WOMEN'S EXPERIENCE OF UNEXPECTED CAESAREAN SECTION BIRTH IN KITUI COUNTY, KENYA

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DECLARATION

This thesis is my original work and has not been presented for a degree in any other University

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DEDICATION

This thesis is dedicated to my beloved children, Emmah Juliet and Crispus Mwendwa, for the moral support they gave me. Special thanks to my supervisors.

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TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

ABBREVIATIONS AND ACRONYMS

AFE	Amniotic Fluid Embolism
ANC	Antenatal Care
BF	Breast Feeding
CBS	Central Bureau of statistics
CHMT	County Health Management Team
CPD	Cephalo Pelvic Disproportion
CS	Caesarean Section
EMCS	Emergency Caesarean Section
ERCD	Elective Repeated Caesarean Section
GIT	Gastro-Intestinal Tract
HIV	Human Immunodeficiency Virus
KCRH	Kitui County Referral Hospital
KHIS	Kenya Health Information System
KMTC	Kenya Medical Training College
KNBS	Kenya National Bureau of Statistics
KNH	Kenyatta National Hospital
MCH	Maternal Child Health
MDG	Millennium Development Goals
MMR	Maternal Mortality Rate
MOH	Ministry Of Health
MRAT	Maternal Role Attainment Theory

NACOSTI	National Commission of Science, Technology and Innovation
NVB	Natural Vaginal Birth
RDS	Respiratory Distress Syndrome
SDG	Sustainable Development Goals
SVB	Spontaneous Vaginal Birth
UK	United Kingdom
USA	United State of America
VBAC	Vaginal Birth after Caesarean Section
WCBA	Women of Child-Bearing Age
WHO	World Health Organization
WRA	Women of the Reproductive Age

OPERATIONAL DEFINITION

Antenatal	Period after conception up to the onset of labour
Antenatal care	The care provided by skilled health care professionals to pregnant women and adolescent girls to ensure the best health outcome of both the mother and baby (MOH, 2022).
Birth asphyxia	Baby, who fails to establish respiration at birth, thus presents with difficulty in breathing and cyanosis**.**
Cesarean section	The birth of a baby by making surgical incisions in the woman's abdominal wall and uterus
Doula	Birth companion or a person that provides emotional support, physical support and advice to mothers during pregnancy, labor and puerperium.
Malposition	A cephalic presentation other than normal well-flexed anterior position of the fetal head (Marshall, 2014).
Malpresentation	Are all presentations of the fetus other than the vertex (Marshall, 2014).
Peurperium	A period after childbirth where the uterus, other organs and structures that have been affected by the pregnancy are physiologically returning to their non-gravid state, lactation is establishing and the woman is adjusting socially and psychologically to motherhood (Marshall**,** 2014).
Precipitate labour	The expulsion of the fetus within 3 hours of commencement

	of contractions (Marshall, 2014).
Unexpected CS	A caesarean section done to mothers who had desire to birth naturally but failed to.
Unplanned CS	A caesarean section that is done to a mother without prior arrangement
Women of the reproductive age	Women between the ages of 15 to 49 years old.
Still birth	A baby delivered with no signs of life known to have died at 24 completed weeks of pregnancy onwards (Marshall, 2014).
Partograph	A graphical tool for monitoring maternal and fetal well-being during the active phase of labor

ABSTRACT

Background: Caesarean Section (CS) is a life-saving procedure for both mother and baby. It accounts for 18.5 million births globally which is approximately 18.6% of all births (World Health Organization (WHO), 2015).Women lived experiences of unexpected caesarean section are often described as less favorable than vaginal birth or planned caesarean section. Midwife care for women with deviations from a normal birth process is currently challenging. Studies describing the experience of unexpected caesarean birth by mothers exist with none of the experience documented from Kitui County, Kenya.

Objective: The study explored the lived experience of undergoing an unexpected caesarean section and the mother's cultural beliefs on the experiences of childbirth.

Methods: Descriptive phenomenology design was used with purposive sampling method being used to select 15 participants who had experienced unexpected caesarean birth. Data collection was one through audiotaped 30 minutes interviews for each of the participant. The interview was analyzed using Colaizzi's method of data analysis.

Results: The study emerged with eight themes and four subthemes which described the lived experience of childbirth and cultural beliefs among mothers who had unexpected CS. The themes identified included; fear, self-care deficit, worry, shattered expectations, positivism, regaining joy after CS, belief and misconception, and consequences of beliefs and misconceptions.

Conclusions: The study concludes that women from Kitui County experience many negative perceptions following unexpected CS birth. These perceptions include; disruption of birth plans, dissatisfaction with the birth process and unmet birth expectations. Healthcare workers including doctors and midwives should be more sensitive when informing mothers of the unplanned CS. They should provide mothers with enough knowledge including eventualities that may crop up during the labour process to allow understanding of the eventualities of labour. They should also identify methods and means of alleviating fear and worry among mothers who are to undergo unplanned CS. Mothers support groups should be developed to allow mentoring of new CS mothers by experienced and competent mothers. Information regarding pregnancy, labour and puerperium should be availed to pregnant mothers. This will help to clear the mothers' doubts, demystify misconceptions and beliefs associated with CS birth and reduce fears related to the unexpected CS birth.

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Caesarean Section (CS) is a life-saving procedure for both mother and baby. It accounts for 18.5 million births globally which is approximately 18.6% of all births (World Health Organization (WHO), 2015).It also accounts for 6% and 27.2% in the least and most developed regions, respectively (Betran, 2016). Childbirth is a crucial event in a woman's life which can be through CS or vaginal birth. CS births can be planned or emergency (EMCS) / unexpected. Unexpected CS birth is when the mother walks in labour ward expecting to have a normal vaginal birth, but the labour process complicates, leading to emergency CS (Juma, 2017).The standard CS rate is set at 10-15% of all births performed in a specific health facility (WHO, 2015). Caesarean section rates have risen in all regions since 1990 and continue to rise globally, averaging from 5% in sub-Saharan Africa to 43% in Latin America. The current rate in New Zealand is estimated at 25-30% (Egwuba, 2020). It is projected that by 2030, the CS rate will have doubled with Eastern Asia at 64% (WHO, 2021). Without effective global interventions to revert the trend, Southern Asia and sub-Saharan Africa will face a complex scenario due to the overuse of resources for the surgical procedure. This trend will lead to increased morbidity and mortality associated with unmet needs and unsafe provision for CS (Betran, 2021). The CS rate in Africa is at 9% (Juma, 2017). The CS rate was high in urban, well-educated, and socioeconomically stable people compared to the disadvantaged group (WHO, 2021). A repeat of CS was 99% across all regions, with 43% of primary CS having no

documented indication. Most (16%) of the CS were done by professionals than housewives in 9% of all births (vander, 2020). The rate of CS in Rwanda is increasing, with private health facilities at a rate of 61% (Kibe, 2022). The CS rate in Kenya is at 14.4% with Nairobi county leading at 25% and unexpected CS rate of 94% (Adan, 2019, & Juma, 2017). A study done at Mama Lucy Hospital in Nairobi, Kenya, showed that the unexpected CS rate was 65.4% (Juma, 2017). According to van der Spek, (2020), CS rates are often low among the poor and very high among the economically advantaged group in low and middle income countries.

Higher CS prevalence rate was found among women in urban area who were well educated and attending private hospitals. The rate of CS increase was found to surpass the medical indication for CS. The trend should be reverted by embracing the sustainable development goals failure to which women remain at risk (Betran, 2017) .The women emotional and cognitive experience of birth is recognized by having a significant impact on her postpartum physical and psychological state. For first timer mothers, the fear of childbirth is complicated by the news of CS. The greater the fear of birth, the worse the women's emotional experience (Fenaroli, 2019). Unexpected CS birth is known to cause post-traumatic stress, thus altering the typical childbirth passage of the mother (Benton, 2019). A birth resulting in unexpected CS complicates the afterbirth situation of the mother and blinds the expected happiness of the mother intrapartally (Patterson, 2018). Literature on unexpected CS birthing shows that unexpected CS brings about psychological and physical stress (Orovou, 2020). A study done by Roudsari (2015) in North Iran among women of childbearing age showed that the mindset, way of life, and

health care delivery services influenced the mother's psychological feelings towards CS birthing. Mothers who underwent unexpected CS birth reported a greater impacts compared to those who underwent vaginal birth due to the nature of intervention involved (Handelzalts, 2017). In Sub-Saharan Africa, CS births in private hospitals accounts for 72% of all births (Juma, 2016). A study done in Nigeria by Ugwu (2015) revealed that 90% of the CS births done were unexpected. Several studies have shown that CS cases have been on rise (Betran, 2016; Ezugwu, 2017; Manzoor, 2018; Rose, 2018; Tadevosyan, 2019 and Thobeka, 2017). Childbirth and passage to motherhood by having a Normal Vaginal Birth (NVB) make a woman feel unique and have a feeling of a total woman (Lyckestam, 2019 & Novita, 2019).

In the last four years, the CS cases in Kenya have risen from 26% to 44% (Juma, 2017 &Wanjohi, 2021).The national rate of CS cases is 55% in private hospitals, with Nairobi at 24% (Betran, 2015 & Juma, 2016). In Kitui County, CS cases has risen from 11% to 18% from 2017 to 2020 respectively (KHIS, 2017 and KHIS, 2020). Despite the upsurge of CS cases, the experience of the women following the unexpected CS birth remains a lived reality of feelings, perceptions, and attitudes (WHO, 2015). From the investigator's experience through interaction with the mothers in the labor ward of Kitui County Referral Hospital (KCRH), mothers who are informed that they will deliver via CS become very anxious, tensed, and verbalize their fears/previous experiences, especially those who had a previous CS, most of them consent because they are informed of no alternative choice on the mode of birthing. According to the investigator's understanding, they can undergo Vaginal Birth after Caesarean section (VBAC).

1.2 Problem statement

Globally, approximately 830 women die daily globally following pregnancy and childbirth-related conditions (Tadevosyan, 2019). Annually unexpected CS account for more than 80% of all the CS done globally. The Maternal deaths due to CS are 100 times higher in developing countries compared to developed countries (Sobhy, 2019). CS accounts for a 255 of all Maternal Mortality Rates. Caesarean section leads to more incision pain, reduced mobility, reduced self-care/ physical deficit, bonding deficit, prolonged hospital stay, anxiety, fear, post-traumatic stress, and depression (Sandall, 2018 & McKernan, 2019).The medical indication of CS include: malpresentation, malposition, cord prolapse, fetal or maternal distress, fetal macrosomia, pre eclampsia, previous CS, multifetal gestation, medical disease in pregnancy and obstructed labour (Anikwe, 2019).

Mothers perceive unexpected CS lowers one's self-esteem, makes them feel incompetent, loss of trust in their abilities and gets the disappointment in their anticipated expectations thus bringing about profound psychological and psychosocial consequences (Kavosi, 2015 & McKernan, 2019). Unexpected CS puts a financial/economic burden on an individual, family, community, and the country (Tadevosyan, 2019).

Various studies on unexpected birthing experiences have showed that it has negative birthing effects, results to patient dissatisfaction and this experience remains a lived experience for the mothers. The unexpected CS birth cause intense fear, worry of the outcome and alteration of routine activities. They term the experience as a last resort and

do accept it in dilemma (Benton, 2019, Kalstrom, 2017, Kavosi, 2015, Novita, 2019, Tadevosyan, 2019, & Sobhy, 2019). The sustained unprecedented rise in CS rates across all the regions is a major public health concern. The rate of CS in Kitui County has been on an upsurge, as recorded in 2017 at 11%, 2018 at 15%, 2019 at 17%, and 2020 at 18% (KHIS Report, 2020). Out of all CS done in Kitui, approximately 80% are unexpected (KHIS Report, 2020). Despite the rising trends, the mothers continue to encounter the consequences of the CS ranging from mortality to morbidity (WHO, 2018). Studies describing the experience of unexpected caesarean birth by mothers exist with none of the experience documented from Kitui County. Therefore, the study aimed on understanding the experience of the mothers following unexpected CS birth in Kitui County.

1.3 Justification

The individual experience of childbirth has an instant and lengthy period of health effects on the mother and her baby. Unexpected CS has been found to have many negative birthing effects like; fear, anxiety, prolonged incision pain, prolonged hospital stay, reduced physical activity, lowered self-esteem, bonding deficit and post-traumatic stress (McKernan, 2019). The study aimed on determining whether the women of Kitui County experience the same negative birthing experience. By coming out with more outstanding of the experience of unexpected CS birth among women in Kitui County, nurses can incorporate effective interventions to reduce negative birth experiences. This study provided an intuition not previously shared by Kitui women. The researcher gained a more profound understanding of the meaning of the experience of unexpected CS birth

through the phenomenology study. A face-to-face meeting with women, who met inclusion criteria, promoted a new understanding of the phenomenon of the unexpected birthing process. This study also aimed to contribute to understanding of the lived experience associated with childbirth complicated by unexpected caesarean birth and provide evidence to inform nursing and midwifery practice. Also, to develop a broad and insightful understanding of factors directly related to Kitui women's lived experience with the first unexpected CS birth.

1.4 Research questions

1. What is the lived experience of undergoing an unexpected cesarean section among mothers in Kitui County?
2. What are cultural beliefs on lived experience of childbirth among women of Kitui County?

1.5 Objectives

1.5.1 Specific objectives

1. To explore the experience of undergoing an unexpected cesarean section birth among women in Kitui County
2. To describe the mothers' cultural beliefs on the experience of childbirth among mothers in Kitui County.

1.6 Significance and anticipated output

The study developed a deeper understanding of the phenomenon of unexpected CS birth among mothers. The study also helped midwives and doctors understand what it meant to pregnant mothers going through unplanned CS. By understanding the negative effects of

the mothers experience, the health care workers of Kitui County health facilities will be in position to develop policies and means to alleviate fear among the mothers as well as form mother support groups which will address the concerns of the mothers. The study is also a partial fulfillment for the award of degree of Master of Science Nursing (Midwifery and Obstetric Nursing) in the school of Nursing, Kenyatta University.

1.7 Delimitation and limitation

The small homogenous sample that was to be used was considered a limitation. However, the need to conduct qualitative interpretive research with this understudied group counterbalances the limitation. The small sample may limit the generalizability of the findings. The findings of this research were limited to those who participated in the study. The results brought insight into the experience of a group of Kenyan women who are more likely to undergo an unexpected cesarean birth. The investigator did not discriminate between planned versus unplanned pregnancies. This distinction could have significant logical consequences for the levels of anxiety, preparedness and adaptation experienced. The women who participated in this research were from one region in Kenya thus limiting generalizability but together with other studies from different regions it can be used for systemic review study. Covid 19 disease was a challenge for those mothers who were followed at home because of quarantine; the researcher followed the Covid 19 disease prevention protocols to meet them. Financial constrain was also a challenge because the researcher had no funding, only had to work within the budget of her salary.

1.8.1 Conceptual Framework

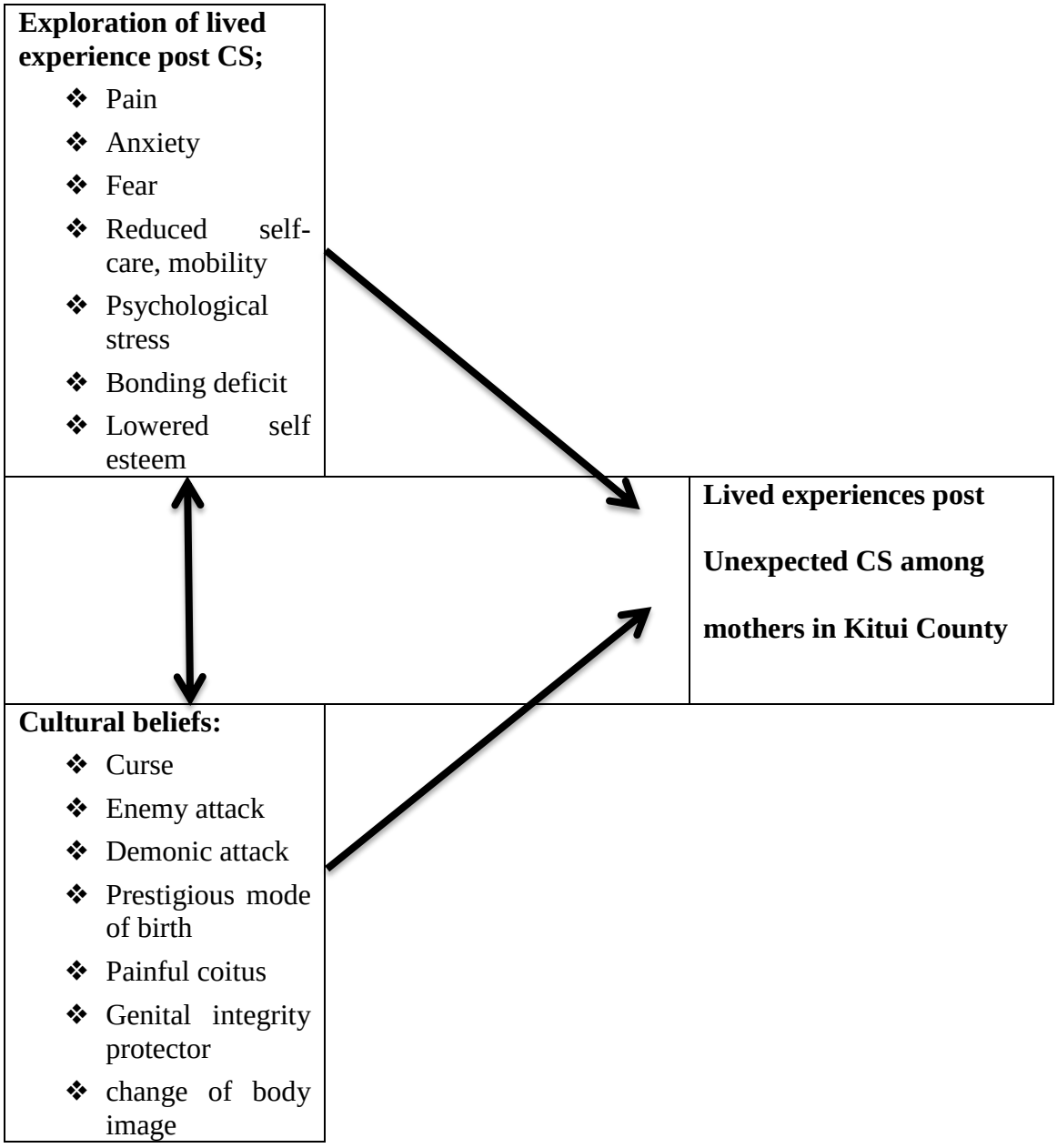

Figure 2: Lived experiences post Unexpected CS Conceptual framework

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews the literature that supports the purpose of this study. It presents information regarding lived experience following unplanned CS, post-traumatic stress, belief & cultural factors related to CS, and birth outcome. It also reviews information on maternal satisfaction on the mode of birth and perceptions and attitude toward CS in urban compared to rural setups.

2.2 Birth experiences

Having a baby is usually a happy and exciting moment for birthing women; however, CS can result to emotional, physical and environmental experiences.

Emotional experiences

Despite the upsurge of CS cases in Australia, mothers' emotional and mental aspect has not been considered (Kavosi, 2015). .Mothers feel incompetent in their life issues because of failing to work with their bodies to give birth naturally. Mothers perceived normal vaginal birth (NVB) as a critical aspect of their feminists and a significant life event for a woman hence a feeling of not into motherhood (Kavosi, 2015).According to Liang, (2018), mothers expressed that babies born via CS had the risk of developing birth asphyxia and RDS. Mothers who had the previous NVB expressed satisfaction and empowerment compared to when they had to undergo unexpected CS, which led to lowered self-esteem, psychosocial, psychological stress, and depression. Mothers stated not having power to control the mode of birthing other than following hospital

instructions (Liang, 2018). Others said they were not well informed of the mode of birth to choose (Biraboneye, 2017). CS leads to more incision pain, reduced mobility, self-care, bonding deficit, prolonged hospital stay, anxiety, post-traumatic stress, and depression (Kavosi, 2015 & Liang, 2019). VBAC has several advantages like the baby born vaginally have a lower risk of respiratory distress syndrome (RDS), reduced hospital stay, less chance of complication in consecutive pregnancies, less abdominal pains, and improved self-care (Betran, 2016). The experience of mothers on CS is a lived reality; the feelings, perceptions, and attitude of mothers regarding birthing registers permanently in their subconscious mind (Sandra, 2018). Unexpected CS has serious adverse effects like fear, and midwives should promote a sense of control (Kalstrom, 2017). Many researchers reported that women who had unexpected cesarean section birthing express a more negative perception of the birthing experience than those who have planned CS (Novita, 2019).

Physical experiences

Physical activities which mothers need to resume post-delivery include the sexual activities. Resuming sexual activity was not easy because the women experienced abdominal pain, and it was taboo to talk about it; thus had to persevere (Philly, 2015). Cesarean section has made the women strain their ability to assimilate the experience of pain, cost, inadequate self-care, etc., compared to vaginal birthing (Novita, 2019). Cesarean Section reduces the mother's physical activity, leading to reduced peristaltic action, thus decreasing the rate of digestion and increasing gastro intestinal tract (GIT) gas, reducing blood circulation and thus increasing the risk of thrombosis (Wanyonyi,

2018). Mothers who had normal vaginal birthing and water birth reported better physical health (Kavosi, 2015). Urinary stress incontinence and increased lochia loss due to endometritis following CS results to discomfort altering physical activity (Sandra, 2018). CS prolongs the mother's hospital stay leading to an increased risk of nosocomial infection and further compromising her physical activities (Novita, 2019). Most women on consecutive CS preferred epidural anesthesia because it had quick re-establishment of gastrointestinal tract activity, quickly mobilized and were less tired thus could attend to their newborn immediately after the operation, enhancing mother-to-child bonding.

Environmental experiences

Despite CS being a noble goal of the birth of a healthy baby, the mother experience negative birth experiences ranging from infection to death (Anikwe, 2019). Caesarean section is a surgical procedure that can effectively prevent maternal and newborn mortality when used for medically indicated reasons. Caesarean section rates have increased steadily worldwide over the last decades (WHO, 2018). This trend has not been accompanied by significant maternal or perinatal benefits. On the contrary, there is evidence that, beyond a certain threshold, increasing caesarean section rates may be associated with increased maternal and perinatal morbidity (Juma, 2017). Caesarean birth is associated with short- and long-term risks that can extend many years beyond the current delivery and affect the health of the woman, the child and future pregnancies. Caesarean birth puts a mother at risk of puerperal sepsis (Kibe, 2019). The medical indication of CS include: mal presentation, malposition, cord prolapse, fetal or maternal

distress, fetal macrosomia, previous CS, multifetal gestation, cephalo pelvic disproportion and obstructed labour (Anikwe, 2019).

High rates of caesarean section are associated with substantial health-care costs. The factors contributing to the rise in caesarean section rates are complex, and identifying interventions to address them is challenging. Factors associated with caesarean births include changes in the characteristics of the population such as increase in the prevalence of obesity and of multiple pregnancies, and increase in the proportion of nulliparous women or of older women (Anikwe, 2019). These changes are unlikely, however, to explain the large increases and wide variations in caesarean section rates across countries. Other non-clinical factors such as women increasingly wanting to determine how and when their child is born, generational shifts in work and family responsibilities, physician factors, increasing fear of medical litigation, as well as organizational, economic and social factors have all been implicated in this increase (WHO, 2018).

Caeserean section causes intense pain that bar the happiness of the after birth process (Jikijela, 2017). A study done by Colmorn, (2017) & Sentilhes (2013) in Denmark showed that CS had short-term risks, long-term risks, risks for future pregnancy, and risks to the newborn. The prolonged incision pain made the mother unable to care for themselves and the newborn (Jikijela, 2017). Most mothers complained of diverse pain on the suture line, back pain, and abdominal pain after CS (Sandall, 2018). Morphine is used to relieve pain post-CS, but its side effects are unpleasant to bear, for they cause respiratory distress syndrome in the newborn (Philly, 2015). Some mothers complain of

fatigue, sleeplessness, and gastrointestinal tract disturbance due to pain following CS (Sandall, 2018). The pain was a hindrance to normal daily activities for mothers following CS (McKernan, 2019).

Pain limits mother-to-child bonding; therefore, pain management after birthing is paramount. General anesthesia reduces the mother's self-care and baby care; sometimes, the baby is admitted to the newborn unit limiting the bonding (Jikijela, 2017).

Cesarean Section remains a lifesaving procedure for the mother and baby, though it's associated with risks for both (Wanyonyi, 2018). CS is indicated for cases like placenta previa (stages 3 and 4), previous multiple CS, other surgeries of the uterus, CPD and congenital anomalies (Wanyonyi, 2018). Current guidelines from the ministry of health state that all breech presentations should be CS birthing, which increases the risks of maternal death following the operation (MOH, 2004). Cesarean Section has a lot of implications like pain, post-traumatic distress, lack of bonding, mixed staff support, change of body image, and physical limitation (McKernan, 2019).

The rate of CS has increased with the increased mortality rate; hence mothers opt for VBAC (Lyckestam, (2019) & Liang, (2018). Medicalization affects the mode of birthing because once a mother comes to the labor ward and they are handled as a sick patient by insertion of a cannular, giving a hospital gown, putting them to bed, treatment/ observation chart put in place, etc. without a clear explanation of the rationale of each procedure, this stimulates the sympathetic nervous system and they set their body for fight and flight; as a result, the adrenaline and noradrenaline rises mother goes into

precipitate labor or off labor respectively thus leading to emergency CS and postpartum complications (Pamana, 2018).

A study done by Thobeka (2017) at Nelson Mandela hospital in South Africa showed that mothers experienced prolonged incision pain, breastfeeding, and bonding challenge. Some medical practitioners undertook CS to meet a given target or rate and meet the client's will rather than following guidelines for indication of CS, and more CS cases were recorded in developed countries (WHO, 2015). CS birth was found to have more mortality compared to those who underwent VBAC (Khooshideh, 2017).

Well informed mothers prefer VBAC to avert the consequences of CS, which include; excessive bleeding, injury to bladder and gut, painful coitus on resumption, prolonged length of recovery/ hospital stay, increased maternal cost, increased chances of nosocomial infections, reduced mother to child bonding, reduced self-care, staff attitude, painful incision site, increased chances of maternal death, thrombosis, mixed support from staffs, scarring of the abdomen, limit number of pregnancies, placenta previa on subsequent pregnancy (Thobeka, 2018 &Lyckerstam, 2019). Multiparous women prefer vaginal birth after cesarean section (VBAC) because they know the first stage of labor is shorter than primiparae. They are eager to experience/ undergo what it takes to have a vaginal birth and be happy like the other women (Grylka. 2015). Cesarean section has made the women strain their ability to assimilate the experience of prolonged pain, cost, inadequate self-care, etc., compared to vaginal birthing (Liang, 2018). Mothers who received adequate support from partners and significant others experienced minor

discomfort and quickly recovered (Jikijeli, 2017). A study done by Colmorn, 2017 & Sentihes, 2013 in Denmark showed that CS had short-term risks (thromboembolism, bleeding, infection, accidental surgical injuries, extended hospitalization), long-term risks (septic wound, pain for almost two months, adhesions, sub infertility), and risk for future pregnancy (uterine rupture, abnormal placentation, accreta leading to hysterectomy). Threats to the newborn were also another risk (RDS, Iatrogenic prematurity, trauma, delayed initiation of B/F, delayed bonding). All the above risks lead to post-traumatic stress. Some interventions done to reduce the chances of EMCS like prolonged fetal heart rate decelerations in labour were found negative birth effects associated with CS birth (Morgan, 2020).

2.3 Post-Traumatic Stress

Women after unplanned CS experience psychological stress. Their positive expectation is a disappointment because they lack the joy other women feel when having vaginal birthing. Birth is not only about the baby; it's also about the mother. Other women experience intense fear and confusion followed by a moment of amnesia after mentioning an emergency caesarean section (Orovou, 2020). Due to fear of cesarean section, most women prefer epidural anesthesia to hear and see what is happening during the operation (Kalstrom, 2017). Caesarean section (C-section) rates are often low among the poor and very high among the better-off in low- and middle-income countries (Lisa, 2020).

Among all the modes of birthing, natural vaginal birthing (NVB), water birthing, assisted vaginal birthing(AVB), and cesarean section, emergency/unplanned cesarean section was reported to have the most negative birthing experience leading to mental distress and

psychosocial problem (Benton, 2019). Sub-Saharan Africa accounts for 56% of the global burden of MMR. Many Sub-Saharan African countries (23) have very high rates of MMR, Kenya being one of the recording 362/per 100,000 live births (Perehudoff, 2022). MMR due to CS is 100 times higher in developing countries (Sobhy, 2019).

Women undergoing cesarean section had tremendous fear and a negative birth experience compared to those undergoing normal vaginal birthing due to the complications experienced in CS (Kalstrom, 2017). Elective CS was less fearful because the mother had to internalize the information about her condition and the indication of the cesarean section than the emergency cesarean section. In emergency CS the woman is told what the miss is and requested to sign the consent of the operation as soon as possible without time to internalize and come into self-consensus (Orovou, 2020). A study done in South-East Nigeria showed that 59.3% of the mothers who had CS were satisfied with the birth process (Anikwe, 2019).

Cesarean section birthing has profound negative experiences ranging from disappointment to severe postpartum depression. Cesarean section leads to prolonged hospital stay leading to more anxiety and depression (Benton, 2019). After a cesarean section, mothers are emotionally overwhelmed and feel like staying alone and keeping off visitors, yet they cannot offer themselves self-care and baby care. Mothers who lack partner and family support experience more psychological problems than those who get total support (McKernan, 2019).

2.4 Cultural beliefs

Women tend to take CS without medical indication as due to a lack of confidence and competence in naturally giving birth, secondary to a lack of information associated with CS complications (Roudsari, 2014). Culture, values, beliefs, and traditions affect how women respond to CS. The positively cultured have been shown to have less psychological stress than the negatively socialized, for fear was already instilled in them (Roudsari, 2015). Many women resist unplanned CS for fear of failing in their culturally assigned gender roles, thus endangering their marriage. Religiously, CS is interpreted as a curse or enemy attack and can be resolved through faith and prayer. (Roudsari, 2015). Husbands contributed too much to the response of mothers towards CS for the care and encouragement they gave to their wives.

Unexpected CS is categorically for those women who can't achieve NVB. This makes it difficult for those women who previously had proven to achieve a NVB to accept the unexpected CS (Orovou, 2020). The NVB was perceived as a religious phenomenon and a sign of God's power. In contrast, CS was viewed as a curse, a demonic attack, a prestigious mode of birth, and a genital integrity protector (Roudsari, 2015). Social, cultural beliefs and attitudes determine how women interpret, perceive, and deal with CS as a mode of birthing. Normal Vaginal Birth (NVB) helps the mother match her expectations to experiences, but unexpected CS makes the mother often feel less satisfied with both the birth experience and themselves (Smithies, 2017).

Women do not know the dangers of CS; e.g., a client can walk into the theatre and be complicated not to reverse from general anesthesia; thus, they die (Jikijela, 2017). A study done in South Australia showed that women had a knowledge deficit concerning risks and benefits of birth options and thus had a dilemma in choosing the consecutive mode of delivery; therefore, they relied on the clinician's view, advice, and counsel or learned through experience (Sandra, 2018).

Multiparous women were motivated to try vaginal birth after cesarean section because the second stage of labor takes shorter than in (Kalstrom, 2017). Despite the complications and dangers associated with CS, women may fail to choose VBAC if the clinicians lack skills and confidence in supporting the VBAC (Orovou, 2020 & Lyckerstam, 2019).
VBAC succeeds so well as long as the current problem is not similar to the previous situation that led to CS and as long as the pelvis is adequate. Having given birth vaginally boosts one's odds dramatically (Grylka, 2015).

The prolonged length of recovery after CS has made the mother opt for vaginal birth after caesarean section (VBAC) (Lyckerstam, 2019). The VBAC has many benefits like reduced blood loss, quick recovery, and quick resumption to routine activities, including coitus, few problems in future childbirth, and reduced chances of infection and injury (like bladder injury) (Grylka, 2015). Cesarean section in high-income countries has increased with equivalent maternal death, thus making most women opt for and desire VBAC (Lyckerstam, 2019). The rate at which CS is done in Turkey has doubled the maximum speed of CS as defined by WHO (2015), which states the recommended CS in

a population is 10-15%. Most of these CS done with non-medical indication is done by the people of higher social, economic class (Roudsari, 2015)

This practice of non-medical CS is rarely accepted and practiced by private consultants in Turkey (Bentoin, 2019). Staffs assume that birthing in whichever way is normal to the mother, but the women have a different view and perception, they know vaginal birthing is normal, and CS is abnormal. Mothers claim that information on what happens with CS to them is paramount for it reduces stress and improves maternal condition (McKernan, 2019). Women valued the data from the health professionals so much that they accepted CS as long as the clinician had said despite its associated consequences (Grylka. 2015). Deciding on the mode of birthing was a complex issue for the mothers; thus, they relied so much on the health professional's views, advice, and counsel (Sandra, 2018). Mothers who had normal vaginal birth and water birth had the best quality of life. Staff did not create this awareness antenatally. Instead, the mothers experienced that by themselves (Kavosi, 2015). Antenatally, mothers, were receiving conflicting information on the best mode of delivery depending on the place they sought the data; for private much information was geared towards CS, while in public, it was geared towards vaginal birth and thus making the mothers face a maternal dilemma on which method to choose (Liang 2018). Misconception about CS birth affected the decision of the mode of birth, as many mothers termed CS as an indicator of high social class (Roudsari, 2015). Women lacked information concerning complications of CS ranging from incision pain, reduced mobility, reduced self-care, urinary incontinence, etc. until they experience themselves

and thus blaming the staff for failure to make an informed choice and the complications associated with the CS and the potential sequelae (Liang, 2018)

Certain professional gestures may influence the mode of birthing; thus very important to make the right gestures to the mothers during the antenatal period (Guittier, 2014). Mothers who received kindness and proper attention from the staff had less harmful psychological birth experiences than those threatened and ignored (Sandra, 2018). Women tend to take CS without medical indication due to a lack of confidence and competence in naturally giving birth, secondary to the lack of information associated with CS birth complications (Roudsari, 2015).

Mothers lack evidence-based questions upon choosing the mode of delivery (Liang, 2018). A study done by Mamuda, (2014) showed that patients, relatives, and medical teams influence CS as a mode of delivery. Other women experience intense fear and confusion followed by a moment of amnesia after an emergency cesarean section mentioned. Intense fear stimulates the sympathetic nervous system, thus leading to increased adrenaline secretion, which leads to increased heart rate, and blood pressure hence complicating the postpartum period (Raja, 2018). A study done by Benton, (2019) showed that medicalization affected labor progress leading to more unplanned CS cases.
Most of these CS are done without medical indication, done as the mother's preference, resulting from a lack of information regarding CS. The only advantage of CS is to save lives in case of obstetric emergencies and complications (Wanyonyi, 2018). In Kenya,

most of the CS is done in a private hospital at a rate of around 55%, where people of high social class attend, compared to the public at a rate of 2 % (Wanyonyi, 2018).

In summary, the gaps identified following unexpected CS in many regions of the world included intense fear of mention of CS, prolonged pain and hospital stay, bonding and physical deficit, PTSS, anxiety, panic, worry, mistrust and depression. There lacks such a study done in Kitui County hence the study aimed to fill the existing gap.

CHAPTER THREE

MATERIALS AND METHODS

3.1 Introduction

This chapter presents the materials and methods employed in the study. Specifically, it outlines the study design, study area and setting, study population, and sample, sampling procedure, sample size determination, sampling method, inclusion and exclusion, data collection method, instruments, pretesting, data collection process, data management, data analysis, ethical considerations, and limitations.

3.2 Research Design

A descriptive phenomenology design was employed in this study. The qualitative study sought to scrutinize the experience of a woman's unexpected CS birthing, which little is known about. The use of qualitative methods strives to reveal and understand the intrinsic nature of the phenomenon (Patterson, 2018). Thus, this study used an interpretive phenomenology design to focus on understanding the meaning of an experience from a personal point of view. Phenomenological knowledge is grounded in the belief that the lived experience is accurate (Manen, 2016). Lived experience is individual's perception and attitude which is produces subjective data hence the study being purely qualitative. Knowledge is generated through reflection and understanding of the lived experience and making sense of it (Matua, 2015). In addition, a phenomenological study is a thorough, intensive, orderly, and planned inquiry of a lived experience to seek meanings that have the significant feature of a phenomenon (Yüksel & Yıldırım, 2015)**.** Phenomenology was

used to reveal purpose in the behaviors, feelings, and thoughts of Kitui/Kamba women following unexpected CS birth.

Phenomenological knowledge is well balanced and sensible in believing that the lived experience shows things the way they exist. Knowledge is produced through serious thought and sympathetic awareness of the lived experience (Frawley, 2019).

3.3 Study concept

Explored experiences of mothers following unexpected CS birth and described cultural beliefs associated with CS birth among mothers post unexpected CS in Kitui County. CS was found to have negative birth effects that include prolonged pain, fear, anxiety, post-traumatic stress, prolonged hospital stay, increased cost, reduced self-care, bonding deficit and lowered self-esteem. Cultural beliefs were viewed as demonic attack, curse, enemy attack and a source of changing one's body image. It was also found to cause delays in consenting for the CS and increase the intensity of fear.

3.4 Location of the study

The study site was Kitui County though the recruitment of participants took place at Kitui County Referral Hospital (KCRH), which serves as the County referral hospital for all the health facilities in Kitui County, thus representing the whole County. This hospital is in Kitui Central Sub County in Kitui County. Kitui County lies between 400m and 1800m above sea level and generally slopes from west to east, covering 30,429.5sq/km (KNBS, 2019). Kitui county is one of the counties in Ukambani; it bounders Machakos County to the West, Tana River to the East, Mbeere to the North, and Makueni to the South. The climate of this County can be described as hot and dry, and it is characterized as an arid

and semiarid area with very unreliable/erratic rainfall. The minimum mean annual temperatures vary from 14^0C to 22^0C.

KCRH is the referral for 13 sub-counties hospitals, 36 health centre, 183 dispensaries, and 19 nursing homes (KHIS Report, 2018). The catchment of population for Kitui County is 1,136,187 (KNBS, 2019). The staff establishment is low with 524 nurses / midwives, 62 doctors and 83 clinical officers among other staff (KHIS Report, 2020). The researcher chose KCRH as the recruitment place to represent the study area; Kitui County, because it has an established operating theatre and does most of the CS in the County. For recruitment, the investigator targeted the maternity unit of KCRH, where the mothers are found following the CS birth. These mothers came from all over the County. The researcher chose Kitui County as the study area because several studies have been done to explore the lived experiences of mothers following unexpected CS, but none has been done in Kitui County, thus wanting to explore whether the Kamba/Kitui women experience the same.

3.5 Study Population

The target population was mothers who wished to have a natural vaginal birth but had to birth their babies via cesarean section due to various unforeseen reasons that arose during labour process.

3.6 Sampling Techniques and Sample Size

3.6.1 Sampling Techniques

The researcher used purposive criterion sampling method to recruit participants who met the inclusion criteria from the Maternity ward in Kitui County Referral Hospital.

Purposive criterion sampling enables the researcher to choose those participants with specific characteristics (Palinkans, 2015). Following ethical approval, participants were identified by a midwife at the KCRH maternity unit. The researcher identified potential participants who met the inclusion criteria by scrutinizing the maternity register and the mother admission files, showing that they came for normal vaginal birthing but later labour complicated and went for unexpected CS. Within the first three days after CS, the researcher approached and sought permission from the potential participant before the researcher entered the birthing suite to meet the participants. On attesting to the right participant, the researcher explained the study and the purpose of recruiting them, then agreed on when and where to meet for the interviews and exchange contacts. The investigator contacted the mother a few days before the agreed interview date to confirm any changes, and this also served as a reminder. The interview took place between the 6th week to six months post-CS birth at MCH, the mothers' home or where the mother felt comfortable. Some mothers were followed at home because their referencing hospital was not KCRH. The interviews occurred between the months of August 2020 to February 2021.

The researcher permitted each participant much freedom to describe the emotions and feelings of the unexpected CS birth. By allowing the mothers to tell their childbirth experiences in their own words, the researcher learned more about their excellent and wrong perceptions.

3.6.2 Sample Size

It is impossible to establish an accurate number of participants in qualitative research before the study. An approximate number of participants were estimated from previous qualitative studies, which indicated a sample size of 5-20 participants (Nascimento, 2018, Moser, 2018 & Braun, 2021). The precise number of participants is determined adequately when no new information is coming from the interviews; thus, data redundancy or saturation is achieved. Data saturation occurs when there is a repetition of themes during participants' interviews (Nascimento, 2018). Sample adequacy was executed when redundancy was noted in the interview content. Based on previous studies, the proposed target sample size for this study was estimated at 25 women. Saturation was reached at the 15^{th} mother, whereby the mothers had nothing new other than repetition of what the mothers had said.

3.6.3 Inclusion criteria

Mothers who desired to birth naturally but instead had a CS birth, aged 15-49 years old, and had no previous CS birth.

3.6.4 Exclusion criteria

Mothers who underwent planned cesarean section birth, had maternal factors such as physical abuse, history of mental or psychological disorders associated with the pregnancy, or women who had terrible intrapartum outcomes like the death of the neonate or birth asphyxia. Mothers with previous CS experience.

3.7 Data collection instrument

3.7.1 Pre-Testing

The researcher did pre-testing to 3 mothers post unexpected CS at Mwingi level IV hospital. This hospital has the same characteristic as Kitui county referral hospital and it's the only established Sub County hospital in Kitui County. The information was used to refine the semi-structured interview tool.

3.7.2 Instrument

The researcher used a semi-structured in-depth interview schedule tool to help understand the phenomenon, with some questions like;

I am interested in your experiences when you had the unplanned CS. Tell me about the pregnancy and the childbirth experiences; what was that experience like for you? Please include what was meaningful and anything unhelpful to you during your CS experience. What do you think might have been significant to you personally? Help me understand how you received the news of the cesarean section and what were your experiences? After the CS, what was your typical day like, and what has changed for you?

Clarification was sought by the investigator in circumstances where the response given by the participant was not clear or had a different meaning to the investigator.

3.7.3 Validity

To ensure validity, the researcher abandoned previous knowledge of CS experiences. The researcher reflected the participant's perception during data collection and employed active and sustained reflection.

To ensure the validity of the results, the researcher provided trustworthiness using Lincoln & Guba's model (1985). This model identifies five applied aspects: authenticity, credibility, dependability, conformability & transferability. To heighten credibility, the researcher employed active and sustained reflection during data interpretation to ensure quality and highlighted the completion of participants' experiences. The researcher aims to abandon previous knowledge to be open to the phenomenon presented and produce a sense of reality and individual recognition of the phenomenon through the precise and rich description.

The results are entirely participant's perceptions of the research conditions with no biases, motivations, or investigator input (Krefting, 1991; Marshall & Rossman, 2014). The researcher ensured transferability by describing the study content and the supposition core to the study. The criterion applied was made clear according to the purpose and orientation of the research (Patton, 2002).

To ensure conformability in this study, the investigator and an internal supervisor, a nursing researcher with knowledge and competence in qualitative research, reached a consensus that the data support the results, conclusions, and recommendations made by the investigator and that the investigator's exposition of the data is meaningful and relevant. Dependability was achieved through distinct and rigorous description methods used in collecting, analyzing, and interpreting data and the accurate and comprehensive reporting of data. Authenticity was ensured by proper documentation, such that other investigators would be able to follow the investigative process and reach the same

conclusions given the researcher's data, perspective, and situation (Marshall & Rossman, 2014).

3.7.4 Reliability

The researchers ensured reliability by amending the interview schedule through the period of data collection, guided by the supervisors. The researcher asked probing questions to generate new information during the interview session. The data analysis steps were adhered to ensure the same themes emerge vividly (Beck, 1994). Sufficient data confirmed saturation, and redundancy had been reached. Informed interview consent was sought before the interview, and privacy and confidentiality were assured so that the participants gave the exact individual experience.

3.8 Data collection techniques

A depth, semi-structured interview schedule was used to collect the data. After recruitment in Maternity unit, a reminder was made through a phone call prior the interview date and agreed where to meet for the interview. The interview took place at the convenience of the mother/ participant, some in the hospital at the maternal and child health clinic (MCH) or at their home. The interview session took an average of 30 minutes. The interview was audiotaped following consent from the participants using an electronic gadget recorder. Interview questions were pretested in Mwingi level IV hospital among three mothers with the same experience. The investigator reflected daily on the conversation and, through the gained knowledge, improved on the tool as the data collection continued. The investigator probed the participants to ask questions and verbalize their feelings to the fullest, eventually leading to further insights, thus

improving the tool. The researcher was prepared to get consent of the participants who were under 18 years from their guardian, but there was none. The data collection continued until it reached saturation/ redundancy. The researcher did the data collection alone for six months, with a tool that was amended throughout the period with the guidance of the supervisors.

3.9 Data storage

Confidentiality of the data was assured by not indicating identifiers on the interview tool but instead assigning a unique number. The tablet audio taping gadget had a password only known to the investigator. The data was locked safely under the custodian of the investigator. The interview took place in a room/place with privacy, and verbally the mother was assured of confidentiality.

3.10 Ethical Considerations

Approval from the Kenyatta University ethics review committee was sought. Authority was sought from National Commission for Science, Technology, and Innovation (NACOSTI), Kitui County Referral Hospital superintendent (KCRH), MCH, and the maternity unit in charge. For those participants followed at their homes, authority was sought from the area chief, sub-chief, and village elder. Participants gave informed consent before the interview session.

Confidentiality while handling the participants' sensitive health information was upheld. No participant identifiers were used. Instead, code numbers were assigned on all data forms, and data was kept under safe custody by the investigator. Interviews were conducted privately in the counselling room in MCH at KCRH or at the mother's home.

Signed informed consent forms were kept separately from demographic and interview data. To undertake the interview was solely free will, and an elaboration of the study purpose, including potential risks and benefits, data gathering from the interview, and ways in which privacy and confidentiality would be maintained, was given to each participant. Mothers were given an opportune time to clear any issue and asked if they would like to participate. Each mother's self-doubt was cleared by informing her that her health care or the health care of her new baby would not be affected if she refused to participate or opted to pull out from the study.

3.11 Data analysis

The investigator employed Colaizzi's method (Edward, 2011) of data analysis: Read and re-read all transcribed interviews to make sense of the transcripts, extracted significant statements, and give meaning to the statements. The researcher repeated the steps above and created themes, compiled a detailed description of the above-generated themes, and summarized and identified the fundamental structure of the phenomenon. Ensured credibility of data through discussion with experts and independent interviews

CHAPTER FOUR

RESULTS

4.1 Introduction

This study aimed to explore the lived experience of mothers at Kitui County following unexpected CS. Data obtain from 15 participants interviews was analyzed to describe the lived experience of the mothers. Open ended questions were used guided by the research questions including; what is the lived experience of mothers following unexpected CS birth and what are the mothers' cultural beliefs on experiences of childbirth. This chapter is organized according to the objectives posed in chapter one.

4.2 Demographic Characteristics of the Study Participants

Demographic characteristics from this sample consisted of 15 mothers who had undergone unexpected CS birth with a response rate of 100%. Majority (67%) of the participants were married, 40% had attained secondary level of education, (73%) were employed and 93% were Christians. Majority (60%) of the participants had experienced less than two normal vaginal births with all (100%) of them having live births as birth outcome. This is as shown on table 4.1.

Table 4.1

Participants' characteristics

Variable	Category	Frequency (N = 15)	Percentage
Age	Women of reproductive age (15-49) years	15	100%
Marital status	Married	10	67%
	Single	3	20%
	Divorced	2	13%
Education level	Primary	3	20%
	Secondary	6	40%
	University	**2**	13%
	College	4	27%
Employed	Yes	11	73%
	No	4	27%
Number of previous births	NVB (< 2 Births)	9	60%
	NVB (≥ 2 births)	6	40%
Religion	Christianity	14	93%
	Islamic	1	7%
Birth outcome	Alive baby	15	100%

Key: NVB- Natural Vaginal Birth, CS-Caesarean section

4.3 Themes

Data was obtained from 15 participants by having an audiotaped interview of 30 minutes for each participant. Eight themes and four subthemes emerged from the interviews as the experience of unexpected CS birth among Kitui mothers. The themes included; fear, self-care deficit, worry, shattered expectations, positivism, regaining joy after CS, belief and misconception and consequences of beliefs and misconception. A summary of themes and sub-themes is as presented in table 4.2.

Table 4.2

Emergence of Themes

Cluster of themes	Sub Themes	Examples
Fear	Operation	*"… I feared instruments may be left in my stomach, and I may never conceive again"*
		" … I fear my husband may start hating me because my ugly looking tummy"
	Death	*"… I feared I may go* (**die**) *kabisa* (**completely**)
		".. I feared I may lose my baby or it may be exchanged with a dead one"
	Disability	*"…I feared the numbness of the legs caused by the theatre drugs will make me unable to turn on bed, walk, bath, feed baby"*
		"I feared I may become punctured (**weakling**) *after the operation"*
	Pain	*" … I feared pain on the operated site, once the drugs from theatre are over, it will be too much to bear"*
Self-care deficit		*''After operation I was unable to perform my normal routine duties"*
Worry	Panic	*"… I questioned my abilities for failing to push, I felt like a lesser woman"*
	Overwhelmed	
Shattered expectations		*"my expectations were tarnished by the CS news"*
Positivism	Satisfied	*"I sensed something must have been wrong to me and my baby. So I was hopeful that the CS could save us"*
Regaining of joy after CS		*".. holding my own baby, I could not hold my tears, I was extremely overwhelmed with excitement"*
Belief and misconception		*"…associate CS with evil deeds, for mother, baby or both to die…"*
Consequences of beliefs and misconception		**"** *Those who undergo CS are believed to be failures and cowards, unable to face the reality of a real woman"*
		"*Others belief CS is a procedure for the dotcom generation to preserve their birth canal for future sexual pleasure***"**

4.3.1 Theme 1: Fear

Most mothers indicated fear of CS births since they were not prepared for the procedure and also the unexpected nature of the procedure. They feared it could make them weakling and unable to perform many activities, the scar could disfigure their shape, they may not wake up from the operation table, their baby may be exchanged while under theatre sleeping drugs (anesthesia), they may lose their womanhood, and also some instrument may be left in the abdomen.

Some mothers also feared of prolonged time to resume marital conjugal rights. Their concerned was related to the pain at the incision site hindering them from resuming sex which may cause their spouse to think they were no longer interested in them and their interested had shifted to the baby. Sub-themes under fear included:

4.3.1.1 Sub-theme 1: Fear of disability

Almost all the mothers in the study consistently reported of not able to undertake their activities of daily living following CS. The mothers reported of not being ready to lose their abilities to engage in their daily activities including holding the baby ,breastfeeding, walking, getting out of bed among others. As a result, they depended on others to complete most of their tasks and had to learn new ways of coping with their experiences. Their fear was due to lack of prior preparations for the anticipated experience as they narrated:

"Though I had labored for long, I was very scared after the mention of the operation and feared the operation might affect me or my baby, I wished there could be another

alternative, but the doctor said no alternative and it should be done immediately to save the baby. I had no time to ask questions so that I could come in to terms with procedure, everything was done in haste" **(Participant 11).**

"…better to birth normally because after theatre you need someone to help you but the person is not there, after operation I had fear on what would happen, you strain to reach things and yet you have no power walk or move" **(Participant 12).**

"I feared the numbness of the legs caused by the theatre drugs will make me unable to turn on bed, walk, bath, feed baby" **(participant 13).**

*"I feared I may become punctured (***weakling***) after the operation"* **(participant 1).**

''I feared how I would perform my routine duties after operation like getting out of the hospital bed, walking to the toilet, taking a bath and changing pads" **(participant 14).**

"I had some fear in attending to my normal duties, like walking to toilet, Squatting in that toilet, holding the baby to breast feed, changing position in bed" **(participant 15).**

"After operation, I requested my husband to stay around for I feared how I would perform my routine duties with cut **(incision),** *I feared it could rupture, but the nurses refused to allow him stay***" (participant 5).**

Other mothers had fear due to the preconceived information they had heard from the community women as they stated:

"When I was told about going to theatre, waah… I felt like a cold stream running down my back, I became unable to talk for some time; I started reflecting what I had heard other mothers say CS is bad, wooh! When you get operated you no longer perform yours

normal duties again, unable to carry heavy things and engage in extraneous activities" **(participant 1).**

She further narrated*: "When you undergo CS, you are looked as downfall, seen as someone who is not strong as a woman. You become punctured* (**disabled*)" (participant 1).***

"When I was told to go for the operation, I got scarred when I remembered what women talk about the operation, that one becomes a weakling, and now that I was not married I wondered whether I will get married because I will become a weakling woman. At first I declined the operation, but the doctor told me I am risking my life and the life of the baby. Being in dilemma I had to rethink again, but during that crisscross of my mind I decided to agree" ***(Participant 3).***

"I was scared because I normally hear people say operation is not good, operation has consequences, though I was scared, I had no option. I only wanted to hold my baby, see my baby, I decided to do it, but I feared I may not wake from the theater table in good state! I prayed to God to give me strength and I then decided to go for it" **(Participant 9**).

"I had negative attitude towards CS because of the information that I had from the mothers in our community, they do say once someone is operated, they become unable to do heavy duties, I wondered how do I survive without dehulling and yet I am a Kamba, how do I survive without eating dehulled maize and it's our staple food" **(participant 6).**

"Our community say when someone is operated she becomes incapable of doing many things so such a person will require physical assistance for several month" **(Participant 8).**

"I fear CS because of the stresses of disappointment associated with it; one is handled like a child: being bathed by mum, escorting to the toilet, changing pads, everything being done for me" **(Participant 4).**

"I ended up going for an operation that I had not set my mind on it; I met what I feared most as I walked to the labour ward" **(Participant 6).**

"On my 6th week after the operation the pain continues up to now, I still feel pain on the incision site, I can't even fulfill my conjugal rights because of the pain and I fear my husband may understand me wrongly thinking that have shifted all the interest to the baby" **(Participant 2).**

Despite the above fears, the mothers in the study consented to the CS because CS was considered to be the only option to get the baby out. The above can be seen from the narrative by Participants 5 and 10, as shown below:

Participant 5: *I got worried about what could happen after the operation …I did not have a second thought when I was told I would be taken to the theatre…Despite the other challenges I was anticipating, I wanted to have my baby.*

Participant 10: *Despite the fear and negative attitude towards CS, I accepted knowing that I have preserved the integrity of my birth canal."*

"Though CS saved me and my baby, it was the last resort, it has given me a scar that will disturb me psychologically while bathing at school with the other girls, this will make the other girls know that I gave birth and I didn't want to disclose" **(Participant 11).**

4.3.1.2 Sub-theme 2: Fear of operation

Majority of the mothers in the study associated the unplanned CS with many dangers ahead. Some had this fear following the information received from the community and peers. Others imagined any operation must be associated with complications or dangers. Most of the mothers had physical and psychological trauma. These mothers had no time to prepare for the operation psychologically and only picked the option as their last resort. Majority of the mothers wished for an alternative mode of birth and experienced intense fear on the word CS being mentioned as they stated:

"The experience was not good, after a long waited for labour for a month, then I don't birth normally" **(Participant 4).**

"After the mention of theatre I had many unanswered questions for I feared for my future, we are both hustler with my husband, so if get operated how do I hustle" **(Participant 11).**

"I felt disappointed, I felt as if am lacking something, I started asking inside me, is it because of my age that am not mature enough to birth normally" **(participant 3).**

"…is it that I worked tirelessly during pregnancy or is it that I declined sex at 7 months of pregnancy that made my pathway not to open, I had many questions inside me, I blamed myself for not birthing normally" **(participant 6).**

*"I feared that I may fail to wake up from the operation table, my baby can be exchanged while am under the sleeping drug in theatre, instruments may be left in the stomach, I may be transfused and the blood may have UKIMWI (***HIV**)" **(participant 7).**

*"I don't like that insertion of knives to my body (***I hate operation***), for I am a hustler who survives on doing hard/ heavy load duties,*

I feared will I regain healing fast and how will I survive in maintaining my basic needs" **(Participant 10).**

"When you undergo CS, you are looked as downfall, seen as someone who is not strong as a woman" **(participant 1).**

*"When I was told to go for the operation, I got scared, feared instruments may be left in the stomach, may never conceive again resulting from scars of the wound, one becomes a weakling, and now that I am not married. I wondered whether I will get married in future after becoming weakling following the operation and the men will be seeing the scar"(***participant 3).**

"This operation has changed my body image, my tummy looks ugly, I don't even want my husband to see it, I have fears that he might start hating me because of it" **(Participant 8).**

"After I received the news for the operation, I asked myself why me! and other mothers are coming and getting a normal birth, even others came after me, where have I gone wrong" **(participant 10).**

"I was scared that baby may have swallowed things in its stomach, and may not be doing good, so being in intense fear, I choose to accept all the challenges of the operation" **(Participant 9).**

"Cesarean section is scaring on mention, it's not something that you take with a sober mind and it makes one feel as if it's like a wave of a dream passing through the ears" **(Participant 5)**.

"…With no other option I accepted. I fear my husband may understand me wrongly thinking that have shifted all the interest to the baby" **(Participant 2).**

As stated above, these mothers had a lot of fears of unknown what may befall them, they were in a dilemma, but they accepted the CS as a last resort. They had many unanswered questions, and there was no time for addressing their concerns, as evidenced by:

Participant 1*: These inner fears made me not like the procedure and became hesitant to agree to the terms of CS, though I had no alternative.*

4.3.1.3 Sub Theme 3: Fear of death

Almost all mothers in this study had strong, uncontrollable emotions following the mention of theatre. They feared they might die on the operation table due to bleeding or as a result of the theatre drugs. They also feared their babies could die during the operation or they could be exchanged for dead ones when under the anesthesia, as evidenced by:

"You may die on the operation table during the operation, baby can also die, your baby can be exchanged, may be, be given a dead baby and yours was alive" **(Participant 7).**

"I feared that I may fail to wake up from the operation and may bleed to death" **(Participant 9**).

" When I entered theatre I feared I may not wake up from the operation or even my baby may die, due to this intense fear I started shaking, but the nurse added me a blanket thinking I was feeling cold" **(Participant 12).**

"I had fears concerning what people say about the CS, that you may fail to wake up from the operation table" **(Participant 7).**

"I feared I may not wake up from the theatre drugs, from the stories I had previously heard from other mothers" **(Participant 5).**

"I had fears that me or my baby or both of us may die. But now that I didn't want to lose the baby after nine months expectancy, I just agreed to the CS" **(Participant 1).**

"eeh… waah, like that injection given at your back in theatre (epidural anaesthesia), you wonder have I died half my body and will I be alive again?

... I feared much I may go **(die)** *kabisa* **(completely),** *I said to God if I will die, take me slowly, but I didn't die"* **(Participant 10).**

"The way the community talk ill about CS made me have a lot of I fear that, I may die on the operation table due to those theatre sleeping drugs, I feared of the cut…yeah may complicate also" **(Participant 2).**

When I was told to go for the operation, I got scared when I remembered what women talk about the operation, that one may not wake up in the theatre, instruments may be left in the stomach that may later complicate me to die, I also feared to lose my baby when I decline the operation, so I was in a dilemma for the complications that may arise. The

doctor had told me, but I decided to agree during that crisscross of my mind" **(Participant 3).**

"I took the news positively though at first I feared whether me or my baby will survive because of the stories I hear from my community that waking up from the theatre bed is by God's grace, I composed myself and said, today this God's grace will work on my favor" **(Participant 4).**

"I was scared, that I may die out of the theatre drugs or my baby may die out of swallowing things during operation" **(Participant 8).**

"During the operation my lower limbs were totally paralyzed, I thought I was half dead on my lower limbs and that I will never walk again other than by use of a wheel chair" **(Participant 12).**

However, despite undergoing intense fear of the outcome of the operation for both the mother and baby, these feelings had to recoil/subside within themselves and consent to the CS; one mother recounted below:

Participant 6: *I had to consent for the CS despite my fears and the negative attitude I had towards CS since I did not want negative outcomes for my baby and me*

" the community say in theatre you are given a drug that make you half dead, such that you don't hear what is going on, then you may fail to wake up and die just like that" **(Participant 11).**

4.3.1.4 Sub Theme 4: Pain

Most of the mothers in this study reported CS to have been a painful experience. The pain experienced by mothers in this study was classified as that experienced after surgery and

after discharge from the hospital. All the women in this study reported experiencing physical pain after the CS birth. As narrated

Participant 12 *"I feared the pain I will experience on the cut wound following the CS will be too much."*

Participant 6 *"…after the numbness was over, the pain on the surgical site was too much more than I anticipated."*

Participant 4 *"The only challenge was pain on the cut site after the theatre drugs were over and it persisted for some time."*

Participant 12 *"The only problem was that pain on the incision site, it was not ceasing with the pain killers that I was given."*

Participant 6 "*Pain on the incision site after the theatre drugs were over, made me unable hold the baby &breast feed, walk to the toilet, squat for long call thus eating poorly, for I didn't know the pain will persist up to when."*

Some mothers in the study also experienced pain even after discharge from the hospital. According to them, post-surgical pain on the incision site persisted up to six weeks following their release from the hospital. As seen from:

Participant 11, "*up to date, I still feel pain in the wound and this is the sixth week after the operation.*"

Participant 1 "*I thought pain on the surgical site would reduce days after my discharge…the pain following this period was still unbearable.*"

Participant 3 "*Then after the numbness, the pain on the cut area was too much that has persisted today. All these experiences have made me hate the hospital and the birth*

process; I remember telling my Mum if I needed another baby, it would come from the supermarket, if there is something like that! "...I couldn't perform to the expectations of my routines because of the pain on the wound site; I predicted this pain may persist; thus, I engaged my sister to take over my chores."

Participant 2 "*On my 6th week the pain continues up to now, I still feel pain, I can't even fulfill my conjugal rights*."

Participant 8 "*The pain I experienced previously during NVB, was just over after birth, but this time round after the operation the pain still persist up to today and this is the 7th week following the operation."*

Participant 5 *"After more than a month of operation, I can't do normal activities because of the tummy pain."*

Participant 2: *I feared being taken to the theatre….however I consented because it would have relieved me from intensive labour pains*

Participant 3*: The labour pains were too much. I was scared of the CS…but it was the only option available to relieve the pains.*

Even though the CS acted as pain relief at first, the pain persisted more than the mothers' thought. Some thought the baby immediately is out, no more pain; others thought it might take a short time to resume their routine chores, but this was not the case; almost all the mothers had to incorporate their family members to assist in daily routine activities like bathing, breastfeeding, holding the baby, changing pampers, eating, walking to the toilet etc.

4.3.2 Theme 2: Self - care deficit

Almost half of the mothers were unable to perform routine activities following the operation. After the procedure they were unable to move in and out of the bed, walk to toilet, hold their baby to breastfed, take a bath, change pads and change baby's pampers. They reported they had to learn and practice to walk again as numbness of the theatre drugs made the lower limbs less sensitive, as they narrated:

''I was unable to perform normal duties including getting out of the hospital bed, walking to the toilet, turning and holding the baby to breastfeed" **(participant 4).**

"I had some difficulties in attending to my normal duties, like walking to toilet, holding the baby to breast feed, changing position in bed, bathing, for real I was unable to support myself physically" **(Participant 7).**

"I was unable to lift myself up, change the sanitary pad, walk to bathroom and toilet, bath and change to other clothes, unable to feed the baby, changing the baby's pampers was also a problem" **(Participant 8).**

"After the operation it was another hell: the baby was crying and I couldn't move to position myself to pick the baby because of numbness of the legs, I asked myself what hell is this! I needed help all round **(all through)** *but there was no one, even the nurses for this, the help was only during visiting hours, the rest of the time I had to strain and do what I could"* **(participant 3).**

"CS gave me challenges like inability to do most of the things for the first few months; I had to learn to walk again, to hold and lift the baby was hectic, squatting for long call was a problem thus ate poorly because of fear of squatting, bending to pick something was not possible" **(Participant 6).**

"After the operation, everything was not possible; going to the toilet, getting out of bed, bathing, when I felt I had sweat, I used to take a cloth and wipe the sweat so that I don't smell, and I don't breast feed my baby sweat" **(Participant 10).**

4.3.3 Theme 3: Worry

Almost all of the mothers in the study also reported experiencing intense anxiety when informed they were to undergo emergency CS. The nervousness was attributed to the unknown outcomes of the CS. The worry was attributed to the effect of CS on their self-image as well as on their abilities. This resulted to panic as they narrated:

Sub theme one: Panic

Participant 1 *"I was worried of being taken for CS because I felt like a lesser woman… I questioned my abilities for failing to push the baby like the other mothers."*

Participant 6, "*I underwent a period of worry that my baby could have problems after passing meconium intrauterine."*

Participant 9 *"My only worry was my baby whom the doctor informed me that it was tired because of passing fecal matter in uterine (***meconium stained liquor***)."*

Participant 3 *"I wondered whether I will get married in future after being considered a disabled person in the society following the operation and the men will be seeing the scar."*

"…then allover a sudden am told I will be taken to theatre. I started thinking what could be the problem and the other pregnancy I had normal birth with no complication, what could have gone wrong and what can I do to correct this, even though the pains was too much, I thought there was another way the doctors could use to get the baby out other than the operation. But the doctors did not even need argument, what they insisted is that

the baby was at risk of suffocating or dying. With no other option I accepted" **(Participant2).**

Participant 1 *"... I was worried that people would perceive me as a lazy woman for not birthing normally"* (**SVB-Spontaneous Vaginal Birth**).

"Being the second pregnancy, I thought the labor process will be even better than the first one, for I hear with subsequent birth the labor time is reduced. That first time I walked in the ward and within 5 hours I had my bouncing baby boy and left the hospital the following day in stable condition, but now being told I will be done CS I got worried, though I was tired of the pain" **(Participant 7).**

Sub theme two: Anxiety

Participant 10 *"The fear of injections during the theatre increased the anxiety that I had on the overall outcomes of the procedure."*

"I felt have failed like a woman, not undergoing labor successfully stressed me and made feel that I had no power of a real woman" (**Participant12).**

*"You know it was gabla! (***Sudden***) so there was no time to prepare; those "small doctors" (***Nurses***) around told me the news of theatre just as by the way, so I imagined it was an option, all of a sudden realized it was serious when the doctors from theatre came and told me now you have to be taken for an operation immediately. Now I had to accept, though psychologically, I was not prepared. Immediately they put needles on both arms and wheeled me to the theatre though I was in shock and scared. They acted with haste that made me experience intense fear"* **(Participant 12).**

"Being the first time, it was very challenging, because as I walked to the labour ward, I thought something will be done for labour pains to start, of which it was done, but it failed!, when I was given those drugs for pain, I took like a day without pains starting, when the pains picked they were too much that I couldn't bear, then being told my pathway for the baby was not opening after such pain, and I have to be taken to theatre for an operation, I got worried what could be happening to my baby and me" **(Participant 5).**

From the above quotes, it became evident that CS birth was associated with misconceptions. The misconceptions predisposed mothers who were to undergo CS to significant anxiety about society's perception of them.

4.3.4 Theme 4: Shattered Expectations

The results show that almost half of the mothers did not expect to undergo CS birth. Most of them anticipated having normal birth since they did not experience any problems with their pregnancies. As a result, the news that they were to undergo CS shattered the expectations of their labour process. The news also shattered their hopes of giving birth normally in the future. Some reported that they expected their labour to take a shorter duration based on their previous experiences. However, the expectation of their labour taking a shorter period and giving birth normally was shattered when they were informed that they needed to undergo an unplanned CS. The evidence of the shattered expectations could be seen in the narratives given by the participants:

Participant 2 "*I expected everything to be normal, to have a normal birth, health baby and also to be okay with no pain after birth….this expectation was shattered by the news that I was to go for the CS.*"

Participant 3 "*I wanted to have a normal birth, of short duration... I thought I will take short duration for I was very active during pregnancy and I hear when you are active during pregnancy the labor duration will be shortened and everything else will be alright…as a result, I did not expect to be taken for the CS.*"

She further stated: "*The labor process was not the best for me because this was my first time and I expected everything to be normal the way my Mum used to walk in labor and come out successfully, but things turned the other way round when I was informed of the operation, the labor pain started as mild to unbearable and yet no normal birth, then when I tried to cry because of the pain I was told I shouldn't cry because that cry can make the baby die."*

Participant 4 "*I thought I would undergo normal birth, be fine, get a healthy baby, and probably go back to my normal chores immediately***."**

Participant 5 "*CS was the last thing I thought about. Being told about the unplanned CS was shocking and shattered my expectations of normally walking to the labour ward, birth, with no complications after birthing."*

Participant 6 *"My expectations and what I underwent was quite different. After undergoing labour pains, I went for an operation that I was not prepared for…, I underwent what I feared the most in my life***."**

Participant 7 "*I expected my labour to take the shortest time because I believed that if the previous pregnancies were normal and you are active up to the time of labour, birthing will be quick…however, this was not the case as I had to go for the unplanned CS."*

Participant 1 *"I expected to have a shorter period of labour pains because I normally hear from the other women that the labour period would be shortened with more deliveries…as such, I expected to have a normal birth. This expectation was not to come true as I had to undergo emergency CS."*

The expectation of mothers wanting to experience labour pains and have a normal vaginal birth to become real women was shattered by having been taken for unplanned CS. The ones with previous birth were confident that the labour process would take a shorter time and have a normal vaginal birth. First-timers were optimistic that their labour process would be normal and take a shorter time because they were active throughout the pregnancy period but this was not the case as their labour complicated leading to unplanned CS.

4.3.5 Theme 5: Hope and Positivism

Almost half of the mothers in this study expressed positivism despite being shocked by the news that they would undergo emergency CS. The mothers were hopeful that the CS birth would save their babies. They were also hopeful that after CS birth, they would recover and have an everyday life like other mothers who had normal births, as they recounted:

Participant 2 "*I sensed something must have been wrong with my baby and me. So I was hopeful that the CS could save us*."

Participant 4 "*I took the news positively because the days for birth were long overdue, induction had failed, and I was eager to get my baby, so I agreed without giving it a second thought. I had also seen others walk to the theatre during the two days I was in the ward and be brought back with their babies alive and healthy***."**

Participant 5 "*I took the news positively, for I was tired of waiting for the baby, and the pains were becoming unbearable."*

Participant 6 "*I took the news positively because I feared the baby might die before birth, so I did not hesitate to agree to the CS birth, for I wanted my baby alive and well."*

Participant 11 "*I though CS saved my baby and me, it was the last resort."*

Participant 12 *"Since the other mothers were going to the theatre and coming back alive with their baby's, I was also hopeful that the same will be unto me."*

Participant 1 *"Though I was scared, my husband prayed with me and told me all shall be well and took the situation positively, and we hoped for good results."*

Participant 4 "*…CS is also good because you feel no pain during the operation and at the end of the procedure you get a healthy live baby, and the mother is also saved from complications, though the fear of unknown experienced before the procedure is the challenge."*

Concerning the above quotes, these mothers had a good second thought which yielded a positive result of an alive and healthy mother and baby after the labour process.

4.3.6 Theme 6: Regaining Joy after unexpected CS

In this study, most mothers expressed joy following their successful births through the unexpected CS. The successful CS birth to healthy babies was a source of joy to the mothers.

The birth of healthy babies also acted as a source of relief following their challenges with the labour process. Most of the participants reported that; they felt elated holding their baby's after the CS. The challenges following the operation were outweighed by the joy of the baby, as they narrated:

Participant 1 "*It was a great experience holding my child; I was delighted despite the challenges I experienced in labour and afterwards*."

Participant 2 "*…it (***the hospital and CS)** *saved my baby and me, now we are elated as a family despite the pain on the wound site."*

Participant 4 *"Despite being in pain and weakness of the lower limbs, I was excited by having a healthy baby."*

Participant 5 *"I was pleased having my healthy baby and coming out of the theatre alive despite the misconceptions associated with CS."*

Participant 6 *"I was excited and overwhelmed by happiness when I saw my baby; I even shed tears because of the unimagined good results."*

Participant 7 "*It was a joyous experience having gotten my live healthy baby after the CS birth."*

Participant 9 "*At the end, I was delighted to hold my baby…I realized how CS helped my baby and me."*

Participant 10 "*I was happy because of getting my baby without feeling pain."*

Participant 11 *"…I was excited when I heard the baby cry…I felt relaxed, as I knew everything would be successful"* She further stated, *"It was a great experience holding my child; I was pleased."*

Participant 12 *"inside me, I made ululations; I felt so happy coming out of theatre alive and well together with my baby."*

Despite all the fears, anxiety and shattered expectations, these mothers at long last had something to make them joyful; by getting alive and well-baby and also coming out of

theatre alive and well. The happiness of holding their baby weared away all the negative feelings and perceptions towards CS birth; even some wished in future to have a planned CS birth instead of experiencing such negative feelings and end up with an operation, thus having double stress as some narrated:

*"…CS is also an equivalent mode of birth, the hospital turned my life that was hell like to a bundle of joy. Next time I will walk in to theatre without exposing myself to that labor pain again" (***Participant 7).**

"At the end of it I was very happy to hold my baby and I came to know operation is not what people term as being bad, to me it was of great help. Operation is done when one is awake, doctors talking to you and giving an eye to what is happening. The fluids I was given in the ward made me not feel hungry after the operation. Given an opportunity to choose the mode of birth, I will choose CS birth" **(Participant 8).**

(Objective two) Description of Mother's cultural belief's on their experiences of Childbirth

The second aim of this research was to explore the influence of the beliefs and culture of the mothers on their experiences on childbirth. The information for this objective was obtained from the 15 study participants, who had undergone unexpected CS birth. The analysis of data obtained from the study participants led to the development of the two themes: a) Beliefs and misconceptions, b) Consequences of Beliefs and Misconceptions on the experiences of unexpected caesarean section.

4.3.7 Theme 7: Beliefs and Misconceptions about CS birth

The analysis of data given by the study participants showed the existence of mixed beliefs and misconceptions about CS. The beliefs and misconceptions that mothers

expressed could be classified into those related to maternal behaviors during pregnancy, the physiological status of the mothers, and those related to evil as per the traditions of the community.

The information obtained from the participants of this study showed that CS was attributed to the lifestyle and behaviors of the mothers during the pregnancy period. Most of the mothers attributed CS to lack of active lifestyle during pregnancy as they stated:

Participant 13 "*it is believed that mothers undergo CS if they were very reluctant/idle/not doing any physical activity during pregnancy*."

Participant 15 "*a mother undergoes CS if she was very idle during her pregnancy period…it also means that the baby got used to the mothers idleness, thereby refusing to come out because it feels it is in the best place."*

Participant 14 *"CS is due to mothers' too much idleness and inactivity during pregnancy."*

Participant 1 "*Our community usually associates CS with being weak and lazy…such people fear pushing their babies during birth."*

Participant 2 "*Our community usually associates CS with the mother's laziness during pregnancy…lack of physical activity made the muscle weak and laxity such that one cannot push the baby."*

Participant 5 *"My community associates CS with weakness; they say when you do not work during pregnancy, you will have no efforts to push the baby out."*

The other aspect of belief that the mothers in the study had was towards the physiology of pregnancy. They reported that; some mothers underwent CS due to issues related to their

body structures. Other mothers were well informed that CS was attributed to the mother's small birth canal or babies being big. They also expressed the fact that the psychological status of the mothers could play a role in them undergoing CS, as they recounted:

Participant 13 "*Mothers are taken for CS because it is believed that the baby is bigger than the birth canal.*"

Participant 14 "*Baby may be bigger than pathway of the mother, thus end up for an operation*."

Participant 15 "*Some babies are bigger than the birth canal, so no way through other than operation.*"

Participant 14 "*Especially for mothers giving birth for the first time, the hips of the mother may be small such that the baby cannot pass through, thus end up for an operation.*"

Participant 15 "*Some mothers are too fearful; they do not want to push instead when the pain comes for the birth they hold their breath until the pain is over retracting the lower back thus preventing the baby coming out*."

Participant 13 "*mother who has had complained of the lower stomach pain, joint pain, numbness of the legs and inguinal pain during pregnancy period, usually do not birth normally, they labour for long and end up being operated*."

Participant 15 "*A mother who keeps complaining of lower abdominal pains portrays that her hips are small for the baby to pass, which is why she feels the pain as the baby tries to force itself through inadequate hips*."

The mothers who narrated as above had got the information from the traditional birth attendant (TBA) who they believed were well informed on what may lead to CS. From the consultation of the TBA, the mothers could predict their mode of delivery as they walked to labour ward.

The other aspect of beliefs and misconceptions evident from this study's results was that participants attributed CS to evil or misdeeds that mothers did in their communities. Almost half of the participants in this study reported that mothers who went for CS could have engaged in some evil deeds that required cleansing before labour as they narrated:

Participant 14 "*It is believed that if a woman has laboured and not birthing, she has been done evil so that the mother, baby, or both may die.*"

Participant 13 "*Others believe that if you have had grudges with anyone during the pregnancy period, you need to seek forgiveness…failure to which you will end up in CS.*"

Participant 15 "*It may mean that a mother has had differences with her close relatives during her pregnancy, so in such a case; one should seek forgiveness from them before going into labour. If she fails, she will end up with complicated labour that will warrant operation or else the mother or baby or both may die.*"

Participant 11 "*Our community usually associates CS with evil deeds; they say someone has been bewitched, so you need traditional practices to overcome the evil intentions for the labour process to be normal."*

Participant 3 "*if the labour process complicates, it means satanic practices have been done on your to die with the pregnancy*."

Participant 8 "…*others think that one has being tied* **(bewitched)** *for the labour to be complicated and as a result, you need to be untied* **(cleansing)** *for labour process to be normal*."

Participant 12 "*To be operated on is not normal; evil practices must have been done on you so that you or baby or both die*."

4.3.8 Theme 8: Consequences of Beliefs and Misconceptions on Mothers' Experience of unexpected CS

This study also developed a theme of consequences of beliefs and misconceptions. The data analysis obtained for this research showed that the beliefs and misconceptions surrounding CS birth predisposed mothers to significant embarrassment and disappointment. Mothers developed a feeling of a lesser woman toward CS. Most mothers feared that they were likely to die or lose their babies by undergoing the CS, as they narrated;

Participant 6 *"CS has robbed me the feeling of a real woman; I feel embarrassment and disappointment for not representing women's power and ability in childbirth."*

Participant 10 *"Being taken total care of as a child for the first few days following the unplanned CS, I feel it's like an abuse in childbirth passage, ended up hating the birth process."*

Participant 12 *"CS scar has disfigured my shape; I can only advice a woman to take it as a last resort."*

Participant 7 "*I feared that I would die in theatre or my baby be exchanged while under those theatre drugs causing sleep* **(anaesthesia)**."

Participant 6 "*I feared going for the CS because it would have meant that I am incapable of doing many things… so I would need physical assistance in doing my daily activities.*"

Participant 3 "*Others say in theatre one may fail to wake up, instruments may be left in the abdomen warranting another operation, the scar inside may make one not conceive again.*"

Participant 10 *"After the operation, one becomes weakling such that they can't do heavy duties in future."*

Some Mothers believed CS was for the wealthy people and NVB was for the less fortunate class; others believed that having CS preserves the genital anatomy as they stated:

Participant 4 "*After mentioning CS, I thought it was a joke. Our community believes that CS is for the well up to class, not for a student like me."*

Participant 11 *"In my community, people associate CS with the prestigious persons. When you undergo CS, you are highly respected and esteemed as a person of high class."*

Participant 7 *"Others belief CS is a procedure for the dot-com generation to preserve their genital integrity for future sexual pleasure."*

Participant 9 *"…NVB is believed to be for the low-class person who is even getting basic provision is a challenge; thus the hospital gives them a chance to give birth per vaginal because they can't afford the operation."*

Participant 12 *"Those who undergo CS are believed to be failures and cowards, unable to face the reality of a real woman."*

Despite the above effect of beliefs and misconceptions on childbirth experiences by the study participants, some mothers reported optimism towards undergoing CS in their subsequent pregnancies. The data analysis obtained from the participants showed that some of them had a positive attitude towards CS and were willing to undergo it in their future pregnancies. Their experience with the CS dispelled their beliefs and misconceptions about the operation, as they narrated:

Participant 5 "*I found it (CS) to be the best mode of birth. During my next birth, I will ask the doctor to take me for CS without exposing me to labour pains.*"

Participant 7 "*I would choose to go for CS in the future if asked so by the healthcare providers; whatever I had heard and believed is quite different from the experience*."

From the above quotes, the mothers had misconceived information from their culture that not only made them have unrest and feel disappointed but also made them embarrassed for no reason.

CHAPTER FIVE

5.0 Introduction

This chapter holds discussions of the study findings in relation to the existing studies. Deals with conclusions made from the experience of mothers following unplanned CS and cultural beliefs associated with CS birth and the researcher's recommendations after conducting the study.

5.1 Discussion

The study used descriptive phenomenological method to explore the experience of mothers following unplanned CS. At the core of the study, the researcher learnt that mothers developed psychological torture on the mentioning of the word CS. The mothers took long to comprehend and articulate the CS news since it was unexpected. The mothers underwent a period of many negative feelings.

The mothers in this study experienced intense fear of pain. The study was consistent with studies done by McKernan, (2019), Novita, (2019), Jikijela, (2017), Thobeka, (2018), Kalstrom, (2017), which stated that CS makes the mothers experience more prolonged incision pain, and negative effects. The mothers' experienced self-care deficit following unplanned CS's birth. The finding concurs with Kregel (2018) study which reported that mothers who had a normal vaginal birth reported better physical health unlike those who underwent CS birth. The study revealed that mothers experienced fear of the operation due to the unforeseen dangers like being transfused with HIV blood, feelings of a lesser woman, unable to resume conjugal rights in time and the incision scar disfigured their shape. Some indicated that they were hustlers and CS birth would make them physically

disabled thus wondered how they would survive in future after undergoing the CS birth. This finding is also similar to the study done by Thobeka (2018), which stated that mothers experience intense fear of the unknown following the mention of unexpected Cs birth. They take time to resume physical activity and the scar due to the operation changes the shape of the mother's abdomen. Other mothers experienced fear of death and feared they might die in theatre or their baby may also die. This finding is consistent with another study done by Novita (2019), which stated that the fear of death from CS birth made mothers deter consenting to the CS birth. The findings are contrary to a study done in Sweden which showed that mothers who underwent CS gained more trust and confidence after the operation (Lyckestam, 2019).

The news of CS birth made the mothers worry; they had negative thoughts about the outcome of CS birth and psychological trauma. They reported experiencing nervousness which was attributed to unknown outcomes of CS. They were also anxious about having lowered self-esteem. They narrated that CS birth was associated with weak and lazy mothers during pregnancy which consequently changed their self-image. These findings are similar to those (Ugwu et al., 2015, Orovou et al., 2020 & Karlström, 2017), which showed that CS lowered the mothers' self-esteem making them feel lesser mothers unable to face the reality of a real woman.

The mothers also reported their normal birth process expectations were reciprocated by CS news thus ending with shattered expectations. These study findings agree with Patterson (2018) study which reported that CS makes the mothers not experience what

they expected for the birth process. These findings disagree with a study done by Anikwe (2019) in Nigeria that showed that 59.3% of mothers were satisfied with CS birth. Despite being shocked by the news of undergoing emergency CS, positivism by the mother was realized as the mothers were hopeful that CS would save them and their babies. These findings are consistent with Wanyonyi (2018) study which showed that despite the mothers having negative feelings toward CS birth, they accepted the procedure as a savior in their lives. The joy of the baby outweighed the challenges following the operation. These results are in line with Jikijeli (2017) study which showed that despite all the fears the mothers had, at long last, they had something to enjoy after the operation of having a healthy baby.

The researcher identified cultural beliefs that mothers had in relation to what led to CS birth. The mothers reported some of the causes to include; laxity of muscles, big baby, babysitting wrongly in the uterus, and failure of descent due to inadequate pelvis. The results concur with the textbook for national guidelines on quality obstetrics and perinatal care (2022), which states that CS birth is due to big baby, malpresentation, malposition, Cephalo Pelvic Disproportion (CPD), prolonged labour due to laxity of uterine muscles among others.

The mothers also believed that the unplanned CS done on mothers could have resulted from their evil deeds or grudges with someone that needed cleansing or reconciliation respectively before labour incepts. These findings agree with Roudsari et al. (2015) study

which stated that in relation to religion, CS birth is interpreted as a curse or enemy attack and can be resolved through faith and prayer.

Mothers attributed CS birth to lack of an active lifestyle during pregnancy. These results are similar to Orovou et al. (2020) & Karlström (2017), which showed that most (67% & 71%) of the mothers who were idle during the pregnancy period ended up undergoing a CS birth.

The researcher also reported mothers feeling embarrassed and disappointed for undergoing CS as the mothers are viewed as failures and cowards for not experiencing the power of a real women which is vaginal delivery. The results concur with Ugwu et al., (2015), which showed that NVB plays a role in describing a mother as a true or proper woman compared to CS birth that terms a mother as a failure.

Despite some mothers thinking CS birth was a curse or an evil attack, other mothers perceived CS as a matter of social class and a way of maintaining their genital quality. The results are inconsistent with Roudsari (2015), which viewed CS birth as a curse, a demonic attack, a prestigious mode of birth and a genital integrity protector. Medical personnel perceive undergoing unexpected CS birth as a routine procedure which is not the case as mothers have different views and opinions about unplanned CS birth.

5.2 Conclusion

This study showed that women of Kitui County experience many negative perceptions following unexpected CS birth. These perceptions include disruption of birth plans, dissatisfaction with the birth process and unmet birth expectations. The CS news

overwhelmed them to a point of giving up. After the operation, the birth experience was not to spare them, other than making them physically incapacitated.

Cultural beliefs affected the mother's attitude towards acceptance of unexpected CS birth. The mothers had misconceived information on CS from the TBA as well as from the society. They believed for a mother to undergo operation, they must have been bewitched or had grudges with someone during their pregnancy period. Other mothers were happy after the operation, for they believed that they have preserved their genital integrity for future sexual pleasure.

The low economic status of women who participated in the study directly impacted the uptake of the procedure since those participants who do manual work for a living were more likely to decline the procedure for fear of being unable to do manual work again.
Lack of trust in the competence of the surgical team and the screening procedure of blood products before transfusion led to a delay in acceptance of surgery. The women feared instruments being left inside them and feared they might die during the operation or acquire HIV from the transfusion. Marital status negatively impacted the study findings because the married women had doubts as to whether they will be able to fulfil their conjugal rights. At the same time, the unmarried feared that they might not get married due to the resultant scars.

5.3 Recommendations

1. Healthcare workers including doctors and midwives should be more sensitive when informing mothers of unplanned CS. They should provide mothers with enough knowledge including eventualities that may crop up during the labour process to allow understanding of the eventualities of labour. They should also identify methods and means of alleviating fear and worry among mothers who are to undergo unplanned CS.
2. Mothers support groups should be developed and should include the experienced and competent mothers who can mentor the new mothers who have undergone unplanned CS.
3. County Health Management Team (CHMT) of Kitui County should prepare easy-to-read pamphlets regarding pregnancy, labour and puerperium with pictures and pictorial heads and make them accessible to mothers. This information is envisaged to clear the mothers' doubts, demystify misconceptions and beliefs associated with CS birth and reduce fears related to the unexpected CS birth.
4. Further research should be done in other locations to attest to these subjective experiences, look for coping strategies to reduce the negative birthing experiences, and uncover underlying issues associated with unexpected CS birth.

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APPENDIX I: INFORMED CONSENT

My name is Zipporah Kimanthi; I am a master's student at Kenyatta University conducting a study on women's experience of unexpected Caesarean section birth in Kitui County, Kenya. The information obtained from this study will be helpful to the nursing fraternity and other health care workers. The mothers will also be expected to benefit from the interventions, which will create a better environment for them to have a better birthing experience.

Procedures to be followed

Participation in this study will require that I ask some questions, which will be audiotaped during the interview session. I will also probe you further for clarification. Kindly note that participation in this research is entirely voluntary, and you are also free to ask any questions related to the study during the interview. You may also decline to respond to or answer an uncomfortable question. Lastly, you are also free to withdraw from the interview at any time you wish, and it will not affect any services you are supposed to get at the hospital.

Discomfort and risks

In case any of the questions you feel offensive or make you feel uncomfortable, please feel free to decline to respond to the question. You may also stop the interview at any time. The discussion will take approximately 30 minutes. (During the interview process, any complaints? I will advise them to go to the hospital if they are at home for review or see the doctor if they are in the hospital).

Benefits / Reward

No incentives/financial assistance will be given to participating in this study, and it is entirely voluntary. However, the outcome of this study will assist the government and society in getting more insights into the birth experience. The participants will understand the meaning of the lived experience of unplanned CS and consequently have a better birthing experience.

The researcher will respect and acknowledge the culture of the people in the study area.

Confidentiality

The interview will be conducted conveniently within the institution or in a suitable position at your home as per the agreement between you and the researcher. Your name will not be recorded in the interview schedule. The interview schedule will be kept safe and will only be used for the purpose of this study.

Contact information

If you have any questions regarding this study, you may contact my supervisors on these contacts:

1. Dr Lister Onsongo – 0700004288 OR Email: onsongolister.ku.ac.ke
2. Mrs. Elizabeth Ambani – 0729496970 OR Email: Ambani.Elizabeth.ku.ac.ke
3. Kenyatta University Ethical Review Committee Secretariat on chairman.

    kuerc@ku.ac.ke

Participant's statement

The above information regarding my participants in the study is clear to me. I have been given a chance to ask questions, and my questions have been answered to my satisfaction. My participation in this study is entirely voluntary. I understand that the information will be kept in privacy, and I can withdraw from the study. I know the research benefits and that no incentives will be given.

Unique code of participant ……

Signature or thumbprint …….Date ……

Investigators statement

I, the undersigned, have explained to the participants in the language she understands the procedures to be followed in the study and the risks and the benefits involved.

Name Interviewer …….....

Signature ……Date…….

APPENDIX II: INTERVIEW SCHEDULE

Thank you for allowing me to meet with you and agreeing to participate in this study. How are you and your family doing with the new baby? Did you choose a name for the baby?

Description of the process

The purpose of this study is to understand the experience of giving birth and becoming a mother for Kitui women in Kenya. I will be asking you some questions about your birthing experience, and you are free to discuss all of the details about the questions. You may not want to provide some responses, but we will talk about your feeling because some experiences may be uncomfortable for you to discuss. You may request to end the interview at any time. I will be recording the discussion using the voice recorder on my phone because the information you provide is vital, and I do not want to miss any part of it. You can ask me to stop recording if you do not wish to put the specific record information. I will be taking some notes, too, if that will be fine with you?

The interview

First, may I ask some questions about you and your family life? Did you work during your pregnancy? Full-time? For how many months of the pregnancy did you forgo work? Did you take childbirth classes before the birth of your baby? Did you attend all the antenatal clinics? Were antenatal profile /tests in the mother booklet done? Did you take prenatal vitamins or any other supplements? If so, what?

The birth experience

Have you ever been in the hospital before this? Where? During the pregnancy, were there times when you felt depressed or sad? At what point in the labor did you arrive at the hospital? Was there anything that you expected? How have you felt after the delivery? Were you able to get some rest? Was your pain managed effectively?

Please let me know the year you were born? I am interested in learning about your experiences when you were told to undergo the unplanned CS? How was the news about the emergency CS delivered to you? Were you told the indication of the CS? Tell me about the childbirth experiences; what was that experience like for you? Please include what was meaningful and anything unhelpful to you during your CS experience. Help me understand how you have coped with the CS experience and what has changed for you? What do you think are the beliefs associated with CS? In your community, please help me understand the cultural practices related to CS? What do you have to comment on CS concerning NVB? Who gave the consent for the CS? Were you satisfied with the consent? Given an option for birthing mode, can you choose the CS?

Expectations and reality

Can you explain how you wanted this birth experience to happen? Was your birthing experience similar to what you expected? Can you describe how the labor experience was for you? Who from your friends and family was with you?

Pain management

How much pain did you experience during the labor? What was done to make the pain better? Was there anything that surprised you or that you did you not expect? What was the hardest part of the experience? The best part? Did you picture the baby as a boy or a girl during your pregnancy? If yes, did you have a preference? Can you share a dream that you had during pregnancy and childbirth?

The baby

Can you describe how you are feeding your baby? How was that moment when you first saw your new baby similar to what you had expected? Have you been separated from your baby at any given time since birth? How was the care of the baby after birthing? Can you tell me the place at home that you have prepared for the baby? Has the baby's father helped you and your baby? Did you get any help from the family members?

The hospital experience

During labor, were you allowed to get up and walk around? How can this hospital make becoming a mother a better experience for you? How was the conduct of the hospital staff towards you during the hospital stay? Was language a problem for you during your stay at the hospital? What would you change about your experience in this hospital? Was there anything that you believe you needed and you did not receive? Is there anything that you could change about your experience in the hospital? Were you satisfied with your birth experience?

Thank you for sharing with me your experience. Is there anything else you would like to share with me about your childbirth experiences? May God bless you and your new baby.

Demographic form

Mother's age……

Baby's age……

County of origin……..

Born in which County ……

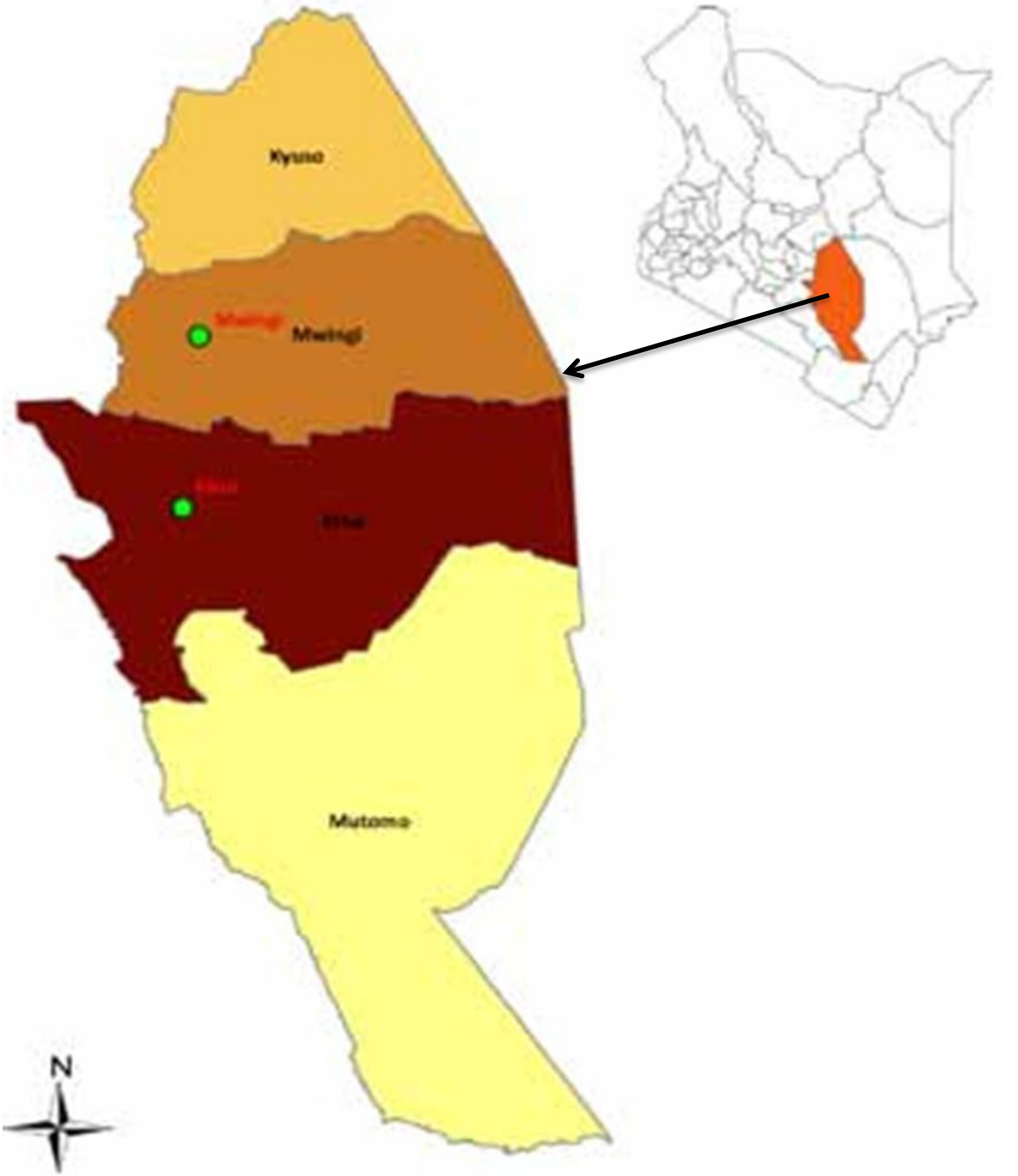
Number of years in Kitui County……

Marital status……...

Level of education……..

APPENDIX III: MAP OF KITUI COUNTY

MAP OF KENYA SHOWING KITUI COUNTY



APPENDIX IV: APPROVAL OF RESEARCH PROPOSAL

KENYATTA UNIVERSITY
GRADUATE SCHOOL

E-mail: dean-graduate@ku.ac.ke
Website: www.ku.ac.ke

P.O. Box 43844, 00100
NAIROBI, KENYA
Tel. 020-8704150

Internal Memo

FROM: Dean, Graduate School

DATE: 12th February, 2020

TO: Ms. Zipporah Kasyoka Kimanthi
C/o Community and Reproductive
Health Nursing Department

REF: R50/CE/34661/2016

SUBJECT: APPROVAL OF RESEARCH PROPOSAL

This is to inform you that Graduate School Board, at its meeting on 29th January, 2020, approved your Research Proposal for the M.Sc. Degree entitled, **"Women's Experience of their Unexpected Caesarean Section in Kitui County, Kenya."**

You may now proceed with your Data collection, subject to clearance with the Director General, National Commission for Science, Technology & Innovation.

As you embark on your data collection, please note that you will be required to submit to Graduate School completed Supervision Tracking and Progress Report Forms per semester. The Forms are available at the University's Website under Graduate School webpage downloads.

Thank you

EDWIN OBUNGU
FOR: DEAN, GRADUATE SCHOOL

CC. Chairman, Community and Reproductive Health Nursing Department

Supervisors:

1. Dr. Lister Onsongo
   C/o Community & Reproductive Health Nursing Dept.
   Kenyatta University
2. Ms. Elizabeth Ambani
   C/o Community & Reproductive Health Nursing Dept.
   Kenyatta University

APPENDIX V: ETHICS REVIEW

KENYATTA UNIVERSITY
ETHICS REVIEW COMMITTEE

Fax: 8711242/8711575
Email: chairman.kuerc@ku.ac.ke

P. O. Box 43844,
Nairobi, 00100
Tel: 8710901/12

Website: www.ku.ac.ke

Our Ref: KU/ERC/APPR.1/VOL.1 Date: 16/06/2020

Zipporah Kasyoka Kimanthi

P.O Box 43844-00100

NAIROBI.

Dear, Ms Kimanthi

RE: APPLICATION NUMBER: PKU/2098/11245 WOMEN EXPERIENCE OF THEIR UNEXPECTED CESAREAN SECTION BIRTH IN KITUI COUNTY,KENYA

img021.jpg
Type: JPEG image
Size: 1.79 MB
Dimension: 2550 x 3509
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This i YATTA UNIVERSITY ETHICS REVIEW COMMITTEE has re above research proposal .Your application approval number is PKU/ The approval period is **16th June 2020 - 17th June 2021.**

This approval is subject to compliance with the following requirements;

i. Only approved documents including (informed consents, study instruments) Will be used.
ii. All changes including (amendments, deviations and violations) are submitted for review and approval by **KENYATTA UNIVERSITY ETHICS REVIEW COMMITTEE.**
iii. Death and life-threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to **KENYATTA UNIVERSITY ETHICS REVIEW COMMITTEE** within 72hours of notification.
iv. Any changes ,anticipated or otherwise that may increase the risk or affected safety bor welfare of study participants and others or affect the integrity of the research must be reported to **KENYATTA UNIVERSITY ETHICS REVIEW COMMITTEE** within 72 hours.
v. Clearance for export of biological specimens must be obtained from relevant institutions.

vi. Submission of requests for renewal of approval of atleast 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal.

vii. Submission of executive summary report within 90 days upon completion of the study to **KENYATTA UNIVERSITY ETHICS REVIEW COMMITTEE** prior to commencing your study, you will be expected to obtain a research license from National Commission of Science, Technology Innovation (NACOSTI) https://oris.nacosti.go.ke and also obtain other clearance needed.

Yours. Sincerely

Prof.Judith Kimiywe
CHAIRPERSON-KENYATTA UNIVERSITY ETHICS REVIEW COMMITTEE

APPENDIX VI: HEALTH FACILITY AUTHORIZATION

Zipporah Kimanthi

KMTC-Kitui Campus

BOX 711-90200

KITUI

12/06/2020

THE MEDICAL SUPERINTENDENT

KITUI COUNTY REFERRAL HOSPITAL

BOX 22-90200

KITUI

Approved 15/6/2020

MEDICAL SUPERINTENDENT
KITUI COUNTY REFERRAL HOSPITAL
P. O. Box 22-90200, KITUI
15 JUN 2020
Tel: 044 4422665
Mobile: 0724 036822
Email: dmosskitui@gmail.com

RE: RESEARCH PERMISSION

I am Zipporah Kimanthi a nurse working at KMTC – Kitui Campus and a student at Kenyatta University pursuing masters degree in midwifery.

Thesis is a partial fulfillment of my degree and I chose this health facility as the point to undertake my research.

I would like to conduct a research on "Women's experience of their unexpected Cesarean section at Kitui County,Kenya.

The purpose of this letter is to kindly request your office to permit me undertake data collection at this health facility. I would like to recruit the client post Cesarean section in maternity unit and collect data during their post natal visits in MCH. Attached please find the authorization letter from Kenyatta University.

Thank you in advance for your kind consideration.

Yours Sincerely,

Zipporah Kimanthi

Cell phone: 0728 067 455

APPENDIX VII: NACOSTI AUTHORIZATION

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR
SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **576260**

Date of Issue: **29/June/2020**

RESEARCH LICENSE

This is to Certify that Ms.. Zipporah Kasyoka Kimanthi of Kenyatta University, has been licensed to conduct research in Kitui on the topic: WOMEN'S EXPERIENCE OF THEIR UNEXPECTED CESAREAN SECTION BIRTH IN KITUI COUNTY, KENYA for the period ending : 29/June/2021.

License No: **NACOSTI/P/20/4682**

576260

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR
SCIENCE,TECHNOLOGY &
INNOVATION

Verification QR Code

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