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RESEARCH TOPIC: SOCIAL CONSTRUCTION OF CAESAREAN SECTION AMONG WOMEN IN NANDOM MUNICIPALITY IN THE UPPER WEST REGION OF GHANA

BY

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DECLARATION

I, Justina Kuuwiedome hereby declare that apart from published data that were used and duly acknowledged, this thesis is the results of my own investigation. This work has duly been guided and supervised by Prof. Florence Naab and Dr. Evelyn Asamoah Ampofo in the school of Nursing and Midwifery, University of Ghana-Legon. The undersigned supervisors certified that they have read through the thesis and have recommended it to the school of Nursing and Midwifery for acceptance. It must be clearly stated that this work has not been given out partially or fully to any university for the award of any other degree.

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ABSTRACT

Caesarean section remains a life-saving obstetric intervention that can effectively be prioritized to deliver expectant mothers when spontaneous vaginal delivery is not feasible due to medical or labour-related challenges to prevent maternal and neonatal mortality. Despite this, women are unwilling to take up CS as an alternative childbirth method when the need arises in labour but are much concerned about the views of their significant others at the expense of saving their lives and that of their unborn babies. However, there is paucity of literature on how the women construct CS in Ghana. This study therefore focused on assessing the social construction of CS among women in Nandom Municipality, Ghana. An exploratory, descriptive design with qualitative approach was employed in this study. Sixteen (16) women who have never undergone CS delivery were purposely selected from St. Theresa's hospital to participate in the study. Face - to -face interview was conducted using a semi-structured interview guide to collect the data from the participants. Thematic content Analysis (TCA) was used to analyse data that was audio taped and transcribed verbatim. Seven (7) themes and twenty-two (22) subthemes were identified from the data. Three (3) main themes were obtained based on the theory of social construction and four (4) additional themes emerged from the data. The findings established that women have their own different subjective meanings about CS based on their understanding as well as varied beliefs, and perceptions that have influence on their decision to choose CS as a birth method in times of need. These findings suggest that several factors influence women's willingness to uptake CS as an alternative childbirth strategy when medically indicated to save their lives and that of their babies. Therefore, there is the need for the development of health education and communication strategies aimed at promoting women's understanding and their willingness to accept CS when the need arises as an alternative childbirth method to normal vaginal delivery. The findings of this study

have implications for nursing and midwifery practice, nursing and midwifery research and policy formulation.

DEDICATION

This work is dedicated to my husband and children, in-laws and uncle for their support.

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LIST OF ABBREVIATIONS

ANC	Antenatal Clinic
CS	Caesarean section
EmOC	Emergency Obstetric Care
GSS	Ghana Statistical Service
JHS	Junior High School
MOH	Ministry of Health
NICU	Neonatal and Intensive Care Unit
SSS	Senior High School
SVD	Spontaneous Vaginal Delivery
TCA	Thematic Content Analysis
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

This chapter consists of the background of the study, problem statement, purpose of the study, objectives of the study, significance of the study, research questions, justification of the study, theoretical framework, and operational definitions of important terminologies.

1.1 Background of the Study

Caesarean section (CS) is one of the most performed surgical procedures in obstetrics and is certainly one of the oldest surgeries in the world (Awoyemi, 2019). The delivery of a baby by caesarian section (CS) is a surgical operation utilized when the expectant woman is unable to deliver on her own due to medical problems or labour-related challenges. It serves as a facilitating and fast birth method of baby delivery when prolong pregnancy and /or labour deemed undesirable and vaginal route is not feasible that is when vaginal delivery poses a risk to the mother and fetus (World Health Organization, 2016). 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, 2015). 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. 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 of a dead pregnant woman without removing the baby. If a baby boy is 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 "caesarean section" (O'Sullivan, 1990; Azene et al., 2019).

Some expectant mothers and their partners opt for a caesarean section because they believe it to be a wonderful method of childbirth (Betran et al., 2021). A caesarian section may also be chosen by mothers who disagree with the social norm that birth must always take place vaginally (Ezeome et al., 2018; Hildingsson et al., 2019). According to research, both high- and low-income nations are showing an increase in the demand for caesarean sections (Rishworth et al., 2016 ; Betran et al., 2021 ; Rai et al., 2019). Data from 2010 to 2018 from 154 countries covering 94.5% of world live births shows that 21.1% of women gave birth by caesarean worldwide, ranging from 5% in sub-Saharan Africa to 42.8% in Latin America and the Caribbean (Assarroudi et al., 2018). The rate of CS has risen in all regions since 1990. Subregions with the greatest increases were Eastern Asia, Western Asia and Northern Africa, while sub-Saharan Africa and North America had the lowest rises (Lokko et al., 2025 ; Betran et al., 2021; Mahama et al., 2025) . their findings indicated that Ghana's CS rate was reported as 21% in its 2022 Demographic and Healturvey, which is not encouraging considering the entire country.

Studies conducted by Hu et al.,(2016) and Ugwu & De Kok, (2015), suggested that a Caesarean section is performed based on the following medical indications: transverse or breech presentation, failure in the progression of labour, foetal abnormalities, foetal macrosomia, ill health of the mother, placenta previa, and bleeding in pregnancy. A mother's weight, age, the number of her previous deliveries, and the shape of her pelvis also play a role in whether a caesarean section is necessary (El-Aziz et al., 2016 ; Afaya et al., 2018). Major obstetric and perinatal difficulties from labour obstruction can negatively impact a child's quality of life and result in vesicovaginal and rectovaginal fistulas, which can cause stress incontinence in the absence of CS. In the end, this may result in the death of either the mother or the child (Gatwiri, 2018; Raheem, Zoaier, &EL-Sheribin, 2017; Drew, 2022; Towoju, 2023). The third sustainable development objective, which

is defined as having adequate health and wellbeing, has a trickle-down negative impact on all 16 of the other goals, (Olowookere et al., 2022; Byskov et al., 2019; Bergman et al., 2018; Hirons, 2020).

It is an undeniable fact that some caesarean sections performed were not based on medical reasons but on maternal requests. A study that included women from Bangladesh, Colombia, the Dominican Republic, Egypt, Morocco, and Vietnam, revealed that elite women with good financial standing who receive regular antenatal care are more likely to deliver via caesarean section, whereas low-income women who tend to get their health information through socialization are less likely to do so (Mia et al., 2019). Additionally, women choose caesarean sections out of fear of giving birth vaginally, to avoid the discomfort of a normal birth, and to permit tubal ligation (Akgun &Boz, 2019; Cinaroglu, 2020).

Studies have also revealed that in Sub-Saharan Africa, surgical birth is underutilized as a delivery method. This is seen from the results of 10 sub-Saharan African countries, which show scores of less than 2% overall, apart from five nations: Ghana, Kenya, Lesotho, Rwanda, and Uganda, where surgical birth rates reach 5% (Cavallaro et al., 2013). Caesarian sections have advantages for mothers and their newborns, but they can have drawbacks which includes bleeding, fetal growth restrictions, preterm delivery, and even stillbirth. Pelvic adhesions and chronic maternal diseases can also cause pain in the pelvis. Caesarean sections are thought to reduce the number of children one plans to have and increase a couple's risk of ectopic pregnancy and unintended pregnancy loss (Abed Saeedi et al., 2013; O'Neill, 2014; Mizunuma et al., 2024). In low-income countries, the probability of being admitted to a neonatal intensive care unit is connected to an increase in newborn sickness and mortality (Fahmy et al., 2018 ; Tasneem et al., 2015).

The underutilization of caesarean sections as a method of birthing in sub-Saharan Africa may be due to social misunderstandings regarding natural births as opposed to aided births as well as a lack of awareness of the fundamental issues mentioned above (Adu, 2024 ; Ssemaganda, 2024). According to research done, most pregnant women are opposed to caesarean sections because of the social environment in which they live (Ugwu & De Kok, 2015; Ezeomeet al., 2018; Naa Gandau etal., 2019). Women are reluctant to undergo caesarean sections as a method of delivery in most sub-Saharan African nations. This resistance is influenced by the perception of the process as a failure and as a sort of retribution for adulterous women.

Even though there is an increased rate of caesarean section in both developed and developing countries, there is a widely held belief that African women have a dislike for it and is perceived as a "curse" of an unfaithful woman (Abazie & Abdul-Kareem, 2019 ; Prah, 2017 ; Anikwe et al., 2019; Ezeonu et al 2017; Elom et al., 2023). As a result of this belief, CS is therefore accepted reluctantly even in the face of obvious clinical indications. This is frankly very alarming taking into consideration the increasing rate of maternal and infant mortality. 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 (Panda et al., 2020 ; Kiruja et al., 2023). The perception of women about birth especially on caesarean section is important for most healthcare providers around the world (Rezai, 2016). Considering the perceptions and attitudes towards caesarean section, most pregnant women and their relations view their individual perception and attitudes towards caesarean section delivery as one that is important in the decision-making process (Smythe et al., 2016; Stoll et al., 2019; Clemons et al., 2022). Also, birth experiences shared by women and significant others and through social networks is considered as a guide to women in taking

decisions with regards to the mode of delivery (Stoll et al., 2019; Reyes & Rosenberg, 2019; Mlambo et al., 2020).

Moreover, the experience women have at childbirth and their perceptions of that event can affect their feelings of satisfaction, strength, esteem, and the value they place on their achievement. Childbirth is a very important event for women of which research shows women have strong expectations concerning this experience (Preis, 2019 ; Märthesheimer et al., 2025). For instance, there are many reported cases of women who have considered themselves to be sexually advantaged after a vaginal delivery, whiles others who have undergone a caesarean section consider it as a disadvantage to the distortion in their body image because of the surgical incision mad (Molgora et al., 2020). 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 (Clemons et al., 2022). According to Mlambo et al., (2020), 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. Apart from this, with respect to developing countries (such as Ghana), the perceptions and attitudes towards caesarean section delivery is still a major cause for concern (Ansah, 2018 ; Abazie & Abdul-Kareem, 2019).

Although there are many who consider caesarean section to be either safe or unsafe, expensive than the normal vaginal delivery and more prone to complications than the Spontaneous Vaginal Delivery (SVD), there are some African women who perceive caesarean section to be a sign of female infidelity, a "curse," or a "failure of womanhood" (Abazie & Abdul-Kareem, 2019; Panti et al., 2018; Ezeonu et al., 2017). Research work done by Doherty et al., (2023), Doherty et al., (2023), Ezeome et al., (2018) and Makinde, Oriji, & Osegi (2020), suggest that in

developing countries, the negative perception of caesarean section has led to the underutilization of the procedure.

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 (Mlambo et al., 2020; Mlambo et al., 2020; Akalin & Sahin, 2021 ; Bakhtari et al., 2019). Choosing between spontaneous vaginal delivery and delivery through surgery becomes a crucial moment especially when women are nearer to the time of delivery (Colomar et al., 2021 ; Walana et al., 2017). Different reasons are given for choosing one birth method over another. Some 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 (Loke et al., 2019; Amike & Yidana, 2022 ; Nosratabadi et al., 2021 ; Konlan et al., 2019 ; Eide et al., 2019 ; Akalin & Sahin, 2021). 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 work and it frees them from the dangers that are associated with caesarian delivery (Panti et al., 2018 ;Amike & Yidana, 2022; Asah-Opoku et al., 2023 ; Boatin et al., 2018).

CS is underutilized significantly in West African nations compared to the significant number of obstetric morbidities that would have required CS (Gandau et al., 2019 ; Trunfio et al., 2021). In most African nations, there is a low rate of prompt caesarean deliveries at critical stages of labour, which is thought to have a significant impact on the rising rates of maternal and perinatal morbidity and mortality (Robson, 2018 ; Boerma et al., 2018) .

The ideal rate of caesarean sections, from the World Health Organization (WHO) which is calculated as the number of CS deliveries in a population needing CS, ranges from 10% to 15% as already mentioned (Carter, & Walker, 2022). Retrospective analysis of data from 42 developing

nations' Demographic and Health Surveys revealed that caesarean section birth rates were frequently less than 1% in the poorest 20% of the population or in all but the richest 20% (Cavallaro et al., 2013). The caesarean section rate in Ghana as of 2015 was 3.33% by the WHO, (Mata et al., 2016).

The Assessment of Emergency Obstetric and Newborn Care for Northern Ghana demonstrated sufficient obstetric coverage. The average CS rate ranges from 5% in sub-Saharan Africa to 42.8% in Latin America and the Caribbean. The WHO has recommended caesarean section rates for populations should range between 5 and 15% (Ayawine, & Atinga, 2023; Betran et al., 2021). The current rate of caesarean section in Ghana with reference to Mahama et al., (2025) was reported as 21% in its 2022 Demographic and Health Survey, which is not encouraging considering the entire country whereas in some regions like upper west is nothing to think of due to the high CS refusal rate even when there is the need for CS delivery (Islam et al., 2022 ; Kumar, & Sharma, 2023).

A retrospective data analysis of the Demographic and Health Survey from 42 developing nations revealed that less than 1% of deliveries were caesarean sections in the poorest 20% of the population or in all but the richest 20% of the population (Boatin et al., 2018). The current rate of caesarean section in Ghana with reference to Mahama et al., (2025) was reported as 21% in its 2022 Demographic and Health Survey, which is not encouraging considering the entire country whereas in some regions like upper west is nothing to think of due to the high CS refusal rate even when there is the need for CS delivery (Islam et al., 2022 ; Kumar, & Sharma, (2023).

The delays in seeking health care services are one of the main obstacles that cause increase in maternal and infant morbidity and mortality. The three main delays includes delay in seeking maternal health services which in turn is associated with the delay to recognise and make the

appropriate decision to seek health care services on the part of the mother and her partner or the family as a whole at the right time which is the major delay among the three delays, delay in identifying the need and reaching the appropriate health facility, and finally the delay in receiving the appropriate health care services on time which is associated with the health facilities, its systems and the staff (Tiruneh et al., 2022; Tesfaye et al., 2020). Research by Sumankuuro et al., (2019) indicated how most expectant mothers tried their best despite the challenges but at the long ran experienced the third delay leading complications that are not any fault of theirs but due to the bureaucratic systems in some health facilities. It is so painful to hear that expectant mothers and their babies die because of the above challenges which are manageable

According to research conducted by Amike & Yidana (2022) and Agbanyo (2019) in Ghana, women exhibit CS aversions that can cause them to put off getting CS altogether or delay getting it for a very long time. The aversion appears to be rooted in the worry that CS may cause major health issues that could impair reproduction or even cause death, as well as in the social and cultural connotations associated with CS. With the knowledge of the factors influencing women who have undergone caesarean section, which could influence and leading to acceptance or rejection of CS by those women who have never undergone caesarean section, this study aims to assess the social construction of caesarean among women. The study is based on the well-known claims made by the anthropologist Kleiman that the systems used in medical practice are comparable to those seen in other cultures (Kleinman, (1980).

The professional, folk, and popular models diverge when it comes to pregnancy problems and CS. Although CS are frequently seen as necessary interventions in the medical and professional worlds, they may be perceived as the woman's "failure of reproductive abilities." This may influence the woman's desire for a vaginal delivery. As a result, this becomes a key

justification for rejecting CS. Social and cultural variables can significantly restrict a woman's ability to make wise health decisions, which raises the risk of complications that could be life-threatening (Yarney, 2019). Social and cultural variables can significantly impair a woman's ability to make wise health-related decisions, raising the possibility of consequences that could be fatal Kennedy et al., (2020). Additionally, faith is a component because religious providers are seen changing the ANC environment and the ways of delivery by promising favourable outcomes basing more on the idea of "divine" or "faith" protection than on the mother's capacity for a safe delivery (Ugwu & de Kok, 2015). The study also emphasizes the problems of gender, religion, and social and cultural elements that support switching to alternative providers and rejecting CS.

There are not many studies on caesarean sections in Ghana, and most of them focused on the preferred childbirth method among Ghanaian women (Abazie & Abdul-Kareem, 2019; Prah, 2017) . According to these studies, only 4% of deliveries in Ghana are attributed to ceasarean sections, and the majority of women prefer vaginal delivery over caesarean sections (Okyere et al., 2022; Afaya et al., 2020). But according to a 2010 study, the Korle Bu Teaching Hospital in Accra has a 35 percent CS rate (Gulati & Hjelde, 2012). Given that this is Ghana's largest public hospital and a referral facility, the high percentage is not shocking; yet it cannot be extrapolated to the entire country because it is not a representative sample. On the other end of the spectrum, a small number of studies indicate that beliefs are the primary cause of the issue, claiming that the rise is brought on by a community misconception that caesarean deliveries are healthier for babies, pay doctors more, and protect doctors from lawsuits if they are difficult (Guzman et al., 2015). The national average of caesarean section rates in Ghana is estimated at 12.8% but it ranges from 11.2–14.6; even then, there are wide disparities in access and uptake of caesarean section in urban and

rural areas which may be partly related to perceptions about caesarean section (Okyere et al., 2022).

To emphasize the meaning and beliefs that individuals and groups collectively attribute to a concept is to view an event or idea as being socially manufactured. "Social constructionism, often known as the social construction of reality, is a sociological and communicational theory of knowledge that looks at how people form collectively built worldviews. According to Berger & Luckmann (1966) and Gergen & Gergen (2009), social constructionism is a viewpoint that holds that social and interpersonal forces play a significant role in shaping much of human existence. Additionally, if society had not created it, the belief or meaning would not have existed (Diaz-Leon, 2015). When a description is given to an occurrence or object, it takes on genuine characteristics. It follows that culture is essential to society's existence, our cultural beliefs and traditions influence how we perceive and respond to circumstances. Research by Greider & Garkovich (1994) and Demeritt (2002) suggest that culture specifies what is appropriate, seen as standard practice in any society, and should be followed by the populace. The choices people make regarding their health difficulties, including the need for self-medication and seeking medical assistance, are heavily influenced by their beliefs about health and sickness. The individual's conception of sickness is shaped by culture and picked up via interactions with important people . (Lupton, 2012 ; Cheng et al., 2020). This affects how persons with the disease are perceived in social settings and, to a greater extent, how they deal with the condition.

According to research done among North American women, women expressed a greater desire for a caesarean section because it is thought to be a method of providing the newborn with standardized care (Molgora et al., 2020). Ugwu & De Kok, (2015) assert, however, that women in Nigeria and other African nations give CS various connotations. As a result, it is viewed as a

surgical treatment used to assist a pregnant woman who is unable to deliver naturally through the vagina, as well as a spiritual punishment meted out by the gods to an adulteress. It follows that women's perceptions of caesarean sections are, in part, influenced by culture, which always has an impact on their decision to use this delivery procedure. For proper understanding of how caesarean section is socially constructed among women in Nandom Municipality, this study proposes to employ the theory of social construction to assess how women in the Nandom Municipality have socially constructed caesarean section.

1.2 Problem Statement

The natural expectation of every pregnant woman to give birth by herself through the spontaneous vaginal delivery (SVD) (Omona, 2021; Khamehchian, 2020). All things being equal, most women can achieve this type of natural birth safely and successfully without assistance. Research by Banchani and Tenkorang (2021) indicated that out of 8645 women surveyed, 86.6% had spontaneous vaginal delivery which showed that majority of the expectant mothers delivered by the naturally known childbirth method (spontaneous vaginal delivery). A similar result was reported by Agyemang et al. (2025) where a retrospective cross-sectional study was conducted among 318 postpartum mothers at the Tamale Teaching Hospital in the Northern part of Ghana indicating that most respondents (91.2%) delivered via spontaneous vaginal delivery. In the Upper West Region of Gha, approximately 85.5% of expectant mothers deliver through their vagina (Sumankuuro, Crockett, & Wang, 2024). The findings indicated that the upper west region has lowest caesarean section rate in the country of which Nandom as a municipality is inclusive. The question is ‘’What then happens to the other percentages of expectant mother who cannot make it by themselves due to certain medical challenges? This suggest that there is the need for other

expectant mothers who cannot delivery per vaginum to also have their babies safely and successfully just like their other colleague women. Fortunately, CS is the next safe and available childbirth method through which such women can deliver their babies to brings joy to such pregnant women. There are circumstances where expectant mothers need CS to deliver their babies for example when their babies are too big to be delivered vaginally, babies or mothers have breathing challenges (foetal and maternal distress) respectively, to mention but a few and most often than not there are expectant mothers who refuse to accept CS as a childbirth strategy to save their lives and that of their babies. Statistics shown by Awoyemi (2019) indicated that 11.6 percent of labouring women refuse CS at the detriment of their lives and the unborn babies contributing to maternal and infant mortality. Most women refuse CS because it limits the number of children they can deliver as women, it makes them unhealthy, coerce some men to go in for second and third wives leading to rivalry and so on. Though these reasons for CS refusal may sound logical but the optimum need here is saving lives of mothers and babies since some mother and their babies die due to refusal to accept CS as a birth strategy so that mothers and their babies can be alive. There is therefore the need for thorough discussion with expectant mothers who refuse CS when medically indicated for them to see the need to accept CS as an alternative childbirth method to also have their babies.

Honestly, a lot of consequences are experienced when expectant mothers refuse CS when the need arises in labour. Some end up with vesicovaginal fistulae, rectovaginal fistulae, foetal and maternal distress and final maternal and infant mortality. Research have shown that 15 percent of women lose their lives because of refusal to accept CS to be performed on them which should not be so (Festus, 2024). Women must not die because of procreation. Is it not prudent to have a smaller number of children and take good care of them than to refuse CS and die with or without

the babies and who then takes care of such orphans? There is the need for expectant mothers to willingly accept CS as an alternative childbirth strategy to have their babies safely and successfully and stay alive to care their children. Though it is the wish and prayer of every expectant mother to deliver per vaginum but in cases that it is not possible, there is the need for some expectant mothers to accept CS as an alternative childbirth method to make it possible for them to have their own babies without coercion.

Despite the knowledge most mothers have on the role caesarean 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 most women in northern Ghana deliver either at home or in a health facility of which Nandom is not an exception (Sumankuuro et al., 2019; Adatara et al., 2019). Moreover, research has also shown that, 71 -79 % and 21-30 % of women in northern Ghana give birth at medical facilities and at home , respectively (Mohammed et al., 2024). All these home deliveries are intentionally done to prevent themselves from CS.

Ghana, and Nandom specifically, is a town characterized by strong familial ties that are supported by widely respected conventions and values. These standards and ideals are developed and revised in accordance with how society perceived the world at the time. Although mothers are aware of how a caesarean section can prevent them from having a difficult delivery, they are considerably more concerned about the negative impact it may have on them and their family (Rishworth et al., 2016). Therefore, it makes sense that several variables, including possibly avoiding a caesarean section, may have contributed to the high ratio of 21-23 % of home deliveries. This places a person in a social structure where people frequently act in ways that are socially acceptable, sometimes even at the risk of their lives. For instance, there is a common misconception that a woman's inability to give birth vaginally indicates a lack of womanhood,

infidelity, and as a result, a divine punishment. Although it might seem unimportant, this tends to influence how people seek out health care, which could influence CS rejection and lead to fatalities (Ansah, 2018; Abdulmajeed, et al 2024). This myth cannot be objectively disproven, but it has therapeutic importance since women who get help during birth may face judgment from society as having committed adultery (Marabele et al., 2020). Other societal norms have an impact on women's delivery choices and can lead to a later refusal of CS when it is needed, particularly if the initial CS was viewed by family, friends, or other social groups as a failure of the woman's reproductive function. It seems that sociocultural factors prevent women from taking CS when it is medically recommended.

Caesarean section restriction on the number of deliveries a woman can have may also be a contributing factor in the social criticism (Sani et al., 2024). Due to cultural and societal influences, each woman has certain notions and opinions about the delivery method she prefers (Litorp et al., 2015). The options for delivery mode must therefore be addressed and understood from the perspective of women (Colomar et al., 2021). Because of this, the mode of delivery options needs to be considered and valued from the perspective of women (Bohren et al., 2014). This raise concerns in the social context because many rural houses in this research area place a high value on family size.

One of the main reasons some women turn to unconventional providers like religious leaders in a desperate attempt to give birth vaginally is because of the existing socio-cultural influences that pressure mothers to do so (Prah et al., 2017). Even though studies have been done on CS in Ghana, not many studies have been done to find out the social construction of caesarean section among women in Upper West Region, most especially in Nandom. Also, other research studies generated their findings from women who were either pregnant or have undergone the

caesarean section procedure but not on women who have never undergone the caesarean section procedure.

Based on the researcher's own experience and observation within the study area, even in cases where there are clear medical indications for a caesarean section, majority of which end in newborn fatalities and maternal morbidities, most women remain septical about the procedure.

When it comes to their subsequent deliveries, majority of the women who have never had CS wish only for vaginal births. In the study area, CS is viewed with misconception and anxiety due to some negative perception of the procedure. Because of the above-mentioned unfavourable sociocultural impression of CS, childbearing women do not choose this therapy as an option for childbirth. As a result, this study seeks to explore the social construction of caesarean section among women in Nandom Municipality.

This study aims to provide light on the social structures that support CS refusal and how these social constructs affect the health and wellbeing of those women who have never experience CS before.

1.3 Purpose of the study

The purpose of this study assessed the social construction of caesarean section among women in Nandom Municipality.

1.4 Specific objectives of the study

The specific objectives were derived from the constructs of the social construction theory to.

i. Describe the meaning / reality (externalization) of caesarean section among women in Nandom Municipality

ii. Identify the various sources of reality (objectification) among women in Nandom Municipality

iii. Assess the beliefs, norms, perceptions, and values (internalization) of Caesarean Section among women in Nandom Municipality.

iv. Description accustomed to social construction of caesarean section among women in Nandom Municipality.

1.5 Research Questions

i. What meaning / reality (externalization) is given to caesarean section among women in Nandom Municipality?

ii. What are the sources of reality (objectification) through which women perceive CS as a birth method in Nandom Municipality?

iii. What are the beliefs, norms, perceptions, and values (internalization) of caesarean section among women in Nandom Municipality.

iv. What description is accustomed to the social construction of caesarean section among women in Nandom Municipality.

1.6 Scope of the study

The study was conducted in Nandom Municipality of the upper West Region.

1.7 Significance of the study

The findings of this study are of significant to the following: It is critical for nurses and midwives to understand the different meanings that women associate with caesarean section. Because of this, the research's findings will give nurses and midwives information about what

Caesarean sections imply to women, as well as their attitudes about them. This will allow them to better inform women on the reasons for caesarean sections, which will increase public acceptance of the procedure when it is medically indicated. Nurses and midwives, for that matter health professionals will be able to educate all women and their significant others on the need for CS when the need arises.

Also, nurses and midwives will be able to educate women to gain adequate knowledge and will ensure that all fears and anxieties are cleared so that whenever CS is indicated, they will freely agree for the procedure to be performed on them confidently.

Finally, labour and delivery room nurses and midwives will be able to recognize and address their patients' thoughts and concerns regarding caesarean sections before, during and after the procedure.

Nursing/Midwifery Education: It is important for nurses and midwives to have better understanding of the social construct of caesarean section among women. For this reason, the findings of this research would equip nurses and midwives with knowledge on the beliefs, norms, perceptions, and values (internalization) of women towards caesarean section.

Nursing/Midwifery practice: This will enable nurses and midwives give better education to women during antenatal on the indications for caesarean section which will lead to the acceptability of the procedure when medically indicated. Moreover, nurses and midwives will be able to reduce or clear fear for women who are undergoing caesarean section. Finally, nurses and midwives who work in labour and delivery rooms will be able to assess and respond to their clients' feelings and concerns about caesarean section before and after the procedure.

Research: This research cannot be underestimated because of its contribution to academia, literature, problem solving, experience and theory.

Policy: The findings of this study will also serve as guiding principles for improvement of health care delivery systems of Ghana health service, the Ministry of Health, the government, and other stakeholders.

1.8 Operational definition of terms

Caesarean 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. This 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 fetal factors such as big babies, fetal distress, and abnormalities among others.

Perception: The way in which women regarded, understood, or interpreted or think about CS. A belief or opinion about an idea about CS.

Significant others: Refers to relatives (husband, siblings, aunties, uncles etc), friends,

Women: Refer to females between the ages of 18 to 45 years who have never undergone caesarean section procedure before.

Beliefs: Refers to personal convictions or ideas about reality, often based on faith or experience

Norms: Refers to social guidelines dictating appropriate behaviour in specific situations.

Values: Refers to abstract ideas that represent what a society or individual considers desirable or important

CHAPTER TWO

THEORETICAL FRAMEWORK / LITERATURE REVIEW

This chapter consists of the detailed description of the theoretical framework that is guiding of this study and the presentation of scientific literature review. The scientific review of literature is based on the objectives of the study and the constructs of the theoretical framework that guides the study (Social construction of reality model by (Berger & Luckman, 1966).

2.1 Selection of Theoretical framework

A theoretical framework is a structure that provides the foundation for the building of research. Furthermore, it provides guidance to the researcher regarding the methodology of the study (Osanloo & Grant, 2016). The researcher located and examined several comparable theoretical models in order to choose the best one to serve as the foundation for this investigation. Some of the frameworks that were identified and reviewed are health Belief Model [HBM] (Rosenstock, 1974); The Levine Conversation Model [LCM] (Levine, 1967); and the social construction of reality model (Berger & Luckman, 1966). The HBM looks at the research population's adherence to advised health behaviours as well as preventive behaviours. The model postulates people have control over their health outcomes. Moreover, HBM implies that an individual's behaviour is dictated by their perception of health risk.

HBM comprises of the following constructs: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action and self-efficacy. Observing the constructs alone informed the researcher that it has no relationship with the research topic so the researcher could not use it to guide the study. According to the LCM, four concepts serve as the foundation for the model: energy conservation, structural integrity conservation, personal integrity

conservation, and social integrity conservation. According to the theory, as people are always interacting with their surroundings, change is a fundamental aspect of life. The idea goes on to show that, despite nursing's role in promoting health and preventing harm, greater focus is given to the individual's sickness condition. However, the construction alone has no relationship with the topic under study and so could not be considered.

According to the theory of planned behavior, behaviours are influenced by intentions, which are determined by three factors: attitudes, subjective norms, and perceived behavioral control. It is also possible for external factors to directly force or prevent behaviors, regardless of the intention, depending on the degree to which a behavior is controlled by the individual, and the degree to which perceived behavioral control is an accurate measure of actual behavioral control (Kobylińska, 2022). The constructs of the Theory of Planned Behavior include attitudes towards behavior, subjective norms, social norms, perceived power, perceived behavioral control and behavioral intentions (Hasan & Suciarto, 2020). From the researcher's analysis, this theory was not suitable for this study because none of the constructs talk about social construction.

Over the years, the social construction theory of reality is widely accepted as a reliable tool for social construction and its suitable for this study because the social construction of reality theory aims to explain how a society's ideas, beliefs, and values are developed by its members and frequently have an impact on how members perceive, act, and respond to circumstances in their daily lives (Gergen, 2022). The central idea of social construction is how meaning is assigned to an event or circumstance, which is not a quality that it possesses but one that society attributes to (Burr, 1995a ; Galbin, 2014).

The concept only emerged because of society's creation of it to fulfill a function. The significance that society assigns to events is a component of societal principles that its members

uphold and put into practice. As a result, depending on one's interests, one can give varied interpretations to social occurrences. Additionally, it implies that if current perspectives and meanings ascribed to social events do not satisfy societal needs, new ones could replace them

(Baghramian, 2011). It also underlines the idea that socializing within a social network is a prerequisite for knowledge acquisition on the part of an individual living within society. During regular human interaction, the jointly developed ideology is communicated and given meaning through language (Berger & Luckman, 1966). The interpretation given to a specific circumstance, however, is unique to the society that created it and cannot be applied to a different setting.

The social construction of reality theory aims to explain how each society's ideas, beliefs, and values are developed by its members and affect how individuals perceive, behave, and respond to situations in their daily lives. The core ideas of social construction are on how meaning is attached to an event or circumstance that has a socially constructed character rather than one that is inherent to it (Burr, 2015). It also highlights the idea that socializing within a social network affects the knowledge that a person acquires. As a result, the social context shapes and accepts situations to a greater extent than how people view and accept them (Coljocaru, 2010). Therefore, how a person views and generally accepts things in life depends on how the social context sees and accepts it (Burr, 1995b ; Galbin, 2014 ; Gough, 2017). Berger & Luckman, (1966) first proposed the social construction theory. There are three major ways to generate reality which include externalization, objectivation, and internalization.

2.2 Explanation of the Concept of social construction

The goal of social construction is to clarify how individuals and organizations give meaning, perspectives, and concepts to situations and occurrences that are seen as norms in society.

It implies that the concept only emerged because of social construction for societal benefit. This suggests that, depending on the interests of society, a different meaning might be given to occurrences in society at any given time. Additionally, it implies that once a manufactured viewpoint or meaning ceases to serve society purposes, it may be abandoned (Perennis, 2022). The interpretation of the incident or circumstance is based on societal norms that society's members uphold and put into effect. However, the meaning or notion attached to the event or circumstance cannot be applied in a different setting. It only has any relevance to the society in which it was made. When we interact as humans daily, the jointly produced ideology is communicated and given meaning through language (Berger & Luckman, 1966).

When people share their views, norms, and principles with their significant others, new practices that eventually gain social acceptance emerge in the setting of the model. Through socialization, people learn what is acceptable and significant in a social setting based on their views and labels about certain things (Galvin, 2014). Berger and Luckman (1966) assert that the environment in which humans are born is both natural and human made. As a result, the person develops biologically, and his life (values, beliefs, and rules) are influenced by his frequent association with and interaction with significant people. Inadvertently interacting with cultural norms, ideas, and practices, the individual eventually adheres to them as the social norms. As a result, an individual's perceptions about a situation or an event are shaped by culture and picked up through interactions with important people within the society (Associado, 2020 ; Galvin, 2020).

2.2.1 Externalization

When people share their beliefs, norms, and principles with valuable individuals, new habits that eventually become socially acceptable arise, according to the model. What is deemed suitable and relevant in a social setting is determined by the beliefs and labels that the people

ascribe to the situations and the events through socialization (Galvin, 2014; Berger and Luckman 1966) .

2.2.2 Objectification

Humans are born into a natural and artificial environment, according to (Berger and Luckman 1966). Thus, although the person develops naturally, his or her existence is influenced by their ongoing interactions and associations with important people who establish and are guided by realities (values, beliefs, laws). Inadvertently, people interact with cultural norms, beliefs, and behaviors and eventually conform to them as the social norms. As a result, an individual's perceptions about an event or circumstance are shaped by culture and picked up through interactions with important people within the society (Associado, 2020; Galvin, 2020).

2.2.3 Internalization

The term "internalization" is used in the model with aim to explain the act of imitating what others have done before; their objectified standards, values, and beliefs govern society's way of life. Berger and Luckman (1966) highlighted that once reality has been established in any given society, people can only be considered members of that society if they can relate to their neighbors and that society by sharing their beliefs and engaging in their practices. Once a person is aware of these predefined truths, they become an integral part of his life. Role modeling and one-on-one interactions with significant others help to attain this. The inherited reality consequently affects how the person acts and emotionally identifies with important persons (Berger & Luckman, 1966; Galvin, 2020).

Figure 2.1 Social construction of reality model

Source: Berger and Luckman (1966)

2.3 Application / justification for social construction theory

Because the women's image of CS as a reality was based on their ideas that an ideal woman is someone who gives birth vaginally (externalization), the social construction of reality theory proposed by Berger and Luckman has been shown to be appropriate for this study. Through the socialization process (objectification), these norms or beliefs are acquired by valuable people. These beliefs are manifested in the idea that every woman must give birth vaginally to be seen as an "ideal woman" in her social environment. Women might prefer vaginal delivery because of this pre-determined blueprint and not choose CS even if internalization is necessary.

2.4 Literature review

A literature review is a critical and analytical summary of previous studies conducted on a certain topic. It entails analyzing research articles that provide material relevant to the research subject under study and identifying any gaps in knowledge (Chigbu, Atiku, & Du Plessis, 2023; Snyder, 2019). This review of literature on the social construction of caesarian section among women in Nandom Municipality is being discussed under sub-sections.

A wide range of books, internet, academic journals, papers, and the internet are the literature searched data sources of information. Databases accessed include HINARI, PUBMED, WILLEY, SAGE, SCIENCE DIRECT, SCIENCE HUB, JOSTER, MEDLINE, GOOGLE, GOOGLE SCHOLAR, and CINAHL. Keywords and phrases used to search included '' social construction'', ''caesarean section'', perception of women about caesarean section, meaning of caesarian section to women, women's behaviours and attitudes towards caesarean section, societal perception about caesarian section, description of caesarian section by women and society. This chapter also provides an overview of alternative frameworks and a detailed description of the social construction of reality model that informs this research. After extracting many publications, the review only includes those that are pertinent to the study and span the years 2010–2024, excluding older classical literature that is empirically sound and pertinent to the subject.

2.5 Overview of caesarian section

The delivery of a baby by caesarian section (CS) is a surgical operation utilized when the expectant woman is unable to do so on her own due to medical problems or labour-related challenges. caesarean section (CS) is one of the most performed surgical procedures in obstetrics and is certainly one of the oldest surgeries. 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 (Antoine & Young, 2021). According Van Dongen (2009) and Dhakal-Rai, et al. (2021) indicated that 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. The origin of the operation's name can be explained in three distinct ways. The Roman laws were arranged by Numa Pompilius, the King of Rome, in 715 BC. It was against the law to dispose of a pregnant lady who had died without taking the infant away. If a baby boy is 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 "caesarean section" (O'Sullivan, 1990 ; Azene et al., 2019).

According to various studies (Hu et al., 2016); Ugwu & De Kok, 2015), a caesarean section is performed based on the following medical indications: transverse or breech presentation, failure in the progression of labour, foetal abnormalities, foetal macrosomia, ill health of the mother, placenta previa, and bleeding in pregnancy. A mother's weight, age, the number of her previous deliveries, and the shape of her pelvis also play a role in whether a Caesarean section is necessary (El-Aziz et al., 2016); Afaya et al., 2018). Major obstetric and perinatal difficulties from labour obstruction can negatively impact a child's quality of life and result in vesi-covaginal and rectovaginal fistulas, which can cause stress incontinence in the absence of CS. In the end, this may result in the death of either the mother or the child (Yeshitila, et al 2022). The third sustainable development goal, which is defined as having adequate health and wellbeing, has a trickle-down negative impact on all 16 of the other goals. Meaning that the third sustainable development goal has badly affected all the other goals. Despite this, caesarian sections are carried out at the mother's request when there is no medical need to do so (Cinaroglu, 2020).

Among the challenge's women face during childbearing years is the choice of the mode of delivering a baby and its acceptability in their social context (Mlambo et al., 2020 ; Akalin & Sahin, 2021; Bakhtari et al., 2019). Choosing between spontaneous vaginal delivery and delivery through surgery becomes a crucial moment especially when women are nearer to the time of delivery (Colomar et al., 2021; Walana et al., 2017). Different reasons are given for choosing one birth method over another.

2.6 Meaning of caesarean section

Caesarean section (CS) is one of the oldest and most commonly performed surgical interventions worldwide, with the WHO noting a substantial rise in its frequency across both developed and developing nations (Awoyemi, 2019; Boerma, et al., 2015). Even though CS frequently save lives, women have varied meanings for it depending on their understanding.

From a clinical standpoint, caesarean sections are often regarded as necessary interventions to ensure the safety of the mother and child in situations where vaginal birth would present significant risks (Spofford, 2016 ; Metwali et al., 2024; (Bendtsen, 2023; Cabre et al., 2022). These CS operations are done whenever expectant mothers faces labour related challenged such as foetal distress, prolonged labour to mention but a few. For women experiencing these complications, C-sections are generally regarded as life-saving procedures enabling a safe delivery of the baby and lowering the risk of death or long-term health issues (Bendtsen, 2023; Neritu, 2022; Jahan, 2019). Because they guarantee a positive outcome when other options are not practical, C-sections are frequently seen favourable in these situations by both medical professionals and the women themselves.

However, when CS are performed in the absence of medical indications, particularly when they are elective or done for convenience, the meaning attributed to the procedure becomes more complex. Some women may feel that their birth experience has been “medicalized” or removed from their control. As reported by M’hamdi et al., (2018), Orovou and Antoniou (2024), Wang and Wang (2021) and Maunder & Branney (2021), women who undergo elective caesarean sections often report mixed emotions, ranging from relief to disappointment, due to their perceived loss of the natural childbirth experience. These complex emotional responses are influenced by the perceived motivations for choosing a CS, whether medically indicated or personal convenience.

The meanings and connotations attached to CS are greatly influenced by cultural attitudes and societal norms. Vaginal delivery is idealized as the "natural" and "empowered" method of childbirth in many cultures. But depending on the area and particular cultural beliefs, CS are viewed very differently in different cultures. Several studies Salter, (2020), Yu, (2016), and Simonelli, et al., (2021) and Yamin, (2017) indicated that, many women who experience a CS, particularly an unplanned one, may feel a sense of inadequacy or failure due to the cultural emphasis on vaginal delivery as the "authentic" childbirth experience. In contrast, the meaning of CS can be quite different in certain regions of the world particularly in parts of Latin America and others, where CS are often viewed with greater acceptance, and even preference (Lazo-Porras et al., 2017); Perner et al., 2022; Festus, 2024; Cecilia De Mello, 1994; Potter, et al., 2008). In Western societies, particularly in the United States, CS have been both medicalized and increasingly normalized (Gesing, 2016; Loewenberg Weisband, 2017; Caughey, 2016; Reyes, 2021).

Despite the growing rates of CS, many women continue to view vaginal birth as the "natural" or "authentic" method of childbirth. This societal belief can lead to the stigmatization

of CS. Women who undergo CS, especially those who feel the procedure was unnecessary or chosen for convenience, may experience feelings of inadequacy or guilt. According to studies by Klimpel, (2011) and Cobuzio, (2019), highlight that in countries like Brazil, caesarean sections are often associated with higher social status and are perceived as more "controlled" and "safe" than vaginal deliveries. This perspective, which frames CS as a modern, sophisticated choice, contrasts with the negative connotations often associated with the procedure in Western societies. This dichotomy of views surrounding CS reflects the influence of cultural values on women's perceptions of childbirth and highlights the role of societal norms in shaping the meanings attributed to CS. In societies where vaginal birth is idealized, women who undergo a CS may experience feelings of social stigma or isolation, while in societies that normalize or even encourage CS, women may feel validated and empowered by their choice.

The psychological impact of CS delivery is highly variable, with emotional responses often shaped by the circumstances surrounding the birth, as well as personal expectations and prior experiences (McKelvin, Thomson, & Downe, 2021). For some women, CS are experienced as a positive outcome, particularly in emergency situations where the procedure is viewed as necessary for the safety of both the mother and the baby and women who undergo emergency C-sections may experience a sense of relief or even gratitude, recognizing that the procedure ensured a positive outcome after a potentially dangerous situation (Eide, Morken, & Bærøe, 2019 ; Simmonds, 2023; Orovou and Antoniou, 2024; Sultana et al., 2022). On the other hand, women who undergo planned or unplanned CS may experience a range of negative emotions, especially if they had planned for a vaginal birth (Greisch, 2015; Böhret, 2020; Van Busum, 2014). If women were unable to have the birth experience, they had hoped for these negative emotions can include feelings of failure, disappointment, and grief. These feelings of loss may result from the

belief that CS interfere with the natural process of childbirth, which leaves women feeling disempowered and detached from the birth experience. Women who have planned caesarean sections may also report a greater sense of control over their birth experience, which can positively affect their emotional responses. Support from partners, family members, and healthcare professionals can amplify these positive emotions.

According to several research Ezeomeet al., (2018), Naa Gandau etal., (2019) and Rishworth et al., (2016), most women saw CS as a sickness and do not want to pass away or have a disability that will harm them for the rest of their lives. On the contrary, some expectant mothers and their partners disagree with the social norm that birth must always take place vaginally and opt for a caesarean section because they believe it to be a wonderful method of childbirth (Betran et al., 2021; Hildingsson et al., 2019). Some expectant mothers and their partners opt for a caesarean section because they believe it to be a wonderful method of childbirth. A caesarian section may also be chosen by mothers who disagree with the social norm that birth must always take place vaginally (Chen et al., 2018; Hildingsson et al., 2019; Firoozi et al., 2021).

2.7 Identification of the various sources of reality (objectification) of caesarean section.

The use of surgical intervention during childbirth has increased in Iran to the point where it is now widely accepted as a standard practice (Abbaspoor et al., 2014). As a result, the intervention has been characterized as an act of display and a current pattern of delivery in Iranian society and the surgery is therefore regarded as safe for both mothers and their newborns. According to Shahoei et al.'s (2014) study in Iran on Kurdish women's preferences for birthing methods, participants stated that information they had heard from close friends and family members painted cesarean section (CS) as a risky technique that did not secure the health of the infant. Their search for CS diminished because of the knowledge they learned. According to

information respondents learned from their significant others, social networks, books, magazines, television, and role models, on the other hand, researchers have reported findings attesting to the fact that CS was perceived as the desirable means of delivery (Colomar et al., 2021). This was made clear in a study on women's knowledge, perceptions, and potential demand for CS that was done by Ajeet et al. (2011) . The results showed that among women, significant others were the most accessible source of knowledge on CS for 54.7% of respondents, followed by social networks (24.5%) and health care providers (20.8%). Research conducted (Konlan et al., 2019b) at Duayaw Nkwanta Hospital in Ghana identified various factors affecting women's decisions to opt for elective caesarian section. The study revealed that 37.2% of women perceived caesarian section as a pain-free method, while 57.1% considered it safe for both mother and child. Additionally, social influences played a role, with 28.2% choosing caesarian section based on friends' advice.

A recent study by Maitanmi et al., (2023) , 67.5% of pregnant women in Nigeria had a favourable opinion of cesarean sections, and 78.5% of them knew a lot about the procedure where the study made clear that women's opinions regarding caesarian sections were influenced by their significant others. Generally, most literate women can access the information online whereas a research done by Omuno et al., (2024), where pregnant mothers confirmed that they had moderate knowledge about CS because they had never received information about cesarean sections from the media. In research by Ameresekere et al., (2011), in the United States of America, 17 of the respondents stated that their decision to undergo CS was heavily influenced by the advice they received from their medical professionals regarding the most effective way to deliver their babies.

Researchers reveal that almost 33% of mothers reported lumbar back pain when asked if they have any health problem after cesarean sections and apart from medical dangers, 90% of the women

thought the cost of cesarean sections was unreasonable and that they could not afford it (Ajeet & Nandkishore, 2013).

The primary reasons why women want a CS are the fears of childbirth and labour pains, to avoid labour pains, followed by certainty or convenience, safer mode of birth for both mother and baby and maintaining pelvic floor integrity. The main justifications for an obstetrician's main reasons and readiness to do CS were financial incentives, convenience, and fears of litigations (Dhaka-rai et al., 2022) . For instance, a study conducted among women in the Northwest of Pakistan showed that, those who undergone CS at the Children and Women Teaching Hospital felt unhappy about the surgery after being discharged because they were rejected by the hospital staff.

According to research by Ugwu & Kok (2015), the extent to which their practices have influenced the way women construct CS is evident in situations where pregnant women first seek the assistance of other birth attendants or continue to express faith in their abilities while in a health facility shows how much their work has affected the way women think about caesarian section.

According to several qualitative research, women's opposition to CS stems from the fact that they stay in the hospital longer after giving birth which makes it impossible for them to go about their daily lives at home and to pursue business endeavors (Rishworth et al., 2016; Shahoei et al., 2014; Mirghafourvand et al., 2022; M Nabil Aboushady et al., 2022) On the other hand, mothers perceived CS as a means of providing the infant with quality care. According to research findings Simkin et al., (2024), the women in the study stated that they thought vaginal delivery was the best option for them because it would allow them to resume their work at home right after. Hunter (2006) argues that when a woman has choice over her care and medical professionals work together to deliver her the greatest possible outcome, the birthing experience becomes more humane.

Based on information from close friends and family, studies by Ghotbi et al., (2014), Rahnama et al., (2016, 2017), and Ugwu & Kok, (2015) have shown that women loved vaginal birth. In their social context, a woman can only be acknowledged as a mother if she has given birth by spontaneous vaginal delivery. Putting that aside, a child's value is primarily determined by the way they are delivered. Women desired to have their children born vaginally because they were seen as more valuable. As a result, a significant portion of research participants desired to carry out their motherly duties by delivering their children vaginally.

2.8 Beliefs, norms, perceptions, and values (internalization) of Caesarean Section

The decision-making process may be significantly impacted by the perceptions surrounding cesarean sections (CS). These complex factors include the reason for the C-sections, the woman's cultural values, her beliefs and expectations surrounding the birth, any potential traumatic events in her past, the availability of social support, and her sense of personal control (Rishworth, 2016). Recognizing the psycho-social aspects of childbirth is frequently referred to as woman-centered care which is when medical personnel genuinely place the woman at the center of maternity care and work to address her.

Social norms have conditioned women to think that a woman is the only one who can give birth to multiple children and can deliver a baby vaginally (Callaway, 2020; Persson, 2018). As a result, even though they were aware of the advantages of CS, they still wanted vaginal delivery so they could be accepted as actual women in their community and gain respect from their colleague women (Ezeome et al., 2018; Amiegheme et al., 2016). Research finding from the above-mentioned clearly defines a woman and womanhood as largely based on a woman's ability to deliver vaginally and give birth to many children, which is what most women want to achieve. These women might oppose CS in future pregnancies because it denies them the status of "being

real women." Unwanted ideas about womanhood could have their origins in societal norms that make it difficult to support women when they are in danger such as complications that need to be fixed surgically during delivery. This is because some women believe having a caesarean section to be a reproductive defect. Some refused to have a caesarean section primarily due to pain, fear of death, and the perception that womanhood was being denied (Panti et al., 2018).

The fact that a woman can only deliver a limited number of children with caesarean sections may also be the source of the social criticism (Yorsaliem, 2016). Cultural and societal influences shape each woman's ideas and beliefs about her preferred method of delivery (Kuan, 2014; Litorp et al., 2015). Because of this, it is important to consider and value the mode of delivery option in the context of women's perspectives (Bohren et al., 2014). Family size plays a significant role in many rural homes in the study area, so this is concerning in the social context.

Despite being a life-saving procedure, caesarean sections cause a variety of social consequences for their victims, including marital and social problems. Women who underwent CS suffer in their marital homes because they were forced to share their husbands with other women who the family believed would bear more children to perpetuate their lineage, according to the qualitative findings of a mixed-method study conducted in Nigeria. In other instances, married women were compelled to vacate their homes so that other respectable women may carry on the family customs (Ugwu & Kok, 2015). They claim that CS limits a woman's ability to become pregnant and have multiple children. Additionally, they said that the women with CS were being mistreated in their neighborhood by friends, rivals, or close connections. The women who hadn't undergone caesarian section refused to have cesarean sections performed because those who had CS delivery were being teased.

The fight against maternal and infant mortality may be compromised by unfavorable, divergent perspectives on the social construction of CS, as this could result in a lower use of surgical births as a backup method when complications arise. According to research by Loke et al. (2015), the study results indicated that participants perceived CS as an uncomplicated and simple delivery method as it provides them with adequate time to get ready for their next delivery. With CS deliveries, clients are advised to protect themselves from pregnancies for about two or more years before their next pregnancy thereby helping them to be physically, psychologically, socially, and anatomically prepared for subsequent deliveries. There may be the result of the negative emotions that surround cesarean sections, which include guilt, misery, anger, aversion, suspicion, and fear (Roy et al., 2023). There are some African women who perceive caesarean section to be a sign of female infidelity, a "curse," or a "failure of womanhood" (Abazie & Abdul-Kareem, 2019; Panti et al., 2018; Ezeonu et al., 2017; Ansah, 2018 ; Abdulmajeed, et al 2024). In research conducted by Ogunlaja et al, (2018), most women perceived CS as very unsafe whiles others felt that delivery by CS would make them unfulfilled as women. According to Ugwu and de Kok (2015), women have also been demonstrated to decline caesarean section due to fear of desertion by their spouses and in-laws, incapacity to conceive due to prior caesarean sections, at the expense of the procedure.

According to a Swedish study that looked at women's and caregivers' perceptions of CS in low-resource environments, the women believed that CS can only be performed if the woman acknowledges that she may die during the process of the procedure (Litorp et al., 2015). Some studies have shown that women believe vaginal delivery is what God has ordained and that cesarean delivery is not natural, is man-made, and is frowned upon by God (Abbaspoor et al., 2014 ; Yorsaliem, 2016). Most women also perceived CS as means of avoiding themselves from death

during childbirth, receiving pain relief, preserving their sense of self-worth, and protecting their newborns from the stress of labour (Ajeet et al., 2011; Firoozi et al., 2021). During normal vaginal deliveries, labouring women go through labour pains which helps the cervical os to dilate fully to allow for safe and successful passage of the baby through the birth canal and are also stressed up including their babies. According to the survey by Ajeet et al. (2011), 91.5% of respondents supported vaginal birth as their preferred method of delivery.

Evidence suggested that women choose caesarean sections due to the combination of professional care and a calm environment provided by medical institutions. They also discovered that, because CS spares them the agony of childbirth, most study participants (68.5%) will accept it as their preferred method of delivery. Conversely, 44% of these mothers believed that CS causes the mother more pain and suffering. According to women's perceptions expressed in research findings from qualitative investigations, any woman who gives birth through surgery is perceived to be weak and disloyal to her husband. These same women added that, CS is believed as also a curse from the ancestors and a way for her immediate associates to punish a disrespectful and unfaithful women (Nabil Aboushady et al., 2024 ; Ugwu & de Kok, 2015). Additionally, a portion of study participants in Litorp et al., (2015) and Rahnama et al., (2015) believe that CS is a divinely mandated procedure for women. Additionally, they think that in most African contexts, having CS makes it impossible to achieve the optimum family size, thus a rival must establish her value to the husband in accordance with custom. Based on this, the caesarean section is rejected as a delivery method (Qazi et al., 2013; Ugwu & de Kok, 2015). However, in a study conducted by Sani et al., (2024), showed that women would rather like to have fewer children born through CS for them to provide the children with the best of care.

According to women in other research by Boz et al., (2016), Rahnama et al., (2015) and Roudsari et al., (2015), vaginal delivery expels all products, whereas women who have CS think otherwise and so some women oppose the use of CS as a birth technique out of fear. According to research by other writers, women believe that a vaginal delivery increases a woman's beauty because perspiration during the birth improves smooth skin and eliminates all traces of sports on the face. In addition, the women also believe that when they give birth via the vagina, God answers their needs more effectively, which is not the case with caesarean sections (Boz et al., 2016).

According to a study on pregnant women's attitudes and perceptions of caesarian sections in Northern Ghana Afaya et al., (2018), all study participants were well-informed on the goal of CS and how the surgery is carried out. They all narrated that CS involves abdominal surgery required to take a child out of the womb. Women also believed that CS could only be performed if the woman agreed to be killed during the process, according to a study conducted in Sweden to understand caregivers' and women's perspectives of CS in low resource contexts with growing CS (Litorp et al., 2015). Studies have indicated that women will respond badly to CS because, within their religious denominations and the social context in which they find themselves, God disapproves of caesarean sections as an attempt by man to change what is regarded as natural (Abbaspoor et al., 2014; Nabil Aboushady et al., 2024).

Other research findings 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 caesarean section as man's idea to change what He has made natural (Yorsaliem, 2016). Therefore vaginal delivery is the preferred method of delivery, as it allows one to be accepted as a woman in her immediate environment (Qazi et al., 2013 ; Ugwu & Kok, 2015).

Women's reluctance to accept CS as a birth strategy may be influenced by experiences like not being able to conceive right away after CS, having trouble losing belly fat due to scars from CS, and experiencing pain in the abdomen during the cold weathers (Agbozo et al., 2016; Boz et al., 2016). According to several research studies, most women believe that vaginal delivery is the only way that God has preordained for women to give birth, and as a result, however, the literature that is now available indicates that women give various justifications for a planned caesarean section. They include: a means of avoiding death during delivery. The findings also showed that women choose caesarean sections due to the professional care and relaxing environment they receive from medical institutions. It was also discovered that most study participants chosed CS as their preferred method of delivery since it spares them the discomfort of childbirth. Contrarily, a few of these women believed that CS causes the mother additional pain (Callaway, 2020; Curtin, et al.,, 2020 ; Newnham,et al., 2018). According to an Iranian survey, many women belief caesarian section deliveries as a respectable procedure and often associating it with wealth and social status (Pilvar, & Yousefi, 2021; Hyman, Taheri, & Rahmati, 2024).

2.9 Description accustomed to social construction of caesarean section

A French doctor Odent (1994) , well-known for his support of natural childbirth and innovation worked on creating home-like birth environments, asserted that a woman's labour experience is greatly influenced by the disposition and demeanour of her caregivers. In the model context, new practices are created when people gradually gain social acceptance by sharing their values, norms, and beliefs with important others. People acquire beliefs and labels about things through socialization, which shapes what is acceptable and significant in each social setting. Humans are born into a natural and human-dominated world, according to (Berger & Luckman, 1966). As a result, the person develops naturally, and his life is influenced by the people he spends

a lot of time with and the values, beliefs, and norms they share. Ignorantly, the person engages with the customs, values, and behaviors of society and eventually adopts them as their own set of ethical standards and as a result, a person's ideas about a situation or event are shaped by their culture and learned through interactions with important people.

The goal of social construction theory is to clarify how people and groups give context, opinions, and ideas to circumstances and occurrences that are regarded as norms in society (Berger, & Luckmann, 2023; Burr, 2024). The idea was only generated by society to fulfill a need. Members of society follow and put into practice the meanings society ascribes to circumstances, which are components of societal principles. As a result, depending on one's interests, events in society can have various interpretations. It also implies that if current perspectives and the meanings attached to social events fail to satisfy societal demands, new ones may replace them (Baghramian, 2011). Social norms have conditioned women to think that a woman is the only one who can give birth to multiple children and can deliver a baby vaginally (Ezeome et al., 2018; Amiegheme et al., 2016).

The Caesarian section is often perceived as a safer option in cases of medical complications, significantly reducing risks for both mother and baby. Several studies showed that elective C-sections result in higher live birth rates compared to vaginal deliveries in certain contexts, emphasizing their effectiveness in ensuring safe outcomes (Singh, Singh, & Gupta, 2024; Palandri, 2021; Spofford, 2016). For example, multiparous women with prior uterine scars, caesarian sections have been shown to be more cost-effective and safer compared to natural childbirth, reducing risks of complications such as uterine rupture and as such CS is not considered expensive (Entringer, Pinto, & Gomes, 2018; Dixon, 2019; Shoemaker, 2016). In certain regions of the world particularly in parts of Latin America and others, CS are often viewed with greater

acceptance, and even with preference (Lazo-Porras et al., 2017); Perner et al., 2022; Festus, 2024; Cecilia De Mello, 1994; Potter, et al., 2008).

In Western societies, particularly in the United States, CS have been both medicalized and increasingly normalized (Gesing, 2016; Loewenberg Weisband, 2017; Caughey, 2016; Reyes, 2021). Despite the growing rates of C-sections, many women continue to view vaginal birth as the "natural" or "authentic" method of childbirth. This societal belief can lead to the stigmatization of CS. Women who undergo C-sections, especially those who feel the procedure was unnecessary or chosen for convenience, may experience feelings of inadequacy or guilt. According to studies by Klimpel, (2011) and Cobuzio, (2019), highlight that in countries like Brazil, caesarian sections are often associated with higher social status and are perceived as more "controlled" and "safe" than vaginal deliveries. This perspective, which frames CS as a modern, sophisticated choice, contrasts with the negative connotations often associated with the procedure in Western societies. This dichotomy of views surrounding CS reflects the influence of cultural values on women's perceptions of childbirth and highlights the role of societal norms in shaping the meanings attributed to CS. In societies where vaginal birth is idealized, women who undergo a CS may experience feelings of social stigma or isolation, while in societies that normalize or even encourage CS, women may feel validated and empowered by their choice.

Vaginal delivery is culturally preferred in many African nations, according to this study, because it is perceived as making women more "womanly" and gaining them respect from their peers. In view of that, cultural views frequently result in the grudging acceptance of cesarean sections, even when they are medically indicated (Amiegheme et al., 2016). In a qualitative study conducted in Nigeria Abdulmajeed, et al (2024) found that women who gave birth surgically are considered as males until they demonstrate their worth by giving birth vaginally. Once they notice

a scar on their abdomen, their children even attempt to disassociate them from being their original mothers because, in their eyes, children do not give birth through the abdomen. These women might oppose CS in future pregnancies because it denies them of being described as "being real women." Unwanted ideas about womanhood could have their origins in societal norms that make it difficult to support women when they are in danger such as complications that need to be fixed surgically during delivery.

This is because some women believe having a caesarean section is described by society to be a reproductive defect. As a result, the study's female participants scowl at the technique. Qualitative research revealed that women believed that any woman who gave birth surgically was weak and dishonest to her husband. According to these women, CS is a sort of retribution from her close friends for being disrespectful as well as a curse from the dead (Ugwu & DeKok, 2015; Mboho, 2013; Afaya et al., 2018). On the contrary, studies by Rahnama et al. (2016) and Nyarkoaa Boateng, (2022) indicated that the participants believed that their experiences of CS was part of God's plan. The results of a prospective cohort study in Ethiopia revealed high rate in delayed wound healing due to increased risk of wound infection in the incisional sites after CS among the respondents contributing to long periods spent at the hospital which was a great worry (Mezemir et al., and Wolder et al., 2023). In a similar vein, 26.4% of mothers who undergone caesarian sections in Tehran research said they consented to the procedure because they were unaware of potential consequences.

According to women's perceptions expressed in research findings from qualitative investigations, any woman who gives birth through operation is described as weak and disloyal to her husband. In addition, according to these women, CS is also described as a curse from the ancestors and a way for her immediate associates to punish a disrespectful woman (Nabil

Aboushady et al., 2024 ; Ezeome et al., 2018 ; Ugwu & de Kok, 2015). Most people in this region of the world are so enmeshed in their immediate social environment and tend to hold it in such high regard that they do not recognize the value of having a health professional on staff for birth Gumanga, et al., (2015).

Most women express concerns regarding their prolonged hospital stays following CS deliveries, due to this, they are unable to conduct their regular daily tasks at home or engage in business endeavours (Rishworth et al., 2016 ; Shahoei et al., 2014; Litorp et al., 2015) . But in the study by Stoll et al. (2014), mothers saw CS to help take good care of the infant. According the findings of Simkin et al., (2024), the women who participated in the study felt that having a baby vaginally was best for them because it would allow them to resume their domestic tasks right away. It's clear that the caesarean section is seen or described as a barrier, keeping them from fulfilling their expected duties as compared to women who deliver per vaginum.

According to other research Roudsari et al., (2015) and Rahnama et al., (2016), women feel that some remnants of childbirth are left in the womb after CS but are eliminated when a woman has a vaginal delivery. Some ladies are averse using CS as a delivery method because of concern of this. Similar researchers discovered that women believe a vaginal delivery enhances a woman's beauty since the perspiration produced during labour ensures smooth skin and gets rid of and clears up any facial blemishes. In addition to the women of all genders believe that when they give birth vaginally rather than via caesarean section, God answers to their needs better. Also, there were shared experiences like women's inability to conceive right away after CS, the difficulty women have losing belly fat because of CS scars, and the discomfort felt on the abdomen during the cold weather all have an impact on women's unwillingness to accept CS as a birth strategy (Akgün & Boz, 2019)

In certain societies, assisted delivery such as CS is interpreted and described as a sign of adultery by the woman and, conversely, as a divine punishment. Although this myth cannot be scientifically verified, it has clinical implications because women who receive assistance during childbirth may face social criticism for having an affair (Abdulmajeed, et al 2024; Nabil Aboushady et al., 2024 ; Qazi et al., 2013). Because some view natural deliveries as a sign that a woman is complete, society may not view women who have had caesarean sections as complete women (Faremi et al., 2014). In a study conducted by Ogunlaja et al, (2018), most women described CS to be very unsafe and make them feel unfulfilled as women, should they deliver by CS.

According to Ansah (2018) and Ugwu and De Kok (2015), the argument against using a caesarean section as a delivery method assumes that one cannot achieve the desired family size in most African contexts, necessitating the necessity for a rival to establish her value to the husband as per custom. On the other hand, according to other studies, women prefer having fewer children because of CS in order to provide them with better care (Litorp et al., 2015). A couple's risk of an unintended pregnancy loss and an ectopic pregnancy is also thought to increase after a caesarean section as reported by (Gerema et al., 2021; Creanga et al., 2015; Simkin, 2024). The research also found that when women are unable to deliver their babies as their creator intended, they view having a caesarian section as a reproductive failure, contributing to limited number of children.

Women's perceptions of CS regarding the number of children they could have create negative feelings, implying that CS robs them of having the ideal number of children they can give birth to as couples. These opinions explained how significant large family sizes we have in our social contexts. On the contrary, study findings by Abbaspoor et al., (2014), and Stoll et al., (2019), found that, women's concerns about the preservation of their genital organs as well as their

ability to enter satisfying sexual relationships after CS influenced their decision to choose CS as a birth method rather than a typical vaginal delivery.

Numerous studies have shown that women think vaginal delivery is what God has ordained and that caesarean delivery is not natural, and described as man-made, and is frowned upon by God (Abbaspoor et al., 2014; Yorsaliem, 2016 ; Ansah, 2018). According to studies, having a caesarean section was believed and described as a "curse" on unfaithful women Ezeomeet al., (2018), Nabil Aboushady et al., (2024) and pregnant women who had one were thought to be weak, and having one was previously thought to be a sign of failure. In research conducted by Ogunlaja et al, (2018), most women described CS as very unsafe whiles others felt that delivery by CS would make them being described as unfulfilled women. Certain communities describe caesarian deliveries as abnormal methods of childbirth and after undergoing CS, some women in these communities felt less of themselves (Litorp et al., 2015; Ghotbi et al., 2014).

Additionally, several studies showed that most women described CS as a disease and will not wish to pass away or experience a disability that will impede their quality of life (Qazi et al., 2013 ; Rishworth et al., 2016). For example, in a descriptive review study conducted by Qaazi et al. (2013), it was found that 36.1% of research participants connected CS to death and 23.1% believed that CS resulted in impairments. A study revealed that most of the study participants experienced CS-related side effects, including wound infections, uncontrollable vomiting, and difficulties from the anesthetic that was delivered to them (Chen et al., 2018; Firoozi et al., 2021). Similar to this research by Ghotbi et al., (2014) in Tehran, 26.4% of mothers who had CS deliveries said they consented to the procedure because they were unaware of any potential side effects.

2.10 Summary of literature review

In summary, research works that have been reviewed so far indicates that women interpret caesarian section (CS) differently and hold distinct opinions about it. A few of the most notable ones are that CS is thought of as a treatment for women who have engaged in extramarital affairs, a procedure for weaker women who cannot bring out their babies by themselves through the vagina, and a means for the gods to punish disobedient woman (Yorsaliem, 2016 ; Nabil Aboushady et al., 2024); Ugwu & de Kok, 2015). According to several studies, women's concerns for a planned CS include pain management, preventing mortality, and determining the best course of action to ensure the mother's and child's safety (Ajeet et al., 2011; Chen et al., 2018 ; Firoozi et al., 2021)

The literature reviewed searched also showed that, women's perspectives on CS as a birth strategy were primarily influenced by their social context, culture, religious denomination, health professionals, and social media (Boz et al., 2016; Firoozi et al., 2021; Ugwu & Kok, 2015). Research has also shown that vaginal delivery is the preferred method of delivery for women in most societies. Additionally, a child's value is primarily determined by the delivery method that mothers choose for their children. According to these studies Ghotbi et al., (2014), Rahnama et al., (2016, 2017) and Ugwu & Kok, (2015), women will choose to have a typical vaginal delivery following CS. There are situations where a woman's social standing is determined by how many children she has. Women said that CS prevented them from achieving their desired family size and from receiving the respect they deserved (Ugwu & Kok, 2015). To preserve the family lineage after the CS epidemic, some women were forced to share their husbands with other women who would bear them more children (Ugwu & Kok, 2015). Others experienced mistreatment in society (Nabil Aboushady et al., 2024 ; Ansah, 2018 ; Abdulmajeed, et al 2024).

The literature reviewed showed that few research were carried out in Africa while majority of the studies were done elsewhere, particularly in the western world. Studies on women's perceptions of CS even in Ghana have been conducted, but a very few of them used the social construction model as a framework to direct their research. Furthermore, the studies' data were obtained from women who were either pregnant or those who have undergone CS before; their major interest was not on women who have never experience CS before to get their true views. Thus, it is evident that no research on the social construction of CS has not been done in the upper west region of Ghana.

CHAPTER THREE

METHODOLOGY

This chapter presents the study's approach, the research design that was used to conduct the study, a thick description of the study setting and participants, the inclusion and exclusion criteria, sampling and sampling techniques that were used to recruit the study participants, data collection tools, rigour, data analysis and data management. The rationale for the choice of the study design and data collection approaches was also discussed, data collection procedures and ethical considerations.

3.1 Research design and approach

Research design serves as the foundation for sound scientific investigations. Important research methodologists state that a research design directs the researcher in organizing and carrying out the study in a manner that is most likely to accomplish the desired outcome (Creswell, & Poth, 2016).

An exploratory, descriptive design with qualitative approach was used to guide this study because it was thought to be the most suitable for gathering information on how women interpret caesarian sections. When conducting research to gain a deeper grasp of a situation, to produce new ideas based on participant responses, or to gain a better understanding of a phenomenon, the qualitative exploratory descriptive design is strongly preferred (Creswell, & Poth, 2016; Jameel et al., 2018). Furthermore, because it is descriptive research, it entails an in-depth examination, evaluation, and explanation of the specific phenomenon under investigation (Creswell, 2024). This kind of design uses open-ended inquiries and data collection with the main goal of using codes to build themes.

In order to better understand the phenomena and acquire firsthand information and a contextually rich understanding of how women and society perceive caesarian section in this region of the country, this approach was determined to be the most appropriate. The goal of the researcher's investigative position, which complements a descriptive technique, was to provide new knowledge. The qualitative research approach was chosen by the researcher because the researcher was very curious to know about the social construction of caesarean section (CS) among women in the Nandom municipality of the upper west region of Ghana and the qualitative research approach was the only and most appropriate approach that helped the researcher to satisfy her curiosity by being able to assess the social construction of CS among the women themselves. The eligible participants were given the opportunity to respond and give very important information concerning the topic at hand to help satisfy the curiosity of the researcher. The researcher had the chance to explore participants various knowledges about the topic under discussion and the participants provided different descriptions based on their own understanding about how they, the women socially constructed CS among them which helped to gain knowledge.

3.2 Research setting

The study was conducted in the Nandom Municipality. Nandom Municipality Assembly was established by legislative instrument (LI, 2068) which elevated the then District Assembly into a Municipality in year 2020. One of Ghana's sixteen regions, the Upper West has a total land area of around 70,384 square kilometers, or 29% of the country's total land area (Ghana Statistical Service (GSS), 2021). With reference to the 2021 Population and Housing Census, the total population of the Upper West Region was region 901, 502 residents with Nandom being populated with 51,328 residents in total. Nandom is divided into twenty (26) political/administrative districts headed by the Municipal Chief Executive.

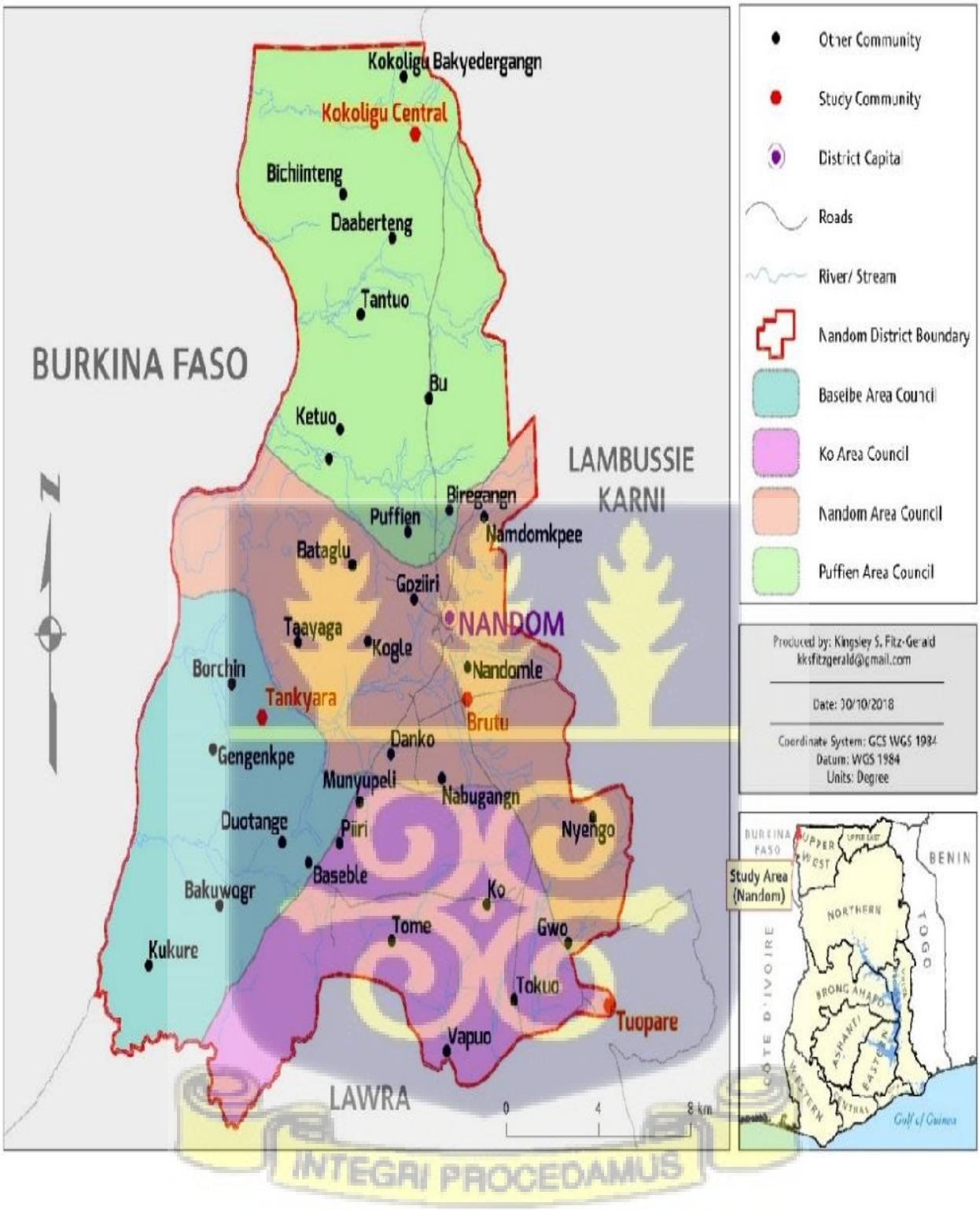

Figure 3.1 map of Ghana

The Upper West Region of Ghana's Nandom Municipality has Nandom as its capital town. The Dagaaba people live in Nandom town and the other villages that surround it to the north, south, east, and west. Although they speak two different dialects of the same language, the Lobr dialect is spoken by the inhabitants of Nandom Municipality, while Ngmere (or Central Dàgááre) is also spoken by the Dagaaba to the south of Nandom, the Dagara and the Dagaaba to the south are the same ethnic group.

Nandom residents refer to the language as "Dagara," while speakers from the South refer to the people as "Dagaaba" and the language as "Dagaare." Contrary to popular belief, these are distinct pronunciations of the same language rather than the names of the two dialects. There is mutual comprehension between the two varieties of the language., G. M. (2012).

According to Apusigah (2013) and Bob-Milliar (2012) formerly, Nandom belonged to the Lawra-Nandom District. It is now a separate municipality, known as the Nandom Municipal since 2020 and it has a parliamentary representative in the Ghanaian Parliament, which is in Accra. It is located between latitude 2°45′00″W and longitude 10°51′00″N. The Nandom town is located 8.0 km/5 miles east of the Volta River, which serves as Ghana's natural boundary with Burkina Faso. There is a route that leads to the river Volta and ends in the village of Dabagteng runs west of Nandom. A legal border with customs and immigration offices separates Ghana and Burkina Faso ten (10) miles north of Nandom in the town of Hamile. The Dagaaba of Nandom speak the same dialect as many of the towns and villages in southern Burkina Faso that are located over the border. In Burkina Faso, other dialects including Waale and Ule are also spoken.

The largest Christian church in West Africa was once the Catholic Basilica church in Nandom, which was constructed out of stone with labor donated by the local populace. The Catholic Missionaries of Africa, popularly known as the White Fathers, began conducting Christian missionary work in the region in the 1930s. Most of the Muslim population, who are mostly from neighboring Burkina Faso or other parts of Ghana, live in the middle of the town. Mossi immigrants from Burkina Faso who moved in the area several decades ago make up most of these Muslims.

The Nandom Nursing and Midwifery Training College (NNMTC), which opened its doors in 2010, is the only postsecondary institution in the Nandom Municipality. Additionally, it has senior secondary educational facilities such Nandom Technical School and Senior High School, all of which were founded by the Catholic FIC Brothers. The Catholic

Basilica church also founded St. Anne's Vocational School for girls. Additionally, the church constructed St. Andrew School and St. Paul School, two elementary schools. Additionally, most of the local communities have their own elementary and/or middle schools.

According to the unpublished data of the 2022 annual health report of Nandom Municipal Health Directorate, the municipality is blessed with one (1) Christian Health Association of Ghana (CHAG) facility (St. Theresa's Hospital, Nandom), one (1) Polyclinic, four (4) health centres, and 22 CHPS.

The St. Theresa's Hospital in Nandom is the main and only notable public health care delivery facility within the Nandom Municipality. It also serves as is the only and main referral health facility for several health centres and polyclinics in the entire Nandom Municipality and beyond. The facility has an estimated staff strength of 1,020 with 500 hundred nurses and midwives (unpublished data). The bed capacity of the hospital is hundred and eighteen (218)

and serves as a clinical teaching institution for all health training institutions in the Upper West Region and beyond. It is equipped with state of the art and modern health care delivery services such as ECG, CT scan, and carries out major surgical procedures. Majority of the deliveries are conducted by the midwives and the doctors. The study was conducted in this setting since it serves as a referral center for caesarian section deliveries in the Nandom municipality and beyond, with well- equipped Neonatal and Intensive Care Unit (NICU).

The town is deeply rooted with different inhabitants and traditions as well as cultural practices which gave unique and diverse opinions and experiences of the people. According to unpublished data from the hospital, it indicated low patronage of highly indicated CS from the maternity unit on account of the perception women and society hold about CS coupled with the researcher's observation on practice on some of such perceptions and researcher's own experiences. For these reasons, the researcher was of the view that collecting data from this setting gave the researcher the opportunity to explore the different knowledge and experiences among the different variety of individuals about their perceptions on CS due to the multicultural nature of the clients who attend this facility. Moreover, it seemed there was no existence of social construction of CS in the study setting, and in the region as well. Most literature on the social construction of CS which had been done elsewhere mostly used the quantitative approach which did not give the participants the opportunity to describe their experiences genuinely as compared to what qualitative study does. Last but not the least, in most of the reviewed literature, the participants involved are those who have experienced CS before and so mostly, participants give limited and ingenuine views since they already had that experience. The fact that the researcher used women who have never undergone or experienced CS in their lifetime, they explicitly gave their actual, real and genuine views about

their perception on CS which gave the researcher the fundamental knowledge and perception women hold about CS which prevented them to accept this birth strategy to save their lives and even that of their babies and they still refuse or prove difficulties with its' acceptance. This had afforded the researcher to gain new knowledge that has been added to research, nursing/midwifery education, and health policy making.

3.2 Target population

A study population, according to Creswell (2016), is a group of individuals who are the focus of the study and to which the results are applicable to. The study population consisted of all women whether pregnant or not who have never undergone caesarean section before and were living within the Nandom Municipality at the time of the study. All participants were recruited from the hospital premises.

3.3 Inclusion criteria

The study involved all women aged 18 years and above as this age group form part of females who were anatomically and physically matured to conceive successfully and deliver by any of the preferred birth strategies. According to the Ghanaian constitution, this group of women was also regarded as the legal age at which any individual may make an informed and autonomous decision about their health care or provide their agreement to any research project in which they would be involved. Also, women who have never undergone caesarean section in their lifetime before because such women have never had that experience, they were able to provide genuine responses as compared to those who have had experience before. Women who visited St. Theresa's Hospital, Nandom for their health needs were included and participants who consented to the study must be living within Nandom Municipality at time of the study. Participants must be those

women who can understand and speak English, Twi or Dagaare language well and are psychologically sound.

3.4 Exclusion criteria

Women who were absent or sick at the time of data collection were excluded. Also, pregnant women who had plans for elective CS at the time of the data collection were not eligible to participate in the study because they may not provide genuine and honest responses.

3.5 Sample size and Sampling technique

Sample size, as defined by Braun & Clarke (2021) , is the total number of participants in a study. Classical of qualitative research design, the sample size for the study is not pre-determined. The study's scope, nature, the quality of the data collected, and the amount of information gathered from each participant are some of the factors that determine the right sample size for reaching data saturation in qualitative research (Shaheen et al., 2018). Therefore, the number of research participants were determined when the researcher noticed that there is repetition in the responses provided by the participants and no new information or responses is emerging and that is called data saturation or satiety in qualitative research. Data saturation describes a point in time during data collection where no new information is generated after interviewing a good number of participants (Hennink & Kaiser, 2022; Terry & Hayfield, 2021).

According to Polit and Beck (2010), sampling is the process of examining a part of the entire population in order to derive conclusions that may be applied to the entire population from which the sample is taken. Qualitative studies employ very small samples where a relatively small number of people are studied in depth (Vasileiou et al., 2018). The purposive or purposeful sampling is a widely used sampling technique for selecting the participants. This sampling method was employed to carefully choose participants who can offer insightful and valuable data to

increase credibility (Campbell et al., 2020; Renjithet al., 2021). The study had benefited from this approach since it had enabled the inclusion of demographics that might provide valuable and unique perspectives on the concepts and issues under investigation.

Nonetheless, the secret to figuring out the efficacy and reasoning behind purposive sampling in a qualitative study is to select participants with a lot of rich information. The researcher used the purposive sampling to select the needed participants for this study. Using purposive sampling helped the researcher to obtain rich information deliberately and intentionally from the selected participants, the researcher believed could accurately provide the needed information for the study. This sampling method ensured that the researcher selected women who had never undergone caesarian section to assess the social construction of caesarean section among them.

The researcher went to the study setting, St. Theresa's Hospital, Nandom) which was the host institution with an introductory letter from School of Nursing and Midwifery, University of Ghana which officially introduced the researcher and the research study. At the site, the ward in-charges were given permission and the introductory letter, and their assistance was sought to identify and select participants. Consent form was explained to the selected participants that met the inclusion criteria. The selected participants were given a 24-hour duration to accept or decline participation. An appropriate time and place for the interview was scheduled within the hospital premises assigned by the hospital authority for researchers working in the hospital based on the convenience of the participants and the researcher. It was a very quiet and well-ventilated place for face-to-face interaction with participants during the interviews. Also, the interview was conducted at any time and conducive environment agreed on by the researcher and the participants apart from the assigned office in the hospital premises.

3.6 Data collection tool

The data collection tool was a semi- structured interview guide with open-ended questions which was used to collect primary data. It consisted of an in-depth face to face interview of the participants after a thorough review of relevant literature. The semi- structured interview guide was designed in line with the study's objectives which were developed from the constructs of the model serving as the framework for this study. Additional tools included a field diary for both electronic and manual recording of non-verbal cues. For this study, a semi structured interview guide was the most suitable and appropriate tool as it permitted participants to openly share their opinions regarding the phenomenon freely and allowed the researcher utilized probes to get clarifications. The interview guide included open-ended questions along with probes that were used to record the date, time, and location as well as the demographic data of the participants which forms section A of the interview guide.

The section B of the interview guide described the meanings women give to caesarean section with its guiding question. The section C of the interview guide elicited the various sources through which women perceived caesarean section as another method of giving birth with its guiding questions. Section D of the interview guide assessed women beliefs, norms, perceptions, and values about caesarean section with its probing questions. Section E of the interview guide described the social construction of caesarean section among women with its probing questions and finally section F assessed challenges the women think they may go through if undergo caesarean section as a birth strategy. To enhance the report, nonverbal cues from the interview were recorded using a field notebook and pen. Participants have the chance to express issues that the interview guide might not have covered.

3.7 Pre-test / Piloting of the interview guide

The process of testing a data collection tool on a small sample of participants whose characteristics are similar to those who participated in the real study is known as "instrument/tool piloting." A pilot or preliminary study is a small-scale analysis or preliminary test of a particular research tool, like a questionnaire or interview guide. A well-executed pilot study guarantees methodological rigor, producing high-caliber, scientifically sound research that can be published. This contributes to the potential advantages for the community in question (Shakir &Rahman, 2022). Before the entire study was conducted, the purpose of piloting was to find misinterpretations and items missed so that modifications are made to the data collection tool before the actual data is collected (Bell, 2014).

After supervisors have reviewed the contents, a semi-structured interview guide was prepared and used to collect data. This kind of interview comprises a number of open-ended questions related to the objectives of the study (Elhami & Khoshnevisan, 2022). This made it possible to ask follow-up questions meant to elucidate the respondent's response and the ideas covered in the interview. A pilot of the semi-structured interview guide on five (5) participants were conducted in St. Joseph hospital, Jirapa which has antenatal and postnatal units, with clients who had similar characteristics as the study population. The pretesting was done to obtain firsthand information on the feasibility of using the tool, comprehensibility of the questions by participants and there was insurances of 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 revised, restructured and the necessary corrections were made before the actual fieldwork was carried out.

3.8 Procedure for Data Collection

Ethical approval to conduct the study was obtained from the Institutional Review Board (IRB) of Christian Health Association of Ghana (CHAG), and an introductory letter from Maternal and Child Health Department of School of Nursing and Midwifery, University of Ghana introduced the researcher and the study to St. Theresa's Hospital, Nandom which was the data collection point, indicating the purpose of the study to the participants. The researcher then moved to the study setting and collected an institutional permission letter which was obtained through formal writing from the Medical Superintendent of St. Theresa's Hospital, Nandom before starting data collection through individualized face-to-face interview sessions.

Each interview was transcribed, and data analyzed using thematic content analysis manually before the next interview was conducted. To assess the quality of probing questions, data collection and analysis are carried out concurrently in qualitative research. The researcher collected data at St. Theresa's hospital, Nandom within a month. The interview guide was the means for the conversation with the participants who attended antenatal, postnatal and public health units and outpatients' department of the facility gave their consent to participate in the study, with an option to opt-out if decided otherwise at any time.

In recruiting participants for the study, the researcher identified potential participants from the above-mentioned units of the facility where participants' addresses and contact numbers were retrieved. Each participant was asked to thumbprint or sign two consent forms after they had read and understood everything in the form. Any participant who could not read the consent form it was read and explained to her by the researcher before commencement of the interview. The participants kept one consent form while the researcher also kept the second for future reference and as part of an audit trial. This was done after the essence of the study had been explained to

participants by the researcher. Privacy was ensured during the interview session by avoiding a crowded environment. The participants were assured by the researcher that their identities would remain anonymous.

Confidentiality was ensured in the study, hence continual reminder of participants not to mention their names. This enabled participants to feel free and relax throughout the interview session. Both the researcher and the participants were fluent in English, Dagaare, or Twi, which was the language used for the interaction. To examine all aspects of the topic and gain deeper knowledge, the conversation continued for at least thirty to fifty minutes. With the participants' permission, the audios were recorded. Participants were refreshed with a biscuit and a soft drink after the interview session as a sign of appreciation for participating.

3.9 Data Management and analysis

According to Braun and Clarke (2006), thematic content analysis (TCA), is a flexible and systematic approach to analysing qualitative data that can be used to identify patterns, themes, and relationships within data. The use of thematic content analysis in qualitative study is justified by its ability to provide a comprehensive and in-depth understanding of complex phenomena. This method allows researchers to identify patterns and themes within data, which can help to answer research questions and develop theory (Nowell et al., 2017). Thematic content analysis is also useful for exploring the perspectives and experiences of participants, as it allows for a detailed analysis of their responses. It is also suitable for both deductive and inductive approaches, making it an adaptable method that can be tailored to the research question and data at hand (Braun & Clarke, 2021).

For easy reference to each participants responses, the transcribed data was assigned unique codes in the order in which they were recorded. Pseudonyms were used in place of the codes that

were used in the interviews to guarantee the study participants' confidentiality regarding their answers. The audio recording, field notes, raw data, and demographic data were separated and kept on an external hard disk. To prevent data loss, hard copies were secured with a strong password and stored on the researcher's laptop and Google cloud storage. Only the researcher and the researcher's supervisor had access. Preferably six years after completion of the study, all the data will be destroyed in accordance with the Data Protection Act 843 of 2012.

In accordance with the research framework supporting the study, thematic content analysis is a technique that clusters similar codes to create major concepts, themes, and subthemes (Saunders et al., 2023). According to Terry et al., (2019) and Renjith, et al., (2021), thematic content analysis involves six steps, which include.

Firstly, data familiarization by the researcher which involved reading and re-reading to get a comprehensive and complete understanding of the whole content. Secondly, generating initial codes which involved identifying and labeling meaningful segments of data with descriptive codes. Thirdly, searching for themes: involved grouping similar codes into themes based on their content and context. Fourthly, reviewing themes: which involved reviewing and refining the themes to ensure they accurately reflected the data. Fifth, redefining and naming themes: which involved defining and naming the themes based on their content and context, and last but not the least writing report: which involved presenting the findings in a clear and concise manner, using quotes and examples to illustrate the themes.

3.10 Methodological Rigour (Trustworthiness)

Trustworthiness in qualitative research ensures findings are believable and accurate. To ensure this, all the recorded interviews were transcribed verbatim, cross-checked for accuracy and completeness by replaying the audiotaped information and comparing them with the transcribed

data at hand several times. The researcher carefully read the transcribed data over and over with field notes, to make meaning of the whole content until the researcher was familiar with the data. Once the researcher was familiarized with the data, the researcher strived to identify small meaning units called the 'codes.'

The researcher then grouped the codes based on their shared concepts to form the primary categories. Based on the relationship between the primary categories, they were then clustered into secondary categories. The researcher then identified themes and interpreted them to make meaning out of data.

Qualitative research investigates the humanistic side of empathy, emotions, and life events; nonetheless, guidelines must be followed to guarantee accuracy and findings that are supported by evidence. Rigor is a method for demonstrating trust in the results of qualitative research. A number of strategies have been proposed to ensure trustworthiness of qualitative findings and it has been recommended that every given qualitative study should employ a minimum of two of these strategies (Hadi & José Closs, 2016).

3.10.1 Reflexivity

The process of critically examining one's own biases, preferences, prejudices, and the researcher's relationship to the participants in the study, as well as how this relationship influences the participants' responses to questions, is known as reflexivity (Hadi & José Closs, 2016). Self-reflection enables qualitative researchers to acknowledge and reduce researcher's bias, a common criticism and to discuss their position within the study and how their personal beliefs and past training have influenced the research findings. In this study, the researcher ensured reflection on the researcher's own biases and assumptions and document how they may have influenced the study. The researcher applied reflexivity in this study through mindfulness, meditation, presencing,

and self-reflection techniques to enable participants to respond more effectively, allowing the researcher to have better sustained awareness of her research, participants, and researcher's own involvement.

The researcher ensured that she was constantly aware of and understand internal perceptions and potential biases, mindfulness, presence, and paying attention on purpose to self-interaction in the present moment are critical as they drive conscious intentionality to execute whatever task was presented (Shufutinsky, 2020). The researcher ensured that field notes are made and maintain the researcher's own reflective journal to recognize and make explicit any personal biases since self-description promotes credibility and confirmability of research findings.

3.10.2 Triangulation

Triangulation is a popular and widely used strategy which involves the use of multiple or different methods, investigators, and data sources to obtain corroborating evidence with the aim to enhance the process of qualitative research which helps the investigator to reduce bias and it cross-examines the integrity of participants' responses (Anney, 2014**;** Korstjens & Moser, 2018). Triangulation involves using at least two related data sources, data collection methods or researchers with the aim of reducing inherent bias associated with a single source, method, or researcher (Ezzat et al., 2020)**.** The researcher employed a variety of data sources in this study which included interviewing health professionals (nurses, midwives, and other categories) and clients on the same issue and triangulation of sources can be surrounded in time, place, and individuals. The researcher also secured data triangulation by using the various data sets that emerged throughout the analysis process which may include the raw material, codes, concepts, theoretical saturation and others (Korstjens & Moser, 2018).

The researcher applied methodological triangulation when gathering data by using different data collection methods such as in-depth interviews and field notes. Investigator triangulation was applied by the researcher by utilization of more than one researcher to collect, analyze or interpret the data (Ghafouri, 2018.

3.10.3 Member checking

Member checks also known as participants'' validation refers to checking of study findings and conclusions by the participants from whom the data were originally solicited (Hadi & José Closs, 2016; Korstjens & Moser, 2018). In the process of member checking where the researcher returns data, analytic categories, data interpretations, and/or even conclusions to study participants because researcher and participants look at the data with different eyes which helps to strengthens the data quality (Ezzat et al., 2020 ; Korstjens & Moser, 2018). The researcher ensured members checks by ensuring that all transcripts of the interviews are sent to the participants for feedback to enable them to correct the interpretation and challenge what they perceived to be 'wrong' interpretations. The researcher ensured that the findings are finally presented to the participants to confirm the theory.

3.10.4 Audit trail

Research audit trial ''implies the ability of another research in pursuing the methods and conclusions made by the main researcher, and use of the tape recorder and the exact registry of data and note taking in interview to assist for improvement'' in carrying out the same research (Ghafouri, 2018). Audit of the decision trail involves detailed description of sources and techniques of data collection and analysis (interview), interpretations made, decisions taken, and influences on the researcher with the aim of demonstrating truthfulness within the findings. The audit of decision trails enable readers to make their own judgments about the quality,

transferability and worth of a study because readers can follow the author's or main researcher's decision trail and associate it with their own conclusions which they have drawn from the information provided (Hadi & José Closs, 2016).

An audit trail involves an examination of the inquiry process and product to validate the data, whereby a researcher accounts for all the research decisions and activities to show how the data were collected, recorded, and analyzed (Anney, 2014). The researcher ensured an auditor was able to conduct a thorough audit trial of these documents such as raw data, interview and observation notes, documents and records collected from the field and others are kept securely for crosschecking the inquiry process.

3.11 Ethical considerations

Ethical consideration is one of the most part of research that seeks to protect the human participants during the research process therefore research activities involving human beings need to critically consider ethical issues and obtain ethical clearance and approval before commencing data collection process (Godwin et al., 2020) . Grounded on this, ethical clearance, and approval to conduct the study was obtained from Institutional Review Board (IRB) of Christian Health Association of Ghana (CHAG) Research Department, Accra. The researcher obtained an introduction letter from the department of Maternal and Child Health (MCH), School of Nursing and Midwifery, University of Ghana, legon, Accra to officially introduce the researcher and the research study to the research setting since it was the host for the study. A copy of the introductory letter was sent to the Medical Superintendent of St. Theresa's Hospital, Nandom. Also, an institutional approval letter was obtained from the St. Theresa's Hospital, Nandom as the host institution for the research study.

The researcher contacted the in-charges of Antenatal, Postnatal and Public Health units and outpatient's department for assistance for the selection of the study's participants. Informed consent addresses the Nuremberg and Helsinki requirements that research participation should be voluntary and that participants should have a full understanding of what is being involved in research will entail (Godwin et al., 2020). Consent was obtained from each potential research participant by reading, explaining the importance, objectives, benefits, and likely risks to them in the language that they understood. The researcher equally allowed participants to think about it for some time before giving their consent by either signing or thumb printing of two volunteered consent or agreement forms.

The decision to participate or not rested solely with each woman. Participants were informed of the possibility of withdrawing from the study at will at any time. No harm or discomfort was inflicted on any participant or any non-participant. None of the participants were exposed to any health or related risks during the research process. However, certain questions may elicit negative emotions or memories, so participants had the option to choose not to answer such questions. Every effort was made to always protect the interests of participants by adhering to the guidelines and requirements specified in all approval or agreement of consent and by requesting for further approval if necessary. whenever a participant experienced an emotional breakdown during the interview, the session is ended and the chaplain (Rev. Dr. Fr. Steven Koya) of the St. Theresa's Hospital was invited to assess, and counsel participants and the interview will be rescheduled later. If it turns out that financial difficulties are the issue, the hospital's social welfare unit was notified to assist in resolving the matter with the assistance of the unit in-charges.

The participants were informed that the interview would be audio recorded and used only for research, and their consent was sought if necessary for any other use. Participants were asked

for their consent to record the interview, which took place in a private setting. Only the researcher and her supervisor had access to the confidential information that will be obtained from the interview. It was stored under lock and key in an office cabinet, on the researcher's laptop, and on Google Cloud Storage using a strong password. According to the data protection Act 843 of 2012, the data was destroyed after six years. The anonymity of the participants was upheld during the coding of audio recordings and the use of pseudonyms when citing the participants in published materials, with no hints that could identify the individual participants.

3.11.1 Privacy

A variety of factors fall under the umbrella of privacy, such as one's physical space, personal data, affiliations with certain cultures and religions, personal choices, associational privacy, and relationships with family and other close friends. The security, privacy, and confidentiality of patient data can have an impact on patient safety and protecting the privacy of patient information improves the effective interaction and can lead to improved quality of care and patient safety (Alipour et al., 2023). The researcher ensured privacy in this study by ensuring that all conversation concerning the interviews of this study existed between the researcher and the participants only. The researcher ensured that all the interview sessions with participants were done in a convenient, confined, and conducive place agreed between the researcher and the participants. The researcher ensured that participants' identities remain anonymous, and their information will only be used for the research purposes alone.

3.11.2 Confidentiality

It has been argued that the assurance of confidentiality is the major safeguard against the invasion of privacy through research and maintaining and improving patient safety is a fundamental expectation when handling client data. To keep something confidential is to keep it

private (Godwin et al., 2020). The researcher ensured confidentiality using pseudonyms to protect the identity of participants and assured participants that whatever they said was kept in private. The researcher ensured that participants' identities remain anonymous, and their information was only used for research purposes alone. The researcher provided opportunities for participants to see, and often, to approve, the data at different stages. For example, the researcher ensured that the participants are allowed to see transcripts and/or excerpts destined to be used in final reports. This can help to avoid surprise and discontent when 'confidential' comments find their way into research publications, particularly those made by participants who were unfamiliar with qualitative research. Furthermore, the researcher ensured confidentiality in the study by continual reminder of participants not to mention their names. This enabled participants to feel free and relax throughout the interview session.

CHAPTER FOUR

RESULTS

This chapter presents the results of the study. The results are presented based on the objectives of the study. Thematic content analysis was used for the data analysis. The demographic details of the participants are reported first, followed by the organization of themes and subthemes. Verbatim quotations from the interview with pseudonyms were utilized to support the subthemes.

4.1 Demographic characteristics

Sixteen (16) women in total who had never experienced CS took part in the research study. The women's ages were between 24 and 47 years. On the part of religion, four (4) of the women were Muslims, while most of the women, totaling twelve (12) were Christians.

Three (3) of the women had eight (8) children through normal vaginal deliveries, one (1) participant had seven (7) children by normal vaginal deliveries, three (3) of the women also had five (5) children through normal vaginal delivery, three (3) women had one child each by spontaneous vaginal delivery, two (2) of them had two children by spontaneous vaginal delivery while four (4) of these women had never had a child before. Regarding tribal affiliation, twelve (12) of the participants were Dagaabas, one (1) participant was an Akan, one (1) Fulani and the two (2) other participants were Frafra women.

Out of the sixteen (16) women, twelve (12) could speak and understand Dagaare, one (1) could not understand nor speak Dagaare. Thirteen (13) could understand and speak English fluently with two (2) not being able to speak English fluently whiles one could neither speak nor understand English. The table below provided more information about the participants.

Table 4.1: Demographic characteristics of participants

S/N	Pseudonyms of participants	Age	Marital status	Educational status	Occupation
1.	Nuonyo	36	yes	JHS	Weaving
2.	Etere	27	Yes	Tertiary	Teaching
3.	Tietaa	39	Yes	SHS	Pito brewing
4.	Vielo	25	Yes	Tertiary	Seamstress
5.	Laura	26	No	SHS	Weaving
6.	Maalo	27	Yes	Tertiary	Schooling
7.	Pognaa	28	No	Tertiary	Schooling
8.	Rena	31	Yes	Tertiary	Teaching
9.	Enkang	24	Co-habiting	SHS	Weaving
10.	Anyuo	29	Yes	JHS	Seamstress
11.	Faalo	27	Yes	JHS	Weaving
12.	Yiiman	43	Yes	JHS	Farming
13.	Aposaana	31	No	Tertiary	Teaching
14.	Tiero	32	Yes	Tertiary	Teaching
15.	Yuora	47	Yes	SHS	Pito brewing
16.	Saataare	35	yes	Tertiary	Teaching

4.2 Organization of Themes

The themes were organized based on the objectives of the study which are consistent with the constructs of the social construction of reality theory. In total, seven (7) themes and twenty-two (22) subthemes were identified from the data. Three (3) main themes were obtained based on the theory of social construction and four (4) additional themes emerged from the data.

Table 4.2: THEMATIC CONTENT STRUCTURE

THEORETICAL THEMES	EMERGED THEMES	SUB-THEMES	CODES
1. Meaning/reality of CS (externalization)		➢ Perceived medical meaning of CS ➢ CS as mode of delivery	MEANING
2. Sources of reality of CS (objectification)		➢ Significant others ➢ Social media ➢ Community gatherings ➢ Health professionals	INFORMATION
3. Beliefs, perceptions, norms, values about CS (internalization)		➢ Religious beliefs about CS ➢ Cultural perception of CS ➢ Social stigma about CS ➢ Perception of CS on reputation ➢ Health concerns resulting from CS	CONCERNS
	4. Social construction of CS	➢ Cultural perspective ➢ Perceived Need for CS ➢ Benefits of CS	REASONS
	5. Consequences of CS	➢ Prolong hospital stay ➢ Financial burden ➢ Support system issues	WORRIES
	6. Complications associated with CS	➢ Limited number of desired children ➢ Delayed wound healing ➢ Excessive bleeding	EFFECTS
	7. Reactions towards medical need for CS	➢ Negative reactions ➢ Positive reactions	FEELINGS

4.2.1 Meaning / reality of caesarean section

This first theme focuses on participants' understanding of caesarean section. It answers the research objective one; Meaning / reality of CS (externalization) women give to CS as a birth method in Nandom Municipality. The participants described the meaning of CS in different categories. Two main categories or sub-themes were described: perceived medical meaning of CS, and CS as a mode of delivery.

4.2.2 Perceived medical meaning of caesaran section

Participants believed that there are medical reasons why women should undergo caesarean section. These medical meanings were described in different forms.

According to Anyuo, who has never undergone caesarean section;

"*caesarean section is an operation that is done to help pregnant women deliver their babies" (Anyuo).*

Etere belief that;

"*caesarean section is when they operate on a woman during child delivery due to the inability of the pregnant woman to deliver on her own to either save the life of the child, mother or both" (Etere).*

In a similar vein, Nuonyo indicated that;

"*as for me, I will just tell that person that oh CS is the operation they will do on you when you are to deliver your baby, and you cannot deliver yourself and they will do it and remove your baby for you" (Nuonyo).*

Tietaa also added that;

"When you are in labour and unable to deliver the baby through your vagina, they will cut into your abdomen and remove the baby without giving the baby chance to move out on its own'' (Tietaa).

Yiiman reported that;

"I will say that CS is the operation they do in the hospital to remove your baby for you when you go to the hospital to deliver, and you cannot deliver by your own and they operate you and bring your baby out for you" (Yiiman).

Etere included that;

"she understands the caesarean section to be the surgical delivery of a baby due to certain implications to either save the life of the baby, mother or both" (Etere).

4.3 Caesarean section as a mode of delivery.

The participants believed that caesarean section is a type of delivery that other women go through to have their babies. Caesarean section as a mode of delivery was described in various ways.

According to Vielo;

"for me I will tell the person that CS is an operation done to remove the baby from a pregnant woman as a form of delivery for her" (Vielo).

In a similar vein, Pognaa indicated that;

"caesarean section is a mode of delivery where operation is done on the woman on the abdomen by cutting and remove the baby" (Pognaa).

Yuora believed that;

"CS is the way other women give birth to their children in the hospital to help them deliver if they are not able to deliver'' (Yuora).

On another note, Nuonyo described the caesarean section as*;*

"another means of giving birth where the pregnant woman's womb is cut open through the abdomen and the baby is then removed. I heard it is surgery where the baby is removed through the abdomen''(Nuonyo).

All the above descriptions of the caesarean section given by participants give information on their knowledge and understanding of caesarean section as unique individuals.

4.4 Sources of reality of caesarean section (objectification)

This is the second theme which addresses objective two (Identify the various sources of reality (objectification) among women in Nandom Municipality) of the research study. Sources of reality refer to the means through which participants obtained information about caesarean section. The participants gave different sources of reality about caesarean section. Four main categories or sub-themes were identified: Significant others, health professionals, social media, Community and gathering.

4.4.1 Significant others

Participants received different information about the caesarean section through various ways.

According to Laura, she had information about the caesarian section through her aunty.

"I had the information from my aunty that, when she was to deliver, the midwife said the baby was "coming with the big head" as such they have to resort to a caesarean section so she nor the baby do not lose their lives'' (Laura).

In addition to Laura's source of information, Rena noted that she heard about CS from a friend. "*According to my friend, she didn't know why the CS was done but after the CS, the class was informed that their classmate had delivered well but they needed to give her blood because she bled a lot at the operation room which she wanted to donate but she was told that her blood was small so she could not donate for her friend. So, most of the males in their class went and donated the blood and they gave her about ten (10) pints of blood, but they said she was pale, and her condition was not good, so she later died leaving the baby and the whole class and family was devastated for that loss'' (Rena).*

4.4.2 Health professional (hospital)

Participants indicated that they received information about the caesarean section from the health professionals, midwives as narrated by Yiiman;

"*My younger rival did CS for her fourth baby and that was the time I got to know about CS. I was the one who sent her to the hospital for her to deliver and when we got there, we were at the hospital for three days and she had not delivered. So, they later put water on her and put some medicine inside the water so the next day morning'' (Yiiman).*

Yuora narrated that;

"I knew of CS when I went to help my daughter deliver at the hospital. The midwife told her that where the baby was to come out is not open so they have to do her CS so that she can have her child" (Yuora).

In a similar way, Anyuo reported as follows;

"I was taking care of my pregnant sister-in- law in labour and she spent three days with no show of delivery but as soon as my sister-in-law was told by the midwife that they will need to do CS on

her, she became so anxious that within two hours after the information she delivered by force delivered with plenty tear tears and was given many bloods. Hmm, that was when I realized that some people don't like CS and so by force my sister in-law delivered, and I was surprised'' (Anyuo).

4.4.3 Social media (mass media)

Some of the participants indicated that they received information about the caesarean section through the mass media which included television.

According to Maalo, she received information about the caesarean section on the television.

"*On the television, a doctor was there educating people on this CS and the part I heard when I switched on my television was when he said that actually CS is good and is done simply with no time wasting to save the lives of mothers and their babies with no delays but the challenge is that people have heard so many false information about it and are not willing to accept it when they need it. According to the doctor, in this 21st century full of modernization and technology era, we can do CS for a woman today and within the next six hours she walks around confidently. As a woman, you can have four children through CS if you want and you will still be healthy. So when I heard what the doctor said I was like aah, then the information I heard that when you do CS it can take you for days before you move out of bed is not even true and that you being able to deliver four children and still be healthy was also good to hear since I heard you can only have two or three children'' (Maalo).*

Similar to Maalo's source of information about CS, Nuonyo added that she heard about CS through the television.

"*Madam, on the television, what they were saying was that in this life, it's not every woman that can deliver by herself so anytime we go to the hospital to delivery and the doctor say they want to operate and remove our children for us that we should try and understand and agree because they do not mean to harm us and our babies but to help save us and our babies'' (Nuonyo).*

4.4.4 Community gathering

Community gathering was mentioned by some participants as a source of information on CS. According to Faalo, she heard about caesarian at a durba*;*

"There was a durbar in our community and at the durbar one midwife gave a talk on the need for pregnant women to agree for CS when the need arises. The midwife said that whenever we come to the clinic and she says that as for you, you need to go to the hospital at this or that place for them to operate us, we should always try and agree and go why because some of us disagree saying that she wants them to suffer that is why she is telling them to go elsewhere and what will she be doing and that the most painful thing is some agree to go but refuse and come to the clinic in a bad state and by the time she sends them to the hospital, she either mother or baby may be lost or any of them may have serious health problem. So, after she finished talking, our chief himself also spoke and encouraged us to listen well and do what the midwife was saying for our own good and development of our community''(Faalo).

In a similar vein, Vielo got to know about caesarian section at the funeral ground;

"Hmmm, we attended a funeral of a lady in our area who died a month ago after delivery. As you know, whenever you attend a funeral, you will try to find out what killed the person so when we were at the funeral ground, I overheard one woman who asked the mother in-law of the deceased lady about what caused the death of the lady leaving a one month old baby and the mother in-law

said that they did that operation (CS) for her and later she was not feeling well so we sent her to the hospital and three days' time, she die ooo while crying bitterly and I couldn't hold back my tears after hearing about it'' (Vielo).

4.5 Beliefs, perceptions, norms and values about caesarean section (internalization).

This is the third theme which addresses objective 3; assess the beliefs, norms, perceptions, and values (internalization) of caesarean section among women in Nandom Municipality. Participants have varied beliefs, perceptions, norms and values about the caesarean section. Five main categories or sub-themes were reported: religious beliefs about CS, cultural perception about CS, social stigma about CS, perception of CS on reputation, and health concerns resulting from CS.

4.5.1 Religious beliefs about CS

Participants have different religious beliefs about CS which include the following. According to Anyuo;

"I think that it is God who decides whether a woman will deliver by herself or by this CS because there are women that I didn't belief they will do CS as they refuse the CS and thought they could deliver by themselves but at the end of the day, they went through the labour pains even for days and still could not deliver and they did CS for them and some even loss their babies after suffering labour pains and doing the CS as well. So, if I need to do CS, it is God's plan and decision, and I will go for it to stay alive and care of my children'' (Anyuo).

Tietaa reported that;

"For me if I will do CS it is the will of God because Madam if I have been able to deliver all these my four children by myself through my vagina, why can't I deliver again? So, if I can't deliver, it means that that is what God plan it this time for me to do the CS'' (Tietaa).

Faalo is of the view that;

"God does not will for women to go through CS during delivery because in the bible there is no single quotation or area where CS was done to any woman to help her delivery and all the delivery cases we heard in the bible, they all delivered safely with no CS so, for me to go through CS, I will not be happy'' (Faalo).

In a similar vein, Faalo added that;

"*Hmm, I belief that if I am to go for this your CS, God is punishing me for a sin that I might have committed because with my knowledge about the Bible, all the women I read about their delivery were normal as they delivered through their vagina without any operation so if they tell me that I need to do CS, it is not God's will and God is punishing me since other women I know in the Bible did not deliver by any CS'' (Rena).*

4.5.2 Cultural perception about CS

On the aspect of cultural perception, the participants have varied cultural perceptions about the caesarean section.

According to Nuonyo;

"*Madam you see that in the Dagaare culture, they will say that if you have cheated on your husband and you become pregnant, and when you are in labour and you don't tell them the truth that someone else impregnated you, you will be in labour for days and you will never deliver till you tell them so, you will hear them say that only cheating wives will go for CS so that they will just cut and remove their babies for them without they experiencing delay labour for us to catch them ask tell to tell the truth'' (Nuonyo).*

Enkang reported that;

"Culturally, people say that when a woman does the CS, it affects your womb and she easily get bone problems and so you cannot deliver as many children as you may want to which pushes some of us from hearing about it'' (Enkang).

In a similar vein Etere sees CS as;

"The beliefs are that one is not a woman enough, it's a foreign culture, and it makes women infertile" (Etere)

Tietaa narrated that;

"Hmm, madam, the cultural beliefs are what the people talk about. The belief is that CS is for lazy women, and it makes women weak. It is not of God only real women delivery naturally that is from their vagina. If you even listen to all those things they say, madam you will die when you are not supposed to die" (Tietaa).

4.5.3 Social stigma about CS

The participants looked at social stigma about CS in the following ways. According to Etere; *"Our community people say that CS operation is for weaker women and so when you do it you become weak and easily become an old woman and because of those things they say about the operation it makes it fearful and scary. Some even say that it is a western culture, and women are doing it blindly and that it causes infertility in women and due to this they say you are infertile" (Etere).*

Laura has this to say similar to that of what Etere said;

"I have the impression that CS is not a bad option in the broader sense aside the backlashes from society that a woman is weak that is why she will have to resort to it as an option" (Laura).

Maalo added that;

"Actually, people see you as a lazy woman when CS is done on you" (Maalo)

Nuonyo narrated *that;*

"You see, there was a time that we were having a conversation about women talk and one of us said that, she has been told that husband's younger wife has delivered and that they did CS for her and our friend said something that, look at all these ones they call them wives and women even her first delivery, she couldn't do it herself and they have cut open and remove the baby" (Nuonyo).

4.5.4 Perception of CS on reputation

Participants have this perception of CS on reputation of women who undergo caesarean. According to Anyuo;

"Hmm, within our society I hear people say that this operation is not good and that when you do it, it means that you are lazy that is why other women deliver and you cannot do and will have to go for CS. Some also say when they do you caesarean section, you are not a complete woman again and that some of your parts had been cut away and because of that you are not a complete woman again" (Anyuo).

Faalo reported that;

"In our society, we belief that when you do CS, the doctors may remove your womb and you will not deliver again in your life and that is the most reason why some women even though we are told that when you want to deliver all your children through CS you can deliver four children but we hear that some women after given birth through CS for one or two children, they are not able

to even conceive again to talk of giving birth because their wombs have been removed during the previous CS operation and so I just don't want to hear of CS and I won't do it"(Faalo).

Similarly, Nuonyo narrated *that;*

"Hmm, madam but this one, you are also a Dagaara and I think you know but what I know is that, there is this belief that women are those where are able to delivery many children and by themselves and so those women who go through CS, some of them are not given that respect as actual women and the most painful part is that your own colleague women look down on you" (Nuonyo).

Rena added that;

"Hmm, in this our community too when they hear that a woman did CS and did not deliver by herself (vaginally), she is not recognized and respected as a real woman and, I don't want to go through any CS in my life because of what they say" (Rena).

4.5.5 Health concerns resulting from CS.

With regards to the health concerns resulting from CS, participants have varied concerns. Anyuo said that;

"Anyway, I think it will affect me in some ways; I heard that when you do the operation, your strength level will be reduced and after CS they will tell you, you shouldn't do hard work which will affect your health so it will affect my work" (Anyuo).

Saataare added that;

"Eeeii…madam the pains and the wound, I don't like it"(Saataare).

Aposaana reported that;

"Hmm this CS thing, I have always been praying not to go through it because it causes some dangerous problems to some women. My sister had this CS, and it was very terrible afterwards. They did the CS and after about a month, she was not fine at all. One of our brothers is also a doctor and works in a different region so she was sent there due to the health problems she was having. When she got to that health facility, they did scan and saw that she was bleeding inside because they didn't sow the uterus well. So, she became pale, and they gave her blood and did another CS and then, they sutured it for her if not she would have even die because of the first CS" (Aposaana).

Tietaa is of the view that;

"I think my friends and fellow women will have the thoughts that I am weak, not a strong woman and cannot bear common labour pains, and that is why I opted for the operation. There may even be times that when my friends and fellow women are doing some activities and I try joining they can tell me to stop since they are aware that am not strong, and they will be thinking otherwise that they will not voice them out'' (Tietaa).

4.6 Social construction of CS

This is the first emerged theme which addresses objective 4 (Description accustomed to social construction of caesarean among women in Nandom Municipality) of the research study. The social construction explains the participants' individual subjective thoughts and societal views about caesarean section. Three main categories or sub-themes were reported by the participants: cultural perspective, perceived need for CS and benefits of CS.

4.6.1 Cultural perspective

On the aspect of cultural perspective, participants expressed varied concerns. According to Pognaa;

"Just on the number of children you would like to have you can't have them and this is what they think it is a curse" (*Pognaa).*

Rena reported that;

"Aaah it is a punishment for your bad deeds" (Rena).

Saataare view is that;

"As for our tradition dirr…I don't really know much about it but all I hear is that it is a punishment from God for your sins" (Saataare).

Similar to that of Saatare, Aposaana is of the view that;

"People think it is a punishment for your evil deeds" (Aposaana).

On another note, Vielo said that;

"Others say that when a woman does not want her husband's lineage to be large, that is when she resorts to caesarean operations" (Vielo).

On the part of Nuonyo, she narrated that;

"In the society we know that women are supposed to deliver naturally, I mean through your vagina but when it comes that they hear that you had your babies by the CS, they start to find out what the problem was. Is it that this is confirmation of what they say you were cheating on your husband or what is it? Or maybe it could be that that your baby cursed, that is why you were able to deliver

three or two children by yourself and this one you went for CS? Madam you see, this is the time that other people who are not Christians will go for consultation to find out the cause of that operation'' (Nuonyo).

Vielo has this to say;

"Hmm, it is believed that CS is evil since it has come to bring reduction in procreation. They belief that CS make the women lazy since it prevents them from going through labours and as such, children born through CS our culture see it as a curse since those children were not born through the natural way, I meant from the mother's private part, the vagina" (Vielo).

4.6.2 Perceived Need for CS

Participants have this to say on perceived need for CS. According to Laura;

"If I am told during childbirth that the baby is too big, you can't give birth by yourself, if you try so you will either die or your baby will, the option is CS, why won't I agree to it'' (Laura).

Nuonyo reported that;

"Even one of my close friends did the CS and told me that the doctor said she was too short and that was why they did it for her" (Nuonyo).

Aposaana narrated that;

"I have heard that there are times they operate some women in the name of saying that the baby was too big and with this one, almost everybody will understand why they did CS on you but should in case they did CS on someone because the baby is small, it will be confusing and that was what my sister went through and everybody was surprise because we are used to the baby was too big

so they did CS but she was told that the baby small and this same CS was also done on her''(Aposaana).

Similar to that of Apogsaana's narration, Yiiman reported that;

"The midwife told us that the baby was not breathing well so they want to operate her and remove the baby for her'' (Yiiman).

4.6.3 Benefits of CS

Participants have the following to say on what they stand to benefit from CS

According to Rena, she said;

"For them, they say it is not good but because it is about the life of the child, they will take it like that but really not their wish" (Rena).

Tietaa is of the view that;

"Madam, the way they talk about this CS and if you are pregnant and you to do this CS to safe yourself and your baby and you listen to them and refuse to do the CS and die, haven't you died a death that could have prevented? Ehenn, that is it" (Tietaa).

According to Etere she said;

"I see it to be a life saver because if there are certain complications making it impossible for a pregnant woman to deliver a baby on her own, that will mean both the life of the mother and baby are at risk as such if caesarian section comes as a means of child delivery to save either or both lives, I will say it's a life saver because without it, the lives of both the mother and baby would be loss'' (Etere).

Nuonyo narrated that;

"Hmm, my sister, some people in our society deliver many children and cannot even care for them well or educate them and so if doing CS will limit my number of future children, I think it will even help me to educate and take good care of them and so I will do CS if the need arises'' (Nuonyo).

Anyuo has this to say;

"I think this operation is good because it can help other women to get their babies if they are not able to give birth by themselves that is through their vagina'' (Anyuo).

4.7 Consequences of CS

This theme is the second emerged theme. The consequences of caesarian section are the outcomes resulting from CS operation, of which participants reported in different ways. Three main categories were reported as follows; prolonged hospital stay, financial burden, and support system issues.

4.7.1 Prolonged hospital stay

Participants reported different concerns about spending much time in the hospital when CS is done. According to Tietaa;

"When They do CS on you, you will be in the hospital for more days before they will tell you to go home and still be going there for them to wash your wound" (Tietaa).

Rena narrated that;

"When you deliver by CS you are going to stay long in the hospital because of the cut on your stomach" (Rena).

Maalo added that;

"When you do CS, the long stay in the hospital is my problem'' (Maalo).

Aposaana reported that;

"Hmm….they were complaining about the long stay at the hospital and the cost" (Aposaana).

Etere narrated that;

"Some of the effects of CS I know are more pain as a result of the wound, being weak for a period of time, excessive blood loss, and the prolonged days of hospitalization''(Etere).

Rena supported Etere that;

"When you deliver by CS you are going to stay long in the hospital'' (Rena).

Maalo added that:

"When you do CS, the long stay in the hospital is my problem'' (Maalo).

Aposaana said this to support Maalo that;

"Hmm…. They were complaining about the long stay at the hospital and the cost" (Aposaana).

4.7.2 Financial burden

On the aspect of financial burden, participants expressed varied concerns. Rena reported that;

"*Hmm madam, CS is costly, and I don't even want to think about it so that one day it may happen that they want to do it on me''(Rena).*

Pognaa narrated this in support of Rena that;

"They did CS on me and the charge was huge that I didn't have money to pay for the bills and come home so, we didn't have any choice than to collect the susu money even though it was not my turn. So, you see if you don't have plenty money, you will not want to do CS'' (Pognaa).

4.7.3 Support system issues

Participants have this to say on support system issues for CS. According to *Vielo;*

"I still remember that CS was done on one of my Aunties and after the operation, since she was weak and cannot work as she used to, I was the one assigned to be helping her in everything after the delivery" (Vielo).

Similar to that of Vielo's report, Enkang said;

''One thing I know is difficulty is caring for the wound and also if you don't really have anybody to support you, things will be difficult for you with other family activities''(Enkang).

Pognaa narrated that;

"The presence of my wound will make it difficult for me to bath and if much care is not taken, the wound can become infected and take longer time to heal. Getting someone to support genuinely after the CS will be a big problem'' (Pognaa).

4.8 Complications associated with CS

This is the third emerged theme. Complications associated with CS is the third emerged theme. Participants reported on several challenges associated with caesarian section operation as a method of childbirth. Three main categories or sub-themes were mentioned. Limited family size, delayed wound healing and excessive bleeding.

4.8.1 Limited number of desired children

On the aspect of the desired number of children participants wish to have in future, they expressed varied concerns about the restrictions that are experienced with future number of children.

According to Rena;

"When you do CS, you will be forced to have limited number of children say two (2) or three (3) and I have even seen a woman who did this CS and never became pregnant again and so she has only and only one (1) child. So, with all these stories I have heard I don't ever want to do any CS so that I can have my larger number of children say ten (10) if that is what my husband wants" (Rena).

Saataare narrated that;

"Eeeii, madam you know we women we talk about everything; they normally say when you do CS you can't give birth to the require number of children you and partner may want to have'' (Saataare).

Vielo reported that;

"Madam you see that when you do CS you can deliver a maximum of three (3) children and with this number of children, it is a small number to them which will not make them have many children as they want to have" (Vielo).

Pognaa added that;

"They usually talk about the operation pain and the limitation it has on childbirth" (Pognaa).

4.7.2 Delayed wound healing

Participants shared concerns about the long periods it takes for wound healing to occur with CS deliveries. According to Etere;

"My aunty did this operation and after that there was pus in the wound, and it was smelling. Hmm, that her wound took a long time to heal''(Etere).

Tietaa narrated that;

"My body is very bad with wound healing so for me it will take me extra, extra, time for that my wound to heal, and it may even become infected since it will be big and on my abdomen. As for me, little sores take longer to heal so I can't imagine how long this one will use to heal''(Tietaa).

Yiiman reported that*;*

"I will see myself with a big sore which may take a long time to heal and the scar after the wound dies'' (Yiiman).

4.7.3 Excessive bleeding

Participants shared concerns about excessive blood loss associated with CS delivery. Etere reported that;

"I can lose a lot of blood during the process''(Etere).

Laura added that;

"I was told that after you go through CS, you become weak and lose a lot of blood which would affect the work I do'' (Laura).

According to Yuora's narration;

"My daughter, it's because I don't want to be cut and remove my baby. I may bleed too much and even die''(Yuora).

4.8 Reactions towards medical need for CS

This is the fourth emerged theme which addresses participants feelings towards CS. Participants expressed mixed feelings or reactions towards medical need for CS delivery as a childbirth option. Two main categories or subthemes were reported: negative reactions and positive reactions.

4.8.1 Negative reactions

On the aspect of negative reactions about CS as a mode of childbirth, Etere has this to say;

"I will be alarmed and sad because I will not know the outcome of this caesarian section operation whether it will be successful due to all what I have heard concerning the CS. Some people say they will remove your womb, and you will not deliver again, I even heard that they can forget certain things in your womb and that alone scares me''(Etere).

Maalo lamented that;

"I will feel highly depressed with myself and the whole operation if am told there is the need for it and my heartbeat alone can make me get high BP and collapse la pass because my aunty once went for this CS and did not come back alive, so the baby was sent to a babies' home nursed there and I don't want to experience such'' (Maalo).

Similarly, Laura added that:

"*I am someone who loves my body so much and can't stand it seeing them operate on me, I will be nervous'' (Laura).*

Nuonyo negatively reacted that;

"I will feel so dejected and disappointed when given the information that CS will be performed on me, because I had a friend, who went for this operation CS and after that her urine leaks without her knowing so later when she reported to a different health facility, and they checked and realized that her urinary bladder was cut during the CS delivery. Because of that problem, the husband married a second wife since she was always smelling of the urine and the husband wasn't treating her as a wife and so married a second wife. I would not want to go through that same ordeal which may cause me losing my marriage''(Nuonyo).

In a similar vein, Tietaa's narrated that;

"Hmm for me I will be worried and anxious upon me being told that there will be the need for CS operation to be done on me just because I cannot deliver through my vagina like my other colleague women after all my four deliveries by myself''(Tietaa)

4.8.2 Positive reactions

On the contrary, some participants have positive reactions towards CS delivery as a childbirth method.

Anyuo is of the view that;

"I will thank God for giving me another way to have my second child. I will just start thanking God and I just be calm and be telling God to help me go through the CS well''(Anyuo).

Faalo naarated that;

"I will feel happy. So, if am told to do the CS, I will comply to and have my baby peacefully and safe myself from this labour pains that at times other women will experience the pains and still they cut them open and remove their babies for them'' (Faalo).

Vielo reported that;

"Anyway, I will be happy if they operate me if that is the only means I can have my own child safely because if the doctor tells me that there is no way I can give birth by myself because my baby is too big or not lying well, madam I don't have any other choice that I will do so I will just agree for the CS to be done so that at least I can save my child and myself''(Vielo).

4.9 Summary of findings

The study demonstrated how caesarian section is socially constructed among women in the Nandom Municipality. Although this was achieved through the social construction model of reality, some of the themes emerged from the data contextually. The demographic characteristics indicated that the women interviewed for the study were aged 24 – 47. Most twelve (12) of the

women were Christians and four (4) were Muslims. Majority Thirteen (13) of the women were married, while three (3) were not married. The women had varied educational levels including tertiary (8), SSS (5), and JHS (3).

The narrations of women showed their subjective and societal meaning of CS, their sources of information about the beliefs, perception, norms and values of CS and the social construction accustomed to CS. The women described the meaning of CS in different categories including perceived medical meaning of CS, and CS as a mode of delivery as the sub-themes. With the sources of information about CS, four main sub-themes were identified including significant others, health professionals, social media, Community gathering. On the aspect of beliefs, norms, perceptions, and values (internalization) of CS among women, five sub-themes were revealed including religious beliefs about CS, cultural perception about CS, social stigma about CS, perception of CS on reputation, and health concerns resulting from CS. Cultural perspective, perceived need for CS and benefits of CS were the three sub-themes that emerged from the social construction of CS. The women's narratives showed that the women knew the basic meaning of CS. Their understanding of CS with regards to the medical meaning of CS is an operation that is done to help pregnant women deliver their babies. From the study, reality about CS was obtained through significant others, health professional, social media and community gathering.

Regarding beliefs, perception, norms and values, the women shared varied concerns about this theme. For instance, religiously, most women belief that so far as they have been able to experience several spontaneous vaginal deliveries, if there is the need for CS in their subsequent deliveries it means that it is the plan of God. The findings revealed that CS even though some women see CS as a perceived need and acknowledged the benefits of CS in saving their lives and that of their babies, they were concerned about its effects on them and the views of their significant

others. The findings revealed that the women are worried with the fact that CS comes with certain risk and complications such as limited family size which deters them from utilizing CS.

The women shared that in their social context CS is seen as a procedure for promiscuous and lazy women as well as a curse to disrespectful women. Socially, the women have been convinced that a real woman is one who can deliver vaginally (naturally) and 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 to be accorded the needed reputation as women in their social context.

The women expressed mixed feelings towards medical need for CS as a childbirth option including positive and negative reactions. It is interesting to note that these women's reactions are influenced by their personal experiences, cultural beliefs, and social norms

CHAPTER FIVE

DISCUSSION

Presented in this chapter is a discussion of the findings of the study. The demographic characteristics of the participants are discussed first, followed by the discussion of the reported themes.

5.1 Demographic characteristics of participants

The study involved 16 women who had never experienced caesarian section, and their ages ranged from 24 to 47 years. Thirteen (13) of them being married while three (3) are not married, which means that majority of them were matured enough to make decisions on the choice of the type of birth method preferred for delivery when the need arises. This is in accordance with previous studies conducted (Mlambo et al., 2020). The participants also had varying levels of education, with 8 having tertiary education, 5 being senior high school leavers, and 3 being junior high school leavers and similar results have been reported in previous findings (Ghotbi et al., 2014; Neuman et al., 2014). However, the differences in educational level indicate that giving birth through CS is not related to educational status and any woman within the reproductive age can deliver by CS when need arises. Women with high education are more knowledgeable, appreciate CS deilivery, and may accept CS as a method of delivery since such women are knowledgeable, welcome change, and would rather have a healthy child irrespective of the mode of delivery.

The participants came from diverse backgrounds, with 12 being Dagaabas, 1 Akan, 1 Fulani, and 2 Frafra women, it is appreciated that delivery through CS is not dependent on tribe but on the need for it when medically indicated.

The demographic characteristics of the participants, such as their age, tribe, education level, employment status, and cultural background, likely influenced their perceptions and experiences of caesarian section in several ways.

5.2 Meaning/reality of caesarean section.

The current study revealed the meaning/reality of caesarean section in different ways. The women expressed perceived medical meaning of CS, and CS as a mode of delivery within their social context. The women's understanding of caesarian section as a necessary medical intervention to ensure the safety of both the mother and the baby is significant as reported by previous studies (Bendtsen, 2023; Neritu, 2022; Jahan, 2019). This understanding might influence their decisions about childbirth, particularly if they are faced with situations where caesarean section is recommended. Moreover, the participants' knowledge about caesarian section might also impact their experiences of the procedure reported previously (Akalin & Sahin, 2021; Bakhtari et al., 2019). For instance, if women are well-informed about what to expect during and after the procedure, they might feel more prepared and less anxious.

Different reasons are given for choosing one birth method over another as participants in this study shared their views concerning the meaning of CS. Although some previous studies El-Aziz et al., (2016), and Afaya et al., (2018) reported CS in Ghana, the most common findings reported in these studies were the medical reasons for CS. The women in this current study had a contrary view and did not perceive CS to be something which is medical but seen CS as a mode through which promiscuous and lazy women give birth to their children. This current finding suggests that the kind of meaning given to CS is dependent on the kind of information individuals receive from their significant others, which are culturally influenced.

5.3 Sources of reality of caesarean section (objectification)

In this current study, the findings revealed that participants received information about CS through different sources. The different sources through which these women reported about the reality of CS included significant others, social media, health professional, and Community gatherings. Participants' expression of the significant others as a source of their information about CS was based on circumstances where family members, and friends gave them information on CS. These findings are consistent with previous studies (Shahoei et al., 2014; Rahnama et al., 2016; Ugwu & Kok, 2015).

The study also revealed social media as another source of information about CS. The most common mass media sources mentioned were television and radio which were consistent with previous research by Maitanmi et al., (2023) and inconsistent with findings of Omuno et al., (2024), where there was confirmation that respondents had moderate knowledge about CS because they had never received information about cesarean sections from the media . It has also emerged in this current study that Health professionals are a relevant source of information.

The participants revealed community gathering as a source of information about CS based on occasions which included community durbars, and funerals which have been previously reported (Konlan et al., 2019; Colomar et al., 2021). These sources of information played a significant role in shaping the women's understanding and perceptions of caesarean section. It is interesting to note that these women's sources of information were largely informal, with significant others and community gatherings being prominent sources as reported by many previous researchers (Shahoei et al., 2014; Rahnama et al., 2016; Ugwu & Kok, 2015; Konlan et al., 2019; Colomar et al., 2021). This highlights the importance of social networks and community-based information in shaping women's understanding of caesarian section.

The health professionals' role in providing information about caesarean section is also noteworthy and has also emerged. The participants' narratives suggested that health professionals played a significant role in providing information about caesarean section particularly in the context of antenatal care and childbirth.

The findings suggested that women's understanding of caesarean section is shaped by a complex interplay of formal and informal sources of information. This has implications for the development of effective health education and communication strategies aimed at promoting women's understanding and their willingness to accept caesarean section when the need arises as an alternative to normal delivery.

5.4 Beliefs, perceptions, norms and values about caesarean section (internalization)

The findings revealed that participants had varied religious beliefs about CS, including cultural perception about CS, social stigma about CS, perception of CS on reputation, and health concerns resulting from CS. For example, the women believed that the fact that they had several histories of vaginal births indicated that they deliver through CS as a childbirth strategy means that God has planned it that way and this contradicts with previous literature (Nabil Aboushady et al., 2024; Afaya et al., 2018; Ugwu & de Kok, 2015). These findings revealed the existing misconceptions about CS.

Regarding cultural perceptions about CS, the findings indicated that CS is for unfaithful and lazy women to avoid delayed labour to cover their shame. This finding is contrary to previous research by (Pilvar, & Yousefi, 2021; Hyman, Taheri, & Rahmati, 2024). Their findings indicated that in an Iranian survey, many women belief CS to be a respectable procedure and often associating it with wealth and high social status.

On the aspect of social stigma associated with CS, the current study findings conflict with previous studies (Lazo-Porras et al., 2017; Perner et al., 2022; Festus, 2024; Cecilia De Mello, (1994), indicating that in parts of Latin America, CS is often viewed with greater acceptance, and even preferred, resulting in medicalized and increasing normalization of CS as a childbirth strategy. This suggest that women in the present study may not have adequate knowledge to inform their decision especially when medically indicated. There is an obvious need for proper education on why CS is done.

The current study also revealed that women battle with perception of CS on reputation which resonates with previous research by Ezeome et al., (2018) and Amiegheme et al., (2016). Contrary to the current findings, CS has been both medicalized and increasingly normalized in Western societies, particularly in the United States as they are knowledgeable about the importance of CS delivery (Gesing, 2016; Loewenberg Weisband, 2017; Caughey, 2016; Reyes, 2021).There is an impression that the women in Nandom are ignorant about the medical indications of CS delivery suggesting the need for education to boost their enthusiastic acceptance when the need arises during labour.

The present study findings revealed that participants reported on health concerns resulting from CS. These health concerns raised by participants can probably challenge them in their daily activities as reported previously by Litorp et al., (2015) and Rishworth et al., (2016), indicating that women face challenges in going about their daily lives after CS. It is obviously clear that CS is seen or described as a barrier, keeping them from fulfilling their expected duties as compared to women who deliver per vaginum. The findings of this present study suggest that women's understanding, and perceptions of caesarean section are shaped by a complex interplay of cultural, social, and religious factors. There is therefore the need for effective and emphasized education on

CS to all categories of women and the public to clear these misconceptions and pave way for women to embrace CS when medically indicated.

5.5 Social construction of caesarean section

The current findings revealed that participants reported on the social construction of CS based on their individual subjective thoughts and societal views about caesarean section. The findings indicated that participants reported their views on the social construction of CS in the area of cultural perspective, perceived need for CS and the benefits of CS. On the aspect of the cultural perspective of CS, the current findings revealed that the cultural perspective of CS showed that the individuals' immediate environment influences their decision to perform an intended behaviour or not. Cultural and social factors that shape these women's understanding of caesarean section are consistent with previous literature (Panti et al., 2018; Ezeonu et al., 2017). The findings of this current study showed that women see CS as a curse or punishment from God which is contrary to findings of Nyarkoaa Boateng, (2022) and Rahnama et al. (2016), indicating that participants believed that their experiences of CS were part of God's plan. This implies that traditional beliefs and societal norms about childbirth might have influenced their views on caesarean section. For instance, if there is a strong cultural emphasis on vaginal delivery, the women might feel pressured to avoid caesarian section, even if it is medically necessary.

The present study revealed perceived need for CS as acknowledged and reported by some of the participants and this does not resonate with previous findings by Hildingsson et al., (2019) and Betran et al., (2021), indicating that expectant mothers and partners opted for CS because CS is believed to be a wonderful method of childbirth. Moreover, some of these women did not underestimate the perceived need for CS and this finding is in alignment with previous studies

(Firoozi et al., 2021; Colomar et al., 2021). The current findings suggest that women's understanding, and perceptions about CS are shaped by a complex interplay of cultural, social, and medical factors implying that more education needs to be done on the medical needs for CS.

Healthcare providers play a crucial role in shaping the participants' understanding of caesarian section and therefore may unintentionally reinforce cultural or societal expectations surrounding childbirth, influencing women's choices regarding caesarian sections when the need arises.

5.6 Consequences of CS

The present findings revealed varied consequences of caesarian section as reported by participants in different categories. These consequences of CS included prolonged hospital stay, financial burden, and support system issues. The present findings indicated that the women reported prolonged hospital stay after undergoing a caesarian section and this finding resonates with previous findings (Mezemir et al. & Wolder et al., 2023). The contributory factors to this prolonged hospital stay may include the incisional wound site infection and excessive blood loss and these could have an impact on daily life, as seen in previous research (Litorp et al., 2015; Rishworth et al., 2016).

On the aspect of financial burden, it was revealed that the estimated costs of caesarian section compared to vaginal delivery is out-of-pocket expenses and potential debt and also long-term financial implications for families which conflict with previous studies (Entringer, Pinto, & Gomes, 2018; Dixon, 2019; Shoemaker, 2016), suggesting that with multiparous women with prior uterine scars, CS has been shown to be more cost-effective and safer compared to natural childbirth.

Regarding support system issues, participants expressed the need for support persons in times of CS as the women involved would need some months off their daily duties as compared to normal vaginal delivery. This concern about the need for support person could probably be the reason why some women resist to CS when the need arises during labour as it may be challenging to get a devoted support person during CS delivery.

5.7 Complications associated with CS

The present study revealed that participants raised concerns about the outcome surrounding the different complications associated with CS. The women reported on limited family size, delayed wound healing and excessive bleeding as associated complications when caesarian section is chosen as a method of childbirth method. Regarding limited family size one can have, this current study postulates that CS restricts women's ability to have their desired number of children. This complication associated with CS is a source of worry to some women and this was also a worry to women in previous research (Amiegheme et al., 2016; Ugwu & Kok, 2015). These findings indicating that, the women had negative opinions of CS in relation to the number of future and desired number of children they could have, implying that they would be deprived of their desired family size. This worry about the limited family size can be attributed to the value placed on large family size with regards to the social context of the study and this is contrary to previous studies by Sani et al., (2024), discovering that women will prefer smaller family size to provide the children with better care.

Delayed wound healing was one of the complications reported. Some of the women shared varied concerns about the physical challenges associated with CS wounds and these findings resonates with previous studies (Mezemir et al., & Woder et al., 2023). This issue of delayed

wound healing could be attributed to either infection or wound complications, resulting in prolonged recovery time and discomfort and an obvious potential impact on their daily activities and this is contrary to previous research (Simkin et al., 2024). The current findings suggest that if women are well-informed about CS as a medical intervention, they might be more than willing to seek medical care if they experience complications during labour or when the need arises.

5.8 Reactions towards medical need for CS

Participants expressed mixed feelings towards medical need for CS as a childbirth option including positive and negative reactions. It is interesting to note that these women's reactions are influenced by their personal experiences, cultural beliefs, and social norms. Some women are worried about the potential risks and complications associated with CS, while others see it as a lifesaving intervention. It was revealed that the women expressed feelings of relief and gratitude for a second chance to safe delivery. However, these women expressed anxiety and fear about CS because of potential complications and emotional distress. On the contrary, women in previous studies reported a sense of relief when CS was indicated (Eide, Morken, & Bærøe, 2019; Simmonds, 2023).

These current findings suggest the need for health care providers to provide accurate and culturally sensitive information about caesarean section which might help to reduce anxiety and fear among women who might need CS.

5.9 Summary of discussion

In summary, the women in Nandom Municipality had varied subjective meaning about caesarean section based on their understanding. The participants revealed that they had the fundamental understanding of CS and how it is performed, and their understanding of CS was

associated with it being the perceived medical meaning of CS and CS as mode of delivery. They had varied common sources of reality about CS including social media, significant others, community members (through community gatherings) and the health professions (midwives and doctors). The findings revealed that participants have varied beliefs, perceptions, norms and values about the caesarian section which have an influence on their decision to choose CS as a birth method when the need arises during labour.

The results indicated that women willingness to agree and accept CS as a birth strategy in medically indicated circumstances is influenced by how their subjective thoughts and societal views about caesarean section have socially been constructed. Irrespective of how CS has been socially constructed by individuals and the society, the findings revealed that most of the women never underestimated the pronounced and immersed benefits of CS in saving the lives of mother and their babies whiles others only concern about the negative effects of CS neglecting their lives and that of their babies. The findings revealed that the women are aware of the varied consequences which are the outcomes resulting from CS operation which deter some of them from selecting CS as a childbirth method in times of need during labour. The findings revealed that participants portrayed some level of resistance towards choosing CS as a method of childbirth because of their knowledge of the several complications associated with CS operation which influence their choice of CS when needed.

The results indicated that participants expressed mixed feelings or reactions towards medical need for CS delivery as a childbirth option which can influence them accepting CS as a birth strategy in times of need. The findings of the study showed that women's willingness and readiness to choose CS as birth method depends on the kind of information they receive about CS

from their varied sources of reality which can influence them based on how individuals and society have socially constructed CS.

CHAPTER SIX

SUMMARY, IMPLICATIONS, LIMITATIONS, CONCLUSIONS AND RECOMMENDATIONS

This chapter presents the summary of the entire study, implications of the study's findings, limitations of the study, conclusions and the recommendations based on the findings.

6.1 Summary of the study

This study explored the meaning given to caesarean section among women who had never experience caesarean section procedure in their lifetime in the Nandom Municipality using the social construction theory of reality proposed by Berger and Luckman (1966) to serve as the organizational framework of the study. The objectives of the study were formulated based on the constructs of the theory. The explorative qualitative design using the purposive sampling technique was employed to engage sixteen women who met the inclusive criteria. The study was conducted at the St. Theresa's hospital in the Nandom Municipality. Data collection commenced after ethical clearance was secured from the institutional review board of the Christian Health Association of Ghana.

Pretesting of the interview guide was done at St. Joseph Hospital in Jirapa to refine the questions. Women who agreed to participate in the study were allowed to sign a consent form before they were interviewed. With permission from the participants, the interviews conducted were audio-taped and transcribed verbatim. Thematic content analysis was used to analyse the collected data. Seven major themes were generated from the data where three of them were consistent with the social construction theory of reality and four of them emerged themes. In total twenty-two (22) subthemes were identified from the data.

The three main themes with their sub-themes included the meaning of caesarian section (externalization) with perceived medical meaning of CS and CS as a mode of delivery which were the sub-themes under this first theme. The next main theme was the sources reality of caesarian section (objectivation) with significant others, social media, community gatherings and health professionals as the sub-themes. The third main theme was the beliefs, perception, norms and values about caesarian (internalization) with religious beliefs about CS, cultural perception of CS, social stigma about CS, perception of CS on reputation, and health concerns resulting from CS as sub-themes.

Among the four emerged themes included the following. Social construction of caesarian was one of the emerged themes with cultural perspective, perceived need for CS, and benefits of CS which were the sub-themes under that theme. Consequences of CS was the second emerged theme with prolong hospital stay, financial burden and support system issues as the sub-themes. The third emerged theme was complications associated with CS with limited number of desired children, delayed wound healing and excessive bleeding as the sub-themes. The last but not the least emerged theme was reactions towards medical need for CS with negative reactions and positive reactions as the sub-themes under this forth emerged theme.

The findings revealed that women had their own different subjective meaning about caesarian section based on their understanding. The participants revealed that they had the fundamental understanding of CS and how it is performed, and their understanding of CS was associated with it being the perceived medical meaning of CS and CS as mode of delivery. The women had varied common sources of information about CS such as the social media, significant others, community members (through community gatherings) and the health professions (midwives and doctors). The findings revealed that participants have varied beliefs, perceptions,

norms and values about the caesarean section which have an influence on their decision to choose CS as a birth method when the need arises during labour. The results indicated that women willingness to agree and accept CS as a birth strategy in medically indicated circumstances is influenced by how their subjective thoughts and societal views about caesarian section have socially been constructed.

Irrespective of how CS has been socially constructed by individuals and the society, the findings revealed the women never underestimated the pronounced and immersed benefits of CS in saving the lives of mother and their babies whiles others only concern about the negative effects of CS neglecting their lives and that of their babies. The findings revealed that participants are aware of the varied consequences which are the outcomes resulting from CS operation which deter some women from selecting CS as a childbirth method in times of need during labour. The findings revealed that participants portrayed some level of resistance towards choosing CS as a method of childbirth as a result of their knowledge of the several complications associated with caesarian section operation which influence their choice of CS when needed. The results indicated that participants expressed mixed feelings or reactions towards medical need for CS delivery as a childbirth option which can influence them accepting CS as a birth strategy in times of need.

The findings of the study showed that women's willingness and readiness to choose CS as birth method depends on the kind of information they receive about CS from their varied sources of reality which can influence them based on how individuals and society have socially constructed caesarean section. Therefore, the need for development of effective health education and communication strategies aimed at promoting women's understanding and their willingness to accept caesarean section when the need arises as an alternative to normal delivery.

6.2 Implications

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

6.2.1 Implications for Nursing and Midwifery Practice

The study findings revealed that participants' knowledge on caesarean section were mainly from informal sources which is a big concern resulting from inadequate knowledge level of participants about CS as a whole and it is very necessary to look at it and correct the inadequacies. Participants had varied beliefs and perceptions influencing most of them to ignore the benefits of CS in saving them and their babies' lives but rather pay more attention on the beliefs, perceptions, norms, and values about CS and how CS is subjectively and societally and culturally constructed at the expense of saving their lives.

The findings suggest that there is the need for effective education about CS at social gatherings such as churches, community durbars, hospital OPDs and ANC especially to address misconceptions women and the public have about CS in general not necessarily during only antenatal period, during labour and after delivery.

The results revealed that women's preconceived notions about caesarean sections, both before and after birth, may not be addressed by the education and counseling provided at the antenatal care level. This means that health care practitioners must make a deliberate and routine effort to educate about the broad indications for caesarean section as a medical condition, to all categories of women in general, and reinforced and re-echoed especially to expectant mothers during antenatal periods.

6.2.2 Implications for Nursing and Midwifery research

The present study assessed the social construction of caesarean section among women through the qualitative approach using 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 for future research could be the social construction of caesarian section among men in the Nandom Municipality to know the views of men about CS. Future research can also explore the social construction of CS among women (those who have never experience CS delivery before and those who have undergone CS delivery before) in the Nandom Municipality so that pattern analysis can done to compare their responses and get a broader understanding of the beliefs associated with the caesarian section.

6.2.3 Implication for policy formulation

The results imply that the women will readily accept the medical indications for a caesarean section and this underlines the necessity of a policy requiring education of all women and the general public, and especially re-echoing at antenatal clinics on the fundamental medical indications for caesarean sections in order to remove any societal stigma or misconception attached to the procedure and make it a freely accepted alternative birth technique when the need arises.

6. 2.4 Limitations

Despite the important findings revealed by this present study on the social construction of caesarean section among women, the researcher duly acknowledged the limitations the study. Sixteen (16) women were recruited for the study which is relatively a small sample size and may not be a representative of the general population. Thus, generalization of the study's findings should be considered with caution. Nonetheless, the results align with some previous research conducted in Ghana, Nigeria most especially and other countries, suggesting that transferability is

feasible in cases where the contexts are similar. In addition, the study was limited to only women and did not include men which skewed the findings to one side.

6.2.5 Conclusion

This study explored the social construction of caesarean section among women in the Nandom Municipality using the theory of the social construction of reality as the organizing framework. The findings ascertained that women have different meanings about caesarean section based on their varied sources of reality about CS. The findings revealed that participants have varied beliefs, and perceptions about the caesarian section which have an influence on their decision to choose CS as a birth method when the need arises during labour. The results showed that women's willingness to agree and accept CS as a birth strategy in medically indicated circumstances is influenced by how their individual subjective thoughts, cultural and societal views about caesarean section have socially been constructed.

According to the findings, the women wish and want to give birth vaginally to be accepted in their social setting as "women." Health care professionals must therefore make a concerted effort to give health education regarding the medical indications for caesarian section as a birth method to all categories of women and the public as a whole to increase the acceptance of CS as an alternative childbirth method when the need arises during labour to safe mothers and babies' lives. This will put Ghana in the right direction to reducing maternal and infant morbidity and mortality by 2030 as anticipated by WHO.

6.2.6 Recommendations

Based on the findings of the study, the following recommendations have been made to the Ministry of Health, Ghana (M.O.H), Ghana Health Service (GHS), Nursing and Midwifery

Council of Ghana (NMC), Ghana Medical and Dental Council (MDC), St. Theresa's Hospital, Nandom, and health care professionals.

6. 2.7 To Ministry of Health, Ghana.

The Ministry of Health should.

1. Increase public awareness of caesarian section indications through mass media in order to enrich public understanding to increase their acceptability of CS, and to encourage families and community members to provide the necessary support for women undergoing caesarean section.
2. Provide subsidized finding for women who need to undergo caesarean section delivery as an alternative to childbirth when the need arises during labour.

6.2.8 Ghana Health Service (GHS)

1. Ensure that in all health facilities and communities, there is increased public awareness of caesarean section indications through mass media to enrich public understanding to increase their acceptability of CS, and to encourage families and community members to provide the necessary support for women undergoing caesarean section.
2. Ensure that there is provision of subsidized finding for women who need to undergo caesarean section delivery as an alternative to childbirth when the need arises during labour.
3. Provide specialized programs for women to receive psychological counseling during even before pregnancy, antenatal, labour and after a cesarean section and normal vaginal delivery.

6.2.9 Nursing and Midwifery Council of Ghana (NMC)

1. Ensure that all nurses and midwives have received training on sociocultural beliefs, perspectives, norms and values about caesarean section.

2. Ensure that all nurses and midwives obligatorily educate the public, women and expectant mothers on the indications for caesarean section to increase the awareness and acceptance of caesarean section when the need arises.

6.3.0 Ghana Medical and Dental Council (MDC)

3. Ensure that all medical staff members have received training on sociocultural beliefs, perspectives, norms and values about caesarean section.
4. Ensure that all medical staff obligatorily educate the public, women and expectant mothers on the indications for caesarian section to increase the awareness and acceptance of caesarean section when the need arises.

6.3.1 St. Theresa's Hospital, Nandom.

Ensure that.

1. All nursed and midwives at the St. Theresa's Hospital, Nandom and other healthcare facilities in the Nandom Municipality make a deliberate effort to offer specialized education on the general medical indications of caesarean section as a medical intervention to save expectant mothers and their babies when the need arises.
2. The use of every resource at your disposal to engage the communities and educate women and their significant others about the need, benefits, and effects, of caesarean sections.
3. A conscious effort is made to dispel the myths surrounding the decision to have a caesarean section and its effects.

4. Community seminars, fora, and durbars on CS. For instance, authority can be given to the public health education unit to educate women, families and communities about the general medical indications of a caesarian section during their regular community visits.
5. Provide specialized programs for women to receive psychological counseling during even before pregnancy, antenatal, labour and after a cesarean section and normal vaginal delivery.
6. Establish policies that incentivize husbands to go with their spouses to the hospital for antenatal appointments.

6.3.2 Health Care Professionals (HCP)

Ensure that.

1. All health care staff must be knowledgeable and make a deliberate effort to offer specialized education on the general medical indications of caesarean section as a medical intervention to save expectant mothers and their babies when the need arises during community seminars, fora, and durbars
2. The use of every resource at your disposal to engage the communities and educate women and their significant others about the need, benefits, and effects, of caesarean sections.

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APPENDICES
APPENDIX I: INTRODUCTORY LETTERS

UNIVERSITY OF GHANA

SCHOOL OF NURSING AND MIDWIFERY
COLLEGE OF HEALTH SCIENCES

Ref: 11007726

30th April, 2024.

The Chairperson
Ethical Review Board Committee
Christian Health Association of Ghana (CHAG)
Accra

Dear Sir/Madam,

LETTER OF INTRODUCTION – ETHICAL CLEARANCE

I write to introduce to you Justina Kuuwiedome, an MPhil Midwifery student in the Department of Maternal and Child Health at the School of Nursing and Midwifery, University of Ghana, Legon.

As part of the requirements for the MPhil Midwifery programme, the student is to undertake a study and she intends to use the St. Theresa's Hospital at Nandom in the Upper West region as her study site.

The title of her research is "**Social construction of caesarian section among women in Nandom municipality in the Upper West Region of Ghana.**"

I write to seek your permission to enable her undertake this study at the facility.

Thank you.

Yours faithfully,

Mr. Charles A. Klutse
(School Administrator)

INTEGRI PROCEDAMUS

P. O. Box LG 43, Legon, Accra, Ghana I Tel: +233 (0) 303 970 801
Email: nursing@ug.edu.gh I Website: www.nursing.ug.edu.gh

UG

UNIVERSITY OF GHANA

DEPARTMENT OF MATERNAL AND CHILD HEALTH
SCHOOL OF NURSING AND MIDWIFERY
COLLEGE OF HEALTH SCIENCES

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Prof Florence Naab
(Research Supervisor)

P. O. Box LG 43, Legon, Accra, Ghana | Tel: +233 (0) 30 251 3250
Email: mchsonm@ug.edu.gh | Website: www.nursing.ug.edu.gh

In case of reply, the number and the date of this letter should be quoted

OUR CORE VALUES
Professionalism
People-centeredness
Team Work
Integrity
Discipline
Innovation

GHANA HEALTH SERVICE
Your Health · Our Concern

Regional Health Directorate
Ghana Health Service
P. O. Box 298
Wa
Upper West Region

17th June, 2024

Tel:+2330392096685
GPS Address: XW -0020-2007
Email: rhds.uwr@ghsmail.org

My Ref: UWR/RHD/ADM/SP-57
Your Ref:

DIRECTOR OF HEALTH SERVICES AT THE NANDOM MUNICIPALITY
MED. SUPT. ST THERESA'S HOSPITAL, NANDOM

INTRODUCTORY LETTER: MS. JUSTINA KUUWIEDOME

The bearer of this letter is a Master of Philosophy student in Midwifery at the School of Nursing and Midwifery at the University of Ghana, Legon. She is seeking to conduct research on the topic **"Social Construction of Caesarian Section Among Women in Nandom Municipality in the Upper West Region of Ghana at St. Theresa's Hospital, Nandom."**

Please accord her the necessary support and cooperation and take the necessary steps to ensure the privacy and confidentiality of our staff and clients are guaranteed.

However, please report any form of misconduct regarding this research to the Research Unit for necessary action.

Thank you.

DR. DAMIEN PUNGUYIRE
REGIONAL DIRECTOR OF HEALTH SERVICES

Cc:
1. MS. JUSTINA KUUWIEDOME
2. RESEARCH UNIT FILE

APPENDIX II: LETTERS OF SUPPORT – ETHICAL CLEARNACE

UNIVERSITY OF GHANA

SCHOOL OF NURSING AND MIDWIFERY
COLLEGE OF HEALTH SCIENCES

Ref: 11007726

30th April, 2024.

The Chairperson

Ethical Review Board Committee

Christian Health Association of Ghana (CHAG)

Accra

Dear Sir/Madam,

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UNIVERSITY OF GHANA

DEPARTMENT OF MATERNAL AND CHILD HEALTH
SCHOOL OF NURSING AND MIDWIFERY
COLLEGE OF HEALTH SCIENCES

Ref: 11007726

30th April, 2024.

The Chairperson

Ethical Review Board Committee

Christian Health Association of Ghana (CHAG)

Accra

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UNIVERSITY OF GHANA

DEPARTMENT OF MATERNAL AND CHILD HEALTH
SCHOOL OF NURSING AND MIDWIFERY
COLLEGE OF HEALTH SCIENCES

Ref: 11007726

30th April, 2024.

The Chairperson

Ethical Review Board Committee

Christian Health Association of Ghana (CHAG)

Accra

Dear Sir/Madam,

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As part of the requirements for the MPhil Midwifery programme, the student is to undertake a study and she intends to use the St. Theresa's Hospital at Nandom in the Upper West region as her study site.

The title of her research is "**Social construction of caesarian section among women in Nandom municipality in the Upper West Region of Ghana.**"

I write to seek your permission to enable her undertake this study at the facility.

Thank you.

Yours faithfully,

DEPARTMENT OF MATERNAL & CHILD HEALTH
SCHOOL OF NURSING AND MIDWIFERY
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA, LEGON

Dr. Mary Ani-Amponsah
(Head Of Department)

INTEGRI PROCEDAMUS

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UNIVERSITY OF GHANA

DEPARTMENT OF MATERNAL AND CHILD HEALTH
SCHOOL OF NURSING AND MIDWIFERY
COLLEGE OF HEALTH SCIENCES

Ref: 11007726

30th April, 2024.

The Medical Superintendent

St. Theresa's Hospital, Nandom

P. O. Box 15

Nandom, Upper West Region

Dear Sir/Madam,

LETTER OF SUPPORT– ETHICAL CLEARANCE

I write to support the application for ethical clearance of Justina Kuuwiedome, an MPhil Midwifery student in the Department of Maternal and Child Health at the School of Nursing and Midwifery, University of Ghana, Legon.

As part of the requirements for the MPhil Midwifery programme, the student is to undertake a study and she intends to use your facility as her study site.

The title of her research is "**Social construction of caesarian section among women in Nandom municipality in the Upper West Region of Ghana.**"

I write to seek your permission to enable her undertake this study at the facility.

Thank you.

Yours faithfully,

Prof. Florence Naab
(Research Supervisor)

Cc:

The Nurse Manager

St. Theresa's Hospital, Nandom

P. O. Box 15

Nandom, Upper West Region

P. O. Box LG 43, Legon, Accra, Ghana | Tel: +233 (0) 30 251 3250
Email: mchsonm@ug.edu.gh | Website: www.nursing.ug.edu.gh

UG

APPENDIX III: LETTER OF PERMISSION

School Of Nursing and Midwifery

College of Health Sciences

University of Ghana, Legon.

23rd May 2024

The Regional Director of Health Services

Upper West Region

Post Office Box 298

Wa,

Dear Sir,

PERMISSION TO CARRYOUT RESEARCH STUDY IN YOUR REGION

I would be grateful if you could grant me permission to carry out my research study in your region. **Justina Kuuwiedome is my name, a Master of Philosophy in Midwifery student** at the School of Nursing and Midwifery of University of Ghana, Legon. As part of my studies, am expected to conduct scientific research, and a result of this need, I therefore write to ask for your permission to conduct my research study on the topic: **''Social construction of caesarian section among women in Nandom Municipality in the Upper West Region of Ghana'' at St. Theresa's Hospital, Nandom.**

I count on your usual cooperation and support, and I hope my request would be considered.

Thank you.

Yours faithfully,

.....

Justina Kuuwiedome (ID: 11007726)

Contact no. 0206615300

Email address: kuuwiedomej@gmail.com

APPENDIX IV: LETTER OF ACCEPTANCE

In case of reply, the number and the date of this letter should be quoted

OUR CORE VALUES
Professionalism
People-centeredness
Team Work
Integrity
Discipline
Innovation

GHANA HEALTH SERVICE
Your Health - Our Concern

Regional Health Directorate
Ghana Health Service
P. O. Box 298
Wa
Upper West Region

17th June, 2024

Tel:+2330392096685
GPS Address: XW -0020-2007
Email: rhds.uwr@ghsmail.org

My Ref: UWR/RHD/ADM/ST-57
Your Ref:

DIRECTOR OF HEALTH SERVICES AT THE NANDOM MUNICIPALITY
MED. SUPT. ST THERESA'S HOSPITAL, NANDOM

INTRODUCTORY LETTER: MS. JUSTINA KUUWIEDOME

The bearer of this letter is a Master of Philosophy student in Midwifery at the School of Nursing and Midwifery at the University of Ghana, Legon. She is seeking to conduct research on the topic **"Social Construction of Caesarian Section Among Women in Nandom Municipality in the Upper West Region of Ghana at St. Theresa's Hospital, Nandom."**

Please accord her the necessary support and cooperation and take the necessary steps to ensure the privacy and confidentiality of our staff and clients are guaranteed.

However, please report any form of misconduct regarding this research to the Research Unit for necessary action.

Thank you.

DR. DAMIEN PUNGUYIRE
REGIONAL DIRECTOR OF HEALTH SERVICES

Cc:
1. MS. JUSTINA KUUWIEDOME
2. RESEARCH UNIT FILE

APPENDIX V: ETHICAL CLEARNACE

CHRISTIAN HEALTH ASSOCIATION OF GHANA (CHAG)
RESEARCH DEPARTMENT - INSTITUTIONAL REVIEW BOARD (IRB)
21 JUBILEE WELL STREET, LABONE, ACCRA. TELEPHONE: 0202904777. EMAIL chagirb@chag.org.gh

16th July 2024

ETHICAL CLEARANCE

CHAG IRB PIN : CHAG-IRB03032024

On **15th July 2024,** the Christian Health Association of Ghana (CHAG) Institutional Review Board (IRB) reviewed and approved your protocol detailed as follows,

TITLE OF PROTOCOL: **Social Construction of Caesarian Section Among Women in Nandom Municipality in The Upper West Region of Ghana**

PRINCIPAL INVESTIGATOR: **Justina Kuuwiedome**

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to CHAG-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till **30th June 2025**. You are to submit annual reports for continuing review.

Signed by: .....

THE ADMINISTRATOR
INSTITUTIONAL REVIEW BOARD
CHRISTIAN HEALTH ASSOCIATION OF GH.

Mr. Okyere Boateng
(CHAG IRB Chairman)

https://sites.google.com/view/chag-research/institutional-review-board

APPENDIX VI: CONSENT FORM

Project Title: Social Construction of Caesarian Section Among Women in Nandom Municipality in The Upper West Region of Ghana

Principal Investigator: Justina Kuuwiedome, MPhil Midwifery, University of Ghana, School of Nursing and Midwifery, Department of Maternal and Child Health (MCH), SONM P. O Box LG 43,

Contact: 0206615300 / 0543982543

Email: kuuwiedomej@gmail.com

General Information about Research

You are being invited to participate in this research to assess your thoughts about caesarian section. You will be asked to thumbprint or sign two consent forms after you have read and understood everything in the form but if you cannot read the consent form, I will read and explained it to you before you then indicate your willingness to take part in the study before we start the interview. You have the option to opt-out if decided otherwise at any time since participation is purely voluntary. You will keep one consent form while I also keep the second for future reference and as part of an audit trial. This will be done after I have explained the importance of the study to you. I will collect data within a month, through an individualized face-to-face semi structed interview guide with open-ended questions which will be the means for our conversation after you have voluntarily given your consent to participate in the study. Privacy will be ensured before, during and after the interview session and the information obtained will be used for only the research purposes. I will ensure that your identity remains anonymous, and confidentiality will be ensured

in the study hence continual reminder of you not to mention your name at the start and during the interview to enable you feel free and relax yourself throughout the interview session.

Our interaction will last at least 35 to 50 minutes, to allow for all angle of the subject matter to be explored for a better understanding, and the audio will be recorded and transcribed on your consent. You will be refreshed with biscuit and soft drink after the interview session as a sign of appreciation for participating.

Possible Risks and Discomforts

The research process will not put you under any health or related risk. However, certain questions may elicit negative emotions or memories, so you have the option to choose not to answer such questions. I will make every effort to always protect your interests by adhering to the guidelines and requirements specified in the approval or agreement of consent and by requesting for further approval if necessary. In the process of the interview, if you break down emotionally, I will discontinue the session and the chaplain of the St. Theresa's Hospital will be invited to assess, and counsel you and I will reschedule the interview later. If it turns out that financial difficulty is the issue, I will notify the hospital's social welfare unit to assist in resolving the matter with the assistance of the units' in-charges.

Possible Benefits

It will enable you to be part of this research study. Your thoughts being shared will help health workers (midwives and doctors) to have adequate knowledge about your thoughts concerning caesarian section and so understand you well and provide you with the necessary education and care when working on you or any other woman.

Confidentiality

I will ensure that confidentiality is ensured by using pseudonyms to protect your identity and you are assured that whatever you say will be kept private. I will ensure that your identity remain anonymous throughout, and your information will only be used for the research purposes alone. I will provide opportunity for you to see, and often, to approve the data at different stages of the study.

Compensation

You will be refreshed you with biscuits and soft drink after the interview session as a sign of appreciation for participating.

Voluntary Participation and Right to Leave the Research

After I have explained this consent form to you, you have a period of 24-hours duration to accept or decline participating in this research. During the process of the interview, you still have that right to leave the research by declining at any time because participation is purely voluntary without any coercion.

Contacts for Additional Information

The right person to be contacted for answers to pertinent questions about this research is the Principal Supervisor (Prof. Florence Naab) because the researcher's Principal Supervisor has been doing thorough reading and making all the necessary corrections to ensure that this study is successful. She can be contacted at any time on this contact number 0204522332 concerning this research study.

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Christian Health Association of Ghana (CHAG-IRB). If you have any questions about your rights as a research participant, you can contact the IRB Administrator, Mrs. Sarah Sackey Martei-Olletey on 0202904777 or email to chagirb@chag.org.gh.

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title … **Social Construction of Caesarian Section Among Women in Nandom Municipality in the Upper West Region of Ghana…**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

APPENDIX VII: INTERVIEW GUIDE

TOPIC: Social Construction of Caesarian Section among Women in Nandom Municipality in the Upper West Region of Ghana.

Your valuable participation and contribution regarding this interview will greatly contribute to this research study. The purpose of this interview is to gather information on how women see and think about caesarian section. Be assured that your responses will be treated with utmost confidentiality.

Section A: demographic information of consented participants

i. Please, tell me about yourself.

Guiding questions

i. Pseudonyms:
ii. How old are you?
iii. What is your level of education?
iv. Please, how many languages are you able to speak?
v. Kindly tell me about your marital status
vi. How many times have you become pregnant before?
vii. How many times have you delivered in your lifetime? (parity)
viii. What is your religious denomination?
ix. What is your ethnicity?
x. What is your nationality?

Section B: Meanings women give to caesarian section.

Guiding Questions

i. What is your understanding of caesarian section?

ii. What do you think about caesarian section?

iii. How would explain caesarian section to someone?

Section C. Sources through which women perceive caesarian section as another method of giving birth.

Guiding questions

i. How did you know about caesarian section?

- Who gave you that information about caesarian section?
- What exactly have you been told?
- How did what you heard about caesarian section affect your belief about it?

ii. Why will you choose caesarian section as a birth method if the need arises?

Section D. Women beliefs, norms, perceptions, and values about caesarian section

Guiding questions

i. What do you know about caesarian section?

ii. What is your impression about Caesarian section as an option to give birth?

iii. What do your family members say about caesarian section?

iv. What do your society say about caesarian section?

v. Kindly tell me about some of the cultural beliefs about caesarian section.

Reactions or behavoiurs of women about caesarian section

i. How would you feel if there is the need for you to undergo caesarian section?

ii. What would be your behaviour or reaction if you are told that caesarian section will be performed on you?

- Why will you put up that reaction or behaviour?
- What decision would you take then?
- How do you think the caesarian would affect you?

Section E. Social construction of caesarian section among women

Guiding questions

i. If there is the need for you to do caesarian section, whose decision will it be for you to do the caesarian section? And why will it be you or that person (s) decision?

ii. How would your colleague women see you if you undergo caesarian section as a birth method?

iii. Please tell me how you would manage your cultural beliefs if you are expected to undergo caesarian section.

iv. How would you see yourself if you undergo caesarian section as an option of giving birth?

F. Please kindly share with me some of the challenges you think you may go through if you undergo Caesarian Section as a birth strategy.