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KNOWLEDGE CONSTRUCTION OF CAESAREAN SECTION AMONG WOMEN IN NORTHERN GHANA

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Abstract

The study sought to determine the prevalence of cesarean section among women who delivered at the Tamale Teaching Hospital. Cesarean section is performed when a vaginal delivery is risky to the baby and mother. Even though the benefits of Caesarean section are known to women, many would often opt for vaginal delivery to boost their social recognition as women. The design was a hospital-based descriptive cross-sectional study among women within the Tamale Metropolis. The study employed a qualitative method. There were four focus group discussions to elicit information from women who experienced Caesarean Section. Many participants had good knowledge about the risk and effects of a Caesarean Section. Respondents with cesarean section experience did not have a choice to decline in the study hospital because all were emergency cases. Friends and relatives influenced the belief of respondents about cesarean section. Some of the reasons assigned for not opting for a cesarean section were; fear of complications, uncertainty regarding the pain during and after the procedure, and the fact that it is not a natural phenomenon. The perception of society regarding womanhood strongly emerged as an order of socialization and revealed that women who experienced Caesarean section go through ridicule in their respective communities. There is a growing trend of misconception about cesarean section. The Ministry of Health in Ghana should ensure that all health personnel, especially nurses and midwives, have location-based training on sociocultural beliefs about Caesarean section.

Keywords: Women, Knowledge, Experience, Social Construction, Caesarean Section

Introduction

Maternal mortalities mostly occur during labour, delivery, and the post-delivery period. A woman dying during pregnancy or within 42 days after the termination of pregnancy is maternal death. This definition does not depend on the location or duration of the pregnancy. It does not depend on factors aggravated or worsened by the pregnancy or the management of the pregnancy. It, however, excludes death as a result of incidental or accidental events (Gumanga et al.,2011). Maternal mortality is a serious problem for low and middle-income countries (LMICs) and accounts for 99% of maternal deaths worldwide (Ugwu & de Kok, 2015). Significant factors contributing to maternal mortalities in LMICs, including Ghana, are mainly due to the availability and accessibility of obstetric services, poor road network and inadequately equipped facilities (Ronsmans et al., 2006).

Among the challenges women face during child delivery is the choice of the mode of delivery and its acceptability within the social context (Boz et al., 2016). The choice between spontaneous vaginal delivery and Cesarean section is crucial, especially when women are approaching their delivery time (Shahoei et al., 2014). It is worth noting that choosing one birth method over another may be explained differently, but the obvious fact is that women would ordinarily prefer spontaneous vaginal delivery. According to WHO (Manyeh et al., 2018), CS may be an unavoidable option for pregnant women and recommends it at a 10% to 15% rate of total births. Among high-income (HIC) countries and some low- and middle-income countries (LMIC), studies have revealed that the provision of CS exceeds the rates recommended. In recent times, however, the trend is changing due to women's changing lifestyles and social roles. Some may opt for cesarean sections on personal grounds other than health issues (Shirazian & Gertz, 2013). A Caesarean section is usually advised when there is a potential risk to the mother or baby if the woman is to deliver through the vagina (Shirazian & Gertz, 2013).

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Some of the conditions that may influence the advice for Caesarean section include obstructed labour, twin pregnancy, hypertension in the mother, breech, issues concerning the placenta, pelvic shape, and history of Caesarean section (Caughey et al., 2014). The World Health Organization (WHO) recommends that Caesarean sections are indicated on medical needs (Betran et al., 2016).
Defining the third sustainable development goal with a negative trickle-down effect on all the remaining 16 as adequate health and wellbeing is the pivot of the Sustainable Development Goals. Women prefer Caesarean Section over normal birth because it relieves them of the pain in normal vaginal delivery. Their life and the baby are protected from danger (Fenwich et al., 2010). Vaginal delivery, on the other hand, is a choice of birth that creates a bond between the mother and the baby from the moment the baby is delivered. It is easier for mothers to get back to their daily work routine, and it frees them from the danger associated with cesarean delivery (Rishworth et al., 2016).
Cesarean delivery rates of less than 2% indicate a real deficit in access to quality obstetric care and is associated with high maternal mortalities (Brooks et al., 2016). It stands to reason that Ghana's rate of 3.22% may reflect a deficit but may not be highly significantly associated with it. Research suggests that one of the very effective ways to reduce maternal mortality is to increase access to CS for women who need it (Duont et al., 2001). It involves a low CS rate and increases the rates of emergency CS. A study by Gulati and Hjelde on indications leading to Caesarean sections at the Korle Bu Teaching Hospital in Ghana in 2012 showed that from 08/12/2010 until 10/02/2011, there were 548 CS; 70% of which were emergency (Gulati & Hjelde, 2012).

Some Ghana studies have reported women's aversions regarding CS, which may lead to prolonged delays or complete refusal to undergo CS (Chigbu & Iloabachie, 2007). Aversion seems to be grounded in the fear that CS may result in serious health complications, infertility, or death (Chigbu & Iloabachie, 2007). From the social angle is the attachment of social and cultural meanings to CS (Aziken et al., 2007). This study sought to further the understanding of the influence of social and cultural factors that determine the acceptance or refusal of CS. The study hinges on the classic arguments by anthropologist Kleiman that systems in medical practice are similar to cultural systems, including kinship and religion, and go with meanings, behavioural norms, and values (Kleinman & Benson, 2006).
Moreover, medical systems embrace multiple areas within which people manage sickness. Many health problems are solved in what is described as the 'popular arena,' which means the social networks provided by families. Social experience reactions eventually determine health-seeking behaviours. The success of 'Folk healers' in some communities may be related to their ability to 'cure' the symptoms of illnesses instead of curing the actual diseases. The study sought to examine the social construction of knowledge of cesarean section among women who have undergone the process of cesarean section in the Tamale Teaching Hospital.

Study Area
The research took place at the antenatal and postnatal care units of the Obstetrics and Gynaecology department of the Tamale Teaching Hospital. This tertiary health care hospital serves the people of Tamale and its environs. The Obstetrics and Gynaecological department is one of the clinical departments, and it provides free antenatal care services, childbirth and postpartum services, and child health services. It also serves as a referral hospital for several health centers and polyclinics and the hospitals within the Northern, Savanna region, Upper East, Upper West, and North-East regions. The hospital has a bed capacity of over one thousand and serves as a clinical teaching institution for all health training institutions in the Northern Region. It is equipped with state-of-the-art and modern health care delivery services such as ECG, CT scan, MRI, and major surgical procedures. Midwives and doctors attend to all deliveries. While located in an urban area, the community represents a mixture of urban and rural life.

Methodology

Population
The study population comprised all women who underwent cesarean section within the Tamale Metropolis at the time of the study. All participants were recruited within the hospital premises.

Sampling Technique
The study employed a purposive sampling technique to recruit 24 participants for four focus group discussion interviews. The researchers contacted the participants in the child welfare clinic (CWC) of the Tamale Teaching Hospital. Participants with knowledge and experience with CS were sampled (Litorp et al., 2015). This sampling method ensured that women who had undergone a cesarean section were selected to share meanings and experiences after the procedure.

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Data Collection and Analysis

The researchers used a focus group discussion guide to elicit information from participants. Dagbani, a local language that all the participants understood, was used during the interview. A trained translator transcribed the audiotaped data verbatim into the English language. Data were cross-checked for accuracy and completeness by replaying the audiotape information and comparing it with transcribed data. Thematic analysis was employed for the interpretation of the transcribed qualitative data. Both descriptive themes and analytical themes were identified and coded.

Results

Major themes and sub-themes identified were; the meaning of Caesarean Section (CS), Beliefs about CS, Beliefs about the restriction on family size, and Beliefs about the outcome. Source of perception about CS; Significant others, Perceived order of socialization about CS; Social perception of womanhood emotions associated with CS; Fear, Anxiety, Sadness, Post CS consequences; Marital and Social consequences.

Meaning of Caesarean Section

Participants expressed different understanding of CS based on their experiences and knowledge. The understanding was associated with CS being a type of delivery that involves cutting open the mother's womb to remove the baby. A focus group discussant indicated that;

When you are in labour, and you are unable to deliver per vagina, they cut your abdomen open and remove the baby without the baby moving or turning to come out by itself." "It's another way of giving birth: they cut your abdomen open, remove the baby, and leave a big wound. (Discussant FGD 4)

These descriptions show knowledge of basic understanding of CS and how it is carried out.

Beliefs about Caesarean Sections

Different reasons were advanced about CS: Caesarean Section, to some of them, is performed on promiscuous women, lazy women, those who fear pain, and a curse on a disrespectful woman. All participants recognized the role CS plays in saving the lives of both mothers and babies. They were, however, concerned about the sociocultural implications of undergoing a Caesarean Section. A discussant averred that;

Though CS saves mother and baby, one will need assistance after the procedure because, after CS, you cannot do arduous work. When I deliver, I must go back to my father's house because nobody will help me in my husband's house, which is my big challenge. (Discussant, FGD 2)

The findings revealed that even though women knew the benefits of CS to save their lives and their babies, they were very particular about its effects on them. They reported that CS comes with some burdens and restrictions. Participants also reported that socially, it is the belief that CS is for the weak, lazy, and women who fear pain. "As for my family, they believe 'operation' is for weak and lazy women who are not matured enough to marry and deliver." (Discussant, FGD 3)

These beliefs about the reasons for Cesarean Section, as expressed above, give an impression that people might not understand why CS is performed or why it is medically necessary.

Restriction of Family Size

The study results revealed that undergoing CS restricts one's ability to have the desired number of children. These sociocultural perceptions were a source of worry to some participants and their significant others. The following extracts make clear how Caesarean Section limits one's ability to achieve her ideal family size;

"Now that I understand, it is not about the number of children I deliver but the future of the children and how you raise them. I don't care what they say. If it is operation God has destined me to deliver, they should talk". (Discussant, FGD 4). These findings indicate that they viewed Caesarean Section negatively, given that it deprives them of having their ideal family size.

The Outcome of Cesarean Section

The findings have revealed that even though women know the benefits of Caesarean Section to save their lives and their babies, they are very particular about its effects. They reported that Caesarean Section comes with some form of complications:

"Operation is a good and another form of delivering, but I first didn't know, and I ran home because I was scared I would die and later when it became critical, and I was in severe pain, I went back and asked them to save me. Today I sit alive with my son, glory be to God". (Discussant, FGD 4)

This finding indicates that most women are not happy after Caesarean Section because they believe that Caesarean Section comes with restrictions and complications.

Role of Significant Others

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

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friends gave them information on CS.
"I was afraid of the pain during and after the operation and that people say they will kill you and remove your baby. I didn't want to die". ((Discussant, FGD 1)
Participants heard about beliefs about CS from friends and family, which put fear in them before they went through it. Some indicated that their sources of information on CS were from social gatherings. These findings indicate that beliefs and information on CS were obtained from various sources by the participants, and based on the information received, participants reacted differently toward the procedure.

Perceived Order of Socialization about Caesarean Section (Internalization)
This theme sought to describe the cultural perceptions surrounding CS and motherhood, which may significantly influence women's decision-making on a birth method. Social perception of womanhood emerged strongly as an order of socialization.
Socially women have been made to believe that a 'strong woman' can deliver vaginally and can give birth to many children. As such, though they knew the benefits of CS, women in this study were interested in vaginal delivery to be recognized as women in their social context. The following expressions by participants exemplified the societal perception of a woman as one who can deliver vaginally:
"I prefer vaginal delivery because, with the operation, you have a limited number of children to deliver, about 4, but in our cultural setting, our husbands prefer having many children". (Discussant, FGD 2).

These findings from the above theme clearly define a woman and womanhood as largely based on a woman's ability to deliver vaginally and give birth to many children, which most participants wanted to achieve.

Emotions Associated with Caesarean Section
Participants exhibited different emotions towards CS, leading to three main themes: sadness, anxiety, and fear. This theme relates to how the women reacted to hearing that they were to undergo a CS. The theme also indicates the level of acceptance of CS as a birth method. Most of the participants in the study reported that they were anxious after receiving the information that they were going to undergo CS. Their description of anxiety centered on worry, being scared, afraid, and expressions of a heartbeat.
"I was afraid and sad of the outcome of the operation because I heard of people dying during the operation but eventually accepted upon my family's advice and encouragement." (Discussant, FGD 4)
These findings revealed under emotions associated with CS suggest that, despite knowing the benefits of CS, it comes with different emotions for these women. While some showed signs of sadness, others were anxious because they did not know what a Cesarean section's outcome might be. That notwithstanding, the news on CS was welcomed by a few participants because they felt they stood to gain should they agree to go through the procedure. This attitude of a few participants emanated from their earlier refusal to undergo the procedure, resulting in a negative outcome.

Post Caesarean Section Consequences
People who had gone through CS had their marriages threatened based on the perception that CS restricted a woman's ability to give birth to many children. For some of these women, their in-laws were advocating a second wife for their sons to give birth to additional children, others were verbally abused. The participants expressed that the number of children a woman could give was important to the family in the prevailing social context.

Marital Consequences
The participants expressed that the number of children a woman can give was important to the family in the social context in which they found themselves. For some of these women, their in-laws were advocating a second wife for their sons to give birth to additional children. Others were abused verbally. Their marriages were being threatened based on the perception that CS restricted a woman's ability to give birth to many children.
"Madam, I'll prefer vagina to the operation because you know this is our setting. We are many wives, and operation delays our return to active sexual relationship with our husbands about three months which can drive your man away from you". (Discussant, FGD 2)

Social Consequences
The study results showed that women also experienced social abuse in their communities after the CS. While some women were mocked and teased for undergoing CS, others, because they underwent SC for the second time, were poorly received upon arriving at their homes. The expressions below illustrate how socially women are treated after CS;
"For me, they use it to insult me that I'm weak and should not be counted as part of women who have delivered, I don't even have respect in the side of my co-wives and that I can't bear the pain. They mock me that I haven't delivered yet". (Discussant, FGD 3)

DOI: https://doi.org/10.47740/775.UDSIJD6i

Discussion

The Social Construction of Cesarean Section

The women had meanings for CS, beliefs about the procedure, and the reasons for CS. The rest were restrictions on ideal family size and physical impairment. Participants' different beliefs about CS tend to influence the acceptability or otherwise of CS as a birth strategy during the gestational age. Similarly, the study results indicate that women believed that CS involved "killing" the woman to remove the baby and "waking her up later." This finding supports the proposition by Mboho (2013), whose findings suggest that these women interpret the process of women undergoing CS under general anesthesia as "killing" the woman and waking her after the procedure. Also, participants' reasons for not opting for CS include promiscuity, laziness, fear of childbirth, pain, and a curse to a disrespectful woman. These findings compare favorably with Sahlin et al. (2013); Qazi et al. (2013); Ugwu & de Kok (2015). These findings suggest that a woman may avoid CS because of the negative societal construction of CS. For instance, women in the study area may avoid Caesarean Section to escape being labeled as promiscuous or being cursed by their ancestors. Respondents also reported that socially, it is the belief that CS is for weak, lazy, and women who fear pain. Another reason women declined CS was that the social perception of womanhood emerged strongly as an order of socialization.

Similarly, a mixed-method study (Ugwu & de Kok, 2015) showed that women suffered in their marital homes during home delivery or even led to women seeking health care from alternative providers when complications are perceived, including prayer centers.

Source of Perception about Caesarean Section

Participants' beliefs about CS in this study came from significant others (community members). It was revealed that participants heard about beliefs on CS from friends and family, which put fear in them before they went through it. Some indicated that their sources of information on CS were from social gatherings. Others were afraid; some tried resisting the CS altogether. The rest attempted running from the hospital. This revelation is in tandem with those of Ameresekere et al. (2011) and Boz et al. (2016), where four women absconded from the hospital after being informed of the planned procedure to deliver their babies.

Perceived Order of Socialization about CS

Socially women have been made to believe that a woman who can deliver vaginally is one who can give birth to many children. As such, women in this study, even though they knew the benefits of CS, were interested in vaginal delivery to be recognized as women in their social context. These findings from the above theme clearly define a woman and womanhood as largely based on a woman's ability to deliver vaginally and give birth to many children, which most of the participants wanted to achieve, as reported previously (Sahlin et al., 2013; Fenwick et al., 2009; Ugwu & de Kok, 2015). These women may resist CS in their subsequent deliveries, given that CS deprives them of being recognized as "women." The undesirable views about womanhood may be rooted in sociocultural beliefs that can hinder attempts to refer women in situations where there are threatened complications during delivery requiring surgical intervention. This is because undergoing a cesarian section, according to the participants, is a perceived reproductive defeat.

Emotions Associated with Cesarean Section

While some showed signs of sadness, others were anxious because they did not know what the outcome might be. The social belief that one is not a woman after CS, being a perceived adulterous woman, was the concern of these women, which resulted in their worry. The women expressed being afraid because they did not know how CS is done and what the outcome of CS might be as also revealed in the case of Tongco, (2007) in the United States of America, eight women of African descent complained bitterly and felt frustrated when they were faced with CS as a choice of delivery. For those unhappy about CS, unplanned CS delivery coupled with longer hospital stay was a factor. The unexpected lengthy stay at the hospital could challenge these women, preventing them from fulfilling their socially-expected responsibilities at home.

The study identified marital and social consequences suffered by the women in their social context after the procedure. Interestingly, some in-laws were advocating second wives for their sons after their wives had undergone CS to give birth to many children. This corroborates the finding of Ugwu & de Kok, (2015) which also showed that women in the study experienced some form of social abuse in their respective communities after undergoing CS. While some were seen as less of a "woman," others were teased (Sahlin et al., 2013), and others were poorly received at home. In a previous study, women similarly reported this issue (Fenwick et al., 2009). Generally, the results bring the urgent need for intensive education among women and the community on the right indications for CS as a birth strategy medically.

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Conclusion

Women did not have a choice to decline cesarean section in Tamale Teaching Hospital because they were performed as emergency CS or with indications such as prolonged labour, breech presentation, foetal distress, and previous CS. Most of the respondents preferred vaginal delivery, and the reasons provided centered on long recovery time from CS, fears, attitudes, values, traditional and cultural beliefs. Most of the study's findings conformed to the constructs of the social construction of the reality model. These include the social construction of CS, sources of perception about CS, and perceived order of socialization about CS. Those that were not consistent with the social construction of the reality model were emotions associated with CS and post-CS consequences. The findings indicated that women had varied beliefs about CS that tend to influence their acceptability of the procedure as a birth strategy. Women obtained beliefs about CS from various sources and reacted differently toward the procedure based on the information obtained. Furthermore, women's decisions about their preferred mode of delivery had cultural and social dimensions.

Ethical Clearance

Ethical clearance was obtained from the University for Development Studies Institutional Review Committee before data collection commenced. Before conducting the survey, permission to carry out the study was also sought from the health care facilities. Informed consent was also sought from all the participants before the study was conducted. Respondents were free to decline or opt-out of the study without any intimidation.

Competing Interest

There is no competing interest.

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References

Ameresekere, M., Borg, R., Frederick, J., Vragovic, O., Saia, K., & Raj, A. (2011) Somali immigrant women's perceptions of caesarean delivery and patient-provider communication surrounding female circumcision and childbirth in the USA. *International Journal of Gynaecology and Obstetrics*, 115, 227–230.

Aziken, M., Omo-Aghoja, L., & Okonofua, F. (200) Perceptions and attitudes of pregnant women towards cesarean section in urban Nigeria. *Acta Obstet Gynecol Scand,* 86(1), 42-47.

Baghramian, M. (2011) Constructed Worlds, Contested Truths, In Richard Schantz & Markus Seidel (eds.), The Problem of Relativism in the Sociology of (Scientific) Knowledge. *Ontos*. 105-130.

Berger, PL, and Luckmann, T. (1966) The Social Construction of Reality: A Treatise in the Sociology of Knowledge. London: Penguin.

Betran, A. P., Ye, J., Moller, A. B., Zhang, J., Gulmezoglu, A. M., & Torloni, M. R. (2016) The Increasing Trend in Caesarean Section Rates: Global, Regional and National Estimates: 1990 2014. *PLoS One*, 11(2), e0148343.

Boz, I., Teskereci, G., & Akman, G. (2016) How did you choose a mode of birth? Experiences of nulliparous women from Turkey. *Women Birth*, 29(4), 359-367.

Brooks, E. C., Genna, C. W., & Mannel, R. (2016) The Lactation Consultant: Roles and Responsibilities. Jones and Bartlett Learning LLC.

Burr, V. (1995) An introduction to social constructionism. *Taylor & Frances/Routledge.* https://doi.org/10.4324/9780203299968

Caughey, A. B., Cahill, A. G., Guise, J. M., & Rouse, D. J. (2014) Safe prevention of the primary cesarean delivery. *Am J Obstet Gynecol*,, 210(3), 179-193.

Chigbu, C. O., & Iloabachie, G. C. (2007) The burden of cesarean section refusal in a developing country setting. BJOG, 114(10), 1261-1265.

Cojocaru, S. (2010) Appreciative supervision in social work. New opportunities for changing the social work practice. *Revista de cercetare si interventie sociala,* 29,72-91.

Dumont, A., de Bernis, L., Bouvier-Colle, M. H., & Breart, G. (2001) Caesarean section rate for maternal indication in sub-Saharan Africa: a systematic review. *Lancet*, 358(9290), 1328-1333.

Fenwick, S., Holloway, I., & Alexander, J. (2009) Achieving normality: the key to status passage to motherhood after a caesarean section. *J Midwifery* 25(5), 554 -563.

Fenwick, J., Staff, L., Gamble, J., Creedy, D. K., & Bayes, S. (2010) Why do women request cesarean section in a normal, healthy first pregnancy? *Midwifery*, 26(4), 394-400.

Gulati, D., & Hjelde, G. I. (2012) Indications for Cesarean Sections at Korle Bu Teaching Hospital, Ghana. Dissertation, University of Oslo

Gumanga, S. K., Kolbila, D.Z., Gandau, B.B.N., Munkaila, A., Malechi, H., & Kyei-Aboagye, K. (2011). Trends In Maternal Mortality In Tamale

Teaching Hospital, Ghana. *Ghana Medical Journal,* 45 (3):105-10

Kleinman, A., & Benson, P. (2006) Anthropology in the clinic: the problem of cultural competency and how to fix it. PLoS Med, 3(10), e294.

Litorp, H., Mgaya, A., Kidanto, H. L., Johnsdotter, S., & Essen, B. (2015) 'What about the mother?' Women's and caregivers' perspectives on cesarean birth in a low-resource setting with rising cesarean section rates. *Midwifery*, 31(7), 713-720.

Manyeh, A. K., Amu, A., Akpakli, D. E., Williams, J., & Gyapong, M. (2018) Socioeconomic and demographic factors associated with cesarean section delivery in Southern Ghana: evidence from INDEPTH Network member site. *BMC Pregnancy Childbirth*, 18(1), 405.

Mboho, M. J. A. R. I. (2013) Perception Of Nigerian Women towards Cesarean Section: A Case Study Of Women Of Reproductive Age In Akwa Lbom State, Nigeria. *Psychology* 4(6), 272.

Rishworth, A., Bisung, E., & Luginaah, I. (2016) "It's Like a Disease": Women's perceptions of cesarean sections in Ghana's Upper West Region. *Women Birth*, 29 (6), e119-e125.

Ronsmans, C., & Graham, W. J. (2006) Maternal mortality: who, when, where, and why. *Lancet*, 368(9542), 1189-1200.

Sahlin, M., Carlander-Klint, A.-K., Hildingsson, I., & Wiklund, I. (2013) First-time mothers' wish for a planned caesarean section: deeply rooted emotions. *J Midwifery*, 29(5), 447-452.

Shahoei, R., Rezaei, M., Ranaei, F., Khosravy, F., & Zaheri, F. (2014) Kurdish women's preference for mode of birth: a qualitative study. *International Journal of Nursing Pract*, 20(3), 302-309.

Shirazian, T., & Gertz, E. (2013) Around the globe for women's health: a practical guide for the health care provider. Springer, 13th Edition. DOI 10.1007/978-1-4419-8258-2 Springer New York.

Souza, J. P., Betran, A. P., Dumont, A., de Mucio, B., Gibbs Pickens, C. M., Deneux-Tharaux, C., . . . Gulmezoglu, A. M. (2016) A global reference for cesarean section rates (C-Model): a multicountry cross-sectional study. *BJOG*, 123(3), 427-436.

Qazi, Q., Akhtar, Z., Khan, K., & Khan, A. H. (2013) Pregnant women view regardingcesarean section in Northwest Pakistan. *J Trop Med Surg*, 1(1), 1-4.

Tongco, M. D. C. (2007) Purposive sampling as a tool for informant selection. *J Ethnobotany Research applications*, 5, 147-158.

Ugwu, N. U., & de Kok, B. (2015) Sociocultural factors, gender roles and religious ideologies contributing to Caesarian-section refusal in Nigeria. Reprod Health, 12, 70.

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