FACTORS INFLUENCING PREFERENCE FOR REPEAT ELECTIVE CESAREAN SECTION AMONG LOW-RISK WOMEN WITH PREVIOUS UNPLANNED CESAREAN DELIVERY AT AIC KIJABE HOSPITAL

LILIANE KADIEVI MUGODO

A Thesis Submitted to the Institute of Postgraduate Studies of Kabarak University in Partial Fulfillment of the Requirements for the Award of Master of Family Medicine in Family Medicine Degree

KABARAK UNIVERSITY

NOVEMBER, 2025

DECLARATION

1. I do declare that:

i. This thesis is my work and to the best of my knowledge, it has not been presented for the award of a degree in any university or college.

ii. The work has not incorporated material from other works or a paraphrase of such material without due and appropriate acknowledgment.

iii. The work has been subjected to processes of anti-plagiarism and has met Kabarak University 15% similarity index threshold.

2. I do understand that issues of academic integrity are paramount and therefore I may be suspended or expelled from the University or my degree may be recalled for academic dishonesty or any other related academic malpractices.

Signed:_____ Date:_____

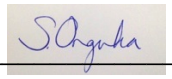
Liliane Kadievi Mugodo

GMMF/0332/01/21

RECOMMENDATION

To the Institute of Postgraduate Studies;

The thesis titled **"Factors Influencing Preference for Repeat Elective Cesarean Section among Low-Risk Women with Previous Unplanned Cesarean very in Kijabe Hospital"** written by **Liliane Kadievi Mugodo** is presented to the Institute of Postgraduate Studies of Kabarak University. We have reviewed the thesis and recommend it be accepted in partial fulfillment of the requirement for the award of the Degree of Master of Medicine in Family Medicine.

Signed:  Date: 16th December, 2025

Dr. Stephanie Onguka

Department of Family Medicine

Kabarak University

Signed:  Date: 16th December, 2025

Dr. Boaz Niyinyumva

Department of Family Medicine

Kabarak University

COPYRIGHT

ACKNOWLEDGEMENT

My greatest gratitude goes to God for providing me with the strength, wisdom, and determination to complete this work. His guidance has been a constant source of comfort and direction throughout this journey.

I am deeply grateful to my family, whose unwavering support and encouragement have been instrumental throughout this journey. To my spouse, Brian, for being my constant source of strength and motivation, and to my children for their patience and understanding during my countless hours of work.

I would also like to thank my supervisors; Dr. Stephanie Onguka and Dr. Boaz Niyinyumva, for their invaluable guidance, mentorship, and support throughout this research process. Their insights and expertise have greatly shaped the direction and success of this study.

Special thanks to my colleagues at AIC Kijabe Hospital and faculty members at Kabarak University whose input was essential to refining this work.

In addition, I would like to extend my deep appreciation to the participants of this study for their willingness to share their experiences, without which this research would not have been possible.

ABSTRACT

Cesarean section rates have risen significantly over the past decade, with many countries surpassing the World Health Organization's standard of 10-15%. Women with a previous cesarean- Robson group 5- contribute substantially to this increase. For low-risk women, Vaginal Birth After Cesarean (VBAC) is a safe and cost-effective alternative that can reduce cesarean-related morbidity and ease the burden higher rates placed on the healthcare system. Despite these benefits, many women in Kenya still prefer repeat elective cesarean delivery in subsequent pregnancies. This study investigates the factors influencing this preference among low-risk women attending AIC Kijabe Hospital, exploring the influence of their previous birth experiences, and that of healthcare providers on their delivery decisions. This qualitative phenomenological study involved 18 women with prior cesarean delivery attending the hospital. Participants were selected through purposive sampling based on predefined inclusion and exclusion criteria. Data was collected through in-depth interviews using a semi-structured interview guide and analyzed using inductive thematic analysis with the Dedoose software. Maternal reasons for preferring repeat cesarean included fear, personal preference versus the influence of loved ones, the convenience of simultaneous bilateral tubal ligation, and the desire to experience a vaginal birth. Prior birth experiences also shaped maternal choice of delivery mode-- traumatic vaginal interventions, an expressed low confidence in successful vaginal birth and the considerations of risks over benefits were all influential. Participants also emphasized the importance of healthcare providers' recommendations, noting counseling gaps and facility preparedness to offer VBAC services. Ultimately, reducing repeat cesareans among low-risk women requires a comprehensive strategy: Strengthening the support for VBAC services, improving the quality of patient-provider communication, and addressing the emotional and psychological impacts of prior birth trauma. Institutional policies that encourage comprehensive counseling and shared decision-making will be key to encouraging safer, evidence-based birth practices.

Keywords: *Birth Trauma, Mode of Delivery, Repeat Elective Cesarean Section, Vaginal Birth after Cesarean Section, VBAC Counseling*

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS AND ACRONYMS

ACOG	American College of Obstetricians and Gynecologists
AIC	African Inland Church
ANC	Antenatal Care
APH	Antepartum Hemorrhage
ART	Assisted Reproductive Technology
BTL	Bilateral Tubal Ligation
CS	Cesarean section
HBM	Health Belief Model
HH	Household
HICs	High-Income Countries
IDIs	In-Depth Interviews
IREC	Institutional Review and Ethics Committee
KHIS	Kenya Health Information System
KNBS	Kenya National Bureau of Statistics
LMICs	Low and Middle-Income Countries
MCH	Maternal and Child Health
NACOSTI	National Commission for Science, Technology, and Innovation
NHIF	National Health Insurance Fund
PCEA	Presbyterian Church of East Africa
PNC	Postnatal Care
RECS	Repeat Elective Cesarean Section.
SBA	Skilled Birth Attendance
SEM	Socio-Ecological Model
TOLAC	Trial of Labor After Cesarean Delivery
UHC	Universal Health Coverage
VBAC	Vaginal Birth after Cesarean Section
WHO	World Health Organization

CONNCEPTUAL AND OPERATIONAL DEFINITION OF TERMS

Low-Risk Women: Women who have no medical, obstetric, or fetal conditions that would increase the likelihood of complications during labor or delivery and have no contraindications to attempting a vaginal birth after cesarean

Maternal Morbidity: Any health condition attributed to and/or complicating pregnancy and childbirth that harms the woman's well-being and/or functioning

Maternal Request: Cesarean delivery following a request from the pregnant woman in the absence of any maternal or fetal indications

Medical Indication: Any medical condition that may make vaginal birth risky or impossible

Neonatal Morbidity: Any medical condition resulting in post-delivery inpatient hospital readmission, observational stay, or mortality in the first 28 days of life.

Phenomenology: A qualitative research approach that seeks to understand and explore people’s experiences of a phenomenon

Robson Classification: A standardized system that classifies pregnant women into 10 mutually exclusive groups based on five obstetric characteristics: parity, previous obstetric history, onset of labor, gestational age, and fetal presentation. This classification allows for a more accurate comparison of cesarean section rates between different settings, whether they are individual hospitals or entire regions or countries.

Unwilling VBAC: Refusal to attempt a trial of vaginal delivery after a cesarean delivery.

CHAPTER ONE

INTRODUCTION

This chapter includes the background of the study, a statement of the problem, the purpose of the study, justification of the study, the objectives, and the significance of the study. This section will also highlight the foreseeable limitations of the study.

1.1 Background of the Study

In the face of an obstetric complication, a cesarean section (CS) is a lifesaving procedure for both the mother and the infant. However, no evidence suggests any additional benefit for either mother or infant when it is not medically indicated (Betrán et al., 2016). CS is often performed in high-risk births such as those complicated by antepartum hemorrhage (APH), fetal distress, abnormal fetal presentation, prolonged or obstructed labor, and in cases of medical and gynecological conditions complicating labor and delivery. Although CS is a relatively safe procedure, as with any other major surgery it is associated with significant risks such as pain, excessive bleeding sometimes requiring blood transfusion or hysterectomy, infection, visceral injury, respiratory distress in the newborn, and in some instances death of the mother and/or infant (Sobhy et al., 2019). This is in addition to potential complications that could arise from the administration of anesthesia for any surgical procedure such as cardiac arrest, venous thromboembolism, and the need for assisted ventilation (Sandall et al., 2018).

Other documented complications that may arise in subsequent pregnancies among women with a previous CS include a high risk of bleeding, uterine rupture necessitating hysterectomy, placenta abnormalities such as placenta previa and accreta, adhesions predisposing to intraoperative surgical injury as well as the need for repeat CS (“ACOG Practice Bulletin No. 205,” 2019; Sandall et al., 2018). Outside of pregnancy, long-term sequelae of CS include pelvic adhesions, bowel obstruction, menorrhagia, dysmenorrhea,

chronic pain, sexual dysfunction, subfertility, urinary and fecal incontinence, and pelvic organ prolapse (Sandall et al., 2018).

Beyond the health risks, CS imposes a significant socio-economic burden on the family unit and the healthcare system at large. A study conducted in Tanzania to evaluate the socioeconomic consequences of CS found that the likelihood of paying out of pocket almost doubled for CS compared to normal delivery (19% versus 34%). The same study established that CS cost almost 12 times the cost of vaginal delivery and hospitalization time was also longer, averaging three times that of normal deliveries (Binyaruka et al., 2021). In Kenya, the average cost of a CS in a level four, five, or six facility averages between Ksh.30,000 to 50,000 in public facilities while costs in private facilities can be up to Ksh.300,000 or more (Chuma et al., 2009).

Despite well-documented evidence of the financial burden and increased morbidity associated with cesarean sections (CS), their global rates continue to rise alarmingly, with many countries exceeding the World Health Organization's (WHO) recommended threshold of 10-15% (Betran et al., 2021). Data from 2010 to 2018 indicate that 21.1% of women worldwide delivered by CS, nearly double the rate from 2000 (Betran et al., 2021). The largest increases were noted in Eastern Asia (44.9%), Western Asia (34.7%), and Northern Africa (31.5%), while Sub-Saharan Africa (SSA) and North America experienced smaller but steady increases of 3.6% and 9.5%, respectively (Betran et al., 2021). In Kenya, despite lower rates in SSA, the incidence of CS has dramatically escalated, with 17% of all live births delivered by CS (KDHS, 2022). The 2022 Kenya Demographic Health Survey reports a surge in cesarean deliveries from 5.3% to 12.3% in rural areas and from 14.7% to 23.8% in urban areas between 2014 and 2022 (KDHS, 2022). According to Van der Spek et al. (2020) these varying rates between rural and urban areas, as well as between high-income and low- and middle-income countries

(LMIC), are due to an increase in primary CS performed without medical indication, contributing to higher rates of repeat cesarean sections.

Despite the relatively lower overall CS rates in Kenya, institutional rates of CS are alarmingly high raising concerns (KHIS Tracker, 2023). AIC Kijabe Hospital, a faith-based level 5 tertiary, teaching and referral hospital in Kiambu County, serves a diverse population from both rural and urban areas across several counties, including Kiambu, Nakuru, Narok, Kajiado, Nairobi, and Machakos. In addition to walk-in patients, the hospital receives referrals from lower-level facilities within and beyond these counties. Kijabe Hospital provides care to both self-paying patients and those covered by health insurance, including the National Health Insurance Fund (NHIF). According to data from the Kenya Health Information System (KHIS), 60% of women at Kijabe Hospital were delivered by cesarean section in the most recent financial year (KHIS, 2023).

This high institutional rate at Kijabe Hospital is far beyond the WHO recommended threshold of 15-20% per population and is comparable to other tertiary facilities such as Kiambu Level 5 Hospital (37.8%), Tenwek Mission Hospital (47.75%), Naivasha Sub-County Referral Hospital (27.8%), Nakuru Provincial General Hospital (52.3%), and PCEA Chogoria Hospital in Tharaka Nithi County, which reported an 81.1% cesarean section rate for the same period (KHIS, 2023). It is possible that these high rates could indeed be influenced by various factors, including referrals of high-risk pregnancies from lower-level facilities. Therefore, to accurately assess and compare CS rates between hospitals in a meaningful manner, it's essential to evaluate these rates within specific obstetric populations, as defined by the Robson classification system (Robson 2001). An evaluation of the drivers of CS rates within these specific populations will help account for differences in case mix between hospitals.

As CS rates continue to rise both globally and locally, it is crucial to investigate the underlying factors driving this trend to mitigate potential maternal and perinatal health risks and the financial implications at the individual level and the healthcare system at large. Understanding these drivers is key to the formulation of targeted interventions to curb this global pandemic. According to Boerma et al. (2018), the witnessed global rise in the rates of CS is primarily driven by two factors: the expanding coverage of health facility deliveries (accounting for 66.5% of the rise) and increasing CS rates within health facilities themselves (33.5%), with considerable variation across regions. Evidence from a sub-analysis of this trend among different obstetric populations as defined by the Robson classification system shows that repeat cesarean sections are a major contributor to overall CS rates, particularly in LMIC (Van der Spek et al., 2020; Vogel et al., 2015).

Despite evidence that non-medically indicated CS confers no additional benefit to mothers or their infants, healthcare providers today are increasingly faced with a dilemma as an increasing number of women prefer delivery by CS even when there is no medical contraindication to vaginal birth (D'Souza et al., 2013). This pattern is evident at Kijabe Hospital, where many low-risk women with a previous cesarean section opt for repeat elective cesarean section (RECS) despite being eligible for a VBAC. A review of the hospital's obstetrics and gynecology surgical log from January 2023 to December 2023 reveal that 21% of cesarean sections were performed on women with a previous cesarean delivery on account of maternal preference for RECS and in the absence of other medical indications for the procedure except for a prior cesarean delivery.

While a previous CS is a well-established risk factor for repeat CS, several other medical and non-medical factors influence the mode of delivery for women with a history of cesarean birth ("ACOG Practice Bulletin No. 205," 2019). The American College of

Obstetricians and Gynecologists (ACOG) asserts that a prior CS, particularly with a low-transverse uterine incision, is not an automatic indication for repeat CS. In the absence of contraindications, such women should be offered the option to attempt a VBAC. Women with a previous unplanned CS present as a special population of women in the sense that they previously attempted or consented to vaginal delivery but encountered complications beyond their control that necessitated the cesarean. The conditions that led to their primary CS may either be absent or modifiable for their current pregnancy. An example of this could be a primary CS due to fetal distress. This particular population of pregnant women thus presents a notable opportunity for intervention. For these women, VBAC is a viable and effective strategy that will help avert the morbidity that is associated with CS and reduce the overall rate of CS. The scarcity of studies conducted among this special population of women presents an obvious contextual knowledge gap. An in-depth exploration of representatives from this population will provide a richer understanding of what influences maternal preference for RECS over VBAC, particularly in cases where no contraindication exists. The findings of this study can inform contextualized targeted interventions to reduce unnecessary CS among low-risk pregnant women with a previous CS.

1.2 Problem Statement

Without effective intervention, the global CS rate is expected to surge by 7.4 percentage points by 2030 (Betran et al., 2021). In Kenya, this trend is already evident, with CS rates rising sharply in both rural (from 5.3% to 12.3%) and urban areas (from 14.7% to 23.8%) (Kenya National Bureau of Statistics, 2022). The Robson Group 5 which comprises women with a previous CS is an overlooked population in research both globally and locally despite its significant contribution to overall CS rates worldwide and locally. At Kijabe Hospital where the overall CS rate is 60%, Robson group 5 alone accounts for 30% of births by CS (KHIS Tracker, 2023; Kijabe Hospital Obstetrics and Gynecology Surgical log, 2023). Of these women, 69.8% who would otherwise be

candidates for a trial VBAC underwent RECS due to personal preference even in the absence of contraindications to a VBAC. For these low-risk women, VBAC is a viable, safe, and cost-effective alternative to CS. Promoting VBAC could help reduce unnecessary CS, mitigate the associated health risks, and alleviate the financial and social burden of surgical procedures that might be avoidable. Literature supports the need for contextual understanding to inform solutions to the problem. Given that Kijabe Hospital's CS rates are much higher than national averages, understanding the decision-making process of pregnant women in choosing between VBAC and RECS is crucial. This study explores this process to develop targeted interventions that can improve care for this population and reduce unnecessary CS rates in a context-specific manner.

1.3 Study Justification

The global rise in cesarean section (CS) rates has been a growing concern for over a decade. While numerous studies have aimed to understand this trend, much of the research has focused on the general increase in CS without adequately addressing the subgroup of women with a previous CS even though they are the largest contributors to the overall rise in CS rates globally. Robson Group 5 women remain under-researched, particularly LMICs like Kenya. Furthermore, the majority of existing studies have been conducted in Western contexts, where healthcare systems, cultural perceptions, and patient preferences differ significantly from those in LMICs. This discrepancy makes it difficult to apply findings from these studies to settings like Kenya, where the dynamics around decision-making may be shaped by different factors. In addition, most studies on this topic have taken a quantitative approach. While valuable, these studies offer limited insight into the personal experiences, fears, and motivations that influence women's decisions regarding their mode of delivery after a previous CS. A qualitative approach enables us to delve deeper into the subjective reasoning that shapes these decisions.

This study is particularly important because it shifts the focus away from healthcare providers who have been the central subject of much of the existing literature and onto the women themselves. Understanding the reasoning behind their preferences is key to providing targeted interventions that could reduce unnecessary repeat CS and improve maternal health outcomes.

1.4 Purpose of the Study

This study explores the factors influencing the preference for RECS after a previous unplanned CS among women without contraindications to attempting a VBAC at Kijabe Hospital. Understanding these factors will help identify high-impact areas for intervention unique to this population.

1.5 Objectives of the study

1.5.1 Main Objective

Description of maternal factors that influence decisions for RECS after a previous unplanned CS at Kijabe Hospital in Kenya.

1.5.2 Specific Objectives

i. Exploring factors influencing the preference for RECS by low-risk women with a previous unplanned CS in Kijabe Hospital.
ii. Examining how previous birth experiences influence women's decisions on their preferred mode of delivery after an unplanned cesarean section.
iii. Exploring the influence of healthcare providers in guiding decisions on a mode of delivery among low-risk women who have experienced an unplanned cesarean delivery.

1.6 Significance of the Study

The findings of this study will serve as a foundation for developing institutional guidelines for the management of low-risk pregnant women with a previous primary CS. By highlighting areas for improvement in the current care, this research equips healthcare providers with actionable insights to improve the counseling and care of women with a primary CS. In addition, the insights and recommendations will be shared with other referral hospitals and surrounding health facilities to enhance education and outreach on risks, benefits, and indications of VBAC and RECS so that families can make informed decisions. Furthermore, the results of this study have the potential to inform broader policy and practice interventions aimed at promoting safe and appropriate birth practices that ultimately optimize maternal and neonatal outcomes.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter gives a general overview of the literature on maternal reasons for the rise in the rates of RECS, population contributors to the rise in RECS, and finally healthcare providers and health system influence on RECS. This chapter will also present the theoretical framework based on this study.

2.2 Maternal Reasons for the Rise in Rates of RECS

Women with a previous CS are more likely to require another CS in subsequent pregnancies. Despite being eligible for a VBAC, an increasing proportion of women with a primary CS opt for RECS in their subsequent pregnancy (Stjernholm et al., 2010). Numerous studies have investigated the reasons behind this preference citing a diverse range of individual, emotional, and situational factors influencing maternal preference of RECS (Jenabi et al., 2020).

Patient satisfaction has long been known to play a pivotal role in fostering strong relationships between healthcare providers and their patients. It serves as a basis for measuring the quality of care provided and can help predict patients' continued utilization of a medical service (Sixma et al., 1998). For women who anticipated an uncomplicated vaginal delivery but ended up with an unexpected cesarean delivery, the prospect of facing a similar situation in future pregnancies can be understandably distressing. Studies have shown that a woman's previous birth experience significantly shapes her perception of delivery methods, often influencing her decision for subsequent births. Women who perceive their prior experience as traumatic or negative are more likely to choose a different mode of delivery in future pregnancies (Jenabi et al., 2020; Moffat et al., 2007). For instance, women who experienced a failed vaginal delivery

cited fear of uncertainty and opted for RECS (Moffat et al., 2007). Conversely, in the same study, some women perceived the social and financial incapacitation that followed their primary CS as a negative experience and for this reason preferred VBAC in their subsequent delivery (Moffat et al., 2007). Still, the concept of what qualifies as a bad experience is itself ambiguous. Research into this concept reveals that women's birth experiences are multifaceted, shaped by an individual woman's interpretation of their care encounters. It is subjective and can evolve throughout pregnancy, childbirth, and the postpartum period (Beecher et al., 2020). In the same study, it was established that a woman's experience is dependent upon their individual needs, expectations, and circumstances (Beecher et al., 2020). These findings highlight the importance of contextualizing care for each woman in line with their previous birth experiences.

One notable example is the fear of childbirth. While this fear can exist among nulliparous women- those who are yet to experience childbirth, it is often more strongly linked to a previous negative birth experience (Handelzalts et al., 2015). For women who have undergone an unplanned CS, the thought of childbirth can understandably evoke feelings of fear, worry, and anxiety, all stemming from their prior birth experience. Tokophobia, a severe fear of pregnancy and childbirth has been frequently cited as a reason for preferring CS over vaginal birth (Konlan et al., 2019; Jenabi et al., 2020). In both studies, women expressed heightened anxiety around gynecological examinations and labor pains resulting in a preference for cesarean delivery over vaginal delivery to avoid these experiences.

Interestingly, the fear of pain is not limited to vaginal delivery. A study conducted in Nigeria examined the views of women with a prior CS and found that those who declined a repeat CS often cited the fear of pain as a major reason (Olofinbiyi et al., 2015). Despite this, most women in the study still opted for RECS, motivated by

concerns about uterine rupture and fetal safety (Olofinbiyi et al., 2015). This variation in how women perceive and tolerate pain across different modes of delivery underscores the importance of understanding and contextualizing the fear of childbirth for each woman. Additionally, these findings highlight the complex interplay between factors and the perplexity of decision-making regarding delivery methods. In this case, safety concerns overrode pain fears, suggesting that women prioritize outcomes related to safety and health over discomfort (Olofinbiyi et al., 2015). This complexity further underscores the need for a nuanced approach to patient counseling and decision-making in obstetric care.

As highlighted above, women's concerns about their safety and that of their infants play a crucial role in their decisions on delivery methods. This is particularly true for women who have had a negative experience or outcome that left them or their infants injured. For example, a study of post-partum women who had undergone RECS revealed that their preference for RECS was significantly influenced by traumatic birth experiences in their previous delivery (Tully et al., 2019). In this study, women considered an emergency CS following needless exhaustion from labor trauma and as a result scheduled RECS for their subsequent pregnancy because they perceived CS to be safe and doubted their ability to achieve a successful vaginal delivery (Tully et al., 2019).

Similarly, another study found that women whose primary CS was performed due to a non-reassuring fetal status were inclined to opt for RECS in future pregnancies, driven by the belief that cesarean delivery better ensures fetal safety (Tita et al., 2009). The findings underscore the importance of having balanced discussions between healthcare providers and patients about the risks and benefits of each delivery method. An evaluation of these discussions as recollected and narrated by participants helped identify gaps in the counseling of these women. Action in these areas will improve decision-

making support for these women as they choose between VBAC and RECS for their current pregnancy.

Finally, a specific subset of patients warrants particular attention: Women with infertility. The journey from infertility to conception is often physically, emotionally, and financially stressful. Consequently, once these women achieve pregnancy, they are likely to become overly anxious about the outcome of their pregnancy even in the absence of prevailing medical or obstetric complications. Research indicates that the odds of medical intervention including elective cesarean section are likely among women plagued by infertility compared to their fertile counterparts (Jenabi et al., 2020; Richmond et al., 2022). While Assisted Reproductive technology (ART) is linked to an increased risk of complications such as preeclampsia, eclampsia, gestational diabetes, multiple pregnancies, and abnormal placentation, all of which can raise the likelihood of a cesarean section, the choice of a delivery method should be based on evidence and tailored to the health status of both the mother and fetus, regardless of the challenges faced during conception.

2.2.1 Population Contributors to RECS

Population factors, or societal determinants of health, encompass the non-medical factors that influence health behaviors and outcomes. These include socioeconomic factors like education, income, and occupation; community influences such as cultural attitudes and social norms; and health system factors like policy, healthcare access, and provider availability. These elements predominantly influence health equity and have been implicated in the witnessed global disparities in cesarean section (CS) rates, notably between high-income and low- to middle-income countries, as well as between the urban elites and the rural poor (Boerma et al., 2018). Evidence shows there exists a strong link between these non-medical factors and the choice of a mode of delivery following a

previous unplanned CS. Two systematic reviews highlighted that older women, those with a higher level of education, high household income, and established family status are more likely to opt for CS (Jenabi et al., 2020; O'Donovan et al., 2018). Similarly, in Kenya, Odongo (2020) found that the preference for CS was more prevalent among older women, women with higher education levels, greater wealth, urban residents, and those with access to health insurance. Most of these studies however focused on women who had a planned primary CS without any contraindication to vaginal birth, a phenomenon known as "cesarean delivery by maternal request" (CDMR). Therefore, there remains a need to explore how these socio-demographic factors influence the choice of CS among women who have experienced an unplanned primary CS.

2.2.2 Healthcare Provider and System Influence on RECS

Midwives and clinicians attending to pregnant women serve as key gatekeepers in obstetric care and are directly involved in guiding women through discussions around the mode of delivery. Understanding their perspectives on RECS, and VBAC as women recollect the conversations they had with their healthcare providers regarding the mode of delivery is crucial. Research highlights that the preferences and recommendations of healthcare providers significantly influence women's choices regarding delivery. For instance, a large systematic review found that women were more likely to pursue VBAC if their healthcare providers were supportive and encouraged this option (Jenabi et al., 2020).

Conversely, the same study found that women were more likely to opt for RECS if their providers voiced concerns or reservations about VBAC. Similarly, a study conducted among pregnant women with a previous CS attending ANC at the Kenyatta National Hospital found that some chose RECS solely based on their doctor's recommendations (Biraboneye, A. 2017). The same study determined that very few women (8.3%) of the

surgical and anesthetic risks related to CS, a majority of them were not aware of the risk of uterine rupture related to VBAC, and additionally, only about half of them were aware of the high success rate of VBAC. While expert opinion is crucial in the care recommendations provided to patients, such opinions should be grounded on scientific evidence rather than swayed by individual biases. A large systematic review of 34 studies, encompassing 7,785 obstetricians and 1,197 midwives from 20 countries, identified three interrelated themes influencing decisions on the mode of delivery: clinicians' personal beliefs, healthcare systems, and clinicians' characteristics (Panda et al., 2018). Of these, clinicians' personal beliefs exerted the greatest influence on the decision to perform a cesarean section, with many favoring RECS based on the perception that CS is safer than vaginal birth.

These clinicians viewed VBAC as less likely to succeed and associated with a higher risk of maternal and fetal complications compared to RECS. Furthermore, the study revealed that many clinicians considered it professional and ethical to respect a woman's autonomy, particularly when her preference for CS stemmed from a fear of childbirth, concerns about maternal or fetal injury, or previous negative birth experiences, even in the absence of clinical indications for repeat CS (Panda et al., 2018).

This finding raises important questions about the precedence of clinician’s personal beliefs and philosophies in patient care. As gatekeepers of healthcare, clinicians are responsible for providing pregnant women with comprehensive, evidence-based information to support informed decision-making, rather than allowing personal biases to override the patient's best interests. In addition, fear of legal consequences and financial pressure shape the decisions of healthcare providers and institutions regarding the mode of delivery. In the United States of America (USA), these concerns became more pronounced in 1996, when studies revealed that women attempting VBAC faced nearly

twice the risk of major obstetric complications compared to those undergoing RECS (McMahon et al., 1996). The result was a steady decline in the rates of VBAC. This prompted the American College of Obstetricians and Gynecologists (ACOG) to issue stringent guidelines, requiring immediate access to clinicians and anesthesiologists during VBAC. In America, the rates of VBAC began to decrease steadily in 1996 following findings that major obstetrical complications were nearly twice as likely in the VBAC group as in women who underwent RECS (McMahon et al., 1996). Concerns over the safety of VBAC prompted ACOG to draft guidelines on VBAC that required clinicians and anesthesiologists to be immediately available during the active phase of labor. These recommendations saw a sharp decline in the rates of VBAC and an exponential rise in the rates of RECS due to the liability imposed on healthcare providers. The influence of legal pressures on obstetric decision-making extends beyond individual clinical concerns, shaping broader healthcare practices globally. Fear of litigation, particularly surrounding VBAC, has been shown to heavily influence healthcare providers' recommendations for CS (Panda et al., 2018). For instance, a cross-sectional study of 403 gynecologists and obstetricians in Brazil revealed that most practiced defensive medicine, driven by concerns over legal risks (Rudey et al., 2021).

This may help explain Brazil's high CS rate: The highest globally (Betran et al., 2021). In contrast, a study in Nigeria found that obstetricians perceived a greater risk of litigation with CS as they believed women viewed complications arising from natural birth as unavoidable (Chigbu et al., 2010). These varied legal landscapes raise critical questions about whether healthcare providers present biased information favoring repeat CS to avert litigation. Examining how women recall their discussions with healthcare providers regarding delivery options will provide deeper insight into this assumption. Beyond legal concerns, financial incentives also play a pivotal role in shaping health

providers' recommendations for delivery options. Although vaginal birth, including VBAC, is significantly less costly than CS, higher reimbursement rates for repeat CS appear to tip the scales in favor of surgery (Binyaruka et al., 2021). Research suggests these financial kickbacks desensitize healthcare providers from promoting VBAC (Jenabi et al., 2020; O'Donovan et al., 2018). The stark contrast in the rates of CS between private and public facilities attests to this phenomenon (Boerma et al., 2018). These findings emphasize the need to promote VBAC as a safe and cost-effective alternative to repeat CS for select patients, particularly in LMIC where reducing healthcare costs and improving maternal and fetal outcomes are critical priorities.

2.2.3 Other Health System Contributors to RECS

In addition to legal and financial factors, certain limitations in the health system also significantly influence the decision to perform CS. This is especially true for LMIC where the healthcare system is characterized by inadequate resources: Medication, equipment, and human resource. A large systematic review of 34 studies found that a lack of trained human resources was a key factor affecting healthcare providers' decisions to recommend cesarean delivery (Panda et al., 2018). Similarly, a study among East African delegates at a regional obstetrics and gynecology conference in Kenya highlighted that the low uptake of VBAC was partly due to insufficiently trained nursing staff and the unavailability of maternal and fetal monitoring equipment (Wanyonyi et al., 2010). This lack of resources led providers to recommend RECS, driven by concerns over the potential for adverse maternal and fetal outcomes in the absence of proper monitoring (Wanyonyi et al., 2010). Interestingly, one might expect that higher resource availability like in high-income countries and private facilities, would correlate with higher VBAC rates and lower cesarean rates. Contrary to this expectation, VBAC rates remain lower and CS rates higher in these settings (Betran et al., 2021; Boerma et al.,

2018). This paradox suggests that the impact of limited resources on RECS rates is more complex than assumed. It not only influences clinicians' decisions but may also affect women's preferences, as dissatisfaction with the available options could lead them to request cesarean sections in subsequent pregnancies. There is a need for further research to investigate this concept.

Inadequate human resources, healthcare financing, and scarcity of medication and equipment are hallmarks of healthcare systems in LMICs (Harrison et al., 2016). Despite the high global rates of CS, LMICs still record population cesarean rates below the WHO threshold indicating an underutilization of the procedure in this region that is linked to poor access (Boerma et al., 2018). The influence of access on the rates of CS is evident in the disparities that exist in the rates of CS between High-Income Countries (HICs) and LMICs (Betran et al., 2021). For example, a study examining trends in CS across southern Asia and sub-Saharan Africa found that CS accounted for less than 2% of births among the poorest 20% of the population (Cavallaro et al., 2013). In Kenya, this disparity is similarly reflected. A survey by the Kenya Demographic Health Survey (KDHS) shows that CS rates are notably lower among the rural poor (12.3) compared to the wealthier urban population (23.8) (KDHS 2022).

These findings are reinforced by another study conducted in the country which found that CS was more common among educated women and those of higher socioeconomic status further suggesting an issue of access rather than medical necessity (Van der Spek et al., 2020). Such disparities raise concerns about whether the women who truly need cesarean sections are receiving them and underscore the capacity challenges faced by LMICs in providing this essential service (Harrison et al., 2016). These studies focus on the overall rates of CS; it is not clear what proportion of these rates represents CS performed on women with a previous unplanned CS. This gap is significant, as it points

to the possibility that some women opt for a VBAC not out of preference, but because their socioeconomic status or geographical location limits their access to RECS even when it is medically indicated. Recognizing the financial barrier to maternal healthcare, many LMICs including Kenya have implemented policies to improve access to skilled birth attendance (SBA) through Universal Health Coverage (UHC). In June 2013, the Kenyan government waived user fees for maternity and primary healthcare services in public facilities, and in 2017, this policy was expanded through the Linda Mama program to also include private healthcare providers.

A recent evaluation of these policies has shown a significant in the rates of cesarean sections across all types of facilities; public, private, and faith-based (Orangi et al., 2021; Oyugi et al., 2023). While the policy has effectively improved access to skilled care during childbirth, the rising rates of CS raise concerns. On one hand, more women are receiving necessary interventions that may reduce maternal and neonatal morbidity in the short term. On the other hand, the growing utilization of CS is leading to higher healthcare costs and risks overwhelming the health system in the long run. If cesarean sections continue to be performed without medical necessity, the healthcare system faces the risk of an unsustainable increase in expenditures. There is therefore an urgent need to ensure that only medically indicated CS is performed. Promoting safer and more cost-effective alternatives, such as VBAC, whenever appropriate is one way to mitigate this.

2.3 Theoretical Framework

This study was grounded on two complementary theories: The Health Belief Model (HBM) and the Socio-Ecological Model (SEM).

2.3.1 The Health Belief Model

Originally developed by Stanhope and Lancaster in 1966, the HBM is widely used in healthcare research to explain and predict health-related behaviors. It suggests that an

individual's health behavior is influenced by several factors: Perceptions of the severity of a health issue, perceptions of their susceptibility to it, the perceived benefits of acting, and the perceived barriers to action. Additionally, this model posits that socio-demographic factors such as age, education level, and socioeconomic status, act as modifying variables that shape these perceptions, thereby influencing behavior. In the context of this study, the HBM helps explain how women with a previous unplanned cesarean section perceive their susceptibility to complications associated with different modes of delivery, as well as the severity of those complications.

Their perceptions are influenced by their prior birth experiences, health status, age, parity, and external factors like social influence, provider influence, and healthcare access. These modifying variables indirectly shape their decision on whether to opt for a RECS or attempt VBAC. When it comes to taking action, a woman's likelihood of choosing one delivery mode over the other is influenced by the perceived benefits of each delivery option and the barriers that may prevent her from achieving their desired outcome, such as financial constraints and the availability of VBAC or CS services in their healthcare facility. Ultimately, these perceptions significantly determine their course of action highlighting the importance of individualized decision-making in healthcare.

2.3.2 The Socio-Ecological Model (SEM)

The SEM provides a broader framework for understanding health behavior as it recognizes that health behavior is shaped by multiple interconnected levels of influence: Intrapersonal, interpersonal, community, organizational, and society. In this study, the decision regarding the mode of delivery after a previous CS is the outcome of interest, and SEM helps to map out the different factors contributing to this decision. At the intrapersonal level**,** individual factors such as knowledge of the risks and benefits of each

mode of delivery, age, parity, education, family dynamics, health financing, and previous birth experiences are central to shaping decision-making. Additionally, a woman's perception of the risks and benefits associated with either VBAC or RECS plays a key role. Interpersonal factors include the influence of spouses, family members, and friends, all of whom can provide support or pressure regarding the decision to pursue VBAC or RECS. At the community level**,** societal norms, cultural perceptions, and community attitudes toward different modes of delivery further shape an individual's decision.

These may include beliefs about the safety of CS versus vaginal birth, as well as general attitudes toward motherhood and childbirth. Institutional factors relate to the healthcare facility where the woman plans to deliver including the availability of VBAC or cesarean section services, the presence of skilled providers equipped to manage either VBAC or RECS, and the support offered by clinicians and midwives. Finally, at the societal level, broader factors such as health policies and the structure of the healthcare system particularly in terms of access to services and coverage through health insurance significantly affect the options available to women, ultimately influencing their decisions.

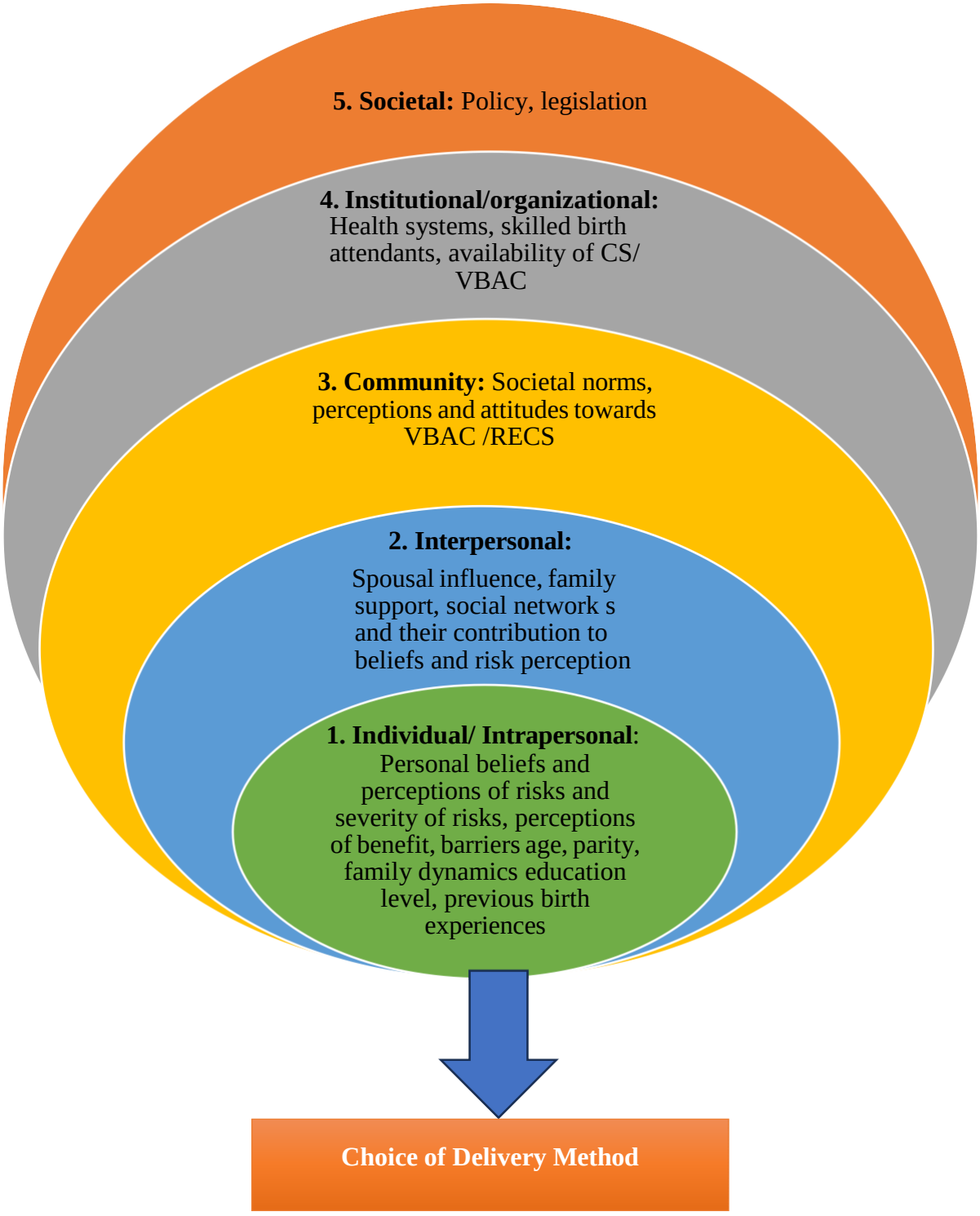
2.3.3 Integration of the Theoretical Frameworks

The integration of the HBM and SEM frameworks in this study merges individual-level psychological factors with broader societal and environmental influences on decision-making. The HBM's emphasis on personal perceptions such as the risks and benefits of VBAC or repeat CS connects with the SEM's broader analysis of factors like social support, healthcare system structures, and societal norms. This integration facilitates a better understanding of how personal beliefs are shaped by external pressures and contextual barriers, providing a robust framework for examining how both women and healthcare providers influence the decision-making process for the mode of delivery.

Through this approach, the study will capture a comprehensive range of factors from individual to societal levels, enabling richer data collection and insights.

Figure 1

Integration of the HBM and SEM



CHAPTER THREE

METHODOLOGY

3.1 Introduction

This section outlines the key methodological components of the study. It details the study design, location, sampling approach, sample size, data collection techniques, and tools, methods of data analysis, and the ethical considerations that guided the research process.

3.2 Research Design

This qualitative study design used a phenomenological to explore the previous birth experiences of women with a prior unplanned cesarean section and how these experiences, along with other factors, influenced their decision-making process regarding the mode of delivery in subsequent pregnancies. Phenomenology enabled an in-depth exploration and analysis of individual birth experiences as narrated by the women (Cridland et al., 2015). This approach also facilitated a thorough evaluation of the perceptions these experiences elicited regarding the mode of delivery in their subsequent pregnancies. A qualitative design was deemed most suitable for evaluating such a complex phenomenon, involving the interaction of past experiences, emotions, attitudes, and the dynamics of family, society, and the healthcare system (Cridland et al., 2015).

3.3 Study Location

The study was conducted at AIC Kijabe Hospital, a 363-bed capacity, tertiary teaching and referral facility in Kiambu County. Kijabe is the largest hospital in the county and manages approximately 6000 pregnant women annually. Its wide catchment area includes both walk-in and referred patients from Kiambu County as well as neighboring

counties such as Nairobi, Nakuru, Kajiado, Machakos, Makueni, Narok, and Bomet. Although the hospital serves a diverse population from both rural and urban areas, with varying socio-economic statuses, education levels, and cultural backgrounds, the participants in this study did not exhibit significant variation in their demographic characteristics. This homogeneity presents a limitation in exploring how socio-demographic factors may influence the choice of delivery mode. However, the setting provides an important context for understanding decision-making processes in a tertiary facility with a broad patient base.

3.4 Study Population

The study targeted prenatal and postnatal women with a history of a previous unplanned CS attending Kijabe Hospital. The choice of this population was informed by the obvious contextual gap in the literature regarding the factors that inform their preference for a delivery mode. In addition, a subgroup analysis of CS across different obstetric groups highlights that women with a previous CS and a single-term pregnancy in cephalic presentation (Robson 5) are the largest contributors to overall CS rates (Robson, 2001). Focusing on this group is crucial, as effective contextual interventions could significantly reduce CS rates and alleviate the health and financial burdens associated with a potentially avoidable procedure.

3.5 Sample Size

According to Guest et al., (2006), a sample of approximately six interviews is generally adequate for developing meaningful themes, with data saturation often occurring within the first 12 interviews. For this study, the initial target was to conduct 15-30 in-depth interviews. Thematic saturation was achieved at the 15th interview, as no new themes emerged and previously identified themes were repeated. To ensure robustness, three additional interviews were conducted, confirming that saturation was indeed reached.

3.6 Recruitment Procedure

Medically stable pregnant women and recently delivered women are attended to at the hospital's Maternal and Child Health (MCH) unit. The triage nurse at the unit identified potential participants as defined by the study's inclusion and exclusion criteria. Pregnant women with a history of an unplanned CS attending the unit for antenatal care, those presenting for delivery either by VBAC or RECS, and women attending the postnatal clinic following delivery by RECS or VBAC were selected for possible recruitment into the study. The researcher approached these potential participants to build rapport and provided detailed information about the study's purpose, objectives, and anticipated outcomes. She explained the possible risks and benefits of participation, emphasizing confidentiality, informed consent, and voluntary involvement. Women who met the inclusion criteria and consented to participate were then recruited into the study.

3.7 Sampling Process

Participants were selected using purposive sampling based on the inclusion and exclusion criteria. This technique was chosen to specifically target individuals who exhibited the phenomena under study, allowing for a detailed exploration of the research topic in a cost- and time-efficient manner (Creswell, 2014). Selected participants meeting the criteria were identified and guided through the informed consent process. During this process, the researcher provided comprehensive information about the study and emphasized the ethical principles of autonomy, confidentiality, and voluntary participation**.**

3.8 Study Subjects

3.8.1 Inclusion Criteria

- Women 18 years and above
- Low-risk pregnant women with a previous unplanned CS

- Postnatal women who have undergone RECS or VBAC following a previous unplanned CS.

3.8.2 Exclusion Criteria

i. Pregnant women with a previous unplanned CS with medical or obstetric contraindications to an attempt at VBAC for their current pregnancy
ii. Women with a history of planned CS in previous pregnancy
iii. Women whose previous unplanned CS was not conducted at Kijabe Hospital
iv. Women presenting in active labor or with illness requiring urgent medical interventions.

3.9 Data Collection Instrumentation/Tools

Data was collected through in-depth interviews with the participants using novel semi-structured interview guides (Appendix I). The interview guides were prepared in basic English and Swahili informed by a review of previous research and theoretical literature. The guides included closed-ended questions to gather information on socio-demographic characteristics and predominantly featured open-ended questions designed to prompt discussions on prior birth experiences, factors influencing the preference for a delivery mode, decision-making processes, knowledge and perceptions about the risks and benefits of each delivery mode, the influence of the healthcare system, and participants' attitudes towards RECS and/or VBAC following a previous unplanned CS. Before data collection, the semi-guides were pre-tested with several respondents with similar characteristics to the study population at the Naivasha satellite clinic of Kijabe Hospital. Pretesting aimed to assess the clarity of the guides, their appropriateness for the target population, and their reliability in eliciting the desired responses. The research assistant participated in the pilot study to familiarize with the research tools and research processes.

3.10 Data Collection Procedure

Data was collected through in-depth interviews (IDIs). The interviews were scheduled to coincide with participants' antenatal care (ANC) or post-natal care (PNC) visits. Each interview was conducted face-to-face by one interviewer in a private room within the MCH unit of the hospital, following the participants' prenatal or postnatal visits with clinicians. Discussions occurred in either English or Kiswahili and lasted approximately 20 minutes. Participants underwent an informed consent process, during which the researcher provided full disclosure of the study and emphasized the ethical principles of autonomy, confidentiality, and voluntary participation. With the participants' consent, the interviews were audio recorded using a digital recorder.

The audio recordings were then transcribed verbatim and anonymized by assigning random pseudonyms in alphabetical and chronological order during transcription. A novel semi-structured interview guide was used to direct the discussion. The researcher employed open-ended questions, and the order of questioning was adjusted based on the flow of each interview. Each interview began with a brief re-screening to confirm the participant’s eligibility, followed by the collection of socio-demographic data. Participants then described their previous birth experiences, focusing on the circumstances leading to the unplanned cesarean section. Additional exploratory questions were posed to elicit responses addressing the research questions and reflecting the thematic areas identified from the literature review. Collected data was stored in a password-protected folder to ensure participant confidentiality.

3.11 Data Management and Analysis

Audio recordings from the in-depth interviews (IDIs) were transcribed verbatim, and Swahili recordings were translated into English. An initial review of the pilot study audio recordings prompted minor revisions to the interview guide, ensuring a smoother flow of

questions and responses. The analysis followed a grounded approach, utilizing the six-step process described by Braun and Clarke (2006). The first step involved familiarizing ourselves with the transcripts through repeated reading and reflection. Next, we generated initial codes: The principal researcher and research assistant independently conducted open coding, examining half of the transcripts line-by-line. We then discussed and synthesized the resulting codes into a unified codebook for consistent analysis. This axial coding process facilitated the identification of themes, which were subsequently named and organized into categories and subcategories. A review of relevant literature was conducted to contextualize the identified themes within existing research on the topic. Ultimately, the Dedoose 9 software was used to apply these codes to the remaining transcripts for systematic analysis. The software's coding features were used to tag relevant excerpts, enabling the identification of recurring patterns and themes across the dataset.

Additionally, Dedoose facilitated visual analysis through charts and matrices, providing insights into the frequency and co-occurrence of key codes. This was essential in uncovering relationships between variables and drawing conclusions aligned with the research questions. To ensure consistency, intercoder reliability checks were conducted within Dedoose, ensuring that coding was both systematic and reliable. The software's analytical outputs directly informed the interpretation of findings and helped answer the study's central questions. To ensure validity and minimize bias, an independent researcher reviewed the transcripts and compared the generated themes and subthemes, confirming their accuracy. Data analysis began after the first week of interviews, allowing for any necessary adjustments in sample selection or revisions to the interview guide. Emerging themes were continually compared with the available literature on the topic to identify any deviant themes and assess data saturation (Sandelowski 1993). To

further enhance the credibility of the process, the researcher maintained a detailed diary documenting challenges encountered and the rationale behind any decisions for adjustments.

3.12 Ethical Considerations

Ethical clearance for the study was obtained from the Institutional Scientific Research and Ethics Committees (ISERC) of Kijabe Hospital. A research permit was also granted by the National Commission for Science, Technology, and Innovation (NACOSTI) before data collection began. Participants were informed that their participation was entirely voluntary based on full informed consent. Both verbal and written informed consent were obtained before the interviews (Appendix 1), which were designed to last no longer than 30 minutes to prevent participant exhaustion. Participants were made aware of their right to withdraw from the study at any stage if they chose to do so.

To ensure anonymity and confidentiality, identifying information such as the actual names of participants was not collected. Instead, participants were randomly assigned alphabetical pseudonyms. Transcripts were stored securely in a password-protected folder on a password-protected laptop. To uphold the principle of justice, counseling services were offered to women who either had not received counseling regarding their mode of delivery or felt the counseling they had received was inadequate. Actionable findings will be shared with participants, Kijabe Hospital and other institutions, healthcare workers handling women with a prior CS, and policymakers to inform decisions regarding the care of these women.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND DISCUSSION

4.1 Introduction

This chapter presents the findings and analysis of results from in-depth interviews conducted with women with a prior unplanned CS attending AIC Kijabe Hospital. This analysis is a representation of the factors influencing their preferences for RECS and in some cases VBAC, as well as the impact of prior birth experiences, healthcare provider influence, and other socio-demographic factors on their decision-making process.

4.2 General Information

Approximately 20 women with a history of a previous unplanned cesarean section were invited to participate in the study, and this target was to be adjusted until data saturation was reached. Twenty women consented to the study but only 18 completed the interviews, resulting in a response rate of 90%. This response rate was largely attributed to the participant's interest in the study's focus, their availability during scheduled antenatal or postnatal visits, and the rapport built during the recruitment process. Two participants, who initially agreed to participate, later withdrew for personal reasons but this did not affect the quality of the study as thematic saturation was achieved after the 15th interview.

Three additional interviews were conducted to confirm that thematic saturation was indeed reached. Most participants (n=15) attended antenatal care (ANC) at Kijabe Hospital, while the remaining three received most of their ANC at nearby facilities due to proximity and convenience. However, these participants preferred to deliver at Kijabe Hospital due to the availability of VBAC services and their trust in the care providers. Several minor challenges arose during data collection. Although the interview guides were prepared in both English and Swahili, some participants had limited proficiency in

either language, necessitating the use of both languages and further clarification to ensure understanding. Additionally, a few participants experienced emotional difficulty discussing previous traumatic birth experiences, requiring occasional pauses during the interviews to address their emotional well-being. Despite these challenges, comprehensive data were successfully gathered, ensuring the reliability and depth of the findings.

4.3 Demographic Data

The participants' mean age was 32 years. All of them were married and had access to health insurance coverage through the National Health Insurance Fund (NHIF). Additionally, half of the participants had supplementary private health insurance. In terms of parity, all participants were multiparous, and most were interviewed during the prenatal stage, while only three were interviewed during their postnatal visits. Most participants had attained tertiary-level qualifications, and there was a noticeable similarity in education levels with their spouses. Regarding their prior CS, 16 out of the 18 participants had undergone CS due to non-reassuring fetal status (NRFS) coupled with poor labor progress. Other indications for previous CS included breech presentation, cord prolapse, and one case of macrosomia. These demographic characteristics are summarized in Table 1 below.

Table 1

Study Participant's Demographic Characteristics

Variable	Description	n-18	Percentage (%)
Age in years	27-30	7	39
	31-34	8	44
	>34	3	17
Residence	Urban	7	39
	Peri-urban	5	23
	Rural	6	33
Level of education	Primary	1	6
	Secondary	2	11
	Tertiary	15	83
Spouse level of Education	Primary	1	6
	Secondary	1	6
	Tertiary	16	89
Health insurance status	NHIF	9	50
	NHIF & Private Insurance	9	50
Monthly household income	Not sure	6	33
	< Kshs. 50,000	4	22
	50,000- 100,000	6	33
	>100,000 Kshs.	2	11
Place of ANC attendance in the previous pregnancy	Kijabe Hospital	17	94
	Other facility	1	6
Place of majority ANC attendance in the current pregnancy	Kijabe Hospital	15	83
	Other facility	3	17

4.4 Data Analysis

Thematic analysis following the inductive approach outlined by Braun and Clarke (2006) was utilized for data analysis. Audio recordings from the in-depth interviews (IDIs) were transcribed verbatim into Word documents and the Swahili recordings were translated into English before transcription. The research assistant and I familiarized ourselves with the transcripts by reading and reflecting on the transcripts multiple times. We then conducted open coding manually; we independently coded half of the transcripts, after which we discussed and synthesized the resulting codes to develop a unified codebook for consistency in the analysis. The axial coding process allowed for the identification of key themes, which were organized to correspond to the study's objectives (Table 2). A

review of the existing literature was also conducted to interpret our findings within the broader context of research on this topic. The Dedoose 9 software was used to apply the codes to the remaining transcripts ensuring thorough and systematic. To enhance the validity of the findings and control for bias, an independent researcher reviewed the transcripts and compared the generated themes and subthemes, confirming their accuracy.

Table 2

Thematic Breakdown of Factors Influencing Delivery Mode Preferences

Objective	Themes
Maternal Reasons for Preferring Repeat Cesarean Section (CS)	Fear Fear of pain Fear of child safety Fear of uterine rapture
	Personal preference versus the influence of loved ones
	The convenience of simultaneous BTL
	Fulfillment
Impact of Prior Birth Experiences	Traumatic Vaginal Interventions Vaginal examinations Process of labor induction Prolonged labor process
	Low confidence in successful VBAC
	Risks over benefits Poor birth outcomes Delayed healing and incapacitation Impact of repeat CS on future fertility
Influence of Healthcare Providers	Impact of provider's recommendations
	Delivery options counseling Lack of counseling Adequacy of counseling Timing of counseling
	Facility Preparedness to offer VBAC services

4.5 Maternal Reasons for Preferring Repeat Elective Cesarean Section

The first objective of this study was to explore the factors that influence low-risk women's preference for RECS after experiencing an unplanned cesarean delivery in their previous pregnancy. Four key themes emerged from the data, reflecting a complex and multifaceted decision-making process. They included fear, personal preference versus the influence of loved ones, the convenience of simultaneous BTL, and fulfillment.

4.5.1 Fear

Fear emerged as a central theme across many participants' stories encompassing both the fear of physical pain, fear for their child's safety, and fear for their own safety, specifically fear of uterine rupture. Most of the participants expressed a profound fear of the pain associated with labor and vaginal delivery. This fear was a driving factor in opting for RECS, as many viewed the pain from a CS to be more predictable and manageable. One participant shared her sentiments,

> *"I was in so much pain that I did not expect… that is what made me go back to this, to the CS." (M8)*.

One participant questioned why epidural services were not more widely available, suggesting that providing access to epidural analgesia could help alleviate the pain associated with labor, potentially encouraging women to consider VBAC. She said,

> *"…. there are services like I heard there is like epidural. …. why is it not being introduced? So, that you can give somebody even the encouragement of (sic) I can try the scar." (R18)*

Conversely, some women acknowledged the intensity of post-operative pain following a CS. Three participants described the post-CS as more severe than labor pain, yet despite this heightened physical suffering, they still chose RECS due to concerns about the

unpredictability of labor. One participant who had undergone RECS at the time of the interview explained her rationale,

> *"... let me just go and get pain at once. CS pain, which is not a joke at all, and then I will heal rather than getting pain twice." (J10)*

Ultimately, for these women, the fear of enduring the unknowns of labor and potentially facing additional pain through an unsuccessful VBAC outweighed their concerns about the post-operative challenges of a repeat cesarean.

Additionally, concerns about their child's safety during labor significantly influenced the choice of RECS. Women whose previous unplanned cesarean section had resolved a life-threatening situation for their infants, such as non-reassuring fetal status (NRFS), were particularly concerned about the implications of attempting a VBAC on their infants. This fear often outweighed any other considerations. For example, believing that a CS would provide a better outcome for her child, one participant said,

> *"... I think the baby will be safer. My main agenda is for the baby to be safe. For instance, if I get prolonged labor, then she has something like, like that cerebral palsy. I'll live regretting because there was another better option." (M8)*

Furthermore, for many participants, concerns about their baby's safety during labor were closely intertwined with fears for their own well-being. While protecting the baby was the primary focus among the majority of participants, some, fearing for their own safety opted for a repeat cesarean which they perceived to be safer compared to a VBAC. Many women were particularly apprehensive about the possibility of uterine rupture; a known risk associated with VBAC. One woman expressed her concern stating,

> *".... Uh, for me basically the rupture.... I fear the rupture ..." (E5)*

Although this complication is statistically rare, the fear of such a serious outcome was enough to discourage them from considering VBAC.

4.5.2 Personal Preference versus the Influence of Loved Ones

The narratives of many women revealed a delicate balance between their personal preferences and the influence of their loved ones in their decision-making process. While some women framed their decision to pursue a repeat CS as deeply personal, others described the significant impact of family members, particularly spouses and mothers on their choice. For many participants, their spouses' influence was notable, with most husbands favoring a repeat cesarean due to the emotional trauma they experienced from witnessing the previous failed attempt at vaginal birth. For instance, one participant on being asked about her husband's opinion on the delivered mode stated:

> *"…. He was not very keen to have labor again, because for him it was very traumatizing… He was traumatized the first time. When I was signing the consent, he disappeared….". (J10)*

Additionally, all the participants mentioned that their friends readily shared their opinions on the delivery methods, some of which were based on their birth experiences. For example, one woman who was initially unaware that a successful VBAC was even possible, changed her mind after being informed by her friends:

> *"I knew if you have a scar just because there is a previous scar. It's automatically a CS in the second baby and then later on, now (sic) talking to other mothers…I've been told I can even try the vaginal one, so I have changed." (I8)*

However, despite this external input, most women expressed that they ultimately made their decisions based on personal preferences and prior experiences. For instance, one participant shared that her mother strongly encouraged her to attempt a vaginal birth after witnessing the difficulties she faced recovering from her previous CS,

> *"My mom is for normal delivery.... she has gone to the extent of looking for herbs so that I can drink so that at least I have that normal delivery to avoid CS. But I'm*

not sure…" (I9)

Despite her mother's urging, this participant still leaned toward a repeat CS because she doubted her ability to have a successful VBAC.

4.5.3 The Convenience of Simultaneous

The convenience of a RECS, particularly for women considering permanent sterilization through bilateral tubal ligation (BTL), emerged as a key factor in their decision-making process. Many women valued the ability to combine both procedures, finding reassurance in the efficiency of scheduling RECS, especially since it aligned with their family planning goals. For instance, two women who had already undergone RECS cited this as their primary reason for choosing the procedure. Another participant, still pregnant and having reached her desired family size, saw a RECS as the perfect opportunity to undergo BTL simultaneously, avoiding the need for a separate anesthesia-requiring procedure later. She explained:

> *"… the reason I want a CS is according to my age, I don't want another child. So, I want to be closed. That's why I want CS." (H7)*

For many women, this practicality made CS an attractive option beyond considerations of the recovery process or associated surgical implications.

4.5.4 Fulfillment

For some women, the desire to experience a vaginal birth was a driving factor in their decision-making. Regardless of their decision, many women expressed a deep longing to experience a vaginal birth, viewing it as an important and fulfilling part of motherhood. For some, this desire stemmed from the perceived emotional benefits, particularly the immediate bonding between mother and child following a vaginal delivery. One participant, who had already undergone a repeat CS, shared her regret at missing out on this moment but felt that opting for another cesarean was the best choice because she was

uncertain about her ability to achieve a successful VBAC. Despite her decision, she still held on to the idealized vision of the intimate connection that occurs right after vaginal birth. She stated

> *"… One of the things that I would always find very exciting is when you deliver a mother, then you put the baby on their chest right there. Just before you tear the placenta... So, I was looking forward to that scenario... very exciting." (J10)*

Another participant, despite her understanding that a successful VBAC was not certain, still felt strongly about attempting a VBAC because she longed to experience childbirth naturally at least once in her life. She shared:

> *"… I'm aware, that I can try and still fail…. but I'm picking it at this level because once I have a second scar, I wouldn't have any time to do any VBAC. That's an opportunity that is closed. (R18)"*

Having previously undergone a cesarean section, she viewed this as possibly her last chance to do so and considered the potential risks of attempting a VBAC worthwhile.

4.5.5 Impact of Previous Birth Experiences on Delivery Method

The second objective was to examine how prior birth experiences shaped women's decisions regarding their preferred mode of delivery after an unplanned CS. These experiences played a pivotal role in influencing whether women opted for a repeat cesarean or considered attempting a vaginal birth. As participants reflected on their previous deliveries, a range of emotional, physical, and psychological factors came to light, each contributing to their decision-making process. These factors that emerged from their stories provide insight into the complex interplay of experiences that guide preferences for a mode of delivery in future births.

4.5.6 Traumatic Vaginal Interventions

Many participants shared distressing aspects of their previous birth experiences that strongly influenced their preference for a repeat cesarean section (RECS) over attempting a vaginal birth. These experiences often centered around painful vaginal examinations, the discomfort of labor induction, and the physical and emotional toll of prolonged labor, all of which left lasting impressions on the women and contributed to their decision-making process.

One common thread among participants was a fear of undergoing vaginal examinations, which they described as painful and traumatizing. One participant shared her experience:

> *"… I think I had like 10 vaginal examinations and my down there was very sore… this nurse would come check... a medical intern comes… then a consultant… So, for me, because actually, it reached a point, I became like if you tell me we check I just start crying…. It was traumatizing. (B2)*

For many women, these repeated and invasive interventions were deeply distressing, making the prospect of a repeat CS more appealing as it offered a way to avoid reliving such painful experiences.

In addition to serial vaginal exams, the discomfort of the induction process, particularly the use of a Foley catheter in the cervix for mechanical dilation, was frequently cited. For some women, the pain and emotional toll of the induction process was so severe that they were determined to avoid another vaginal birth attempt. One participant vividly recalled her experience with the induction process:

> *"I came at 42 weeks. They said, um, they have to induce me… they started with something. They were calling mechanicals; I don't know mechanical something. They were hot balloons; they were putting hot balloons. They were opening you like a vehicle…imagine all that pain, never." (A1)*

For the majority of the participants, the thought of enduring the pain of induction again was overwhelming and contributed to their reluctance to attempt a VBAC.

For some, previous negative birth experience was compounded by a prolonged labor process that felt never-ending and exhausting. Reflecting on her experience, one participant stated:

> *"…I was traumatized. I labored the whole night morning up to around 12 pm…. for me it was traumatizing. I labored for over 18 hours, of which I think it was so long It was torturous." (B2)*

For these women, the sheer physical and emotional toll of enduring long hours of labor made them women hesitant to try a vaginal birth again.

4.5.7 Low Confidence in Successful

Another recurring theme was a strong sense of uncertainty regarding the success of VBAC and the perception of the failed vaginal birth as a "waste of effort." Having undergone an unplanned CS, many of the participants doubted their ability to deliver vaginally, which made them opt for a RECS. The failure of their previous attempt at vaginal birth left them feeling apprehensive about the risks of enduring labor only to face the possibility of another emergency cesarean. One participant shared her concerns, stating:

> *"…chances are that you know, I'm still me. Nothing has changed. So, if I was not opening up then, what is it going to make me open up now?" (A1)*

Most respondents viewed the emotional exhaustion and physical toll of enduring labor only to ultimately end up with a cesarean delivery as a "waste of effort." Some even referred to it as "double pain" referring to the suffering from both a failed VBAC attempt and the subsequent cesarean section. One participant expressed this sentiment stating:

> *"…. if by then, if I would have gotten through vaginal birth, it could be worth the pain, you know? It was just torture for nothing…. I wish I would have gone there direct (sic)… it was double pain." (A1)*

This sentiment led them to automatically opt for RECS which they perceived as a more predictable and controlled option sparing them the uncertainty and exhaustion associated with attempting a VBAC.

4.5.8 Risks Over Benefits

For a few women, the decision-making process regarding their preferred mode of delivery was significantly influenced by the complications they experienced after their initial CS. Although healthcare providers often discuss the risks versus benefits of any healthcare decision, these women described a preference for considering risks over benefits, placing higher importance on the former. These adverse experiences heightened their awareness of the potential risks associated with attempting a VBAC causing them to prioritize safety over the potential benefits of a vaginal delivery. Concerns about poor birth outcomes, the implications of delayed healing and incapacitation as well as the impact of repeat cesarean sections on future fertility emerged as critical factors guiding the preferences for either RECS or VBAC.

For five participants, the trauma of their first birth experience was directly tied to poor birth outcomes, as their infants experienced birth asphyxia. This led to an overwhelming fear of the potential risks associated with attempting a vaginal birth again, pushing them toward choosing a RECS to avoid a similar ordeal. One participant, for example, had prolonged labor during the birth of her second child, who suffered birth asphyxia and later developed cerebral palsy. In her third pregnancy, she once again experienced prolonged labor, leading to an emergency cesarean due to non-reassuring fetal status. As a result, she was hesitant to attempt a vaginal birth and preferred a RECS, fearing a

repeat of the neurological complications her child had faced. She voiced her concerns, saying:

> *"My second born, I gave birth normal, and they got a problem, I had prolonged labor. So, the child was big, he was 4.8kgs…they got a problem. Even now they have a problem, they are special…. I don't want to be given normal because of that case because I am afraid for this child to have problems." (H8)*

In addition, three women described a difficult and prolonged recovery process complicated by infection of the cesarean wound. These experiences left them wary of undergoing another cesarean section, as they feared facing similar or worse recovery challenges. One participant vividly recounted her frustration with the recovery process stating:

> *"… I'll still prefer normal delivery. Because even for my recovery in the CS, the feeling was not okay… The wound itself took time to heal and every time I was, I used to come here to be checked…Even at three months, I was not stable." (R18)*

Conversely, despite experiencing complications such as prolonged recovery, wound infection, and dehiscence, two other women still opted for a repeat CS. For these women, the emotional and physical toll of their prior post-operative complications did not outweigh their fear of labor pain and the induction process. In their decision-making, the unpredictability of labor and the possibility of undergoing mechanical induction posed a greater concern than the known challenges of recovering from a CS. One participant, who had a difficult recovery from her previous cesarean, specifically expressed that her fear of labor and the possibility of facing a difficult induction made a planned cesarean feel like the safer and more controlled option. In contrast, some participants recounted the difficulties they encountered in resuming daily activities, including self-care and caring for their newborns, which left them feeling frustrated and reliant on others. As a

result, they preferred VBAC, hoping for a quicker recovery and the independence to care for themselves as well as their babies. One participant shared:

> *"... you can imagine you're not able even to wash your baby, even just simple breastfeeding you have to be held. Just getting out of bed. You are supported. It's tough." (I7)*

This finding illustrates the complex interplay between fear and past negative experiences. While some participants sought to regain their independence through vaginal delivery, the perceived control and predictability of a repeat cesarean by others outweighed their fear of a vaginal birth highlighting the nuanced nature of the decision-making process.

All the participants recognized the cumulative effect of multiple cesarean sections in limiting their future family size, a factor that significantly influenced their decision-making. As scar tissue builds up with each CS, so does the risk of complications in future pregnancies, such as uterine rupture, placenta accreta, and surgical difficulties which can predispose to visceral injury. This heightened risk is behind the recommendation to limit the number of future pregnancies, as each additional surgery becomes more complex. One participant, aware of these potential risks, expressed a strong desire to preserve her reproductive options, stating,

> *"I don't want to experience a limitation in the children I would want to get because of previous CSs…" (D4).*

In contrast, other women who acknowledged the potential impact on future fertility still opted for repeat CS. Their decisions were primarily driven by factors such as fear of labor pain and concerns for their own safety or the safety of their infants as previously indicated. This divergence in choices further underscores the multifaceted nature of their decision-making processes. While the potential limitation on family size was a

consideration for many, it was not always the determining factor in their choices.

4.6 Influence of Healthcare Providers and Health Systems in Guiding Decisions on a Mode of Delivery

This objective sought to explore how healthcare providers influenced women's decisions about their mode of delivery after an unplanned CS, drawing solely from the participants' recollections of their discussions with providers regarding delivery options. The findings highlight the significant role healthcare providers play in the decision-making process. Several key themes emerged.

4.6.1 Impact of Provider's Recommendations

The recommendations of healthcare providers emerged as an important factor influencing women's decisions regarding their mode of delivery. Many participants expressed a profound trust in their providers, often basing their choices on the guidance received during antenatal care. For instance, one participant articulated her reliance on her doctor's expertise, stating,

> *"...the doctors who will be seeing me. Whatever. They'll advise me, that is what I'm going to do because you are experts in this field. I have a wish, but if it's contradictory to whatever the doctor wants, then I have to follow the one for the doctor." (I9)*

Conversely, another participant revealed that her inclination towards a repeat CS stemmed from the negative recommendations she received from providers, specifically from the nurses:

> *"...I have many opinions from nurses who are (sic) with me in my previous experience…. They are like, E5, I hope you're not coming back here to labor… Come get a cesarean and go." (E5)*

It was clear to her that the nurses recommended against attempting a VBAC because they doubted her ability to have a successful VBAC. This reliance on provider

recommendations underscores the powerful role that healthcare professionals play in influencing women's decisions, particularly when women feel uncertain or overwhelmed by the decision. Furthermore, these findings illustrate how the authority and competence of healthcare providers can strongly impact women's choices regarding their delivery methods, highlighting the need for effective communication and support throughout the decision-making process.

4.6.2 Delivery Options Counseling

The counseling provided by healthcare providers significantly influenced women's decisions regarding their mode of delivery. Participants reported varied counseling experiences highlighting several aspects of counseling that impacted their decision-making. These included the lack of counseling, the detail and depth of counseling provided, and the timing of counseling.

More than half of the women reported that they received no counseling regarding their delivery options, especially concerning attempting a VBAC. Failure of providers to counsel on their delivery resulted in a lack of information particularly on the benefit and possibility of VBAC led to automatic preferences for RECS, as women were unaware of the alternative options available to them. One of the participants narrated her encounter with her healthcare provider,

> *"...It was, like this…. will you have a VBAC? I said No. Then he said, okay, …. It was as simple as that. Like I didn't hear a no, you should try vaginal birth because it has one to three advantages. Or No, don't try VBAC because you'll have no risk of this. No. That did not happen." (B2)*

For some, the lack of discussion on VBAC as an option made them assume that a cesarean was their only choice. For instance, one respondent, who was well into her third trimester, expressed her uncertainty about her delivery options, saying:

> *"… I don't know. The option I know is that I'll go back to the CS because I hear when you start with the knife, it's there you will go back." (C3)*

This theme was particularly evident among participants who were also healthcare providers who had themselves experienced a prior unplanned cesarean delivery. All of them reported that they received no counseling regarding their delivery options during their antenatal care. Their perception was that the providers assumed they were already knowledgeable about their delivery options. In reality, several were unaware of the details of the delivery options available to them. One participant shared:

> *"… especially for us. I'll speak in the place of the staff and me as a medical practitioner. When we step in the shoes of going to a clinic… sometimes the info is being held because somebody assumes you know it. They assume we know it, or somebody will give you shallow information…. that one is one thing that needs to be changed…I don't work in Mat so I don't know …." (R18)*

Participants who received comprehensive information about either mode of delivery expressed a greater sense of confidence in their choices. Most participants noted that when providers took the time to explain the risks, benefits, and criteria for both VBAC and RECS, it helped them make more informed decisions and allowed them to feel more confident in their choices. For instance, one participant narrated the difference in her experience during her first and second pregnancy saying,

> *"… the first time we never had a chance to discuss about cesarean with any medical practitioner. But the second time at least I knew things. And even I had a chance to ask questions. And the doctor was really nice. He gave me good answers. So, even if you are compromising, you feel you're making a decision from a sober point…" (N14)*

Some women, dissatisfied with the information provided by their healthcare providers, used the Google search engine to seek information to fill knowledge gaps about their delivery options. For instance, one participant who reported receiving no formal

counseling but was aware of the risk of uterine rupture explained:

"I've made research on my own. I've Googled." (B2)

These findings highlight the importance of detailed counseling, which, when provided, empowers women to make informed decisions with greater clarity and confidence. In contrast, insufficient guidance can drive women to seek information independently, which may not be accurate or comprehensive.

The timing of counseling also emerged as a key factor in shaping participants' decisions regarding their mode of delivery. Many participants expressed the need for counseling to begin early in pregnancy, ideally at the initial antenatal care (ANC) visit, and to continue throughout the pregnancy. This would provide sufficient time for women to reflect on their options, seek clarity, and engage in meaningful discussions with their healthcare providers. Continuous counseling was also viewed as essential in helping to reassure women and alleviate anxiety as they approached their delivery. One participant highlighted the value of early and ongoing counseling, explaining:

> *"… information from the word go…. once a woman comes for the first antenatal clinic. It's important to prepare her psychologically. For the whole period. Not like you're coming for the last clinic and then that's when you're discussing most of these things…" (N27)*

This insight underscores the importance of consistent, timely, and comprehensive counseling in supporting informed decision-making among women with a prior unplanned cesarean section.

4.6.3 Facility Preparedness to offer VBAC Services

The availability of VBAC services at healthcare facilities played a crucial role in shaping women's decisions. This was particularly evident among women attending ANC outside Kijabe Hospital. They made special arrangements to bypass the nearest ANC facilities to

reach a facility with VBAC services, sometimes at great distances. One participant, despite wanting to attempt a VBAC, initially felt she had no choice but to opt for a RECS because VBAC services were unavailable at her local facility in Taita Taveta County. However, after learning from a friend that Kijabe Hospital offered VBAC, she traveled nearly 400 kilometers to the facility, determined to pursue a vaginal birth there.

> *"I realized that here they allow VBAC like there are other hospitals that don't allow VBAC. Like where I was going, um, for clinic they didn't, uh, you know…. They were saying even if you come in labor, we will still do a CS on you." (D4)*

This example underscores how the lack of VBAC services in some facilities can limit women's delivery options, often forcing them to choose a repeat CS even when they might prefer a vaginal birth. Access to such services is crucial in providing women with the autonomy to pursue their desired mode of delivery.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents a discussion of the key findings of the study reflecting on how they align with, differ from, or expand upon existing literature. The generated themes will be critically analyzed to understand the various factors influencing the preference for RECS among low-risk women with a previous unplanned CS. The discussion will also examine the influence of prior birth experiences, healthcare providers, and the healthcare system, focusing on how these factors interplay in the decision-making process. Additionally, this chapter will address the study's limitations and examine the broader implications of the findings in the local and global contexts, offer recommendations for changes in clinical practice and policy, and suggest areas for future research.

5.2 Summary

In this study, key factors influencing the preference for RECS were considered under three main objectives: Maternal reasons for preference for RECS, the impact of previous birth experiences, and the influence of healthcare providers and the healthcare system. Fear was a large driver of maternal preference for RECS. It encompassed the fear of labor pains, concern for the safety of the child, as well as the safety of the mother, specifically concerns about the possibility of uterine rupture. Additional factors included personal preference versus the influence of loved ones, the convenience of undergoing simultaneous BTL, and a desire to experience a vaginal birth. Previous birth experiences, such as traumatic vaginal interventions and prolonged labor were compounded by low confidence in successful VBAC and heightened concerns about poor outcomes and delayed healing. Lastly, healthcare provider recommendations, the adequacy and timing

of counseling, and the preparedness of facilities to offer VBAC services were also influential in guiding participants' decisions on the mode of delivery.

Having established the key factors that influenced the maternal preference for RECS, it is important to examine these factors in detail, beginning with the fear of labor pain which was a major factor that influenced the preference for RECS in this study. Many participants described the profound pain they experienced during labor as a key reason for not wanting to attempt a VBAC. This aligns with findings by Jenabi et al. (2020) where women preferred cesarean sections as a way to avoid the pain of labor. Interestingly, despite some women in this study acknowledging that cesarean pain was severe and prolonged compared to labor pain, they still opted for RECS due to safety concerns both for themselves and their infants, which outweighed their fear of surgery-related pain.

According to these women, pain following a CS was more controllable and predictable because it could be managed with medication. Conversely, a Nigerian study that evaluated pregnant women's views on repeat CS found that the majority of the women preferred VBAC because they perceived CS as more painful (Olofynbiyi et al., 2015). Despite the initial preference for VBAC almost 70% of the women in this study ultimately chose repeat CS, primarily due to concerns about infant safety and concerns about the possibility of uterine rupture. These findings echo the findings of my study as many women expressed significant concern about uterine rupture, a known risk associated with VBAC. This fear influenced their preference for RECS, despite the statistical rarity of this complication. The American College of Obstetricians and Gynecologists (ACOG) indicates that women with a single low transverse incision in their previous CS have a 0.2% to 1.5% risk of uterine rupture during a VBAC delivery which translates to approximately 1 in 500 births ("ACOG Practice Bulletin No. 205,"

2019). This highlights the need for healthcare providers to offer comprehensive counseling that addresses the medical aspects of VBAC versus RECS with their corresponding risks. Counseling should also acknowledge and address women's fears about pain and safety, ensuring they feel supported and empowered in making an informed decision. Additionally, counseling should incorporate discussions on available pain management options for VBAC, such as epidural anesthesia, other forms of analgesia, and non-pharmacological interventions to reduce pain in manners that are safe for both mother and infant could further help alleviate these fears. Simply put, alleviating fears might encourage women to consider vaginal delivery as a viable option. The Centering Pregnancy model supports this approach as it combines traditional healthcare practices with group support. During these group-based sessions, women meet with their healthcare providers and peers to engage in discussions about pregnancy, childbirth, and parenting.

The ultimate goal is to enhance the prenatal care experience, improve health outcomes, and empower women by allowing them to take an active role in their care (*CenteringPregnancy*, n.d.). Liu et al. (2017) found that group prenatal care as implemented in the Centering Pregnancy model, positively affected the birth experience of women, emphasizing the importance of addressing fears through comprehensive counseling and support. This model aligns with my findings, as it highlights the importance of addressing women's fears through comprehensive counseling and support. Kenya is arguably a long way from reimbursing providers and hospitals for group consultations. However, facilitated support groups with trained healthcare professionals can be formed at minimal or no costs within hospitals, churches, or other community centers. Furthermore, by integrating the principles of the Centering Pregnancy model

into prenatal care, healthcare providers can empower women to make informed decisions regarding their delivery options.

Another recurring theme was the women's personal preference for a delivery method versus the influence of their loved ones. My study highlights the tension between individual preferences and the strong influence of family particularly spouses, and parents as well as social networks on women's decisions regarding delivery methods. Although familial influence was significant, women ultimately made independent choices regarding their mode of delivery based on their previous birth experiences, the perceptions of potential complications, and external factors like provider influence, and healthcare access. Similarly, a study conducted in Southern Ethiopia also found that women faced familial pressures regarding the mode of delivery (Zewude et al., 2022). In their study, Zewude and colleagues found that the influence of elders and family, particularly spouses and in-laws was significant, with many women acknowledging that their partners or in-laws had the upper hand in the decisions regarding a mode of delivery. However, the contrast is evident when considering the extent to which women in my study exhibited autonomy. Despite external influences, participants in my study ultimately prioritized their personal preferences based on factors at the interpersonal level as described above.

This difference underscores the varying degrees of familial influence between cultural settings. It also highlights the need for healthcare providers to consider and understand family dynamics in counseling sessions to support women's decision-making in a manner that balances cultural sensitivity while encouraging autonomy and informed consent. By empowering women with knowledge and validating their experiences, healthcare providers can help them and their families make decisions that resonate with their values and priorities.

The convenience of undergoing a simultaneous BTL during a repeat CS emerged as an important reason for the preference for RECS among some women in my study. This finding was particularly prevalent among women with large family sizes who expressed a preference for this combined approach, as it eliminated the need to schedule another surgical procedure in the future. This finding appears to be underexplored in existing literature as I did not find comparative studies addressing this finding. Nevertheless, my findings provide valuable new insights into how logistical convenience and cost-saving efforts in low- and middle-income countries can influence delivery mode decisions. Healthcare providers must acknowledge that convenience is a legitimate consideration because the women hope to avoid separate procedures.

This is especially evident in our context where women hope to optimize their healthcare experiences by minimizing the number of surgical interventions required due to financial constraints, fear of surgery, awareness of risks or multiple surgeries, or other competing responsibilities. Healthcare providers should prioritize discussing the option of simultaneous BTL with women undergoing repeat CS, as this can improve patient satisfaction and align with their family planning goals. These conversations must occur within the framework of informed consent, considering the medical indications and potential risks associated with both procedures. Providers should also be attuned to the emotional and cultural implications of sterilization, ensuring that women feel supported in their choices without feeling coerced into choosing sterilization solely based on convenience without fully exploring other family planning options. By facilitating open dialogue and offering comprehensive information, healthcare professionals can empower women to make informed decisions that align with their health needs and personal circumstances.

Personal fulfillment of experiencing a vaginal delivery was a theme reported in other African studies. A systematic review of studies conducted among postpartum women in various parts of rural Africa, including Kenya, Uganda, Ethiopia, Sudan, and Nigeria reveal that some women prefer vaginal birth due to the cultural and personal sense of fulfillment it offers (Fantaye et al., 2019). Fantaye and colleagues suggest that this preference reflects deeply ingrained societal norms where successful vaginal birth is seen as a marker of resilience and validation of womanhood. Similarly, a study from Mbale, Uganda, emphasizes that vaginal birth is culturally valued, symbolizing strength and perseverance (Namujju et al., 2018). In that study, many women associated vaginal birth with personal achievement and the fulfillment of their maternal role.

These findings echo the sentiments shared by women in my research at Kijabe Hospital, where the longing to experience vaginal birth was common, reflecting broader cultural values in which childbirth is intertwined with notions of fulfillment and validation. However, despite these deep-rooted emotional and possibly cultural desires, most women in my study ultimately opted for RECS. This decision was driven largely by concerns for the safety of their child, previous traumatic birth experiences, and low confidence in achieving a successful VBAC highlighting a complex decision-making process in which emotional and cultural desires and the practical realities of medical risks and past experiences have to be considered. Healthcare providers should be attuned to these cultural and emotional aspects when counseling women. While it is essential to honor and validate women's emotional needs and cultural beliefs, providers must also offer clear, evidence-based guidance to ensure that decisions align with the safest medical options. Sensitivity is key and providers should approach the conversation in a way that respects the woman's desires, offering empathetic explanations and alternative paths to fulfillment, such as celebrating the mother's role in ensuring a safe birth,

regardless of the mode. Ultimately, ensuring culturally sensitive care while prioritizing best clinical practices will help women feel supported in their decisions.

Prior traumatic birth experiences such as distressing induction processes, painful vaginal exams, and prolonged labor played a pivotal role in many women's preference for RECS. For these women, opting for RECS was not merely a decision of convenience but a deliberate choice to avoid reliving the physical and emotional toll of a previous traumatic birth. This aligns closely with the findings by Jenabi et al. (2020) and Tully & Ball (2013), who also noted that women with negative birth experiences frequently choose cesarean delivery to avoid the unpredictability and potential trauma of VBAC. The consistency between these findings underscores a shared perspective of the pivotal impact that traumatic birth experiences have on future delivery decisions. Interestingly, while these studies collectively illuminate the commonality of this preference, they also highlight the nuanced differences in individual experiences. The findings of this study are particularly striking in terms of how personal these experiences are. While Jenabi et al. (2020) identified broader patterns of fear around unpredictable labor among women in countries across Africa, Asia, Europe, and North America, this study provides a more detailed perspective on potentially modifiable birth-related traumas such as vaginal exams and prolonged labor that can leave lasting physical and psychological scars.

This difference adds detail to our understanding of how birth trauma affects decision-making; it is not just the unpredictability of labor but the memory of specific, deeply distressing moments that drive this preference. However, acknowledging that these distressing experiences are not fixed outcomes underscores the importance of trauma-informed maternity care: An approach that recognizes the lasting impact of birth trauma and emphasizes the need for creating a safe, supportive environment that addresses both the psychological and emotional needs of women (Seng & Taylor, 2015). Key principles

of this care model include safety, trustworthiness, choice, collaboration, and empowerment, all of which are crucial in mitigating the effects of previous trauma. Interventions such as better pain management strategies, gentler examination techniques, avoidance of excessive vaginal exams, the use of a partograph to monitor labor, and enhanced communication throughout labor by healthcare providers can address and potentially mitigate these traumatic experiences. It is worth noting that while the specific aspects of the trauma may vary, the overarching theme of a traumatic experience remained consistent implying that each woman's decision-making process is deeply personal. This points to the need for healthcare providers to offer personalized counseling and care, acknowledging the distinct fears each woman carries from her previous birth experience. Trauma-informed care can play a pivotal role in this, ensuring that future birth planning is guided by compassion and sensitivity to past trauma. Notably, no studies were found that directly contradict these findings, suggesting a probable consensus in the literature regarding the influence of traumatic birth experiences on preference for the alternate mode of delivery. This alignment across various studies emphasizes the critical need for healthcare providers to individualize care by acknowledging and addressing past trauma when discussing future delivery options with expectant mothers.

Additionally, the uncertainty surrounding the success of VBAC emerged as a critical factor in the decision-making process. Many women in my study expressed reluctance to attempt VBAC due to the fear that their effort might once again end in an unplanned cesarean section. For these women, the emotional and physical exhaustion of labor, followed by the need for emergency surgery, was seen as futile, a "waste of effort." This sentiment was similarly observed by Tully (2019), where women who endured a lengthy and painful labor only to undergo a CS often chose RECS to avoid repeating such an

exhausting and unpredictable experience. Interestingly, while Tully's work emphasized the emotional exhaustion stemming from failed vaginal deliveries, my findings suggest a more profound sense of personal failure among women in my study. This begs the question as to whether there is a cultural influence on this feeling. There is evidence in the literature on how cultural attitudes around childbirth can shape women's delivery preferences. For instance, in Tanzania, Penn-Kekana et al. (2007) explored how cultural norms position vaginal birth as the preferable mode of delivery, with CS, perceived as an emergency solution for "failure" in labor. Although these sentiments were not uniformly experienced across all women, those who underwent CS were sometimes viewed as having failed to live up to the societal standard of giving birth vaginally. In many African contexts, where traditional norms and community expectations often emphasize the importance of vaginal delivery, women may feel a heightened sense of loss when opting for CS (Ohaja & Anyim, 2021).

Therefore, for African women, the potential for a successful VBAC may carry significant emotional and cultural rewards, allowing them to reclaim a sense of control and fulfillment in their childbirth experience. Given the profound emotional, physical, and possibly cultural weight associated with failed vaginal births, healthcare providers must approach counseling with sensitivity and emphasize shared decision-making. Acknowledging the emotional impact of prior birth experiences and addressing concerns about perceived personal failure, while also providing clear, evidence-based information on the risks and benefits of VBAC, can help women make more informed choices. Tailored, compassionate care may alleviate feelings of inadequacy and empower women to feel confident in their chosen mode of delivery.

Closely tied to prior traumatic experiences is the perception of risks over benefits, another influential factor in the preference for RECS. Many women viewed CS as a safer

option for both themselves and their infants particularly if their previous birth experience was marked by a life-threatening complication such as fetal asphyxia. In such cases, women viewed RECS as offering a predictable and controlled environment that mitigated the potential associated with a vaginal birth. These sentiments mirror the findings of a study conducted in South Africa among postpartum women with a prior CS who had undergone a repeat planned or unplanned CS (Tully & Ball, 2013). In their study, women whose primary CS was due to NRFS preferred repeat CS, as they associated cesarean delivery with safeguarding their child's health. Both studies highlight how a previous emergency crystallizes the perception of CS as the "safer" option, making RECS appear medically advisable and emotionally reassuring. However, it is important to recognize that cesarean sections are not inherently safer and carry important risks for both the mother and infant, as outlined by Sandall et al. (2018).

Additionally, the conditions leading to NRFS in the prior pregnancy are not guaranteed to repeat and often do not. In many cases, and under appropriate medical supervision, women can safely attempt a VBAC which may provide similar safety outcomes without the inherent risks of surgical delivery ("ACOG Practice Bulletin No. 205," 2019). Additionally, my findings expand upon those of (Tully & Ball, 2013) by capturing a broader range of safety concerns. While they focused primarily on fetal safety, the women in my study also weighed their own physical recovery. Women who experienced complications directly related to their CS, such as delayed wound healing, infection, or prolonged physical incapacitation, were more inclined to attempt VBAC. Their views align with the findings of Moffat (2018) in which women viewed recovery after VBAC as less physically taxing and thus preferred VBAC to avoid the physical incapacitation following their primary CS. These findings further emphasize the complexity of women's decision-making who want to ensure their baby's safety and avoid personal

harm. It is an important reminder that healthcare providers must address both maternal and fetal safety concerns in their care of pregnant women.

This study also revealed a subtle yet complex interplay between perceptions of future fertility and the choice of delivery mode among women with prior CS. Many participants recognized the cumulative risks associated with repeat cesarean sections on their future fertility. While some women opted for VBAC to preserve their reproductive options, others, motivated by fears of labor pain and concerns for their safety and that of their infants, chose repeat CS. This divergence underscores the multifaceted nature of decision-making processes, where concerns about family size are just one of several factors at play. We did not find studies in the African context to support these findings. However, a recent study conducted in Iran found that women were concerned about the impact of CS on their future fertility (Khalajinia & Alipour, 2024). In many African communities, large families are often valued, and the desire to preserve reproductive options may take precedence over immediate health concerns. These contrasting perspectives emphasize the importance of personalized counseling that considers cultural, economic, and social contexts, ensuring that women's individual needs and experiences are addressed in their decision-making processes.

The influence of healthcare providers and healthcare systems significantly shaped the delivery preferences of women with a prior CS in my study. Key themes included a lack of comprehensive antenatal counseling, provider recommendations, and the facilities' preparedness to offer VBAC services. Many participants reported inadequate counseling during antenatal care (ANC), receiving insufficient or poorly timed information regarding the risks and benefits of VBAC and RECS. This left several women ill-equipped to make informed decisions, leading some to seek information from non-medical sources such as the Google search engine. However, relying on online

information can be risky, as the quality and accuracy of these resources vary widely. This highlights the urgent need for healthcare providers to offer comprehensive, clear, and accessible information about the different delivery options, allowing women to make informed choices. Insufficient counseling can lead to misinformation and increased anxiety, pushing women towards RECS even when they may be suitable candidates for a VBAC. Additionally, providers' recommendations also played a pivotal role in shaping women's choices as many of them reported that they trusted and would follow their provider's recommendations because they perceived them as experts in the matter. This finding resonates with Biraboneye (2020), who determined that a majority of the participants opted for RECS simply because their healthcare providers recommended it. This Kenyan study also identified gaps in patient education, finding that only a small fraction of women (8.3%) understood the anesthesia and surgical risks associated with cesarean sections.

Additionally, around half of the women were unaware of the VBAC success rates, which typically range from 60% to 80% for those with a single previous cesarean delivery. This underscores the failure of healthcare providers in Kenya to deliver detailed, evidence-based counseling. Developed by Grobman et al. (2007), the VBAC score model has been validated for assessing the likelihood of a successful VBAC based on several key factors such as maternal age, BMI, prior vaginal delivery, the indication for the previous cesarean and current pregnancy details like gestational age and fetal size. By providing a predictive assessment of success rates, this tool can be used by providers to enhance counseling by quantifying the benefits and risks associated with VBAC thereby empowering women with personalized information tailored to their unique situations. Implementing VBAC scoring as a standard practice can bridge the knowledge gap regarding VBAC success rates, ensuring women receive the

comprehensive, evidence-based counseling they need to make informed choices about their childbirth experiences. Moreover, my study found that inadequate counseling was not only about content but also about timing. Many women indicated that counseling either occurred too late in their pregnancies or was sporadic, leaving them insufficient time to weigh their options. This contrasts with Biraboneye's (2020) findings, which focused more on the counseling content than its timing. Therefore, my study emphasizes that comprehensive counseling must be informative, continuous, and well-timed throughout pregnancy, allowing women the necessary time to reflect on their choices.

The unavailability of VBAC services in some facilities further compounded the issue, limiting women's ability to consider VBAC as an option. One participant in my study traveled a distance shy of 400 kilometers to Kijabe Hospital after learning through a friend that VBAC services were offered there. This lack of access forced women into choosing repeat CS, not because of preference, but because of systemic limitations. Wanyonyi et al. (2010) also identified this issue among East African obstetricians, who reported being reluctant to recommend VBAC due to a lack of trained personnel and equipment to monitor VBAC which would potentially translate to poor maternal and fetal outcomes. This concurs with Wanyonyi et al., (2010) that the unavailability of VBAC services, whether due to institutional barriers or provider fears, severely restricts women’s autonomy in choosing their preferred mode of delivery. Unlike the study by Wanyonyi and colleagues, my study highlights how women actively seek out services despite systemic barriers, an aspect that is often underexplored in provider-centered studies. These findings emphasize the urgent need for healthcare systems to invest in infrastructure and human resources to support VBAC services, ensuring that women have access to safe services. By prioritizing the establishment of such services, we can

empower women, improve maternal and fetal outcomes, and enhance overall reproductive health autonomy.

While the primary focus of this study was to explore the factors influencing delivery preferences, an additional observation was made regarding the role of VBAC scoring of study participants. Of the four women who were assessed using the institution's VBAC score, three had high scores of over 90% suggesting a 90% chance of success and went on to achieve successful VBAC. The fourth woman had a low score of less than 50% and did not have a successful VBAC. Her score was significantly impacted by the need for induction of labor, which accounts for a loss of 10 points in the total scoring system. However, not all participants could be scored since a vaginal examination, which is a critical parameter in the VBAC scoring system was not always indicated. This finding further emphasizes the practical value of predictive tools in guiding delivery decisions. The consistent use of such scoring tools could be a valuable addition to clinical practice, helping to identify strong candidates for VBAC and potentially reducing unnecessary repeat CS. Furthermore, this finding also stresses the need for personalized, evidence-based counseling during antenatal care to support informed decision-making among women with a previous cesarean.

There were a few limitations to this study. All participants in this study were educated, employed, and married, with health insurance coverage through the National Hospital Insurance Fund (NHIF) or a combination of NHIF and private insurance, which covered both RECS and VBAC. This lack of diversity in the sociodemographic factors limited my ability to assess their potential impact on delivery mode preferences. Existing literature however highlights how these variables contribute to disparities particularly between high-income and low- to middle-income countries, as well as between affluent urban populations and their rural counterparts (Boerma et al., 2018). For instance, in

Kenya, Odongo, A, (2020) found that urban-dwelling women, those with higher household income, and those with health insurance coverage were more likely to demand for CS even in the absence of contraindication to a vaginal birth. This suggests that the details of individual backgrounds are crucial for understanding healthcare choices. Nevertheless, the observed lack of variability in sociodemographic characteristics among my participants may simply reflect a broader societal change and evolving population dynamics. For instance, in recent years, increased access to health insurance, particularly through the National Hospital Insurance Fund (NHIF), has significantly altered the healthcare landscape, allowing all socioeconomic sectors of the Kenyan population to secure coverage for essential medical services, including childbirth options. It is worthwhile to note that while NHIF has improved access to healthcare services for many, this study highlights the need for ongoing efforts to look beyond financial barriers but also examine individual and institutional factors that influence women's healthcare choices. For instance, even with insurance coverage, women may still experience provider biases or a lack of comprehensive counseling that affects their decision-making regarding delivery modes.

In addition, the majority of study participants mirrored the local catchment area of the hospital and identified as Kikuyu. This translated to a homogenous cultural background among participants, including cultural views on pregnancy and delivery. Given these observations, future research should incorporate a more varied participant profile to better explore how different sociodemographic and cultural factors influence preferences for delivery modes. This approach will provide a richer understanding of the complexities surrounding maternal healthcare choices and may lead to more tailored interventions that address the needs of diverse populations.

Furthermore, while the qualitative nature of this study allows for an in-depth exploration of women's experiences with prior CS, it is crucial to recognize the potential for recall bias. To mitigate this, I included women in the immediate postnatal period, capturing their narratives regarding recent experiences while the details were still fresh. For antenatal participants, I facilitated discussions that encouraged reflection on their prior cesarean experiences, including any trauma they may have encountered. Many of the women in this study had undergone their previous cesarean deliveries within the last three years. However, despite our best efforts, it is imperative to acknowledge that addressing recall bias in this group presented a significant challenge, as their recollections may have been influenced by their current pregnancy context and emotional state. This could limit the accuracy of their narratives regarding past experiences, highlighting a limitation in the study's approach.

In addition, the subjective nature of qualitative research may have allowed the researcher's own biases to influence the interpretation of data (Holloway & Galvin, 2016). To minimize this potential influence, the researchers employed several strategies: We engaged in reflexivity throughout the research process by regularly reflecting on our own beliefs and experiences and how they might shape our interpretations. The principal researcher also sought peer debriefing with colleagues as well as an independent researcher to discuss findings and interpretations, ensuring a broader perspective and enhancing the credibility of the analysis.

5.3 Conclusions

In summary, the decision-making process regarding the preferred mode of delivery following an unplanned cesarean section (CS) is highly complex and multifaceted. It is shaped by a convergence of factors, including painful past experiences, perceptions of safety, and concerns over the uncertainty and perceived futility of attempting vaginal

birth after cesarean (VBAC). This interwoven complexity suggests that the solutions are equally multifaceted. Healthcare providers must therefore approach discussions about delivery options with sensitivity, acknowledging the emotional weight of past experiences, and the influence of societal factors all of which are implicated in shaping women's decisions on a delivery mode. Understanding these deeply personal factors enables healthcare providers to offer better support and guidance to women, ensuring they feel informed and empowered in their choices. The influence of healthcare providers and systems exemplified by insufficient counseling, limited availability of VBAC services, and provider biases reveals critical gaps contributing to the rising rates of repeat cesarean sections. While existing literature reflects similar patterns, my findings underscore the necessity of not only enhancing the content of counseling but also improving its timing and delivery.

Furthermore, the systemic shortcomings highlighted in both this study and supporting literature emphasize the urgent need for healthcare systems to expand VBAC services across facilities nationwide and for providers to consciously separate their personal experiences from clinical advice. These steps are essential to support women in making well-informed decisions that align with their preferences and health needs, ultimately improving maternal care and outcomes.

5.4 Recommendations

5.4.1 Policy Recommendations

i. Mandatory counseling on delivery Options: AIC Kijabe Hospital should establish policies requiring comprehensive counseling for all women regarding their delivery options. The hospital should develop and disseminate standardized guidelines for mandatory counseling that is sensitive to past traumatic experiences, tailored to individual needs, and includes the frequency of

counseling sessions during ANC visits.

ii. Standardized training for providers: Mandate training for healthcare providers on comprehensive counseling on delivery options, addressing the emotional and psychological aspects of childbirth in a patient-centered manner.

iii. Guidelines on trauma-informed maternity Care: In the Kenyan context, this could involve training healthcare providers to evaluate for or recognize signs of trauma and to communicate sensitively with women about their birth experiences. This can include offering options for birthing positions, providing continuous support during labor, and ensuring that women feel in control of their birthing process, especially if they have a history of trauma.

iv. Reducing the frequency and improving gentleness during Vaginal Exams: Institutions can reduce the frequency of vaginal exams by adopting clear guidelines that prioritize patient comfort and avoid unnecessary examinations. Gentle, trauma-sensitive approaches to vaginal exams should be standard practice, with healthcare providers trained to minimize discomfort and explain each step to patients.

v. Enhanced access to pain relief during labor: The Ministry of Health, in collaboration with healthcare facilities, should prioritize the availability and accessibility of effective analgesia for labor, including epidural anesthesia and other pain management methods. To address current barriers such as cost and a shortage of trained personnel, policies should be implemented to subsidize the cost of analgesia, particularly for lower-income women. Training programs should also be developed to equip healthcare providers with the skills to administer pain relief and educational campaigns should be launched to raise awareness among women about available pain management options.

vi. Expansion of VBAC services: The Kenyan government through the MOH should formulate a policy that promotes VBAC as a viable option for women with a previous CS. This policy should also enhance the availability of VBAC services in healthcare facilities through adequate resource allocation particularly in rural and underserved areas, to improve infrastructure and equip them with the necessary tools and trained personnel to safely offer VBAC services.

5.4.2 Recommendations for Healthcare Providers and Health Systems

i. Encourage individualized care plans that consider each woman's unique history and preferences, ensuring that care is patient-centered.

ii. Implement regular continuous medical education (CME) programs for healthcare providers focused on the latest evidence in maternal care, including counseling techniques and the importance of informed consent.

iii. Emphasize the utilization of VBAC scoring systems during counseling to stratify risk and facilitate informed discussions about the safety and feasibility of VBAC for each woman.

iv. Emphasize the routine use of partographs to monitor labor progression and prevent prolonged labor, reducing the need for interventions that may be perceived as traumatic.

5.4.3 Recommendations for Future Research

i. Conduct studies involving participants with varied sociodemographic and cultural backgrounds to assess the impact of these characteristics on delivery mode preferences and experiences.

ii. Investigate healthcare providers' perspectives on counseling and delivery options, exploring their training, biases, and experiences to identify gaps in knowledge and practice.

iii. Implement longitudinal studies to track the choice of delivery methods of women who receive trauma-informed care versus those who do not, assessing its impact on their overall birth experiences and mental health.

iv. Conduct a large, multi-center comparative study in Kenya to evaluate and analyze the outcomes and complications associated with RECS versus VBAC. The research should focus on maternal and neonatal health outcomes, including recovery times, rates of complications, and long-term implications for both mothers and infants. This research is essential to provide evidence-based guidance for healthcare providers and women considering their delivery options.

REFERENCES

ACOG Practice Bulletin No. 205: Vaginal birth after cesarean delivery. (2019). *Obstetrics & Gynecology*, *133*(2), e110–e127. https://doi.org/10.1097/ AOG. 0000000000003078

Beecher, C., Devane, D., White, M., Greene, R., & Dowling, M. (2020). Women's experiences of their maternity care: A principle- based concept analysis. *Women and Birth*, *33*(5), 419–425. https://doi.org/10.1016/j.wombi.2019.11.001

Betran, A. P., Ye, J., Moller, A.-B., Souza, J. P., & Zhang, J. (2021). Trends and projections of cesarean section rates: Global and regional estimates. *BMJ Global Health*, *6*(6), e005671. https://doi.org/10.1136/bmjgh- 2021-005671

Betrán, A. P., Ye, J., Moller, A.-B., Zhang, J., Gülmezoglu, 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. https://doi.org /10.1371/ journal.pone.0148343

Betran, A., Torloni, M., Zhang, J., Gülmezoglu, A., & Section, the W. W. G. on C. (2016). WHO Statement on Caesarean Section Rates. *BJOG: An International Journal of Obstetrics & Gynaecology*, *123*(5), 667–670. https://doi.org/1 0.1111/14 71-0528.13526

Behruzi, R., Hatem, M., Fraser, W., Goulet, L., Ii, M., & Misago, C. (2010). Facilitators and barriers in the humanization of childbirth practice in Japan. *BMC Pregnancy and Childbirth*, *10*, *25*. https://doi.org/10.1186/1471-2393-10-25

Binyaruka, P., & Mori, A. T. (2021). Economic consequences of caesarean section delivery: Evidence from a household survey in Tanzania. *BMC Health Services Research*, *21*(1), 1367. https://doi.org/10.1186/s12913-021-07386-0

Biraboneye S, P., Ogutu, O., van Roosmalen, J., Wanjala, S., Lubano, K., & Kinuthia, J. (2017). Trial of labor or elective repeat caesarean delivery: are women making an informed decision at Kenyatta national hospital? *BMC Pregnancy and Childbirth*, *17*(1), 260. https://doi.org/10.1186/s12884-017-1440-3

Boerma, T., Ronsmans, C., Melesse, D. Y., Barros, A. J. D., Barros, F. C., Juan, L., Moller, A.-B., Say, L., Hosseinpoor, A. R., Yi, M., de Lyra Rabello Neto, D., & Temmerman, M. (2018). Global epidemiology of use of and disparities in caesarean sections. *Lancet (London, England)*, *392*(10155), 1341–1348. https://doi.org/10.1016/S0140-6736(18)31928-7

Cavallaro, F. L., Cresswell, J. A., França, G. V., Victora, C. G., Barros, A. J., & Ronsmans, C. (2013). Trends in caesarean delivery by country and wealth quintile: Cross-sectional surveys in southern Asia and sub- Saharan Africa. *Bulletin of the World Health Organization*, *91*(12), 914-922D. https://doi.org/ 10.2471 /BLT.13.117598

Centering Healthcare Institute. (n.d.). *Centering Pregnancy*. Retrieved from https://centeringhealthcare.org/what-we-do/centering-pregnancy

Chigbu, C. O., Ezenyeaku, C. C., & Ezenkwele, E. P. (2010). Obstetricians' attitudes to caesarean delivery on maternal request in Nigeria. *Journal of Obstetrics and Gynaecology*, *30*(8), 813–817. https://doi.org/10.3109/01443615.2010.489165

Chuma, J., Musimbi, J., Okungu, V., Goodman, C., & Molyneux, C. (2009). Reducing user fees for primary health care in Kenya: Policy on paper or policy in practice? *International Journal for Equity in Health*, 8, Article 15. https://doi.org /10.1186 /1475-9276-8-15

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches /*. SAGE Publications, https://eduq.info/xmlui/handle/11515/19498

Cridland, E. K., Jones, S. C., Caputi, P., & Magee, C. A. (2015). Qualitative research with families living with autism spectrum disorder: Recommendations for conducting semi-structured interviews. *Journal of Intellectual and Developmental Disability*, *40*(1), 78–91. https://doi.org/10. 3109/1 366825 0.2014.9 64191

Diema Konlan, K., Baku, E. K., Japiong, M., Dodam Konlan, K., & Amoah, R. M. (2019). Reasons for Women's Choice of Elective Caesarian Section in Duayaw Nkwanta Hospital. *Journal of Pregnancy*, *2019*, 2320743. https://doi.org/ 10.1155 =/2019/2320743

D'Souza, R., & Arulkumaran, S. (2013). To "C" or not to "C"? Caesarean delivery upon maternal request: a review of facts, figures, and guidelines. *Journal of Perinatal Medicine*, *41*(1), 5–15. https://doi.org/10.1515/jpm-2012-0049

Fantaye, A. W., Gunawardena, N., & Yaya, S. (2019). Preferences for formal and traditional sources of childbirth and postnatal care among women in rural Africa: A systematic review. PLoS ONE, 14(9), e0222110. https://doi.org/ 10.1371/jo urnal.pone.0222110

Guest, G., Bunce, A., & Johnson, L. (2006). How Many Interviews Are Enough?: An Experiment with Data Saturation and Variability. *Field Methods*, *18*(1), 59–82. https://doi.org/10.1177/1525822X05279903

Handelzalts, J. E., Becker, G., Ahren, M.-P., Lurie, S., Raz, N., Tamir, Z., & Sadan, O. (2015). Personality, fear of childbirth and birth outcomes in nulliparous women. *Archives of Gynecology and Obstetrics*, *291*(5), 1055–1062. https://doi.org/1 0.1007/s00404-014-3532-x

Harrison, M. S., & Goldenberg, R. L. (2016). Cesarean section in sub-Saharan Africa. *Maternal Health, Neonatology and Perinatology*, *2*(1), 6. https://doi.org/ 10.1186/s40748-016-0033-x

Jenabi, E., Khazaei, S., Bashirian, S., Aghababaei, S., & Matinnia, N. (2020). Reasons for elective cesarean section on maternal request: A systematic review. *The Journal of Maternal-Fetal & Neonatal Medicine: The Official Journal of the European Association of Perinatal Medicine, the Federation of Asia and Oceania Perinatal Societies, the International Society of Perinatal Obstetricians*, *33*(22), 3867–3872. https://doi.org/10.1080/14767058.2019.1587407

Kenya National Bureau of Statistics, Ministry of Health/Kenya, National AIDS Control Council/Kenya, Kenya Medical Research Institute, & National Council for Population and Development/Kenya. (2015). *Kenya Demographic and Health Survey 2014*. https://dhsprogram. com/pubs/pdf/ FR308/FR308.pdf

Khalajinia, Z., & Alipour, Z. (2024). Identifies current trends in vaginal birth after cesarean section in Iran: A qualitative study. Iranian Journal of Nursing and Midwifery Research, 29(3), 330-336.https://doi.org/10.4103/ijnmr.ijnmr_359_22 KHIS Tracker. (n.d.). Retrieved August 2, 2023, from https://histracker. health.go.ke/dhis-web- commons/security/login.action

Liu, R., Chao, M. T., Jostad-Laswell, A., & Duncan, L. G. (2017). Does CenteringPregnancy Group Prenatal Care Affect the Birth Experience of Underserved Women? A Mixed Methods Analysis. *Journal of immigrant and minority health*, *19*(2), 415–422. https://doi.org/10.1007/s10903-016-0371-9

McMahon, M. J., Luther, E. R., Bowes, W. A., & Olshan, A. F. (1996). Comparison of a trial of labor with an elective second cesarean section. *The New England Journal of Medicine, 335*(10), 689–695. https://doi.org/10.1056/NEJM199609053351001

Moffat, M. A., Bell, J. S., Porter, M. A., Lawton, S., Hundley, V., Danielian, P., & Bhattacharya, S. (2007).

Decision making about mode of delivery among pregnant women who have previously had a caesarean section: A qualitative study. *BJOG: An International Journal of Obstetrics and Gynaecology*, *114*(1), 86–93. https://doi.org/10.1111/j.1471-0528.2006.01154.x

Namujju, J., Muhindo, R., Mselle, L. T., & Kohi, T. W. (2018). Childbirth experiences and their derived meaning: A qualitative study among postnatal mothers in Mbale Regional Referral Hospital, Uganda. Reproductive Health, 15(1), 183. https://doi.org/10.1186/s12978-018-0628-y

Odongo, A. A. (2020). *Determinants of Choice of Cesarean Section Among Women of Child-bearing Age in Kenya* [Thesis, University of Nairobi]. http://erepository. uonbi.ac.ke /handle/11295/153656

O'Donovan, C., & O'Donovan, J. (2018). Why do women request an elective cesarean delivery for non-medical reasons? A systematic review of the qualitative literature. *Birth (Berkeley, Calif.), 45*(2), 109–119. https://doi.org/10.1 111/birt .12319

Ohaja, M., & Anyim, C. (2021). Rituals and embodied cultural practices at the beginning of life: African perspectives. *Religions, 12*(11), 1024. https://doi.org/ 10.3390 /rel12111024

Olofinbiyi, B. A., Olofinbiyi, R. O., Aduloju, O. P., Atiba, B. P., Olaogun, O. D., & Ogundare, O. R. (2015).

Maternal views and experiences regarding repeat Caesarean section. *Nigerian Journal of Clinical Practice*, *18*(4), Article 4. https://doi.org/10.4314/njcp.v18i4

Orangi, S., Kairu, A., Malla, L., Ondera, J., Mbuthia, B., Ravishankar, N., & Barasa, E. (2021). Impact of free maternity policies in Kenya: An interrupted time-series analysis. *BMJ Global Health*, *6*(6), e003649. https://doi.org/10.1136/bmjgh-2020-003649

Oyugi, B., Nizalova, O., Kendall, S., & Peckham, S. (2023). Does a free maternity policy in Kenya work? Impact and cost-benefit consideration based on demographic health survey data. *The European Journal of Health Economics*. https://doi.org/10.1007/s10198-023-01575-w

Panda, S., Begley, C., & Daly, D. (2018). Clinicians' views of factors influencing decision-making for caesarean section: A systematic review and meta-synthesis of qualitative, quantitative and mixed methods studies. *PloS One*, *13*(7), e0200941. https://doi.org/10.1371/journal.pone.0200941

Richmond, E., Ray, J., Pudwell, J., Djerboua, M., Gaudet, L., Walker, M., Smith, G., & Velez, M. (2022).

Caesarean birth in women with infertility: Population-based cohort study. *BJOG: An International Journal of Obstetrics & Gynaecology*, *129*(6), 908–916. https://doi.org/10. 1111/1471-0528.17019

Robson, M. S. (2001). Classification of caesarean sections. Fetal and Maternal Medicine Review, 12(1), 23–39. https://doi.org/10.1017/S0965539501000122

Rudey, E. L., Leal, M. do C., & Rego, G. (2021). Defensive medicine and cesarean sections in Brazil. *Medicine*, *100*(1), e24176. https://doi.o rg/10.10 97/MD.0000000000024176

Sandall, J., Tribe, R. M., Avery, L., Mola, G., Visser, G. H., Homer, C. S., Gibbons, D., Kelly, N. M., Kennedy, H. P., Kidanto, H., Taylor, P., & Temmerman, M. (2018). Short-term and long-term effects of caesarean section on the health of women and children. *Lancet (London, England)*, *392*(10155), 1349–1357. https://doi.org/10.1016/S0140-6736(18)31930-5

Seng, J., & Taylor, J. (2015). Trauma-informed care in the perinatal period. Liverpool University Press. https://link.springer.com/chapter/10.1007/978-3-030-04342-1_8

Sixma, H. J., Kerssens, J. J., Campen, C. van, & Peters, L. (1998). Quality of care from the patients' perspective: From theoretical concept to a new measuring instrument. *Health Expectations*, *1*(2), 82–95. https://doi.org/10.1046/j.1369-6513.1998.00004.x

Sobhy, S., Arroyo-Manzano, D., Murugesu, N., Karthikeyan, G., Kumar, V., Kaur, I., … Thangaratinam, S. (2019). Maternal and perinatal mortality and complications associated with caesarean section in low-income and middle-income countries: a systematic review and meta-analysis. The Lancet. https://doi:10.1016/s0140-6736(18)32386-9Statistics, K. N. B. of, Health/Kenya, M. of, Council/Kenya, N. A. C., Institute, K. M. R., & Development/Kenya, N. C. for P. and. (2015). *Kenya D emographic and Health Survey 2014*. https://dhsprogram.com/pub lications/ publication-fr308-dhs-final-reports.cfm

Stjernholm, Y. V., Petersson, K., & Eneroth, E. (2010). Changed indications for cesarean sections. *Acta Obstetricia et Gynecologica Scandinavica*, *89*(1), 49–53. https://doi.org/10.3109/00016340903418777

Tita, A. T., et al. (2009). Outcomes of cesarean delivery versus vaginal birth after cesarean. *American Journal of Obstetrics and Gynecology*, 201(3), 267.e1-267.e7. https://doi.org/10.1016/j.ajog.2009.06.058

Tully, K. P., et al. (2019). Women's perspectives on repeat cesarean delivery versus trial of labor after cesarean. *Journal of Maternal-Fetal & Neonatal Medicine*, 32(22), 3745-3752. https://doi.org/10.1080/14767058.2018.1483156

Van der Spek, L., Sanglier, S., Mabeya, H. M., van den Akker, T., Mertens, P. L. J. M., & Houweling, T. A. J. (2020). Socioeconomic differences in caesarean section - are they explained by medical need? An analysis of patient record data of a large Kenyan hospital. *International Journal for Equity in Health*, *19*(1), 117. https://doi.org/10.1186/s12939-020-01215-2

Vogel, J. P., Betrán, A. P., Vindevoghel, N., Souza, J. P., Torloni, M. R., Zhang, J., Tunçalp, Ö., Mori, R., Morisaki, N., Ortiz-Panozo, E., Hernandez, B., Pérez-Cuevas, R., Qureshi, Z., Gülmezoglu, A. M., Temmerman, M., & WHO Multi-Country Survey on Maternal and Newborn Health Research Network. (2015). Use of the Robson classification to assess caesarean section trends in 21 countries: A secondary analysis of two WHO multicountry surveys. *The Lancet. Global Health*, *3*(5), e260-270. https://doi.org/10.1016/S2214-109X(15)70094-X

Wanyonyi, S. Z., Mukaindo, A. M., & Stones, W. (2010). Perspectives on the practice of vaginal birth after caesarean section in East Africa. *East African Medical Journal*, *87*(8), 335–339.

Zewude, B., Siraw, G., & Adem, Y. (2022). The Preferences of Modes of Child Delivery and Associated Factors Among Pregnant Women in Southern Ethiopia. Pragmatic and observational research, 13, 59–73. https://doi.o rg/10.214 7/ POR.S370513

APPENDICES

Appendix I: Semi-structured Interview Guide

Preliminaries

Introductions and the purpose of the interview will be explained to participants while assuring confidentiality and obtaining informed consent.

General Information

Date	
Start time	
End time	
Interview number	
Audio file name	
Moderator	
Scribe / Note-taker	
Language of interview	

Socio-demographic characteristics of the participant

Pseudonym	
Age	
Parity	
Trimester of pregnancy	
Family status	
Residence	
Ethnicity / Cultural background	
Religious affiliation	
Education level	
Livelihood activity	
Household income	
Health insurance status	
Spoken language	
VBAC Score (If eligible)	

Beginning the discussion

Introductions

Participant's consent will be obtained before the recording of the interview. START RECORDING HERE

Interview Questions

Section 1: Prior birth experiences

1. Could you please tell me a bit about your previous pregnancy and childbirth experiences especially focusing on the cesarean section you had?

   Probe:

   a. How did you feel about your previous cesarean section experience?

   b. In your opinion, what aspects of your experience do you consider went right? What aspects went wrong?

   c. Could you describe how you felt when you found out you were pregnant again?

2. How does your ideal childbirth experience for this pregnancy look like?

   Probe: Are there specific aspects of your previous experience that you would like to be different?

Section 2: Delivery options

1. Are you aware of the available delivery options for your current pregnancy?

Yes	**No**
Could you please share them with me? VBAC Repeat CS	

3. Could you please describe your understanding about VBAC and/or repeat elective cesarean section?

Probe

a. How does VBAC differ from repeat CS?

b. How would you describe the advantages and disadvantages of VBAC and/or

repeat CS?

c. Could you share your thoughts on the risks and benefits of VBAC compared to repeat elective cesarean section?
d. Do you have any knowledge about who qualifies for VBAC/ repeat CS?

4. How did you come by this information? Could you describe the circumstances that led to your knowledge of these options?

Probe:

a. Could you describe any discussions you may have had with family or friends regarding your delivery options?
b. Can you describe any discussions you remember having with your healthcare provider about your delivery options?

5. **Have you decided on your preferred mode of delivery?**

<table>
<tr><td colspan="2">YES</td><td rowspan="2">NO</td></tr>
<tr><td>RECS</td><td>VBAC</td></tr>
<tr><td colspan="2">Follow up:
a. How did you arrive at that decision? For example, could you describe any personal preferences or values that have influenced your choice of delivery mode?
b. Could you share some advice or opinions that you have received from your family, friends, or religious leaders and how that has influenced your decision?
c. Were there any specific recommendations or opinions provided by your healthcare provider that influenced your decision?
d. Does your previous birth experience have anything to do with how you feel? For instance, are there any specific aspects about your previous birth experience that have influenced the choice of your preferred mode of delivery?</td><td>Follow up:
a. Do you have any reasons or concerns that have contributed to your indecision?</td></tr>
</table>

Section 3: Recommendations

1. How can healthcare providers better support women like yourself in making this decision?

Probe:

a. Do you feel adequately supported by the nurses and or clinicians in deciding on your preferred mode of delivery? For example, do you think you received sufficient counseling or information from the nurses and clinicians to help you make an informed decision?

b. Are there specific changes or improvements by the hospital and/or government you believe would enhance the support provided to women making a similar choice?

Conclusion

Is there anything else you would like to share about your experiences and thoughts on this topic? Please feel free to express any additional insights, experiences, or perspectives that you think are important to this discussion**.**

Thank the participants for their time and input. Reiterate the confidentiality of their responses. Provide them with any necessary contact information for follow-up or additional questions.

Swahili Version

Mwongozo wa Mahojiano Yasiyo Rasmi kwa Wanawake Wajawazito na Waliojifungua

Maandalizi

Mwanzo wa mahojiano na kusudi la mahojiano yataelezwa kwa washiriki huku uhakikishaji wa usiri na kupata ridhaa ya kuelewa yakipatikana.

Maelezo ya Jumla

Tarehe	
Muda wa kuanza	
Muda wa kumaliza	
Nambari ya mahojiona	
Jina la faili ya sauti	
Mwongozaji	
Mwandishi wa Kumbukumbu	
Lugha ya mahojiaono	

Tabia za Kijamii na Ki-demografia za Mshiriki

Jina la uwongo	
Umri	
Idadi ya mimba	
Trimesta ya ujauzito	
Hali ya familia	
Makazi	
Kabila / Asili ya utamaduni	
Imani ya dini	
Kiwango cha elimu	
Shuguli ya kipato	
Mapato ya familia	
Hali ya bima ya afya	
Kipimo cha JKUBU (Ikiwa anastahili)	

Kuanza mjadala

Utambulisho

Ridhaa ya mshiriki itapokelewa kabla ya kurekodi mahojiano.

ANZA KUREKODI HAPA

Maswali ya mahojiano

Sehemu 1: Uzoefu wa awali wa kujifungua

1. **Tafadhali, ungeweza kunieleza kidogo kuhusu uzoefu wako wa ujauzito na kujifungua uliopita, ukilenga hasa kwenye upasuaji uliofanyiwa?**

   Kichunguzi:

a. Una maoni au una hisia gani kuhusu uzoefu wa upasuaji uliopita?

b. Kwa maoni yako, ni vipengele gani vya uzoefu wako unazingatia vilikwenda vizuri? Na ni vipengele gani vilikwenda vibaya?

c. Ungeelezea vipi ulivyohisi ulipopata habari kwamba ulikuwa mjamzito tena?

2. **Kwa maoni yako, kulingana na jinsi unavyotamani katika ujauzito huu, uzoefu bora ni kama vipi?**

Kichunguzi: Je, kuna vipengele maalum vya uzoefu wako uliopita ambavyo ungependa vionekane tofauti katika uja ujauzito huu?

Sehemu 2: Chaguzi za njia za kujifungua

1. **Je, unafahamu chaguzi za njia za kujifungua zilizopo kwa ujauzito wako wa sasa?**

Ndio	Hapana
Unaweza kunieleza ni zipi? a. Jaribio la kujifungua kwa njia ya asili baada ya upasuaji wa cesarean (JKUBU) b. Kujifungua kwa upasuaji wa cesarean uliopangwa upya (KUCI)	

2. **Unaweza kuelezea kile unachoelewa kuhusu aitha jaribio la kujifungua kwa njia ya asili baada ya upasuaji wa cesarean au kujifungua kwa njia ya upasuaji wa cesarean uliopangwa?**

   Kichunguzi:

   a. Jaribio la kujifungua kwa njia ya asili baada ya upasuaji wa cesarean inatofautianaje na kujifungua kwa upasuaji wa cesarean uliopangwa upya?

   b. Unaweza kunifafanulia faida na hasara za aitha ya njia hizi mbili?

   c. Je, ungependa kushiriki mawazo yako kuhusu hatari na faida za kujifungua kwa njia ya asili baada ya upasuaji wa cesarean ikilinganishwa na kujifungua kwa upasuaji wa cesarean uliopangwa upya?

   d. Je, una ufahamu kuhusu ni nani anayefuzu kujifungua kupitia Jaribio la kujifungua kwa njia ya asili baada ya upasuaji wa cesarean na kujifungua kwa upasuaji wa cesarean uliopangwa upya?

3. **Unaweza kunieleza ulipataje taarifa hizi? Unaweza kuelezea mazingira yaliyopelekea kujua kuhusu chaguzi hizi?**

   Kichunguzi:

   a. Je, unaweza kuelezea mazungumzo yoyote uliyoweza kuwa nayo na familia au marafiki kuhusu chaguzi za kujifungua?

   b. Unaweza kuelezea mazungumzo yoyote unayokumbuka kufanya na mtoa huduma wako wa afya kuhusu chaguzi za kujifungua?

4. Je, umekwisha amua ni njia ipi ya kujifungua unayopendelea katika ujauzito huu?

Ndio		**Hapana**
JKUBU	**KUCI**	
Kufuatilia Ulifikaje katika uamuzi huu? Kwa mfano, unaweza eleza mapendekezo au thamani zako binafsi ambazo zimeshawishi chaguo lako? Je, unaweza kunieleza ushauri au maoni ambayo umepokea kutoka kwa familia yako, marafiki, au viongozi wa dini na jinsi ambavyo ushauri huo umeshawishi uamuzi wako? Kuna mapendekezo au maoni yeyote maalum yaliyotolewa na watoa huduma wa afya yako ambayo yalishawishi uamuzi wako? Naomba unieleze kwa undani. Je, uzoefu wako wa kuzaliwa uliopita una uhusiano wowote na jinsi unavyohisi? Kwa mfano, je, kuna vipengele maalum kuhusu uzoefu wako wa kuzaliwa uliopita ambavyo vimeathiri chaguo lako la njia ya kujifungua unayopendelea?		**Kufuatilia:** Je, una sababu au wasiwasi wowote ambao umesababisha kutokuwa na maamuzi?

Sehemu ya 3: Mapendekezo

1. **Ni kwa jinsi gani watoa huduma za afya wanaweza kusaidia wanawake kama wewe katika kufanya uamuzi huu?**

Kichunguzi:

a. Je, unajisikia kusaidiwa vya kutosha na wauguzi na/au wataalamu wa matibabu katika kufanya uamuzi kuhusu njia yako unayopendelea ya kujifungua? Kwa mfano, je, unafikiri ulipata ushauri au taarifa za kutosha kutoka kwa wauguzi na wataalamu wa matibabu ili kukusaidia kufanya uamuzi wenye ufahamu?

b. Je, ungependekeza mabadiliko au marekebisho yapi maalum kutoka kwa hospitali na/au serikali ambayo labda yanaweza kuimarisha msaada unaotolewa kwa wanawake wanaofanya uchaguzi kama huu?

Hitimisho

Je, kuna mawazo mengine ungependa kushiriki kuhusu mada hii? Tafadhali jisikie huru kueleza ufahamu wowote wa ziada, uzoefu, au mitazamo mingine ambayo unafikiri ni muhimu katika mjadala huu.

Shukuru washiriki kwa muda wao na mchango wao. Sisitiza tena usiri wa majibu yao na uwapatie taarifa yoyote muhimu ya mawasiliano kwa ajili ya mfuatano au maswali zaidi.

Informed consent form

Participant Information:

Date of birth	
Family status	
Contact information	
Socio-economic activity	
Parity	
Period of last delivery	

General Introduction:

This consent form is for women with a previous unplanned cesarean section. You are invited to participate in a research study titled: **"Factors Influencing Preference for Repeat Elective Cesarean Section Among Low-Risk Women with Previous Unplanned Cesarean Delivery in Kijabe Hospital."**

Principal investigator: Liliane Kadievi Mugodo

Name of organization: Kabarak University

This consent form has two sections:

i. Information sheet

ii. Respondent's statement

Information Sheet

Introduction

My name is Dr. Liliane Kadievi Mugodo, a master's student at Kabarak University Department of Family Medicine and currently stationed at Kijabe Hospital. I am researching factors that influence women's preference for repeat elective cesarean section in the absence of contraindications to a trial of labor after cesarean.

Should you have any concerns about the study or your participation in it, please contact me **Dr. Liliane at 0723-307-797**. You can also contact the Kijabe Hospital Institution Research and Ethics Committee office at **0709-728-200.**

Purpose of the Study

This study aims to capture the birth experiences of women with a previous unplanned cesarean section. It also seeks to understand the factors that influence their decision-making process regarding the mode of delivery in their subsequent pregnancy.

Study Procedure

If you agree to participate in the study, we will ask you to sign this form as proof of your voluntary consent to participate in the study.

In addition, you will be subject to a private interview that will last about 30 minutes. During the interview, you will be asked a series of questions about your previous birth experience and the factors that influenced the choice of your preferred mode of delivery in your current pregnancy. You will also be asked to share your general perspectives on the topic of study.

With your permission, the interview will be audio recorded, and the interviewer will also take notes during the interview.

Risks and Discomfort

There are no known risks associated with participating in this study. However, because the discussion will be focused on your personal birth experiences, the discussions may elicit some discomfort. An additional inconvenience could be the time and effort you take to participate in the study. To mitigate this, the interviewer will ensure that the interview is within the specified time frame. Should you be uncomfortable at any time and feel the need to stop the interview or not touch on some topics, please inform the interviewer and they will oblige to your requests. There will be no consequences to your involvement in this study.

Confidentiality

Your participation in this study is confidential. The researcher will not use your real name or any other identifying information in any publications or presentations without your permission. Your identity will not be recorded on the forms, you will instead be assigned a pseudonym. The information gathered will be stored securely on a password-protected computer and will only be accessible to the study team.

Benefits and Compensation

The benefits of participating in this study include the opportunity to share your personal experience and perspectives on this important topic. Your views, experiences, and insights are valuable and will contribute to the knowledge gap on this topic. An understanding of factors that influence the decision-making process regarding the mode of delivery in the subsequent pregnancy among women with a previous unplanned cesarean section will form the basis for the development of measures to improve the care of these women.

You will be provided with some refreshments during the discussion.

Your rights

You have the following rights as a participant in this study:

- You have a right to voluntary participation. Your refusal to participate in this study will not affect your access to healthcare services or any other benefits you are ordinarily entitled to.
- You have the right to withdraw from the study at any time without penalty.
- You have the right to refuse to answer any question.

Do you have any questions? (Tick (✓) as appropriate **Yes___No __**

If yes, please note your questions below:

_____

If you have further questions, please contact **Dr. Liliane Kadievi Mugodo at Tel: 0723307797**.

Would you be willing to participate in the study?

Yes_____No_____(If 'No', thank you for consideration)

Respondent's Statement

I have read or have been read the above considerations regarding my participation. I have been given a chance to ask any questions, and my questions have been answered to my satisfaction. I understand that the information I provide will be kept private. I understand that I have a right to withdraw from this study at any time, and it will not affect my

access to healthcare. I agree to participate in this study as a volunteer.

Participant Signature:_____

Date: _____

Investigator or Person Who Conducted Informed Consent Discussion:

I confirm that I have personally explained the nature and extent of the study, procedures, potential risks and benefits, and the confidentiality of personal information.

Signature of Person Obtaining Consent:_____Date: _____

Informed Consent - Swahili version

Fomu ya Ridhaa ya Kufahamu

Maelezo ya washiriki:

Tarehe ya kuzaliwa:	
Hali ya familia	
Shughuli ya kiuchumi	
Idadi ya mimba	
Kipindi cha kujifungua kilichopita	

Maelezo Mafupi:

Fomu hii ya ridhaa ni kwa wanawake waliojifungua kwa njia ya upasuaji au operesheni ambao haukuwa umepangwa au kutarajiwa awali.

Unakaribishwa kushiriki katika utafiti wenye kichwa: **"Viashiria Vinavyoshawishi Upendeleo wa Wanawake Kujifungua kwa Upasuaji wa Cesarean Iliyopangwa Upya kwa Wanawake Wenye Hatari Ndogo Waliojifungua awali kwa Upasuaji wa Cesarean ambayo Haikupangwa au Kutarajiwa Katika Hospitali ya Kijabe."**

Mtafiti Mkuu: Liliane Kadievi Mugodo

Jina la Shirika: Chuo Kikuu cha Kabarak

Fomu hii ya ridhaa ina sehemu mbili:

i. Maelezo kwa Washiriki

ii. Kauli ya Mshiriki

Maelezo Kwa washiriki

Utangulizi

Jina langu ni Dk. Liliane Kadievi Mugodo, mwanafunzi wa shahada ya uzamili katika Idara ya Tiba ya Familia ya Chuo Kikuu cha Kabarak na kwa sasa niko kazini katika Hospitali ya Kijabe. Ninafanya utafiti juu ya viashiria vinavyoshawishi upendeleo wa wanawake kujifungua kwa Upasuaji wa Cesarean Iliyopangwa Upya (KUCI) pasipo na vikwazo vya kufanya jaribio la kujifungua kwa njia ya asili baada ya upasuaji wa cesarean (JKUBU).

Ikiwa una wasiwasi wowote kuhusu utafiti huu au ushiriki wako ndani yake, tafadhali wasiliana nami **Dk. Liliane kupitia nambari 0723-307-797**. Unaweza pia kuwasiliana na Ofisi ya Kamati ya Utafiti na Maadili ya Taasisi ya Hospitali ya Kijabe kupitia nambari **0709-728-200.**

Lengo la Utafiti

Utafiti huu unalenga kukusanya uzoefu wa kujifungua kwa wanawake waliojifungua awali kwa upasuaji wa cesarean ambayo haikupangwa au Kutarajiwa. Pia utafiti huu unalenga kuelewa viashiria vinavyoathiri mchakato wao wa kufanya maamuzi kuhusu njia ya kujifungua katika ujauzito wao unaofuata.

Mchakato wa Utafiti

Ikiwa unakubali kushiriki katika utafiti huu, tutakuomba utie saini fomu hii kama ushahidi wa ridhaa yako ya hiari ya kushiriki katika utafiti.

Zaidi ya hayo, fahamu kuwa utakuwa chini ya mahojiano ya faragha ambayo yatachukua takriban dakika thelathini. Katika mahojiano hayo, utaulizwa mfululizo wa maswali kuhusu uzoefu wako wa kujifungua uliopita na viashiria vilivyoshawishi uchaguzi wako wa njia ya kujifungua unayopendelea katika ujauzito wako wa sasa. Pia utaulizwa kutoa maoni yako kwa ujumla kuhusu mada ya utafiti. Kwa idhini yako, mahojiano yatarekodiwa kwa sauti, na mpiga mahojiano pia atachukua maelezo wakati wa mahojiano.

Hatari na Usumbufu

Hakuna hatari inayojulikana inayohusiana na kushiriki katika utafiti huu. Hata hivyo, kwa kuwa mazungumzo yatajikita kwenye uzoefu wako wa kibinafsi wa kujifungua, mazungumzo yanaweza kuleta usumbufu fulani. Usumbufu wa ziada unaweza kuwa

muda na jitihada unazotumia kushiriki katika utafiti. Ili kupunguza hili, mpiga mahojiano atahakikisha kuwa mahojiano yanafanyika ndani ya mda uliopangwa. Ikiwa utajisikia usumbufu wakati wowote na uhitaji wa kusitisha mahojiano au kutokugusa baadhi ya mada, tafadhali mwambie mpiga mahojiano na atatii ombi lako. Hakutakuwa na matokeo yeyote mabaya kwa ushiriki wako katika utafiti huu.

Usiri

Ushiriki wako katika utafiti huu ni wa siri. Mtafiti hatatumia jina lako halisi au habari yoyote ya kutambulika katika machapisho au mawasilisho yoyote bila idhini yako. Utambulisho wako hautaandikwa kwenye fomu, badala yake utapewa jina bandia. Taarifa zilizokusanywa zitahifadhiwa kwa usalama kwenye kompyuta iliyo na nenosiri na itapatikana tu kwa timu ya utafiti.

Manufaa na Ufidiaji

Manufaa ya kushiriki katika utafiti huu ni pamoja na fursa ya kushiriki uzoefu wako binafsi na maoni kuhusu mada muhimu hii. Maoni yako, uzoefu, na ufahamu ni muhimu na utachangia pengo la maarifa kuhusu mada hii. Kuelewa viashiria vinavyoathiri mchakato wa kufanya maamuzi kuhusu njia ya kujifungua katika ujauzito unaofuata kwa wanawake waliojifungua awali kwa upasuaji wa cesarean ambayo haikupangwa au Kutarajiwa kutakuwa msingi wa kukuza hatua za kuboresha huduma kwa wanawake hawa. Utapewa kinywaji wakati wa mjadala.

Haki Zako

Una haki zifuatazo kama mshiriki katika utafiti huu:

- Una haki ya kushiriki kwa hiari. Kukataa kwako kushiriki katika utafiti huu hautaingilia upokeaji wako wa huduma za afya au faida nyingine yoyote ambayo kawaida unastahili.
- Una haki ya kujiondoa kutoka kwenye utafiti wakati wowote bila adhabu.
- Una haki ya kukataa kujibu swali lolote.

Je, una swali lolote? (Tia alama (✓) kama inavyofaa

Ndiyo ☐ **Hapana** ☐

Ikiwa ndiyo, tafadhali andika maswali yako hapa chini:

Ikiwa una maswali zaidi, tafadhali wasiliana na **Dk. Liliane Kadievi Mugodo kwa Simu: 0723307797.**

Je, ungependa kushiriki katika utafiti?

Ndiyo ☐ **Hapana** ☐ (Ikiwa 'Hapana', asante kwa kuzingatia)

Kauli ya Mshiriki

Nimeisoma au nimesomewa maelezo yaliyotajwa hapo juu kuhusu ushiriki wangu. Nimepewa nafasi ya kuuliza maswali yoyote, na maswali yangu yamejibiwa kwa kuridhisha kwangu. Naelewa kwamba taarifa nitakazotoa zitahifadhiwa kwa faragha. Naelewa kwamba nina haki ya kujitoa katika utafiti huu wakati wowote, na haitaathiri upatikanaji wangu wa huduma za afya. Ninasalia kukubali kushiriki katika utafiti huu kama mwanaharakati.

Saini ya Mshiriki:_____

Tarehe:_____

Mpelelezi au mtu aliyefanya mazungumzo ya ridhaa ya kufahamu:

Nathibitisha kwamba mimi binafsi nimeeleza asili na kina cha utafiti, taratibu, hatari na faida za uwezekano, na usiri wa taarifa binafsi.

Saini ya Mtu Anayepata Ridhaa:_____

Tarehe:_____

Appendix II: Letter of Introduction from the Institution

KABARAK UNIVERSITY
INSTITUTE OF POSTGRADUATE STUDIES
OFFICE OF THE DIRECTOR

Private Bag - 20157 **Tel: 0773265999**
KABARAK, KENYA **E-mail: directorpostgraduate@kabarak.ac.ke**

26th February 2024

The Chairman
Institutional Scientific and Ethics Review Committee (ISERC)
Kabarak University

Dear Sir,

RE: LILIAN KADIEVI MUGODO – GMMF/M/0332/01/21

The above named is a candidate at Kabarak University pursuing Masters in Family Medicine. She is carrying out a research entitled ***"Factors Influencing Preference for Repeat Elective Caesarean Section among Clinicians and Low-Risk Women with Previous Unplanned Caesarean Delivery in Kijabe Hospital".***

The student has defended her proposal and has been authorised to proceed with field research.

Kindly provide the KUREC clearance to enable the student obtain NACOSTI research permit.

Thank you

KABARAK UNIVERSITY DIRECTOR POST GRADUATE STUDIES 26 FEB 2024 PRIVATE BAG - 20157, KABARAK

Dr. Nehemiah Kiplagat, PhD
Ag. Director, Institute of Postgraduate Studies

Kabarak University Moral Code
As members of Kabarak University family, we purpose at all times and in all places, to set apart in one's heart, Jesus as Lord. (1 Peter 3:15)

Kabarak University is ISO 9001:2015 Certified

Appendix III: Authorization Letter from Kijabe Hospital

AIC Kijabe Hospital
Health Care to God's Glory

KIJABE HOSPITAL INSTITUTIONAL SCIENTIFIC AND ETHICAL REVIEW COMMITTEE
PO Box 20 Kijabe 00220, Kenya
Tel: 0709728200/637
Fax: 020-3246335
E-mail:researchcoord@kijabehospital.org
Website: www.kijabehospital.org

REF NO: KH/ISERC/0025/2024

Approval No: KH/ISERC/02718/0018/2024

Date May 21, 2024

Dear Dr. Liliane Kadievi Mugodo

RE: Factors Influencing Preference for Repeat Elective Cesarean Section Among Low-Risk Women with Previous Unplanned Cesarean Delivery in Kijabe Hospital

Many thanks for your submission to KH ISERC.

This is to inform you that KH ISERC has reviewed and **approved** your above research protocol. Your application approval number is **KH/ISERC/0025/2024**
The approval period is starting from May 17, 2024 to May 16, 2025. This approval is subject to compliance with the following requirements;

i. Only approved documents including (informed consent, study instruments, MTA) will be used.
ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by KH ISERC.
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 KH ISERC within 72 hours of notification.
iv. Any changes, anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to KH ISERC within 72 hours.
v. Clearance for export of biological specimens must be obtained from relevant institutions.

Appendix IV: NACOSTI Research Permit

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: 553430

Date of Issue: 04/June/2024

RESEARCH LICENSE

This is to Certify that Dr.. LILIAN KADIEVI MUGODO of Kabarak University, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Kiambu on the topic: Factors Influencing Preference for Repeat Elective Cesarean Section Among Low-Risk Women with Previous Unplanned Cesarean Delivery in Kijabe Hospital for the period ending : 04/June/2025.

License No: NACOSTI/P/24/36285

553430

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

NOTE: This is a computer generated License. To verify the authenticity of this document, Scan the QR Code using QR scanner application.

See overleaf for conditions

Appendix V: Conference Participation Certificate

NAIROBI CITY COUNTY
1ST NAIROBI HEALTH
SCIENTIFIC CONFERENCE

CERTIFICATE
OF PARTICIPATION

THIS CERTIFICATE IS AWARDED TO

Mugodo Kadievi Liliane

for active participation in the 1st Nairobi County Health Scientific Conference themed **'Advancing Health Equity Towards Resilient and Sustainable People - Centered Primary Healthcare Systems for Nairobi'** held on 20th to 22nd November 2024 at Emara Ole Sereni - Nairobi, Kenya.

Dr. Irene Muchoki
Chief Officer - Medical Services

Suzanne Silantoi
County Executive Committee Member-
Health, Wellness and Nutrition

Appendix VI: List of Publication

JOURNAL OF CLINICAL CARE AND MEDICAL ADVANCEMENT

https://doi.org/10.58460/jcma.v2i1.116

ORIGINAL ARTICLE

Open Access

MJM BIOLABS

Factors Influencing Preference for Repeat Elective Cesarean Section Among Low-Risk Women with Previous Unplanned Cesarean Delivery at Kijabe Hospital in Kenya

Liliane KADIEVI MUGODO[1*], Boaz NIYINYUMVA[1], and Stephanie ONGUKA[1]

[1]Department of Family Medicine, School of Medicine and Health Sciences, Kabarak University

*Corresponding author: lkmugodo@gmail.com

Article History

Submitted: 18th October 2024

Accepted: 17th November 2024

Published Online: 20th November 2024

To read this paper online, please scan the QR code below:

ABSTRACT

Cesarean section (CS) rates have risen significantly over the past decade, with many countries surpassing the World Health Organization's standard of 10-15%. Women with a previous cesarean- Robson group 5- contribute substantially to this increase. For low-risk women, vaginal birth after CS is a safe and cost-effective alternative that can reduce cesarean-related morbidity and ease the burden higher rates placed on the healthcare system. Despite these benefits, many women in Kenya still prefer repeat elective cesarean delivery in subsequent pregnancies. This study investigated the factors influencing this preference among low-risk women attending Kijabe Hospital. This qualitative phenomenological study involved 18 women with prior cesarean delivery attending the hospital. Participants were selected through purposive sampling based on predefined inclusion and exclusion criteria. Data was collected through in-depth interviews using a semi-structured interview guide and analyzed using inductive thematic analysis with the Dedoose software. Maternal reasons for preferring repeat CS included fear, personal preference versus the influence of loved ones, the convenience of simultaneous bilateral tubal ligation, and the desire to experience a vaginal birth. Prior birth experiences also shaped maternal choices of delivery modes. Traumatic vaginal interventions, an expressed low confidence in successful vaginal birth, and the considerations of risks over benefits were all influential. Participants also emphasized the importance of healthcare providers' recommendations, noting counseling gaps and facility preparedness to offer VBAC services. Ultimately, reducing repeat cesareans among low-risk women requires a comprehensive strategy: Strengthening the support for VBAC services, improving the quality of patient-provider communication, and addressing the emotional and psychological impacts of prior birth trauma. Institutional policies that encourage comprehensive counseling and shared decision-making are key to encouraging safer, evidence-based birth practices.

Keywords: *Birth trauma, Mode of delivery, Repeat elective cesarean section, Vaginal birth after cesarean section, VBAC Counseling,*