strategies that researchers could use to enhance the worth of their study.
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Credibility

Credibility is aimed at gaining the confidence from readers of qualitative study that the findings are a true reflection of data gathered from the study participants (Anney, 2014; Shenton, 2004). The researcher ensured reflexivity’ thus her own experiences, interest, beliefs and professional background did not influenced the responses from the participants (Horsburgh, 2003). Hence the participants were allowed to freely express themselves without any directive. The researcher also devised a means of eliciting true responses from the participants. The researcher achieved this by probing and reframing questions that were initially answered by the participants to ensure that there was no change in information initially provided.

Only participants who met the inclusion criteria were involved in the study to provide an in-depth information on social construction of caesarian section. In addition, interviews that were conducted in the local language were transcribed to English and given to someone who understood the dialect to determine the true reflection of the participants’ responses. At the end of each interview session, the participants were reminded of the questions asked and the audiotaped data was replayed for the participants to assess if the answers provided were really what they intended to provide. This ensured that the researcher captured a true in-depth meaning of CS from the respondents’ point of view.

Transferability

Transferability in qualitative research is based on the idea that study findings from one particular study can be applied to similar situations (Anney, 2014; Shenton, 2004). To ensure the transferability of the study findings, the researcher gave a detailed description of the study design, the setting in which the study was done, the number of participants that
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were involved, the method of data collection, data collection tool, the duration of data collection in a field diary.

**Dependability**

Dependability concerns the degree to which the results of the study are consistent or replicable with the same subjects or in similar context (Gunawan, 2015; Shenton, 2004). The findings from this study were made reliable by ensuring there is constant interaction between the researcher and her supervisor to make changes and corrections were necessary. Also, an audit trail on the study was made accessible. The researcher also ensured that a clear description of the research design, means of data collection, data collection tools, how data was analyzed and challenges encountered during the study were clearly and vividly spelt out.

To further ensure dependability a concise logical, non-repetitive account of the data was presented. Besides verbatim quotes were used to serve as a prove on themes that emerged from the data. A concise definition and naming of the themes that emerged was done to give the reader a sense of what the themes were about.

**Confirmability**

Confirmability in qualitative research aims at ensuring that, the findings generated in a study are a true account of the responses gathered from the respondents and not that of the researcher (Shenton, 2004).

To establish objectivity in the study, the researcher ensured that she gave an in-depth methodological description of the study. The researcher was also conscious of her own biases. An audit trail on audiotaped data, transcripts, field notes, copies of documents,
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diaries, consent forms, semi-structured questionnaire of the study can be traced at any point in time.

3.11. Ethical considerations

This research was conducted according to the Helsinki declaration for medical research. In connection with this, Marianna and Paraskevi, (2011) indicated that research activities involving human beings need to employ ethical issues. In view of this, ethical approval to conduct the study was obtained from Institutional Review Board (IRB) of Noguchi Memorial Institute for Medical Research. In addition, permission to conduct the research was requested from the chief executive of the Tamale teaching hospital through the research and monitoring unit of the hospital. Consent was obtained from each potential research participant after explaining the essence, objectives, benefits and likely risks to them in the language they could understand. The researcher equally allowed them to think about it for some time before consenting.

The decision to participate or not rested solely with each woman. Participants were informed of the possibility of withdrawing from the study at will. No harm or discomfort was inflicted on any respondent or any non-respondent. They were notified of the fact that the interview session was to be audiotaped and used solely for the intended purpose. To ensure that information obtained from the participants was confidential and anonymous, unique codes were assigned to each participant. Also, the names of localities where data was collected was not recorded as part of the research work. The findings from the study will be published while ensuring anonymity of the participants.
This chapter presents mainly the findings of the study. The first part of this section reports the demographic characteristics of the participants. Secondly, the emerging themes and subthemes are reported in line with the social construction model, the theoretical framework used for the study. In order to provide contextual meaning to the reported themes, verbatim quotes with pseudonyms from the interview were used to support the main themes.

4.1 Demographic characteristics

In all, 12 women who underwent CS participated in the study. The ages of the mothers ranged from 22 to 49 years. Majority of the participants representing eight (8) were Muslims while the remaining four (4) were Christians. All the participants indicated they were married. Three of the participants had three children and delivered them through CS three had two children through CS, six others had only one child through CS, lastly one woman with seven children delivered her last born through CS. Most (7) of the mothers had tertiary education with few (5) SSS leavers. Almost all (9) of the women understood and spoke Dagbani. Three could neither speak nor understand Dagbani. Majority (10) were fluent in English with two who could speak and understand English but not fluent in it. Table 4.1 presents an overview of the participants in the study.
Table 4.1: Demographic characteristics of study participants

<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequency (N)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Participants</td>
<td>12</td>
<td>100</td>
</tr>
<tr>
<td><strong>Age of participants</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>4</td>
<td>33.3</td>
</tr>
<tr>
<td>30-39</td>
<td>7</td>
<td>58.3</td>
</tr>
<tr>
<td>40-49</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christians</td>
<td>4</td>
<td>33.3</td>
</tr>
<tr>
<td>Muslims</td>
<td>8</td>
<td>66.7</td>
</tr>
<tr>
<td><strong>Educational Level</strong></td>
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<td></td>
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<tr>
<td>SSS/secondary</td>
<td>5</td>
<td>41.7</td>
</tr>
<tr>
<td>Tertiary</td>
<td>7</td>
<td>58.3</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
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<td></td>
</tr>
<tr>
<td>Married</td>
<td>12</td>
<td>100</td>
</tr>
<tr>
<td><strong>Number of Children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One child</td>
<td>6</td>
<td>50.0</td>
</tr>
<tr>
<td>Two children</td>
<td>3</td>
<td>25.0</td>
</tr>
<tr>
<td>Three children</td>
<td>2</td>
<td>16.7</td>
</tr>
<tr>
<td>Seven</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td><strong>Number of Caesarian Sections</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One</td>
<td>3</td>
<td>25.0</td>
</tr>
<tr>
<td>Two</td>
<td>3</td>
<td>25.0</td>
</tr>
<tr>
<td>Three</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Languages Spoken</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluent in English</td>
<td>10</td>
<td>83.3</td>
</tr>
<tr>
<td>Either spoke or understood</td>
<td>9</td>
<td>75.0</td>
</tr>
<tr>
<td>Dagbani</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neither speak nor understand Dagbani</td>
<td>3</td>
<td>25.0</td>
</tr>
</tbody>
</table>
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4.2 Organization of the themes

The findings of the study have been categorized based on the social construction of reality model which are in line with the objectives of the study. Overall, based on the social construction model, three main pre-determined themes are reported whilst two other themes were derived based on contextual analysis of data. Three themes (social construction of CS, sources of perception about CS and perceived order of socialization about CS) were consistent with the constructs of the social construction model while two themes (emotions associated with CS and post CS consequences) were derived from content analysis. In total five (5) themes with seventeen (17) sub-themes were derived.
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Table 4.2 Synthesis of the themes and subthemes from transcribed data

<table>
<thead>
<tr>
<th>MAJOR THEMES</th>
<th>SUB-THEMES</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social construction of CS</td>
<td>• Meaning of CS&lt;br&gt;• Beliefs about reasons for CS&lt;br&gt;• Beliefs about how the procedure is carried out&lt;br&gt;• Religious beliefs&lt;br&gt;• Beliefs about the outcome&lt;br&gt;• Beliefs about disfigurement&lt;br&gt;• Beliefs about restriction of ideal family size&lt;br&gt;• Beliefs about physical impairments</td>
<td>BLF</td>
</tr>
<tr>
<td>(externalization)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sources of perceptions about CS</td>
<td>• Social media (mass media)&lt;br&gt;• Significant others (community members)</td>
<td>SOP</td>
</tr>
<tr>
<td>(objectivation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceived order of socialization</td>
<td>• Social perception of womanhood</td>
<td>POS</td>
</tr>
<tr>
<td>about CS (internalization)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotions associated with CS</td>
<td>• Anxiety&lt;br&gt;• Depression&lt;br&gt;• Positive emotions</td>
<td>Emo</td>
</tr>
<tr>
<td>Post CS consequences</td>
<td>• Marital consequences&lt;br&gt;• Social consequences</td>
<td>PCC</td>
</tr>
</tbody>
</table>
4.3 Social construction of caesarian section

The social construction of CS refers to the individual subjective thought and societal beliefs about CS as mentioned by the participants. Under this theme, seven subthemes were notable; namely meaning of CS, beliefs about how the procedure is carried out, beliefs about reasons for CS, religious beliefs, beliefs about the outcome, beliefs about disfigurement, beliefs about restriction of ideal family size and beliefs about physical impairment.

**Meaning of caesarian section**

Participants in this study expressed varied understanding of CS based on their own experiences and perspectives. Participants generally showed that the idea of CS was not new to them. Their understanding of CS was associated with being a form of delivery involving an act of cutting a pregnant woman to bring out the baby. The following verbatim quotes from participants illustrate women’s understanding of CS.

“*Oooh that it is a mode of delivery for women who may not be able to deliver vaginally for one reason or another*” (Nasara)

“*CS is a form of delivery where the woman is operated upon to remove a baby that is how I understand cs*” (Rahama)

“*It is another way of giving birth, for that one they are going to cut open your abdomen and remove the baby and after that you feel pains, because there is a wound*” (Freda)
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These descriptions given by the participants indicate they had a basic understanding of what CS is and how it is done.

The data however revealed a perception that CS procedure involves killing the woman to remove the baby and waking her up later. Ethel and Freda had this to say;

“Truly what they are saying is that, they are praying that nobody should deliver through CS again because CS is a bad thing you will die. How will they kill you remove a baby and wake you up again” (Louisa)

“Madam for instance, in the olden days we believed that when a woman is to be operated, they will ‘slaughter’ her and take the baby and wake her up again. So, anytime they were to operate any woman, Dagombas they will tell you to put down cooking pots and don’t cook since the fellow will die; this belief is still common among our old folks” (Nasara)

Vanessa added that;

“Eeh madam, CS is like our old people will say they will kill you and remove the baby and you get up again, nooo you are signing your own death sentence then cut open and bring the size of a baby out and then they will sew nooooo” (Vanessa)

Beliefs about reasons for CS

Beliefs about reasons for CS is one of the subthemes that emerged from social construction of CS. The women’s belief about reasons for CS were expressed variedly: CS is performed on promiscuous women, a procedure for lazy women, a procedure for
women who fear pain and a curse to a disrespectful woman. All the women in the
interviews recognised the role of CS in saving their lives and that of their babies. They
were, however, concerned about the socio-cultural perception of undergoing a CS. They
indicated that in their communities, the belief is that if you slept with a different man
apart from your husband it is perceived as a good reason for you to undergo CS;

“The CS they performed on me, I know it helped me and my baby even though the
rest of my children I delivered them normal, but you know in my area, people are
saying that women who slept with a different man during the pregnancy will be
the one they will always operate on. So that was my worry, what they will be
saying about me? Even one woman in my area died, she didn’t want her rivals to
think she slept outside home so she refused the CS and died” (Binta)

“After that CS, though for me it helped me and my baby to be alive, the only
problem I encountered was that, when I went home, my sister in laws started
looking at me in some way as if I did something wrong; by now they are saying I
went behind my husband. In our area that is how they see it” (Ethel)

“Some will say ehee when she was young she was there aborting aborting, so that
made her womb to be very weak, she can’t give birth, she can’t push a lot of things
they say but for me I won’t mind them the baby is fine” (Louisa)

The women reported that socially, it is believed that CS is meant for lazy women. The
following statements give credence to this point of view.

“They are saying that you are a weak or a lazy woman that is why you have gone
through CS, because others are delivering normally and you cannot deliver
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normally unless CS and as such they are looking down upon you and it makes you worried and ashamed” (Louisa)

Rahama shared her own belief about CS before she was operated. She had this to say;

“In the beginning, my mentality was always like everything should be done the natural way, if you should have a baby it should pass through the birth canal that is how I used to think and I used to feel women who go for CS are kind of lazy or they just feel like not going through the pain that was when I even never thought of having children” (Rahama)

Another reason for CS as given by the participants was that CS is a suitable method of delivery for women who fear pain. The following narratives by two women depicts how CS is seen as a procedure for women who fear pain:

“My belief has been that those women who cannot undertake pain, they fear the delivery pain hence, they are the people who will be screaming too much and the doctors will say they have to operate them, but they forget delivery need patience. So, we thought women who were operated were really so fearful of labour pain” (Binta)

“My mentality was that, CS is for women who fear pain and don’t want to go through normal delivery that was the mentality I had about it, so after I went through it, I sat back and said it is not really about women who fear pain and do not want to go through labour or anything” (Tracy)
According to the women, in their social context, undergoing CS means the woman has been cursed due to her disrespectful nature. Based on this belief most women in this study did not embrace CS when the idea was shared with them.

“Madam you know, me when they just said CS I was very very sad, you see my aunties daughter, when she was pregnant she quarreled with an old lady in our area, she said she will see and during the time she was to give birth, they operated her. So, me they say I talk any how so to go for CS what will people say”

(Myela)

“Eiikh aunty, in my area they have this idea that when you are pregnant and you misbehave towards your elders, when they say some things to you, you will not deliver like the Hebrew woman you know the Hebrew woman had easy delivery I couldn’t take this whole CS thing” (Freda)

“How to go for CS for the third time nooo do you know what they (in-laws) will say? they are not far from concluding that am not a good wife maybe I have caused somebody again. I will not be happy they will even say I should confess”

(Louisa)

These beliefs about reasons for CS as expressed above gives an impression that, people might not understand the reasons for which CS is done or why is medically necessary.

**Religious beliefs**

The study revealed participants had different religious connotations and subscriptions about CS. Religiously, some participants were of the view that the CS they experienced was ordained by God while others were of the belief that CS is not the will
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of God. The following quotes for example illustrate participants’ religious beliefs about CS.

“I give everything to God, because it was god who said they should do me that CS, if God didn’t say they should do me that CS I would have delivered normal. So, when she came and said that I thank God, it is God who said they should do me that CS and I entered and I have come out alive I thank God” (Abigail)

“Well I feel bad for that but I just take it easy but I belief and hope that God, it is god who gave this thing (CS) to me” (Louisa)

In the contrary, some women belief that CS is not the will of God. They had this to say:

“Sister, I don’t understand this whole CS thing and how it came, you know eeihhh, if you go to church often and pay your tithes, why will you become pregnant and God will not let you deliver like the Hebrew woman? or will I say normally? I did all that yet look at me I think the doctors were in a hurry” (Rahama)

Similarly, Abigail shared that;

“In the Quran, normal delivery is accepted I think that if you are prayerful and put all your trust in Allah I don’t think CS will come your way, why will Allah say they should cut you to bring life? but am prayerful that is why I have a problem with this hospital people; for me and my husband we have decided that my next pregnancy we will go to a different hospital” (Abigail)

These illustrations clearly showed that though a cross section of the women have the strong conviction that CS is ordained by God, others felt it is not the will of God.
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Beliefs about the outcome

Besides documenting the issue of CS and religiosity, another interesting dimension is women’s beliefs about their health outcomes after undergoing a CS. Here, two main categories regarding the participants’ beliefs about the outcome of CS were identified. These include CS preserves sexual function and maintains genital appearance, beliefs about complications after caesarean delivery. With regards to the maintenance of sexual satisfaction and genital appearance after CS, some of the participants had this to say;

“When you go through the vaginal delivery the vagina becomes enlarged and all that but because it is the operation and not through vagina everything is intact all the muscles are intact” (Nasara)

“With CS I will say this is one of the benefits of CS, because the baby doesn’t actually come out from the vagina, your vagina seems to be intact as compared to normal labour. So, after CS, the place (vagina) becomes tighter than when the birth had come from the vagina. So, with that one your sex life is ok” (Safura)

Similar to the perspective of Nasara and Safura, Binta shared how a friend felt happy about the state of her genital organ after CS;

“You know the woman I said she went through CS delivery the first time, she was now kind of bluffing us that as for her, her private is still fresh, you see because they operated her and removed the child so her private is not spoiled; her husband still enjoys her like a virgin and so on and so on” (Binta)
Beliefs about complications after CS

The women also indicated with CS the blood clots and other waste in the woman womb are left in there which cause the woman to have a smelly vagina because the waste will be coming out small small. The following narratives describes how CS leads to retention of waste in the woman’s womb;

“Aunty, let me tell you, I went through vaginal delivery before and after that the blood in my womb all came out after sometime. This CS I see that at times I will be bleeding when it is not time for me to bleed and the scent is bad I know the blood and other small things are still there” (Binta)

“I have no problem with CS but my fear is that not all those things the blood and other things come out after the operation if it is vagina birth the baby will force all out but CS nooo, I can’t be roaming with dirty blood” (Louisa)

“Hmmm this CS thing one problem with it is that my sister after they operated her, we were going out when she slipped and fell, when we got home, she was bleeding and my mother said ehee, you see that blood is not normal is the CS blood that they didn’t bring out since then you see my sister bleeding and we went to the hospital” (Ethel)

These findings have revealed that even though women knew the benefits of CS to save their lives and that of their babies they are much particular about its effects on them. They reported that, CS comes with some form of complications typically, retention of blood and waste product in their wombs. In other situations, CS comes with some form
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of benefits as women indicated that sexual satisfaction is maintained after the procedure.

Beliefs about disfigurement

Participants reported that CS disfigures a woman. This they attributed to the inability of the woman to tie her abdomen for the womb to return to its original position because of the sore created on the abdomen which leads to most of them having pot bellies. This was evident from the following narratives;

“If it had been normal labour straight after discharge in three days’ time I could have used a cloth or a corset to hold my stomach back, but with CS it took me about six weeks before I actually use the cosset or the cloth to hold my stomach, by then my stomach became big, because I had to allow the wound to heal before I could tie my stomach to go back to its normal state. this was a worry to me(laughing) you know as a woman we all want to appear good in the sight of our husbands ahaa, so if you have this big belly it actually distorts your form it doesn’t bring out your shape well so it is a problem” (Safura)

“When you deliver normal you can tie your tommy, but when it is CS you can’t tie it, because of the pain and the sore you can’t tie it, if you want to tie it, you will harm yourself. It has affected me, now if you see my stomach, my stomach is big and I have no shape again, but first when I just delivered normal, I just tied it and it was just normal but now, because of the CS I didn’t tie, my shape is not there again” (Abigail)

This finding indicates that most women are not happy after CS because they hold the belief that CS comes with disfigurement making them not attractive to their husbands.
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Beliefs about restriction of ideal family size

The results of the study revealed that undergoing CS restricts one’s ability to have the desired number of children. These are socio-cultural perceptions which was a source of worry to some participants and their significant others. The following extracts makes clear how CS limits one’s ability to achieve her ideal family size;

"You won’t give birth any more after CS, that there are some organs in you that they are not supposed to touch, but once they open you up and they touch those organs or even some of the organs touch each other, then you won’t be able to give birth again. So, we all think about it when we go to deliver it’s not our wish to refuse CS” (Paulina)

“Like I know somebody who delivered first through caesarean but second time the person went normal birth and even delivered the third one. But my people are thinking that, when you go through caesarean for the first time, the second will also be CS and you can’t deliver again. So, to tell a woman in my area she will deliver by CS she will curse you” (Abigail)

“We believe that if they do you the operation, they will turn your womb upside down after removing the baby and you can’t deliver again and we don’t want that, we all have the number of children we want to give birth to before we die” (Tracy)

These findings are an indication that they viewed CS negatively given that it deprives them from having their ideal family size.
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Culturally, the women shared the belief that CS is associated with some physical impairment later in life. This was evident in the following narratives;

“Our old folks think that, when you go through CS, when you become old, that’s when you will be having problems like joint pain and knees and you can’t even walk well. Those perceptions, they are scaring people away” (Vanessa)

"They say when they operate you, you won’t be strong again till you die and the things that you do sometimes you can’t do them anymore you have to sit at one place” (Paulina)

“In my area, they are saying that if you do operation, when the thread weakens or are broken, that your waist will start to pain and that at old age it will give your waist more problems” (Ethel)

4.4 Sources of perception about CS (objectification)

Sources of perception about CS provides a construct that has to do with how participants obtained information on beliefs about CS as a mode of delivery. From the study, it was established that all the participants have heard beliefs about CS but from different sources. The findings from the study revealed that participants beliefs about CS were obtained through two main sources; namely significant others (community members) and social media (mass media).

Significant others (community members)

The study revealed how most of the women got information on CS from the community in which they live. Participants expression of the community members as a
source of their information on beliefs about CS was based on instances were family
members, neighbours and friends gave them information on CS.

Paulina and Louisa shared their sources of beliefs about CS in the following instances
where their respective family members gave them information on CS.

“Eihhh my mother in-law was once operated; her last child she was operated so I
got to know of it (CS), that was even before I married my husband and the old
people in our house were saying we should try and go and greet her because they
killed her before the baby came so if she is alive we should all thank God”
(Paulina)

“Ooh by then it was just in the house, when we were there my brother’s wife they
operated her and when she came home they were saying it CS CS CS that CS is
not good that if you are found of going through it you lose your life you will die,
you will not be able to give birth again and all those things, there that I got to
know till I also married not knowing am also going to be operated. So, my first
operation madam, the nurse had to talk aaah before I agreed” (Abigail)

“My grandmother and her stories, I remember her telling my mother and her
rivals that their time when this CS was not common they operated a certain
woman and left some things in the stomach and she died. She was now telling us
to be careful of that thing they call CS. Up till now I still think about it anytime
they say they will operate me am always afraid” (Louisa)

Ethel and Binta, heard about beliefs on CS from friends which made them afraid and
scared before they went through it. This is what they had to say:
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“I heard of CS from my friend, so I was not praying to God to let me deliver through operation because the way she was talking about it, she was saying that if you go through CS by the time you recover it will take a week or more or you die after the operation and that people are even saying you the woman, you went behind your husband so I was so much afraid about it so when they were to operate me, I was saying no they shouldn’t operate me I may have problems at home after I leave the hospital” (Ethel)

“My friend said when they want to do you operation this and this is what they will do to you before they operate you; they will kill you and bring the baby and wake you up, and all the time they will now be operating operating; I was so scared, so I said for me I will never go in for this CS thing, that day they were to operate me it wasn’t easy for me I even wanted to run home” (Binta)

Responses from Myela and Vanessa indicate that their sources of information on CS was from social gatherings. They had this to say:

“At the wedding ,they mentioned her name and said she has delivered but she has gone through CS and as for the CS they are afraid of it, is a matter of life and death but she has succeeded in giving birth through the CS the baby is alive and the mother is also alive, but the way they were talking about the CS the one saying it said it made her not to like the CS, that they say if one is going through the CS the doctors can cut some part of your stomach and that will be your all you won’t give birth again; so I was sad when the nurse told me they said they will operate me” (Myela)
“Mostly social gatherings like we’re sitting in a naming ceremony or wedding ceremony and somebody says how old is your child? and somebody will say when are you planning for the next one? and someone will say you know it was CS, then you see that the conversation will start; that is how we hear things about CS; for instance I got to know that CS is done on lazy women during a conversation at a friend’s wedding and that it is only when you deliver and the baby pass through your vagina that you are a woman; this was even before I even got married so I really wanted to give birth normally and that resulted in the death of my first child” (Vanessa)

Social media (mass media)

Mass media served as another source through which women obtained information on CS. Typical sources mentioned were the radio and television. Below are statements by participants that suggest that beliefs about CS were obtained from the mass media.

“It was on radio, they were talking about it (CS) on air. They said sometimes in the olden days, they could use three days on the same person until they finish so I told myself for CS dierr I don’t want it after they have finished their talk on it”

(Freda)

“When they were doing the discussion on television, I heard someone asking that is it true that if air enters your stomach during the operation whether you will die? because someone died after this CS and they said air entered the stomach in her area, since then I told myself this CS it will not come my way so I was really
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sad when I was told of the operation. I just couldn’t imagine seeing death and

signing for it” (Tracy)

These findings are an indication that, beliefs and information on CS was obtained from various sources by the participants and based on the information received participants reacted differently towards the procedure.

4.5 Perceived order of socialisation about CS (internalisation)

This theme seeks to describe the cultural perceptions surrounding CS and motherhood which may have a significant role in the decision-making process of women on a birth method. Social perception of womanhood emerged strongly as an order of socialisation.

Social perception of womanhood

Socially women have been made to belief that a woman is one who can deliver vaginally (naturally) and also one who can give birth to many children. As such women in this study, even though they knew the benefits of CS, were interested in vaginal delivery in order to be recognised as women in their social context. The following expressions by participants exemplified the societal perception of a woman as one who can deliver vaginally:

“No no no, I really wanted to have the experience like what my mother had. I wanted to deliver naturally; as a woman I should deliver naturally so that in future I will also have history to tell my children how I went through pain before I delivered them. As a woman if you say all your children you gave birth to them
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through CS, fine the sexual aspect your husband will keep on enjoying you and you look fresh but you miss the experience of normal childbirth, you can tell the experience of pregnancy but you cannot share the experience of pushing for a child to come out through you ahaa so I will advise every woman to try and deliver vaginally like our mothers did” (Binta)

“In the beginning I was so awful, I felt like I wasn’t a woman enough to have gone through CS. I was expecting that I should also go through normal delivery to show that am a woman like the way my family have seen it; when you go through normal delivery it shows that you are healthy and a strong woman” (Rahama)

“They are saying that you are a weak or a lazy woman that is why you have gone through CS, because others are delivering normally and you cannot deliver normally unless CS and as such they are looking down upon you and it makes you worried and ashamed, but am not a lazy woman or weak woman and that is what they believe in, so I pray to deliver normally to prove them wrong” (Freda)

Vanessa shared how she lost her child because she wanted to deliver naturally like others;

“Eiihh that’s what I said, they always say you the woman you are lazy like they expect that every woman should give birth normally then you have gone through CS, so it’s like I don’t know how to put it, it’s like you are less of a woman be, you should have given birth normally and you have gone through CS; that was the perception I had during my first pregnancy and I delayed at home and the child died” (Vanessa)
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Louisa shared how her in-laws felt she would not have performed her role well as a woman because delivering through CS will put a restriction on the number of children expected of her.

“My husband’s people ahaa even though my husband has no problem but the family, they will say ehee, it has been said that with CS you are given only four chances, so his people will say, the four I will give birth to will not be enough he should get a second wife, he should marry again those things. Even for now, they have started saying it; that as a man you have to marry again because, your father didn’t marry to one wife, because of that my husband’s behavior has started changing towards me. They said for a woman to give birth to only four children she has not done anything; they will just be saying it and that is always my worry, looking at my structure it isn’t that, God! in fact they should have given chances may be by chance one can just go through the labour and deliver so that, as they say four children and teasing at you I could get five, six and also stop because I have seen myself to be someone who still have the strength ehee”

(Louisa)

Similarly, Safura had this to say;

“Not in my area, you don’t deliver many children and think you are also a woman, even your friends will tell you things you don’t want to hear so CS dierr is just that women don’t have a choice when it comes our way if not” (Safura)

Paulina shared how one could be cursed for advocating for CS for a mother who has had vaginal delivery before. She had this to say;
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“You know not all of us think the same; there are some people who give birth naturally and at the end they operated them; if there is someone who gives birth naturally and you want to talk about CS they will curse you, they will say you should send your troubles away, because of what people will say, maybe if the person has gone through natural before and is about to go through CS they might say you have been giving birth naturally why CS now so it’s the perception of people that will make us like to deliver normally and not through CS” (Paulina)

These findings from the above theme clearly defines a woman and womanhood socially as largely on woman’s ability to deliver vaginally and been able to give birth to many children which most of the participants wanted to achieve.

4.6 Emotions associated with cs

This theme relates to how the women reacted on hearing that they were to undergo caesarean section. The theme also indicates the level of acceptance of caesarean section as a birth method. Participants in this study, exhibited different emotions towards CS which led to three main themes namely: depression, anxiety and positive emotions.

Depression

The women’s description of depression was centred on sadness, crying, unhappiness. The quotes below from participants indicate how crying was seen as an expression of depression.

“When they told me they will operate me, immediately I was crying, because they say sometimes they may operate somebody and the person will die. And when I was crying the nurses came and told me to stop crying, the CS is not anything bad
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and that nothing will happen to me, and that if it delays again my baby may die
and then I stopped crying and told them to operate me” (Freda)

Other participants described their depression as sadness. Tracy had this to say;

“When they told me about the CS, I was sad; because I have never gone through
operation but the way I hear people talk about operation, if you deliver yourself it
is better than the operation hmmm” (Tracy)

Unhappiness was the expression of depression by Binta on receiving the information that
she had to be operated. Binta narrates:

“I wasn’t happy, I wasn’t happy at all, because my children were alone their
father is now old and he went to Bolga to do some work and I didn’t have any
sister to come and live with them, their senior most sister was in the university
Abetife she would have been there to take care of them, the second born too is
somebody who is also in the university and the third one too was in secondary
school in Kumasi, because these three senior ones were not there, that was my
pain. How will the rest of the children cope? and when I was leaving the house, I
had prepared myself as usual when I go today, tomorrow I will come back that
was what I told the children and I came to the hospital and stayed for almost 5
days” (Binta)
Anxiety

Most of the participants in the study reported that they were anxious after receiving the information that they were going to be operated. Their description of anxiety centered on worry, being scared, afraid, and expressions of heartbeat.

According to Louisa she was worried and after the CS she still felt worried because she wanted to give birth vaginally.

“Ooh for that one dei, it is a worry to me. I was very worried even up to now, like I don’t know, I wish I could have been giving birth through my vagina so that, those nonsenses and talks they say; that you are not a woman, somebody wouldn’t have been able to say that whereby I can’t utter a word” (Louisa)

Another woman added:

“I was worried and I was thinking about it because I should have also delivered normally, are they going to say I slept with another man? nooo, but everyone is not the same” (Ethel)

Tracy and Safura were afraid because they didn’t know what the outcome of the CS will be as illustrated by these quotes:

“I was afraid because I didn’t know what operation is how is done, others say they kill you and take the baby out, what will happen? will I die? and after the operation what will happen? I was just praying that they will do it successfully” (Tracy)
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“When I was told I will be sent to the theatre for CS, it wasn’t easy but I had to, there was this anxiety like unknown outcome like what will happen if I go what will happen, you don’t know the uncertainty you don’t know what will actually come out of the surgery so that one alone brings some kind of fear” (Safura)

Abigail reported how she experienced heart beat on daily basis upon hearing that she had to be operated:

“Every day my heart was beating, they themselves told my husband that he should just get something for me so that if am sitting I will not be thinking about the operation, so my husband just bought me a new phone with some funny videos and still I was just thinking” (Abigail)

Paulina lamented that:

“I couldn’t take it, my first delivery and I had to go through CS you know, it wasn’t a good encounter, CS the way I have heard about it that they can forget certain things in your tommy and what and what that really scared me” (Paulina)

Vanessa added that the news on her CS was unpleasant and as such she wouldn’t even recommend that for an enemy.

“ahaaa I mean you know definitely I mean to welcome it, well cut open I mean to cut open, you can imagine the size of a baby, cut open (laughing) to bring a child out it wasn’t pleasant at all I didn’t at that time I didn’t even imagine that it could happen to me, cutting open to bring a child out of your body it wasn’t something pleasant I would have wish for an enemy” (Vanessa)
Positive emotions

Positive emotion is yet another emotion exhibited by the women towards CS in this study. Some participants showed positive emotions toward caesarean section through the following expressions:

Nasara a mother of three through CS shared this.

“I mean in no time I mean the joy of seeing my baby I mean the doctor when I was diagnosed of having the fibroid I mean the doctor made it known to me that I may not be able to have children, if am married and am pregnant, I should come back so I was just grateful that I have been able to have a child. And I was happy by whatever means so I mean, I bored the pain koraa” (Nasara)

“When they operated me I was happy, because I laboured for three days and could not deliver in the house and they brought me to the hospital and operated me” (Ethel)

Vanessa a 32-year-old teacher, who was once operated yet lost her first child because she delayed at home due to her desire to deliver naturally on arrival at the hospital expressed strong positive emotion towards CS.

“I like the fact that I was operated and I had my baby. The first one I was operated yet I didn’t get my baby but this one they booked and I complied and I had my bouncing baby girl. I mean I feel good about it, nothing of CS somebody will say again that will scar me if my third delivery I have to go for CS I will even dance to the hospital” (Vanessa)
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These findings revealed under emotions associated with CS suggest that, despite knowing the benefit of CS, to these women it comes with different emotions while some showed signs of depression, others were anxious because they did not know what the outcome of CS might be. That notwithstanding, the news on CS was welcomed by few participants because they felt they stood to gain should they agree to go through the procedure. This attitude of few participants was grounded on their earlier refusal to undergo the procedure which resulted in a negative outcome to them.

4.7 Post caesarean section consequences

Post CS consequence as a main theme emerged contextually from the data. Even though CS is a lifesaving procedure, women suffer in the social context in which they find themselves after the procedure. Two main categories regarding the consequences after caesarean section were reported by the participants. These included marital consequence and social consequence.

Marital consequence

The participants expressed that in the social context in which they found themselves, the number of children a woman can give was important to the family and as such their marriages were being threatened based on the perception that CS restricted a woman’s ability to give birth to many children. For some of these women their in-laws were advocating a second wife for their sons to give birth to additional children, others were verbally abused.

“My sister let me tell you, the truth is that no mother in-law in our culture will sit and watch you deliver only three children or so for the son; even after the second
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CS, she will start to look for another woman for the son for more children, it has happened to me. They know as for CS it is only three children that you can give birth to” (Freda)

“Whenever we quarrel, he will just tell me my mouth is too sharp yet common childbirth I can’t do unless they cut, I should wait and see I don’t know what he wants to do ooh but you know our people maybe he wants to bring in a second wife” (Tracy)

Social consequence

The results of the study showed that women in the study also experienced some form of social abuse in their respective communities after the CS. While others were seen as less of a woman, others were being teased, for some they were poorly received at home after their second CS. The expressions below illustrate how socially women are treated after CS;

“Me I just think it is normal, there is nothing wrong with it(CS) ehee, what God has given to you, you have to accept it, just that the people around you will be teasing you and doing certain things just to differentiate you from them, even when we go to wedding grounds, naming ceremony and you sit with them, they will say things like, unless the child you give birth pass through your vagina that you can call yourself a woman but through CS deii you shouldn’t call yourself a woman, even they say the baby you have given birth to through CS, that baby can’t compare herself to the baby who came from the mothers vagina; yet you have to keep quite because when you say something you will quarrel among
yourselves and in case you don’t want to quarrel or to make more people know who you are, you just keep quiet or maybe you change your sitting position or leave the place” (Louisa)

“hmmm aunty, do you know one thing about this CS thing? when you do it and you are with your friends like wedding time or outdooring and you are talking, they can just tell you to keep quite when you want to say something, or whatever you say, they will do as if they have not heard you; when they behave like that it can be painful and annoying. I pray they will all go through this CS as they are all still delivering, and see how it is” (Abigail)

“the atmosphere at home, it was not conducive like the way they used to receive me after the previous ones, they know that when you go through CS twice, the rest you can’t give birth naturally” (Paulina)

4.8 Summary of the findings

The study revealed how caesarian section is socially constructed in the Tamale Metropolis. Even though this was achieved using the social construction of reality model, some of the themes emerged contextually from the data. The demographic characteristics revealed that the women interviewed for the study were aged 22-49 years, majority (8) of whom were Muslims with four (4) being Christians. The mothers had different educational backgrounds including tertiary (7) and SSS (5).

Narrations of mothers revealed their subjective and societal beliefs about CS, their sources of information on beliefs about CS, the perceived order of socialization about CS, emotions associated with CS and then post CS consequences.
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The participants gave varied beliefs about CS in the following areas; meaning of CS, beliefs about how the procedure is done, religious beliefs, beliefs about disfigurement, beliefs about restriction of ideal family size, beliefs about physical impairment. Social media, significant others (community members) were subthemes on sources of perception about CS. Social perception of womanhood, anxiety, depression, positive emotions, marital and social consequences were the other subthemes that emerged from the study. The participants indicated they had a basic understanding of what CS is and how it is done. Their understanding of CS was associated with being a form of delivery involving an act of cutting a pregnant woman to bring out the baby. The belief however was that, CS involves killing the woman and waking her up after the procedure. The women shared that in their social context CS is seen as a procedure for adulterous, weak and lazy women as well as a curse to disrespectful women.

Religiously, participants were of the view that the CS they experienced was ordained by God while others felt it wasn’t the will of God. The findings have revealed that, even though women knew the benefits of CS in saving their lives and that of their babies, they were much particular about its effects on them. Most of them believed it comes with disfigurement and retention of blood and other waste in their wombs. In other situations, CS comes with some form of benefits as women indicated that sexual satisfaction is maintained after the procedure.

The results of the study revealed that undergoing CS restricts one’s ability to have the desired number of children, which was a source of worry to some participants and their significant others.
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Participants held the belief that CS comes with some physical impairment later in life from waist pain to not being able to walk later in life. The study found this to be a major concern among most of the study participants. From the study, beliefs on CS were obtained through two main sources; namely significant others (community members) and social media (mass media). Socially, the women have been made to belief that a woman is one who can deliver vaginally (naturally) and also one who can give birth to many children as such women in this study though knew the benefit of CS, were interested in vaginal delivery in order to be recognised as women in their social context.

The women exhibited different emotions towards CS; depression, anxiety and positive emotions. Following the incidence of CS, women suffered in the social context in which they found themselves, ranging from marital consequences to social consequences.
CHAPTER FIVE
DISCUSSION OF FINDINGS/RESULTS

This chapter discusses the findings of the study in relation to existing literature so as to put it in a historical context. The findings are discussed based on the themes which are consistent with the constructs of the model used. The demographic characteristics of the participants are discussed first and followed by major findings.

5.1 Demographic characteristics

The findings of the study revealed that majority (66.6%) of the mothers who had CS fell between the ages of 30-49 and the least that is four (33.3%) were in the age category of 20-29 years. Studies have established that an increased age at the time of conception could lead to delivery through CS (Yoshioka-maeda, Ota, Ganchimeg, Kuroda, & Mori, 2016). This variation in ages gives an impression that giving birth through CS has no regard for one’s level of maturity. It is also logical that women from age 30 up to 49 years are those who are more likely to present obstetric complications, lack the necessary strength to push out their babies at the time of childbirth birth as compared to those 29 years or less who may have the strength to go through normal vaginal delivery.

The study findings indicate that all the participants were married. This implies that child-birth occurs mostly in marriages which is a virtue cherished in the Ghanaian culture. This compares favorably with (Marazyan & GUILBERT, 2013). This meant that they were all staying with their husbands and children.
In terms of Religion, majority (8) were Muslims and the remaining four were Christians. In the social context in which the study was being carried out, family size is important in this part of the country. Northern Ghana is generally a pro-natalist society where reverence is adored to the number of children a woman has. The more children a woman has, the better respect she commands from both her husband and the community (Ugwu & Kok, 2015). However, in marriages where women deliver through CS, it puts a limit to the number of children a woman may desire to have. With majority of these women being Muslims, it stands to reason that their husbands could marry again or even reject them for other women who can give birth to many children.

The participants level of education was generally high as most (7) had tertiary level education with few (5) SSS leavers. Similar results have been reported in some studies Ghotbi et al., (2014) and Neuman et al., (2014). These differences in educational level gives an indication that giving birth through CS has no respect for one’s educational status. Any woman within the reproductive age can give birth through CS. However, with the high educational level of most (7) women who underwent CS in this study, one can assert that women with higher educational levels may embrace CS as a mode of delivery because they are open minded, they embrace change and will prefer having a healthy baby regardless of the mode.

Furthermore, the research revealed that majority (six) of the mothers were first time mothers. Ajeet et al., (2011) made similar findings in their study where most of the participants who underwent CS were first time mothers. This may be due to advance age, fear of labour pain or probably because, women delivering for the first time could present obstetric complications.
5.2 Social construction of caesarian section

In this present study, different beliefs and connotations have been assigned to CS as a form of delivery as expressed by the study participants within their social context. The women had meanings for CS, beliefs about the procedure and the reasons for CS. Other beliefs were based on religion, outcome of CS, disfigurement associated with CS. The rest were restrictions on ideal family size and physical impairment. This implies that the different beliefs about CS as reported by the women tend to influence the acceptability or otherwise of CS as a birth strategy during gestational age of a woman.

The study posits that mothers who had CS associated it with a form of delivery that involved an act of cutting a pregnant woman to bring out the baby. The results conform with studies conducted by Aziken, Omo-aghoja, and Okonofua, (2007). These descriptions given by the participants indicated they had a basic understanding of what CS is and how it is performed. Similarly, the results of the study indicate that women had the belief that caesarean section involved “killing” the woman to remove the baby and “waking her up later”. This finding supports the proposition by (Litorp, Mgaya, Kidanto, et al., 2015). The findings suggest that the process of women undergoing CS under general anaesthesia is interpreted by these women as “killing” the woman and waking her after the procedure.

Also, the present study showed that participants had varied beliefs for the procedure of CS to be carried out. The women explained reasons for CS to include promiscuity, laziness, fear of childbirth pain and a curse to a disrespectful woman. These findings compare favourably with that of Mboho (2013 a), Qazi et al., (2013), Sahlin et al., (2013) and Ugwu and De Kok, (2015). These findings suggest woman may avoid CS
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because of the negative societal construction of CS. For instance, women in the study area may avoid CS to escape being labelled as promiscuous or being cursed by their ancestors. The undesirable, different views of social construction of CS may jeopardize the fight against maternal and neonatal deaths because it can lead to underutilization of surgical births as an alternative means of childbirth when complications occur.

Furthermore, the study found that participants had different religious connotations and subscriptions about CS. Religiously, participants were of the view that the CS they experienced was ordained by God. Others were of the view that it is when you are not prayerful and committed to your religious duties including payment of tithes that CS will be performed on you. This finding is similar to that of Litorp, Mgaya, Kidanto, et al., (2015). This gives an impression that the indications for CS may not be understood by these group of women or they might have the conviction that nothing happens by chance. For such women, based on this belief, it is unlikely for them to go back to such hospitals for delivery.

Expressions of concern over the outcome of CS revolved around complications associated with CS and preservation of their vaginas. The study revealed that participants were worried over retention of blood products after CS. This manifested in the form of smelly discharges from the vagina, which was also reported in several studies (Boz et al., 2016; Latifnejad Roudsari et al., 2015; Rahnama, Mohammadi, & Montazeri, 2016). It is clear that these women had misconceptions about CS. This implies that more education has to be provided for pregnant women attending antenatal services on the indications for CS.
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The findings also established that the participants were of the view that their vaginas were preserved after CS as compared to vaginal delivery. To these women, sexual satisfaction is maintained after the procedure since the vagina maintained its original state. These vaginal concerns were also reported in previous studies (Latifnejad Roudsari et al., 2015; Stoll et al., 2014). With this perceived benefit in mind, women are most likely to opt for CS in the absence of any medical indication in order to keep their vaginas for sexual gains. If this idea is held by many women, this may result in an increase in CS rates in health facilities in the Tamale Metropolis.

Another finding in this current study worth noting is participants’ perception that CS disfigures a woman. This they attributed to their inability to tie their abdomen for the womb to return to its original position because of the sore created on the abdomen. This led to most of them developing pot bellies which they were not happy about because it made them unattractive to their husbands. This concurs with an earlier study by Boz et al., (2016). This finding suggest that women are likely to avoid CS by resorting to home delivery in order to escape the possibility of CS at the time of giving birth in the hospital to avoid the perceived disfigurement of their bodies.

In terms of the number of children one can have, the findings postulate that undergoing CS restricted one’s ability to have the desired number of children. These were socio-cultural perceptions which was a source of worry to some participants, which was also a worry to women in previous studies (Qazi et al., 2013; Ugwu & Kok, 2015). This finding is an indication that, the women viewed CS negatively in terms of the number of children they can have, suggesting that CS deprives them of their ideal family size. This is attributable to the importance attached to large family size within the social context of the
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study area. Contrary to this finding, Litorp, Mgaya, Kidanto, et al., (2015) found that women will prefer smaller family size resulting from CS in order to give them better care.

The findings from the study also indicated that, culturally, women shared the belief that CS comes with physical impairment later in life such as waist, joint and knee pains to inability to walk and work. The women were scared of this revelation, consistent with feelings of women in previous studies (Qazi et al., 2013; Rishworth et al., 2016). In a social context where most household chores are solely the responsibility of the woman especially in the study area, a woman may refuse CS because of the perceived physical burden associated with it. This may also increase delay in seeking for hospital health care when complications develop during home delivery or even lead to women seeking health care from alternative providers when complications are perceived including prayer centres. All these could increase the risk of adverse maternal and neonatal outcomes including maternal and neonatal deaths.

5.3 Sources of perception about CS

In this current study, sources of perception about CS refers to the various means through which information on beliefs about CS was obtained. The present study revealed that participants’ beliefs about CS was obtained through two main sources, namely significant others (community members) and social media (mass media). Participants’ expression of the community members as a source of their information on beliefs about CS was based on circumstances where a family member, neighbour(s), and friends gave them information on CS such as the process involves killing the woman to remove the baby and waking her up later, one dying after the procedure and the fact that objects are left in the womb after the procedure. The study also revealed mass media as a major
source of information on beliefs about CS. Typical sources mentioned were the radio and television. Based on the information received, participants reacted differently towards the procedure. While others were afraid, some tried resisting the CS altogether. The rest attempted running from the hospital. This revelation is in tandem with those of Fenwick et al., (2010) and Munro, Kornelsen, and Hutton, (2009). Though CS is performed in hospitals, health personnel or hospital did not emerge as sources of information on beliefs about CS. This finding therefore seems to suggest that information on beliefs about CS are derived from informal sources which could be inaccurate and may deter women from patronizing CS as a birth strategy when the need arises. This confirms the position of Ajeet et al., (2011). The above analysis points to the fact that the education and counselling given at the ANC level does not address beliefs women might be holding about CS before and after delivery. This therefore calls for a conscious effort on the part of health care providers to provide tailored made education on the general indications for CS as a medical condition particularly during ANC attendance of pregnant mothers.

5.4 Perceived order of socialisation about CS

Perceived order of socialisation about CS in this study seeks to describe the cultural perceptions surrounding CS and motherhood which influenced the decision-making process of women on a birth method. Social perception of womanhood emerged strongly as an order of socialisation. Socially, women were made to belief that a woman is one who can deliver vaginally (naturally) and also one who can give birth to many children. As a result, women in this study though knew the benefits of CS, had the strong desire for vaginal delivery in order to be recognised as women in their social context as also reported previously (Mboho, 2013a; Qazi et al., 2013; Ugwu & Kok, 2015).
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Clearly, these women may resist CS in their subsequent deliveries given that CS deprives them of being recognized as “women”. The undesirable views about womanhood may be rooted in socio-cultural beliefs that can hinder attempts to refer women in situations where there is/are threatened complications during delivery requiring surgical intervention. This is because undergoing caesarian section according to the participants is a perceived reproductive defeat.

5.5 Emotions associated with CS

Reactions towards CS varied among the study participants. Reactions such as depression, anxiety and positive emotions were expressed when the women heard that they were going to be delivered of their babies through CS. The women’s expression of depression manifested in the form of, crying, sadness, and unhappiness. Women, who cried attributed it to the belief that one might die during the procedure. For those who reported being sad, it was based on the social beliefs surrounding CS. For those who were unhappy about CS, unplanned CS delivery coupled with longer hospital stay was a factor. The unexpected lengthy stay at the hospital could present challenges to these women, preventing them from fulfilling their socially expected responsibilities at home.

Other women were worried, scared, afraid and experienced heart beat after receiving the information that they were going to be operated on to have their babies delivered. The social belief that one is not a woman after CS, being a perceived adulterous woman were the concerns of these women which resulted in their worry. For some of these women, they expressed being afraid because they did not know how CS is done and what the outcome of CS might be as also revealed in the case of Ameresekere et al., (2011).
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However, the findings disclosed that some women exhibited positive emotions towards CS. This was manifested in the form of happiness. For some of these women, the idea of CS was quickly embraced. That is, previous health information indicated the need for CS owing to prolonged labour they had experience. For some others it was grounded on their earlier refusal to undergo the procedure which resulted in a negative outcome to them. The literature reports similar positive feelings given by women who have undergone CS (Ajeet, Jaydeep, Nandkishore, & Nisha, 2011; Buyukbayrak et al., 2010; Fenwick, Staff, Gamble, Creedy, & Bayes, 2010; and Sahlin et al., 2013). These positive feelings suggest significantly to the fact that medical indications for CS is easily accommodated by some women.

5.6 Post CS consequences

The study identified marital and social consequences suffered by the women in their social context after the procedure. For some of these women, their in-laws were advocating a second wife for their sons to give birth to additional children, which is in line with findings of Ugwu and Kok, (2015). The findings of the study also showed that women in the study experienced some form of social abuse in their respective communities after the CS. While some were seen as less of a “woman”, others were teased (Mboho, 2013a). The results revealed a high level of ignorance about CS in the participants’ communities. For some of the women, they were poorly received at home after their second CS. This issue was similarly reported by women in a previous study (Qazi et al., 2013). Generally, the results bring to fore the urgent need for intensive education not only among women but the community as a whole on the right indications for CS as a birth strategy medically.
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In summary, women in Tamale Metropolis have different beliefs about CS. They had meanings for CS, beliefs about the procedure and the reasons for CS. Other beliefs were based on religion, outcome of CS, disfigurement associated with CS. The rest were restrictions on ideal family size and physical impairment. Generally, the woman had basic understanding of the meaning of CS. The process of women undergoing CS under general anaesthesia was interpreted by the women as “killing” the woman and “waking her up later” after the procedure. The women explained reasons for CS to include promiscuity, laziness, fear of childbirth pain and a curse to a disrespectful woman.

Women in the study area may avoid CS to escape being labelled as promiscuous or being cursed by their ancestors. The women had different religious connotations and subscriptions about CS. Religiously, participants were of the view that the CS they experienced was ordained by God while others were of the view that it is when you are not prayerful and committed to your religious duties including payment of tithes that CS will be performed on you. For those who believed that they were religious and still underwent CS, they attributed it to the hospital or the health workers being in a hurry.

The women were of the view that their vaginas were preserved after CS as compared to vaginal delivery. To these women, sexual satisfaction is maintained after CS since the original state of the vagina is maintained. The women believed CS comes with disfigurement as they developed pot bellies after the procedure which makes them unattractive to their husbands. That aside they were of the concern that, blood and other waste are retained in their wombs after CS which manifested in the form of smelly discharges from their vaginas. In terms of the number of children one can have, the
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women mentioned that, undergoing CS restricted one’s ability to have the desired family size which was a source of worry to some of the women.

The women beliefs about CS were obtained through two main sources, namely significant others (community members) and social media (mass media). The women expression of the community members as a source of their information on beliefs about CS was based on circumstances where a family member, neighbour(s), and friends gave them information on CS. Also, mass media was a major source of information on beliefs about CS. Typical sources mentioned were the radio and television. Social perception of womanhood emerged strongly as an order of socialisation. Socially, the women were made to belief that a woman is one who can deliver vaginally (naturally) and also one who can give birth to many children which most of the women wanted to achieve. Reactions such as depression, anxiety and positive emotions were expressed when the women heard that they were going to be delivered of their babies through CS. For some of these women, the idea of CS was quickly embraced. This was because previous health information indicated the need for CS owing to prolonged labour they had experienced. For others, it was grounded on their earlier refusal to undergo the procedure which resulted in a negative outcome to them. However, marital and social consequences were experienced by the women in their social context after the procedure.
CHAPTER SIX

6.0 SUMMARY, IMPLICATIONS, LIMITATIONS, CONCLUSION AND RECOMMENDATIONS

This chapter presents the summary of the entire study, implications of the findings, limitations, conclusion and recommendations.

6.1 Summary of the study

The study explored the meaning of caesarian section among women who have undergone caesarian section in the Tamale Metropolis, using the theory of social construction of reality as the organizational framework. Data collection started after ethical clearance approval was obtained from the institutional review board of the Noguchi Memorial Institute for Medical research in the University of Ghana. Pretesting of the interview guide was done at the Tamale West hospital. Data collection started on 15th of January and ended on the 10th of April 2018. Twelve (12) participants were recruited for the study. Participants gave their consent by signing or thumb printing consent forms before interviews were conducted. Each interview was audio taped and transcribed verbatim and data analysed using thematic content analysis. Each interview lasted for 40 minutes to an hour.

The key findings of the study revealed women’s subjective and societal beliefs about CS, their sources of information on beliefs about CS, the perceived order of socialization about CS, emotions associated with CS and post CS consequences. The participants gave varied beliefs about CS in the following areas; meaning of CS, beliefs

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about how the procedure is done, religious beliefs, beliefs about disfigurement, beliefs about restriction of ideal family size, beliefs about physical impairment.

Social media and significant others (community members) were common sources of perception about CS. Social perception of womanhood, anxiety, depression, positive emotions, marital and social consequences were the other subthemes that emerged from the analysis of the study. The participants indicated they had a basic understanding of what CS is and how it is done. Their understanding of CS was associated with being a form of delivery involving an act of cutting a pregnant woman to bring out the baby. The belief however was that, CS involves killing the woman and waking her up after the procedure. The women shared that, in their social context, CS is seen as a procedure for adulterous, weak and lazy women as well as a curse to women who are disrespectful.

Religiously, participants were of the view that the CS they experienced was ordained by God while others felt it was not the will of God. The findings showed that, even though women knew the benefits of CS in saving their lives and that of their babies, they were much particular about its effects on them. Most of them believed it comes with disfigurement and retention of blood and other waste in their wombs. In other situations, it is believed that CS comes with some form of benefits as women indicated that sexual satisfaction was maintained after the procedure.

The analyses of the results revealed that CS restricted one’s ability to have the desired number of children, which was a source of worry to some participants and their significant others.
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Participants held the belief that CS comes with some physical impairment later in life from waist pain to not being able to walk later in life. The study found this to be a major concern among most of the study participants. From the study, beliefs on CS were obtained through two main sources; namely significant others (community members) and social media (mass media). Socially, the women have been made to believe that a woman is one who can deliver vaginally (naturally) and also one who can give birth to many children as such women in this study though knew the benefit of CS, were interested in vaginal delivery in order to be recognised as women in their social context.

The women exhibited different emotive reactions towards CS such as depression, anxiety and positive emotions. Lastly, flowing from the incidence of CS, women suffered within the social context in which they found themselves, that ranged from marital consequences to social consequences.

6.2 Implications

The findings of the study have some implications for nursing practice, nursing research and policy formulation.

6.2.1. For Nursing Practice

The findings revealed that even though the women knew the benefits of CS to save their lives and that of their babies, they were more particularly concerned with the beliefs on CS that they obtained from informal sources such as community members. These beliefs were a source of hindrance to the acceptability of the procedure by most women. This therefore implies that nurses have a critical role to play in identifying and addressing these beliefs about CS before and after delivery.
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The findings suggest that the education and counselling given at the ANC level does not address misconceptions women might be holding about CS before and after delivery. This therefore calls for a conscious effort on the part of health care providers to provide tailored made education on the general indications for CS as a medical condition particularly during ANC attendance of pregnant mothers.

6.2.2. For future research

The study revealed the need for further research on social construction of CS to provide better understanding of the phenomenon. The present study explored the social construction of CS through the qualitative application of the social construction of reality model. Future studies could determine the relationship between the various constructs of the social construction of reality model.

Other areas of interest may be to explore the meaning of CS among fathers or from the perspectives of health workers in the Tamale Metropolis in order to get a broader understanding of the beliefs associated with CS.

6.2.3. For policy formulation

The findings suggest that medical indications for CS was easily accepted by the women. This reinforces the need for a policy on mandatory education at the antenatal clinics on the essential medical indications for CS to make it freely acceptable as an alternative birth method devoid of the social misconception associated with it.
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6.3 Limitations

The researcher acknowledges limitations of the study. The relatively small sample size may not be representative of the general population and, therefore, generalization of the findings should be considered with caution. However, the findings are consistent with other studies in Ghana and other countries and therefore transferability is possible when there is similarity of context.

Translation of some data may pose a threat to trustworthiness as the exact meaning of some expressions may be lost. However, extreme efforts were made to use words and expressions that are closest to the translated words.

6.4 Conclusion

Most of the findings of the study conformed to the constructs of the social construction of reality model. These include social construction of CS, sources of perception about CS, perceived order of socialisation about CS. Those that were not consistent with the social construction of reality model were emotions associated with CS and post CS consequences. The findings indicated that women had varied beliefs about CS that tend to influence their acceptability of the procedure as a birth strategy. Women obtained beliefs about CS from various sources and based on the information obtained, they reacted differently towards the procedure. Furthermore, women’s decisions about their preferred mode of delivery had cultural and social dimensions.

The findings suggest that the women were interested in vaginal delivery so that they could be recognised as “women” in their social context. Therefore, there is the need for
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Health care providers to make conscious efforts to conduct health education on the medical indications for CS as a birth strategy.

6.5 Recommendations

Based on the findings of the study, the following recommendations have been made to the Ministry of Health and Health care providers.

6.5.1 To Ministry of Health (MoH)

The MoH should:

- Ensure that all health personnel especially nurses and midwives have training on socio-cultural beliefs about CS.

- Intensify education of the public through the mass media on indications for CS to enrich their knowledge and to solicit the needed support from families and community members for women undergoing CS.

6.5.2. To Health Care Providers (HCP)

HCP Should:

- Ensure that midwives in the Obstetrics and Gynaecology unit of the Tamale Teaching Hospital as well as health facilities in the Tamale Metropolis make conscious effort to provide tailored made education on the general indications for CS as a medical intervention.

- Empower the Public health education unit within the Metropolis to educate families and communities on the indications of CS during their routine visitation to communities.
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- Organize tailor-made programmes on psychosocial counselling for women before and after CS.

- Institute measures to encourage husbands to accompany their wives to the hospital for antenatal classes.
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REFERENCES


SOCIAL CONSTRUCTION OF CAESARIAN SECTION


Boghossian, P. A. (2001). What is social construction?


Coljocaru, S. (2010). Appreciative Supervision in social work. New opportunities for changing the social work practice. Revista de Cercetare Si Interventie Sociala, 29,
SOCIAL CONSTRUCTION OF CAESARIAN SECTION


SOCIAL CONSTRUCTION OF CAESARIAN SECTION


SOCIAL CONSTRUCTION OF CAESARIAN SECTION


SOCIAL CONSTRUCTION OF CAESARIAN SECTION


Litorp, H., Mgaya, A., Mbekenga, C. K., Kidanto, H. L., Johnsdotter, S., & Essén, B.
SOCIAL CONSTRUCTION OF CAESARIAN SECTION


SOCIAL CONSTRUCTION OF CAESARIAN SECTION


SOCIAL CONSTRUCTION OF CAESARIAN SECTION

perceptions of caesarean sections in Ghana’s Upper West Region. Women and Birth. https://doi.org/10.1016/j.wombi.2016.05.004


SOCIAL CONSTRUCTION OF CAESARIAN SECTION

https://doi.org/10.4103/1119-3077.86766

https://doi.org/10.1016/j.midw.2007.10.002

https://doi.org/10.1053/j.semperi.2012.04.014


https://doi.org/10.1186/s12978-015-0050-7
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Appendix C: Introductory letter

The Chief Executive
Tamale Teaching Hospital
Northern Region
Tamale.

Dear Sir/Madam,

INTRODUCTORY LETTER

I write to introduce to you Millicent Kala, M.Phil Year II student of the School of Nursing, University of Ghana, Legon. As part of the M.Phil programme, she is conducting a research on “Social Construction of Caesarian Section among Women after Surgical Intervention in the Tamale Metropolis.” Your outfit has been chosen as her data collection outlet.

I would be grateful if you could kindly offer her the necessary assistance needed to enable her collect data for her thesis.

Thank you.

Yours faithfully,

Dr. Florence Naab
SUPERVISOR
Appendix D: Consent form

CONSENT FORM

Title: Social construction of caesarian section among women after surgical intervention in the Tamale Metropolis.

Principal Investigator: Kala Millicent

Address: School of Nursing and Midwifery, College of Health Sciences, University of Ghana, Legon-Accra.

General Information about Research

Different meanings are given to childbirth that is as a result of surgery. The reason for this research is to understand the meaning women give to surgical delivery after the procedure. If you agree to be part of this study, I would like you to share with me what you think about giving birth through surgery, what people say about giving birth through surgery, where you first heard about surgical birth, your reaction before and after the procedure. You will be invited for an interview in which you and I will have a chat for about thirty minutes to one hour. However, you may be contacted after the interview or chat for any clarifications or confirmation on the information you give within three months after the chat.

We will use English, Dagbani, Mampruli or Gonja depending on which one you can speak well. You are free to share with me information that you have about surgical birth. You will be required to sign or thumbprint a consent form to show your agreement to participate before we begin the chat. With your permission, the chat will be recorded with an audio tape and written out later.

Possible Risks and Discomforts

You will not be exposed to any risk by your participation in this study. However, some questions may make you uncomfortable during the interview. You have the right to refuse to answer any questions that may make you feel uncomfortable.
Possible Benefits

There are no direct benefits to you as a participant. However, the potential benefit of your participation is that you have the opportunity to share your experiences which may be used to help other mothers in similar situations. Also, your participation will provide health workers and the general public an insight into the meaning women give to childbirth through surgery to help prepare them before and after they give birth.

Confidentiality

The interview will be audio-tape recorded with your permission. However, your name, address or any information that may link you to the information you provide will not be recorded. If you mistakenly mention names during the interview, such names will be replaced with false names instead. The information you will provide will be secured in a locked cabinet in the supervisor’s office, preferably for five years and made accessible only to my supervisor and me.

Compensation

You will not be given any money but a snack (coke and meat pie) will be provided to replenish your energy after the interview.

Voluntary Participation and Right to Leave the Research

Your participation to this study is voluntary and you have the right to withdraw from the study at any point in time. Your withdrawal from the study will not affect any services you will need in the hospital.

Contacts for Additional Information

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mkala@st.ug.edu.gh

Dr. Florence Naab
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Email: fnaab@ug.edu.gh

Your rights as a Participant
This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: nirb@noguchi.ug.edu.gh
VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title “Social construction of Caesarian section among women after surgical intervention in the Tamale Metropolis” has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

__________________________
Date

__________________________
Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

__________________________
Date

__________________________
Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

__________________________
Date

__________________________
Name Signature of Person Who Obtained Consent

University of Ghana  http://ugspace.ug.edu.gh
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Appendix E: Interview Guide

Interview Guide
Section A: Demographic Information
Pseudonym/code no:
Age:
Level of education:
Occupation:
Languages spoken:
Place of residence:
Nationality:
Religion:
Marital status:
Number of children:
Number of Caesarian section:
SECTION B: Guiding Questions

A: Women beliefs about Caesarian section

1. What do you know about Caesarian section?
2. In your family, what do they say about caesarian section?
3. How do you see Caesarian section as an option of giving birth?
4. Tell me some of the cultural, beliefs bout caesarian section.

B: Social construction of Caesarian section

1. How do your colleague women see you after going through Caesarian section?
2. Can you tell me how you manage your cultural beliefs with Caesarian section?

C: The process through which women perceive Caesarian section as a birth strategy

1. How did you get to know about Caesarian section?
   - What were you told?
   - How did that affect your belief about Caesarian section?
2. Why did you choose to give birth through Caesarian section?

D: Behaviour of women towards Caesarian section

1. Tell me how you felt when you first heard about Caesarian section.
2. How was your reaction when you were being informed that you will be operated?
   - Why did you react the way you did?
   - What decision did you take?
2. How has the Caesarian section affected you?