

**ADDIS ABABA UNIVERSITY**  
**COLLEGE OF HEALTH SCIENCES**  
**SCHOOL OF NURSING AND MIDWIFERY**  
**DEPARTEMENT OF MIDWIFERY**

**WOMEN'S DECISION-MAKING PROCESS ON THEIR MODE OF BIRTH  
AMONG PREGNANT WOMEN WITH PREVIOUS CAESARIAN SECTION  
IN TIKUR ANBESSA SPECIALIZED HOSPITAL, ADDIS ABABA,  
ETHIOPIA 2023: A QUALITATIVE STUDY**

**PRINCIPAL INVESTIGATOR: MEKDES MOLLA (BSc.)**

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## **List of Abbreviations and Acronyms**

ACOG.....American College of Obstetricians and Gynecologists

CS.....Caesarean section

EDHS.....Ethiopian demographic and health survey

HFSUH.....Hiwot Fana Specialized University Hospital

PI.....Principal investigator

PMTCT.....Prevention of Mother to Child Transmission

RCOG.....Royal College of Obstetricians and Gynecologists

RCS..... Repeated caesarean section

SPHMMC.....Saint Paul's Hospital millennium medical college

TOLAC.....Trial of labor after cesarean

VBAC.....Vaginal birth after caesarean

WHO.....World health organization

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## ABSTRACT

**Background:** Women who have had previous cesarean delivery face a decision to birth option in a next pregnancy. Vaginal birth after caesarean is an alternative choice for most women with a prior cesarean section (CS) whereas its uptake is low. Reflects the limitations imposed on decision making. This decision making process varies for individuals and may result from considering several factors. In Ethiopia, no qualitative research is conducted, particularly on women's decision making of their birth mode following previous CS.

**Objective:** To explore decision-making processes on mode of birth among pregnant women with previous cesarean section in Tikur Anbessa Specialized Hospital, Addis Ababa, Ethiopia 2023.

**Methods:** An explorative qualitative study was conducted from February 20 to March 20, 2023 among women seeking antenatal care. A total of 20 Participants were selected purposively and interviewed using semi-structured guide until data saturation reached. Thematic analysis was used. ATLAS ti 9 qualitative software was used to support the analysis and management of the data.

**Result:** Three themes were identified: Women's involvement in decision making, factors affecting Women's decision making and women's decision-making process. Women put forward their plan of mode of birth for next pregnancy immediately following caesarean delivery. Out of women who have a decision most decide to attempt Vaginal delivery after caesarean (VBAC). Conversely, some women plan repeated CS (RCS) because of labor pain experience and concern towards vaginal birth. However women's decision is only in their mind and not discussed with their antenatal care providers. The process of decision making involves judging the experience, wanting VBAC or RCS, seeking information and wanting a supportive health provider.

**Conclusion:** However women made the decision about their mode of birth themselves, their decisions were not based on thorough understanding of the advantages and disadvantages of vaginal versus caesarean delivery, rather on their previous experiences and their attitude in combination with other factors. Supporting women by providing clear, appropriate and adequate medical education timely will help women to make informed decisions that are consistent with their values and preferences.

**Key words:** decision making, caesarean section, vaginal birth after caesarean, repeated caesarean section, women, Ethiopia

# 1. INTRODUCTION

## 1.1. Background

Caesarean section (Cs) is a surgical birth method performed with abdominal and uterine incisions. When used for medically prescribed purposes, it can successfully prevent maternal and neonatal mortality. It can be necessary in conditions like prolonged or obstructed labor, fetal distress, or abnormal fetal presentation. While CS is absolutely necessary to save lives in cases where vaginal deliveries would present risks, it can place mothers and children at unnecessary risk of short- and long-term health concerns if done without medical need(1).

In recent years, the global CS use continues to rise accounting for more than 1 in 5 (21%) of all childbirths(1). In Ethiopia, the rate of CS varied between regions with a range of 3 % in rural area to 16% in urban area and the overall prevalence is 5.44%, which is said to be low, while the report in Addis Ababa is opposite. The overall prevalence of 38.3% in Addis Ababa hospitals has been documented(2-4).It is above the World Health Organization (WHO) statement, “the optimal proportion of CS was considered to range between10-15 %”(5).

Women who have had CS for first delivery have two birth options for their subsequent pregnancy either vaginal birth after cesarean (VBAC) which is a planned trial to give birth vaginally or repeated CS (RCS). Starting from 1996, recommendations supporting VBAC as a viable choice for many women with a previous CS were reflected (6). The American College of Obstetricians and Gynecologists (ACOG) and the Royal College of Obstetricians and Gynecologists (RCOG) also concur that women with a history of one low transverse CS, a clinically adequate pelvis, and no previous classical uterine scar or rupture are good candidates to try a VBAC (7-8).

Whereas, RCS becomes prevalent and one of the major factors in an overall rise in CS rate and maternal and baby health risks as well. It accounts for more than one-third of all Cesarean deliveries all around the world(1). About 35 - 43 % of RCS in high income settings, are without medical indication either due to maternal request or in the absence of other recorded indications(9). Studies done in different teaching hospitals of Ethiopia including Addis Ababa also showed that the rate of CS among women with previous CS is high such as 41.1% in (HFSUH) Hiwot Fana

Specialized University Hospital, 21.4% in Hawassa University Referral Hospital, 39.7% in Sent Paul's Hospital Millennium Medical College (SPHMMC). Among women who underwent RCS, 21.1%, 20.3%, and 36.2% respectively were non absolute medical or obstetrical indications (10-12).

It is known that any therapeutic result is an outcome of decision made by the client and medical team. The term decision-making in healthcare has become more prevalent over the last decade, with a focus on how people make decisions about their care(13). According to United Nations Population fund (UNFPA, 2019) a study of 47 countries found that 56% of married women empowered to make their own decisions on sexual and reproductive health. Which greatly varied across countries 6.5% in Mali to 75.6 % in Cambodia. In Ethiopia, based on Demographic and Health Survey (DHS) data women's autonomy in health care decision-making was 19.1% in 2016 and women who resides in urban areas was 98.7% higher than rural residents (14-15). To choose either VBAC or RCS in a subsequent pregnancy is one of the health care decisions women with previous CS faced. However women's decision making process regarding mode of birth (MOB) and women's interactions with obstetricians varies for individuals from passive decision-making to shared decision-making (13).

Making the choice among the available options easier and improving decision making quality are directly related to the routine provision of evidence based information and supporting women in their choice (WHO, 2018). To: provide appropriate information, support their decision-making and offer a positive experience understanding the women's desire in the decision making process would necessitate. Therefore, this study was aimed to explore how women make decisions regarding MOB among pregnant women with previous CS in Tikur Anbessa Specialized Hospital, Addis Ababa, Ethiopia.

## 1.2. Statement of the problem

Both RCS and VBAC have benefits and risks for pregnant women and the child. Yet, researchers have found VBAC as an appropriate delivery option for the majority of mothers and is associated with less complications than planned repeated caesarean procedures (16-18). A successful VBAC has more advantages over a RCS done without adequate indication, starting from shortening mothers' recovery individually up to decreasing maternal morbidity and mortality, risk of complications in the next pregnancy and the rate of CSs at a population level (19). Implies decisions made to RCS without adequate indication can pose more risks. Whereas, CS is overused once the mother has given birth by CS and the proportion of mothers who undertake TOLAC is declining which in turn this raises the possibility of detrimental effects on maternal and newborn health as well as economic burden especially among low income countries(9).

The decrease in VBAC reflects the limitations that certain health institutions placed on TOLAC as well as patients decision (13). The decision making process on a delivery mode after a CS is a personal choice that every woman will make if given the chance. Decision making regarding the MOB is one of the challenging decisions for pregnant mothers and the medical team. Given the complexity nature of the decision making process, health education ought to start early in the course of prenatal care and possibly even before conception is required to enhance and facilitate decision making. During the counseling process, possibilities of success as well as the benefits and hazards of a trial of labor for the mother and the baby enlighten in order for a woman to make a personal decision(20).

In addition to a range of initiatives to improve decision making, shared decision making (SDM) is one strategy promoted as having the ability to lessen clinical variation and the overuse of interventions. It refers to a process of decision-making where women are provided with unbiased and evidence based information about the risks and advantages of various treatment alternatives to enable them to make an informed decisions that are consistent with their values and preferences. The RCOG also recommends that all women with a previous CS to thoroughly informed and decide with health professionals (21-22).

However, decisions made with inadequate or no information regarding RCS and VBAC are still continue to be a concern in many countries. Likewise, Women's fear and uncertainty regarding

vaginal birth and lack of empowerment in making a decision is one of the primary determinants of high RCS rates in low- and middle-income countries (19, 22). Studies also reported that even though women exercise a degree of choice, their decisions may ultimately be influenced by factors outside their control given their lack of awareness and information about various MOB. Historically, it has been said that, connected with the proverb of “once a caesarean, always a caesarean” (23). Health professionals suggestion, and information provided from others, are also found to influence woman’s decision making(24-25).

To overcome the fear of VBAC, to promote women’s decision-making and to maximize a desired outcome for women are closely associated to the clear, culturally appropriate, unbiased and evidence-based information regarding birthing options and the implementation of a mother-friendly antenatal care strategy(22). In order to provide appropriate education and individualized care, a thorough and nuanced understanding of the women’s desire in clinical decision making process and the variety of influences is needed since it will reveal information about health beliefs, concerns, and overall health behaviors of women.

While different studies from high income countries have assessed women’s decision making regarding MOB and factors associated, Ethiopia has a different social context from high income countries and those findings may not explain the phenomenon in Ethiopia. Existing quantitative research on CS and/or VBAC, fall short of providing a complete understanding of the diverse attitudes and elements that underpin women's decision making. Therefore, this qualitative study aimed to explore the process women go through when making decision on their MOB following a previous CS in Tikur Anbessa Specialized Hospital, Addis Ababa, Ethiopia in 2023.

### **1.3. Significance of the study**

Although the significance of presenting the risks and advantages of options to maternity consumers has been recognized, successful pregnancy related strategies are yet to be validated (26). A strategy to address informed decision making, as well as women's ability to make appropriate birth choice in light of the inherent complexity of influencing factors, is needed to reduce unnecessary CS or to support women's decision-making. There have been a limited evidence on this issue. It is important to understand the element that would support women during their decision making and to identify factors that influence women's decision-making about MOB. To address this need, this study aimed to explore how women made decisions on their MOB.

The finding of this study will be used by policy makers and other stakeholders as a baseline data for designing and development of public health policy about on what range information, advice and decision support could be appropriately offered by health services.

The findings of this study will inform health care providers to take in to account the various perspectives that women bring to decisions regarding MOB for routine provision of explanations regarding alternative birth options.

Also, the finding will have many significant use to the community such as to encourage women to involve in decision making based on reliable information about birthing options, as a result to reduce unnecessary CS and to reduce child and maternal risks of health problems and economic burdens.

This study is the first of its kind in Ethiopia and it will serve as a baseline for future research.

## 2. LITERATURE REVIEW

### 2.1. Introduction

A grounded theory generated in Loyola University Chicago stated the decision making process of birth mode after a primary Cesarean delivery begins with having a CS for the first birth followed by the women's judgments of the CS experience. Then, women start to seek information about subsequent MOB, which leads them to learn more and helps them to decide whether they want VBAC or RCS for the next. Depending on desired birth mode, women search for a supportive provider (13). Another constructivist grounded theory conducted in Canada stated Women's decision making for birth mode after a Cesarean delivery as a process of "seeking control in the midst of uncertainty" consisting of, reflecting on their birth, clarifying their values, becoming informed, considering the feasibility of options, deliberating with the care team, and making an actual choice. Similarly, a study done in Taiwan, showed the decision-making process for women involved searching for information, listening to obstetricians' professional judgment, evaluating alternatives, and making a decision regarding mode of birth (27-28).

Most women, express the desire to be engaged in their choice of delivery mode if given the chance. However the level of involvement varies depending on the individual ranging from minimum to complete. Most women believed themselves as having little power over MOB. Moreover, while some want total control over the decision, most women are hesitant to make the choice on their own (13).

A survey study from the US (N = 68) found that 86 % of women had not received the information needed to make an informed choice. This study also found that women reported having little power in terms of their MOB choices, and that information was provided in a biased manner in order to influence them towards a specific MOB. Moreover, this study noted that while women felt as having little power on their MOB, this was enjoyed by many who did not want to make a decision. Similar study from Taiwan found that Obstetricians rarely offered advice about MOB during consultations, and women rarely asked questions. However some women were informed about their MOB alternatives, the majority did not informed or given a choice. Similarly, a study from Peru (N = 17) found that over half of women had been involved in the decision of MOB, while the remaining were either provided no information, or only told about one option(25,28,29).

A descriptive cross-sectional study conducted in Nigeria showed that among 215 respondents 50.2% were fully persuaded by the obstetricians, aware of the risks, and registered their agreement to participate in the choice to have a CS. In Ethiopia there is no specific study on women with previous CS. A single institutional cross-sectional study conducted in SPHMMC on 288 women who underwent elective or emergency CS showed that only 50 (17.4%) of participants reported having information of risks of the CS. 54% of respondents reported that no enough time were given for them to decide whether to have the CS (30-31).

Having said that, attitude and support from healthcare professionals, continuity of care, and information provided during pregnancy could play an important role in maternal decision, Pregnant women additionally utilize the internet, information from family, friends, and other women's experience of birth mode decision making process ,as well as relative risks and benefits of vaginal versus cesarean delivery for information empowerment in their decisions (32-35).

## **2.2. Factors influencing women's decision making**

### **2.2.1. Previous birth experience**

A study conducted in Taiwan revealed that Women's prior delivery experience was the most often mentioned element that influenced women's decisions. Often women who had a positive experience for their prior delivery choose similar MOB for the next. Oppositely, women choose a different MOB if they had negative experience of prior birth. Likewise a study done in Peru mentioned that women made decisions based on their own previous experiences. Women chose TOLAC since their prior CS experiences had been painful and required a lengthy recovery. (25,28).

Another study conducted in Italy stated that women's feelings regarding the prior experience played a big part in how mothers made decisions. Mothers who were less satisfied with their prior CS experience want to attempt a VBAC (32). Similarly, a descriptive cross-sectional study conducted in Turkey revealed that women's views on VBAC were shaped by their birthing experiences and the care services they got. It was determined that the most important factor influencing their willingness and desire for VBAC to become widely used in the country was their

prior unpleasant CS experience. Moreover, a study conducted in Nigeria mentioned prior experience as one of the factors influencing women's decision to have a CS or not (22, 30).

### **2.2.2. Concern about the risks of vaginal birth**

A global qualitative evidence synthesis of 52 studies explores women's desires for MOB and factors determining desires for CS showed that some women had deep seated fears towards vaginal birth including pain and harm to the mother and baby during labor and delivery. Among other unfavorable effects, women noted vaginal deformation and diminished sexual pleasure, as a result of exertion of delivery process. Uterine rupture was also mentioned (24). Also a cross-sectional web-survey conducted in Western Switzerland stated that woman's personal values and what was thought important to them influenced the choice for VBAC or RCS. For example, reduced likelihood of VBAC was predicted by women's perceptions of their safety (20).

Another study conducted in Taiwan noted that Concern about vaginal birth influenced women to choose RCS. Uterine rupture and labor pain are mostly mentioned fears related to vaginal delivery following CS. A similar qualitative prospective study conducted in Peru also reported that. Mothers terrified the pain of a vaginal birth. Similarly, study done in Turkey found that preference towards VBAC was markedly lower in women who hold an unfavorable view of VBAC. Women fear to have VBAC and claimed it as very risk full. concerns about safety and vaginal delivery were also highlighted as factors for women who had CS in a study conducted in Nigeria (22, 25, 28).

### **2.2.3. Information from health care providers and knowledge**

Information about health and practical issues related with the various delivery modes, tended to come from health professionals. Many women trust their health providers and they comply with what the health care professional believes is best (20).

According to a cross-sectional web-survey conducted in Western Switzerland medical guidance is one of the most significant influences on women's birthing option preferences, it is proven, as care provider recommendation was the biggest predictor for a VBAC at term. This study found that most women who did not get enough counselling regarding their likelihood of having a successful VBAC underestimated it. This study also highlighted that, the caregiver's advice and mother's

preferences throughout the third trimester may support one another (20). A similar study done in Australia noted that continuity of care with a midwife has been observed to rise mother's confidence by enhancing normality, making women to feel comfortable and secure and giving options. Midwives' confidence in women leads women to feel more confident by themselves (36).

Another study conducted in Turkey found that women who participated in SDM counseling sessions experienced less conflict in MOB choice. On the other hand, they were more aware of the advantages and risks of birthing options, social support, and sound decision making. In this study, it is believed that women's inability to get objective, fact-based advice on birth modes result them to abstain from decision making (22). In another study conducted in Peru it is also mentioned that the majority of women were at ease with their decision, due to unawareness of the most important risks associated with vaginal birth or in RCS (25).

A global qualitative evidence synthesis of 52 studies reported that the idea of CS as a pain-free delivery method promoted by healthcare professionals, enticing mothers to make this choice. Many women who voiced concerns about how their health care providers pressured them to accept a CS despite potential risks were concerned about undergoing an unneeded CS, and felt they had little power on the choice but nevertheless went along with it since they trusted their providers. This synthesis also noted that, regardless of how much self-education women completed before their labor, they often still became entangled in the hierarchies of medical paradigm in ways they had no control over. Thus, women's ability to make a decisions was significantly hampered since they lack the ability to contest the doctor's assertions of superior knowledge (24).

In study conducted in Italy over 82% of the participants said that their doctor recommended them an ERCS which inspired fear in women who want to make the right decision This study highlighted women require information at the point to their situation, rather than broad information about various delivery methods (32). Similarly, study done in Taiwan mentioned that, Obstetricians' recommendations were among the information sources that had a significant impact on women's choices. The obstetricians' recommendations that the following birth should be a cesarean after one caesarean influenced women to choose RCS. Also women reported that they did not provide with any explanation despite they followed their obstetrician's decisions (28).

Moreover, in a study conducted in Nigeria it was found that doctors play the most role in women's choice to have a CS (44.7%) (30).

#### **2.2.4. Other Information resources**

Different studies mentioned that Women did not only receive formal information about MOB from obstetricians and nurses. Instead, they obtained information from variety of sources, including the experience of significant others (partners, family members, friends and work colleagues) and Internet. According to a study done in Italy both the other's experience and information from online appeared to play a role into maternal decision-making (32).

##### **2.2.4.1. The experience of significant others**

A study done in Western Switzerland revealed that Women claimed that their decision-making was more influenced by their family members specifically mothers, mothers-in-law, sisters and sisters-in-law who had birth experiences who had birth experience over other female friends or colleagues. Most of significant others evaluated birth mode based on their prior birth decisions. For example, they suggested RCS because they experienced a VBAC led to a RCS (20, 22, 24,25,).

A global review of 52 studies also found that the motivations for women's preferences for different birthing modalities are influenced by social, cultural, and personal aspects as well as characteristics of health systems (24). Another study conducted in Peru found that the majority of participants often chose their own birth method. However, usually the women's decisions were not on based on thorough understanding of the advantages and disadvantages of vaginal versus cesarean delivery, rather their own prior experiences or those of their family or friends (25).

##### **2.2.4.2. Internet**

According to a study done in Taiwan, Platforms like Yahoo, Facebook, and Google were commonly used by women as information sources. On the internet, some women who had CS previously revealed their experiences in regards to birth preferences. In addition due to the dramatic internet portrayals of uterine rupture, pregnant women were hesitant to undergo a VBAC. A survey conducted in Western Switzerland also mentioned that, women actively sought information online to learn about the dangers and advantages of both delivery modes since

healthcare personnel were unable to adequately explain why a CS was performed (20). A similar study done in Italy also showed that when women feel they have not been given enough information on the MOB, they attempt to remedy this by finding and searching online (32).

### **2.3. Conceptual framework**

The conceptual model shown in Figure 1 below is adapted from theory developed in 2019 on the decision making process for women as they choose a birth option after a previous Cesarean delivery in Loyola university Chicago(13). It defines the decision making process of subsequent pregnancy birth mode as “having a Cesarean delivery for the first birth, followed by the women’s judgments of the experience of Cesarean delivery, seek information, know more, getting to a decision of wanting a VBAC or wanting a RCS, and searching for a supporting provider.” This model is chosen as the conceptual framework for this study to explore how women with previous CS make a decision towards their MOB among pregnant women in Tikur Anbessa Specialized Hospital.

This conceptual model is along with stages in which what women go through and consider to make the decision. It claims that the decision making process of subsequent pregnancy birth mode after a primary CS begins with having a Cesarean delivery for the first birth after a cascade of interventions at the hospital, causing women to judge their own experiences with it (CS). women’s judgments varied greatly either having a bad or a tolerable experience(13,25,28,30). From the experience, Women seek information from a variety of sources to understand the causes of their first CS and their alternatives for next pregnancies. Women may seek ought information independently through online forums and search engines. Women also got information from other women who had Cesarean birth previously, women trying and/or having a successful VBAC, women who have a RCS, and from their providers lead them to know more about pregnancy and about birth options in contrast to their initial (13, 20,24,25,32).

Knowing more about the advantages and disadvantages of both VBAC and RCS lead women to a decision whether they want a VBAC or RCS for their next pregnancies. Wanting a VBAC reflects women underwent primary CS for their first birth, had a bad experience with it, looked for information, became aware about alternative birth options, and want a VBAC for their next pregnancy(13, 22,32). Women Wanting a RCS may have had a suitable CS experience, looked for

information, became aware about alternative birth options, and are wanting a RCS because they know what to expect and afraid of trying a vaginal delivery (13,25,28). Based on birth option desired, Women search for a supportive provider to have the delivery they want (13).

This model will be used in the study because it is a multilevel theory and as such, enables the study to ascertain both the process women go through making a decision on their MOB and the factors influencing the decision making process among pregnant women with previous CS since decision-making is described as a process in which various factors are considered before a decision is made(32).

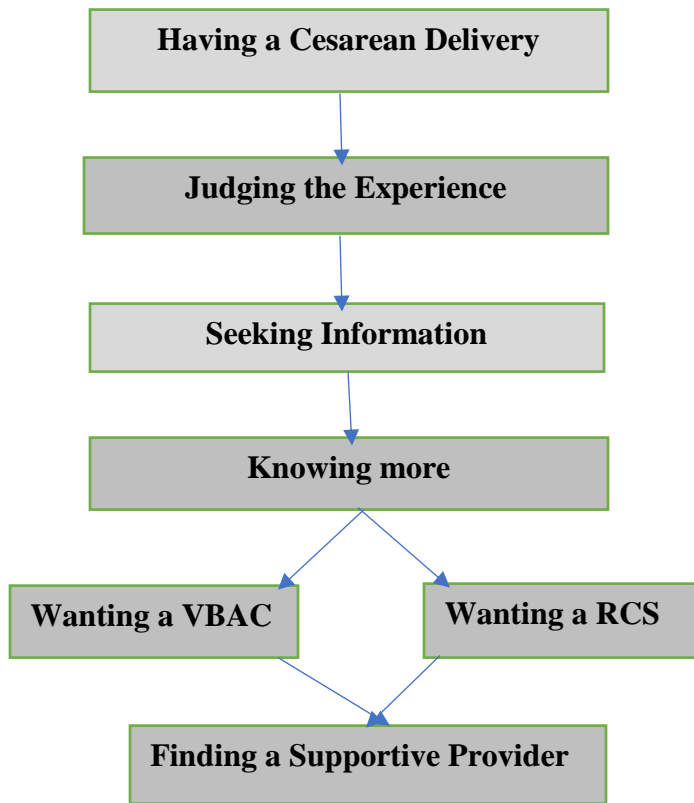


Figure 1. Conceptual framework of the decision-making process of birth mode after a previous cesarean delivery adapted from prior study (Dixon M, 2019)

## **3. OBJECTIVES**

### **3.1. General objective**

- To explore decision-making processes on mode of birth among pregnant women with previous cesarean section in Tikur Anbessa Specialized Hospital, Addis Ababa, Ethiopia 2023.

### **2.2. Specific objectives**

- To describe study participants decision making processes towards their mode of birth after previous cesarean section
- To examine study participants involvement in decision making process
- To explore what influences study participants decision making process

## **4. METHODS**

### **4.1. Study setting and period**

This study was conducted in Tikur Anbessa hospital Addis Ababa, Ethiopia. Addis Ababa is the capital and largest city in the country of Ethiopia. There are 13 public hospitals. From those Tikur Anbessa, hospital is selected purposively. Tikur Anbessa, which is Specialized Hospital, is a referral and teaching hospital under the Ministry of Education of Ethiopia (37). Maternal health care is one of the services provided to clients devoted in different units such as MICHU, gynecology emergency ward, gynecology impatient ward, labor, delivery ward and postnatal ward. Participants for this study were selected from MICHU clinic. The unit is Reproductive Health Clinic and appropriately named Michu, which means “comfortable”. In Tikur Anbessa specialized hospital, this clinic provides clients with antenatal care, family planning, postnatal follow up and PMTCT. This unit has eight rooms and it encompasses seven staffs including one midwife, one nurse, two interns and three residents. In average around 90 women receive antenatal care in this clinic per day. Women with CS scar make up 80% of the overall number of women receiving ANC in this clinic (Coordinator of Michu unit 2022/23).

The study was conducted from February 20 to march 20, 2023.

### **4.2. Study Design**

A qualitative study design was conducted using an explorative approach to explore the decision making process of women who have had previous cesarean section for their next mode of birth.

### **4.3. Study participants and sampling**

Women with previous CS seeking of antenatal maternal services were considered as a study participant. A total 20 Participants who match the inclusion criteria and able to offer detailed information were chosen using a purposeful sampling procedure. A midwife who work in the Michu clinic assisted in the recruitment of the study participants. There was a flexibility in the sample size based on saturation of the data.

#### **4.4. Eligibility Criteria**

##### **Inclusion criteria**

To be selected for the study, participants had to have immediate CS history (no any other pregnancy between the previous CS and the current pregnancy) and also they had to be in the third trimester of the pregnancy (from week 27 of gestation to the end of the pregnancy).

##### **Exclusion criteria**

Participants who were unwilling to participate in the study, and women who had an indication for RCS were excluded.

#### **4.5. Operational definition**

**Decision making:** Health care decision making is “a process involving information processing, evaluation of evidence, and application of relevant knowledge to select the appropriate intervention that provide high quality care and reduce risk of harm”(38).

**Shared decision making:** where the mothers and health care givers share information and they can jointly decide based on the best reliable evidence, as well as the values and preferences of women (21).

**Passive decision making:** in which women not actively engaged in the consultation, take no action in choosing their plan and they delegate responsibility of the decision to their physicians (13).

#### **4.6. Data Collection tools and Procedures**

The data was collected via an individual, in-depth interview technique by using semi- structured guide in Amharic. Three volunteers who match the established qualifying requirements was used to test the interview schedule. Those participants and the findings were not included in the main research as the goal is to test if the research questions could elicit adequate responses and how much time will the interview possibly took. The researcher was able to improve the interview guide as a result of the pretest by adding more probing questions and clarifying the guide.

The interview guide consisted of basic sociodemographic characteristics (age, marital status

educational status residency), decision on MOB, the process women go through when making decision, and what influences birth option choices. Interviews was scheduled by the principal investigator (PI) and conducted with one trained assistant data collector. There was a flexibility in the order of questions and prompts were employed to better grasp the distinctive experiences of the participants. An in-depth interviews were done until saturation reached. When more data failed to reveal any new emergent codes or themes. Interview was took place in a private room in the hospital. With the participants' permission, audio-record and written notes were taken during the interviews. The interviews were done in Amharic and lasted approximately 14-31 minutes.

#### **4.7. Trustworthiness**

Trustworthiness of a qualitative study is the degree to which the acknowledged meanings characterize the viewpoints of the participants truthfully. The four criteria for confirming trustworthiness which comprises credibility, transferability, dependability, and conformability were addressed. To assure the report's credibility, several procedures were used, including prolonged engagement and the use of the same interview guide throughout the study. Preliminary findings were presented to colleagues to receive input and comments. To ensure the transferability of the research results to similar contexts, a detailed explanation of the study area, methods, and the process for participants' recruitment and comprehensive explanation of the research background is provided. An audit trail was kept for researchers to confirm the methodologies used in the study to ensure dependability. By using bracketing, the researcher guarantees that their attitudes, thoughts, and experiences about the topic under inquiry have no bearing on data collection and analysis. The study's data gathering, and analysis techniques were also unaffected by the researchers' backgrounds.

#### **4.8. Method of Data Analysis and Processing**

Descriptive statistics was used to summarize the socio-demographic characteristics of participants. Data from audio recorders was transcribed verbatim concurrently with data collection. Transcribed verbatim was translated into English and imported to ATLAS.ti 9 software. The PI choose the transcripts at random and create the first codebook. The Primary advisor was then go over the data that are coded and combined the main and sub-themes. Both a priori codes (from the query guide) and emerging inductive codes was used in the study. The

thematic method of analysis involve stages such as the construction of textual data, organizing the data in meaningful and systematic way, the description of the data themes, reviewing themes and the interpretation of the structure and content of the themes. Finally, the views shared by respondents are used as a quote to support the points to be made in the study.

#### **4.9. Ethical Considerations**

This study was conducted after full approval and ethical clearance is obtained from Addis Ababa University, College of health sciences, school of nursing and midwifery. Written request to conduct the study made to Tikur Anbessa Specialized Hospital. First the purpose of the study was explained to all participants and informed written consent was obtained from every participant to conduct the interviews as follows: The voluntary nature of participation in this study will be underlined. The information obtained will be kept confidential. Your name will not be written so that the gathered data remained anonymous. You have the right to withdraw your participation at any moment without any cost. Finally, the researcher ensured that whether the participants are understand the information given at the level of their understanding before they sign to the consent form.

#### **4.10. Dissemination of Study Findings**

The findings of this study were submitted and presented to the School of Nursing and Midwifery at Addis Ababa University's College of Health Sciences. Finally, attempts will be made to publish portions of the research findings in reputable local and/or international journals. Workshops and seminars will also be used to disseminate the findings.

## 5. RESULTS

The findings of this study have been presented in two sections an overview of the individual characteristics of participants and the emerged themes related to decision making towards MOB.

### 5.1. socio-demographics characteristics of the participants

This study enrolled a total of 20 pregnant women who have had one previous CS. The mean age of the women was 27.85 (SD=3.9) years with range of 21 to 37 years. Abnormal fetal presentation was the reason for CS for five mothers. Twelve participants had their CS in TASH. And eighteen participants have three and above years gap between their previous CS and the current pregnancy. Eight mothers are with 37 weeks and above of gestational age. The number of ANC follow up ranged from 4 times to 13 times.

Table 1 : socio-demographics characteristics of the participants in Tikur Anbessa specialized hospital, Addis Ababa, Ethiopia.

| Cx of the participants      | Range                 | Median           |
|-----------------------------|-----------------------|------------------|
| Age (years)                 | 21-37                 | 27               |
| Time gap (years)            | 2-8                   | 4                |
| Gestational age(weeks)      | 29-40                 | 36               |
| Number of ANC follow up     | 4-13                  | 7.5              |
| Socio-demographic cx        |                       | <b>Frequency</b> |
| Occupation                  | Government employee   | 4                |
|                             | Self – employee       | 7                |
|                             | House wife            | 9                |
| Education                   | No formal education   | 1                |
|                             | Elementary (1-8)      | 3                |
|                             | Secondary (9-12)      | 9                |
|                             | College and above     | 7                |
| Residency                   | Addis Ababa           | 18               |
|                             | Out of Addis Ababa    | 2                |
| Reason for previous CS      | Abnormal presentation | 5                |
|                             | Foetal distress       | 4                |
|                             | Prolonged labour +FD  | 4                |
|                             | Macrosomia            | 2                |
|                             | Post term             | 2                |
|                             | PROM                  | 1                |
|                             | Oligohydramnios       | 1                |
|                             | HTN/DM                | 1                |
| Place previous CS performed | TASH                  | 12               |
|                             | St.Paul               | 2                |
|                             | Private hospital      | 3                |
|                             | Welayita sodo         | 1                |
|                             | Torhailoch            | 1                |
| Parity                      | ParaI                 | 18               |
|                             | Para II               | 2                |

## 5.2. Emerged themes

This study aimed to explore how pregnant women with previous CS in Tikur Anbessa Specialized Hospital make a decision on their MOB following cesarean delivery. Based on the data three themes are identified which are in line with the objectives of the study and somehow related with the conceptual framework used for this study. Namely: women’s involvement in decision making, the factors influencing women’s decision making and decision making process.

Table 2. Themes, sub-themes, and codes identified from interviews of women with previous CS seeking ANC service in Tikur Anbessa specialized hospital, Addis Ababa, Ethiopia, 2023

| <b>Themes</b>   | <b>Subthemes</b>   | <b>Codes</b>  |
|---|--|---|
| <b>Women’s practice/<br/>involvement in decision<br/>making</b> |  | Decision made<br>Decision not made but prefer one<br>By own self<br>Together<br>Health professional’s<br>Contribution |
| <b>Factor influencing<br/>women’s decision making</b>           | Previous experiences   | Cs experience<br>Labor/ vaginal birth experience<br>previous pregnancy situation<br>Experience of decision making     |
|   | Women’s attitude   | Attitudes towards MOB<br>Concerns about vaginal birth<br>Attitude towards decision making                             |
|   | Information sources  | Significant others<br>Health professionals<br>Internet  |
|   | Cultural and religion views<br>towards MOBs and<br>children  | Cultural views towards MOB<br>Religion views towards MOB<br>Religion views towards children                           |
|   | Women’s knowledge  | Awareness about advantages and<br>disadvantages<br>Lack of awareness  |
| <b>Decision making process</b>                                  | Judging the experience<br>Want VBAC or want RCS<br>Seeking information<br>Wanting a supportive health<br>care provider |   |

### **5.2.1. Women's practice (involvement) in decision making**

Participants were asked their current decision to MOB. The results of this study shows that all the study participants have information as they have two options of birth following CS. Women have a desire to make or involve in a decision of birth mode if given the chance. Almost all of the participants express that their previous CS was not their plan. The interview involves both who had emergency and elective CS because of complications. Out of the interviewed women 11 participants had elective CS by health professional's initiation because of abnormal fetal presentation, macrosomia, post term, oligohydramnios and maternal hypertension.

16 women have their own decision for their birth mode currently and almost all made the decision by themselves. One of the participants who plan to try VBAC said, "I made it by myself other ways still now they didn't say anything." Also women raised that health care providers both in the health center and in TASH were passive to discuss about the birth preparedness. The only contribution of ANC providers is asking mother's interest rather than discussing and deciding together.

*"They asked me my interest...they gave me it as a choice. It is like that of giving a food menu."*  
(39 weeks of GA Woman who plan VBAC)

In the other hand, some women are passive to make a decision and wish if the health care providers decide for them. Those women abstained from making a decision but prefer vaginal birth if it would be.

*"The doctor asked me the way by which I want to give birth, and I told him that the decision will be theirs'. But I would be happy if god permissioned and I could deliver by labor."* ( 38 wks of GA woman)

### **5.2.2. Factors influencing women's decision making**

Based on the data many factors tend to influence women to choose VBAC, RCS or not to make a decision at all. The identified factors involves women's experience, women's attitude, information sources, cultural and regional views towards MOB, and Women's knowledge about MOB.

### 5.2.2.1. Women's experience

As many participants expressed both previous birth experience and decision making experience found to lead women to desire one MOB or not to make a decision for the next pregnancy. Women who underwent elective CS previously and who faced side effects mostly want VBAC. Out of 11 women who plan VBAC 7 had no labor history. Long time to heal, inability to do any work they want, needing assistant to take care of them and their children and weight gain are some of the side effects of CS that most women raised and leads them to need VBAC.

*“This because I hate surgery relative to the time it takes to recover. Previously I hadn't work and there was no problem but now I want to back to work quickly”.* (32 wks. of GA Woman who plan VBAC)

Intent to try vaginal delivery also a cause for women to choose VBAC. some women who never tried labor before mentioned that since they didn't see what labor looks like, their interest to try became one of the reasons to choose VBAC now.

*“That is not since I have other information but that is because I saw the cs and I didn't saw the labor so it is just to see the labor”.* (39 wks. of GA Woman who plan VBAC)

In the other hand women experienced labor and vaginal birth tend to compare both their experiences and skew to the one birth option. Out of 5 women who plan RCS 4 had CS following unsuccessful labor and one had successful vaginal delivery before. Labor pain is the main bad experience which make them to vaginal birth ever. Some also raised the procedure like forceps and augmentation medicines did to assist labor as an unedifying. Those women described cesarean delivery as a reliever (ገላገሌ). As stated by those participants even if women know the risks and disadvantages of CS, they choose RCS because of bad labor experience.

*“ They insert spoon(forceps) in to me. Something said to be a spoon (forceps), something to pullout, all metals also ringing on my ear still”.* (32 wks. of GA Woman who plan RCS)

*“CS doesn't have use it has harms like bleeding, the wound might be untied, can't heal quickly, infection might be occur. I know that it is possible to give birth by labor for the second but the reason is the agony during labor.”* (32 wks. of GA woman who plan RCS)

Moreover, some participants abstained from making a decision because their expectation of vaginal delivery failed previously. Those women raised their previous pregnancy conditions lead them to CS as the final decider for the current pregnancy too. So, the fear of those condition if occurred again hold them from making a decision.

*“To make a decision is something which makes a confusion. For example, previously I gave birth by CS after I thought to deliver vaginally... May be the case for my previous cs can happen now ... so to decide is difficult”.* (36 wks. of GA Woman who have no plan but prefer VBAC)

In addition, Women had previous CS by only health professional’s decision fail to decide now even if they have preference towards vaginal birth. Because they believe that the final decision will be the health care provider’s. One participant who is a clinical nurse in TASH also witnessed that “as Tikur Anbessa I didn’t see many times when the mother’s choice is considered to make a decision. They (health providers) will make the decision by their self.” And some claimed that women are not supposed to make a decision since they didn’t involve in previous CS decision.

*“I have no plan. I know that the health professionals will decide. Because my previous CS was also their decision. So I don’t know that my interest is necessary. (29 wks. of GA Woman VBAC)”.*

#### **5.2.2.2. Women’s attitude**

The women’s attitude towards both MOBs and decision making is another factor influence women’s decision making. To give birth without limit, to stand quickly and to do any work are some of the benefits of vaginal birth over CS many women perceived. One participant who plan to try VBAC said: “More than three is impossible. Even the pain... labor is for few days or for today only I guess like that. For example me, we live out of the town and we carry water from other area; so I will do as I want.”

*“Number one ,to give birth many. As long as the CS is continued , even if you wish to have ten children, since the limit is said to be 4 you will be limited by four.”* (32 wks. of GA Woman who plan VBAC)

Labor is natural, normal, healthy, god’s gift, and a measure of being female are several women’s perceptions towards vaginal birth. Those women consider CS as human made, planned and something with a gap.

*“Whatever it is, the normal thing and something that has some gap are never related. This is just god’s gift; god brings it us; so, without any doubt no one will hate something clean and normal (33 wks. of GA Woman who plan VBAC)*

In the opposite, some women have concerns towards vaginal birth like labor pain, stitch, and impact on child which lead them to prefer RCS. Those women consider CS as a simple process. One participant explained it as “You will just sleep and a child will be given to you with in 30 minutes. Labor has many feelings like pain, tiredness. You won’t know the time that you give birth. May be it can take a day and night”.

*“..maybe I don’t want anything to be happened to my child while I am trying labor. That means both you and your child will be healthy.” (34 wks. of GA Woman who plan RCS)*

Women also have an attitude towards making a decision that limit them from choosing one birth option. Some thought decision making towards MOB as a hard to do. Some participants revealed that making a birth mode decision is not their role. Those women have no wish to involve in a decision and ready to accept whatever the health provider will say. In addition, some women thought it is early to talk or to decide about birth.

*“I didn’t decide still. it would be good if the health professional decide for me. I have to accept and implement what they are going to tell me. I just won’t negotiate.” (36 wks. of GA woman)*

*“.... Because this is not the thing to be decided now. I don’t also believe that it can be decided now”. (33 wks. of GA Woman)*

Women’s attitude towards a referral hospital is another thing holding them from making a decision. As participants mentioned what comes in women’s mind when they join a referral hospital is that a cesarean delivery. So, they leave to think about deciding birth mode since they claimed that their option is only CS.

*“Not only me but others too will stun. Especially people who sent to referral hospital, what directly comes in their mind is that operation is the final choice.” (34 wks. of GA Woman)*

### 5.2.2.3. Information sources

Women tend to get information from significant others, health professionals, internet and those found to shape their decision or not to make a decision.

#### **Health care professionals:**

Recommendation towards one birth option from health care providers who did the previous CS and/or the ANC provider may make women to desire that option. Two participants, plan VBAC and RCS, described a recommendation from the health care providers who did their previous CS.

Moreover, a good number of participants raised that enough information from the health professional is critical for them to make the right decision and to be confident. Out of the interviewees only one participant mentioned that she received a detail information from her ANC provider. The others expressed that even if detail education from professionals is very useful, they provide a minimal and general information or no information at all. One participant said “first of all, did the health professionals here in Tikur Anbessa talk to mothers like this? even the condition of the fetus will be told to you if you ask. I never see a doctor who talk to you here. even they will not give you a way to ask.”

Many women raised the inability to be followed by one ANC provider throughout the pregnancy as a problem related to this. Women in TASH had a follow up in health center first. Plus they tend to find different physician with each schedule of ANC follow up in TASH too. As many participants reported women going to asked similar things as the beginning with in each schedule rather than birth preparedness. One participant who is a clinical nurse in TASH witnessed that “firstly this is governmental hospital and also a teaching staff. For every follow up you come you will get another doctor. So only some may listen you and gives you an awareness. So the awareness creation practice is somehow low.”

*“... During my stay I never found one doctor for the second time. i think this is the problem. because when you get different doctor they will always ask you similar things like LNMP, your interest.”* (29 wks. GA woman)

Likewise women who had ANC follow up in private mentioned that what they heard in private is opposite from the TASH which made women unable to choose one option.

*“...the doctor who followed me up in private previously told me to not to try labor again...But when I came here (TASH) I get to know that I can try labor. And I was somehow confused when I get a different thing between the doctors in private and here.”* (36 wks. of GA Woman)

Related to this many women recommend the ANC providers to improve their culture of discussion with mothers. One participant stated that “the health professionals should teach the mothers not by the way he understands but the way that most of the society could understand. I think mothers won’t face a difficulty of decision making if the health care professionals aware them the condition they (mothers) have, about side effects and advantages of each MOBs”.

In the opposite, some participants support the health care professional’s limited information described knowing more about the risks and benefits of both birth options can cause women to worry about that. What participants expressed is that if the health care provides tell them about the risks of RCS women will face a fear like what if those risks will happen on me. Also if the health provider tell them about the benefits of VBAC women will face a fear like what if I can’t give birth by that.

*“They presented to me CS or labor and I choose. But I believe they do by the magnitude they have to talk, if they told me everything in detail I will be so much disturbed. so I think their minimized information is good.”* (37 wks. of GA Woman who plan RCS)

### **Significant others:**

Women also use other’s information, recommendation, birth experience, and others attitudes towards MOBs to choose their current birth option. As several women expressed most of the information women used to know more about birth options is from others like families, friends and/or society. Which aids them in their decision.

Women also look at families and/or friends birth experience after CS. Women tend to get hope for themselves when they see women having a successful VBAC. Conversely women who plan to try VBAC became confused and unstable when they hear about other women’s unsuccessful VBAC.

*“There were my friends before who gave birth by CS like me. So now when I saw them ... I also should deliver I said and I make my mind to believe.”* (32 wks. of GA woman who plan VBAC)

*“Do you know what poisons my mind now? when I talk with many person who had surgery, they said even if the labor comes, we didn’t deliver. One woman told me that even if labor started and amniotic fluid ruptured, she couldn’t to give birth.”* (39 wks. of GA woman who plan VBAC)

Moreover, women notice other’s attitudes towards MOBs and that influences their own attitude towards MOB too. Other’s: perceptions, reactions towards CS and advices for women with CS are some of the raised factors lead women to prefer VBAC.

One woman mentioned that people count giving birth by CS as god’s rage or badness and that is the main reason she decided to try VBAC. Also people count inability to give birth vaginally as lack of capacity or laziness. Some participants mentioned that the advices related to taking a care of women with CS provided by other people make them scared about CS. This make women to think about the limitations of cesarean delivery which lead them to prefer VBAC. In addition, the society reacts for CS like a death and that also lead women to prefer VBAC.

*“...for anything you act, for anything you hold, for anything you do, why the advices like: she have to be like this, be like this comes? This because of I gave birth by CS. those things make me to think like what if it will try labor.”* (36 wks. of GA woman who plan VBAC )

In the opposite, other’s perceptions toward benefits of CS like to escape: labor pain, stich, and breast feeding push some women to prefer RCS.

*“Indeed previously I heard positive things about CS. Women who don’t want to feed a breast, who are shappy choose CS. Now their thought comes to me too because labor has somuch things.”* (34 wks. of GA woman who plan RCS)

### **Internet:**

Some women sought information from websites like google, YouTube and Tik tok to know about the possibility of birth options following CS and preconditions too.

*My eagerness increased when I read that women with a surgery can gave birth by labor... I read that the child’s presentation can be turned when I lift heavy objects and I am taking care of that also.”* (39 wks. GA woman who plan VBAC)

However some participants mentioned that they don't want to know about both MOB's but only about the way they want/plan.

*“Now I don't want to see about surgery. I read well about labor. I read the time when labor starts, the processes and the feelings of it.”* (32 wks. of GA woman who plan VBAC)

*“I read properly on google...I didn't read any about labor means I don't want to know and hear about it. I read and kept only what is concerned to me.”*(34 wks. of GA woman who plan RCS)

#### **5.2.2.4. Cultural and religion views towards MOB's**

As some participants pointed regional and cultural views towards MOB's and children have some part on choosing a birth option. Labor is natural law for females but CS is human made and technology; labor starts by itself but CS is planned are some views of our religions and/or cultures on birth options. Thus, it has a part on women's preference to wards VBAC too. One woman explained it as follows “the culture accepted the labor. Because labor is a natural way to give birth and it will start by nature. But CS most of the time is planned. So people may relate those things with god because CS is planned and done by person rather than waiting the natural way that god gives us.”

In addition one participant mentioned that undergoing CS repeatedly has a limit. And that is against a religion since calculating number of children to give birth is not permissioned by religions. She explained as, “when it is the surgery, you will be limited by four children. In our religion a calculation like how many children will I have is not working. So since there is a belief like this, I won't face a calculation like that if I gave birth by labor.”

#### **5.2.2.5. Women's knowledge about MOB's**

The findings of this study also revealed that awareness or lack of awareness about birth options following CS have a significant role in decision making. Some participants made a decision based on their Knowledge about benefits and risks of MOB's. In addition most women mentioned that knowledge and a deep understanding about both options is needed to make a decision.

*I know both the advantages and side effects by myself. So when I compare both relative to their side effect and advantage I prefer labor and I would be happy if it could be. (38 wks. of GA woman who plan VBAC)*

Conversely, there are women leave the decision for the health providers and failed to make a right decision since they lack awareness. Moreover many participants mentioned women's health condition as one prerequisite to give birth by RCS or VBAC. Hypertension and diabetes mellitus are diseases that many women mention as an indicators of RCS. Indicates women have some misunderstanding about indications of RCS. Also as elicited from some participants, women understand cesarean delivery economically rather than health related benefits and side effects. Seems women have a knowledge deficit about risks and benefits of birth options.

*“... what I understood is that labor is better. If mothers don't have chronic illnesses like DM, HTN, they can try labor.” (32 wks. GA woman who plan VBAC)*

*“... if you are luxurious, wealthy, operation is nothing. It is trimming that means after the procedure. I don't think it has other bad things.” (36 wks. of GA woman who plan VBAC)*

### **5.2.3. Decision making process**

Of the women who made a decision, the majorities start to think about their next MOB following their CS delivery. The process of decision making among women who have a plan on MOB involves judging their experience, wanting VBAC or wanting RCS, seeking information, and wanting a supportive health care provider.

#### **I. Judging their experience**

Following the cesarean delivery women tend to judge mode of delivery based on their previous experience. Through that women notice the benefits and side effects of MOB. Women who only experience CS mostly report the side effects of CS such as long time to recover, inability to regain daily activity and care for their child within short period, possibility of body image disturbance and inability of breast feeding. In the other way women whose CS was following unsuccessful vaginal delivery more of reported the bad feeling they felt related to labor like pain of labor and

procedures did to assist vaginal delivery. In addition most women compare their CS experience with others vaginal birth experience to distinguish side effects and benefits of both.

*“Surgery needs time to relieve, to move, and to lift objects too... and also to take care your child, to feed a breast... when you give a birth by surgery you need a person to bring you the child. It was hard for me to move as I want and to do a work what I want”.* (32 wks. of GA Woman who plan VBAC)

*“Firstly suffering is above everything whenever we think about labor. So for me CS is best...it is based on what I see.* (32 wks. of GA Woman who plan RCS)

## **II. Wanting VBAC or wanting RCS**

Based on their experience of birth in combination with their attitude towards MOBS women tend to choose VBAC or RCS for the next pregnancy. Experienced side effects of CS and Women’s intent to try vaginal delivery lead women to want VBAC. In the other hand bad experiences of labor lead women to want RCS.

*“... this is because of things that the surgery has. You can’t hold your child properly and you need others to hag and bring you your child for more than a week. There was also a difficult to stand or you need assistant. So I want labor to prevent those things”* (40 wks. of GA Woman who plan VBAC)

*“I will never try labor.... I don’t want to repeat that history I passed through. I know it (CS) will have a pain but is better than labor.”* (36 wks. of GA Woman who plan RCS)

## **III. Seeking information**

After making a decision on their preference of next MOB, women start to seek information from different sources. Because of their desire to know about the possibilities of VBAC, indications for RCS and ways to minimize side effects of RCS. However the outcome of their information seeking varies with in individuals. Some expressed getting information about MOB’s make them to know more about the side effects and benefits, to be confident by their decision and to do things helping them to be successful. Conversely, some women expressed as they get to be confused and unstable.

And some complained that they didn't get the necessary information from the health care providers even if they asked.

*“When I was grieving because of that CS I asked my friend. she reassured me. She told me that she gave birth by labor after a year. But I have four years now.”* (32 wks. of GA woman who plan VBAC)

*“...For example last week I asked the doctor to tell me the final thing, what I should do, should I prepare or what. But he shortly answered me no problem. And what always shuttles in my mind is that what a woman previously delivered by surgery should do for the second, for how much weeks she should be patient, and what will be done if the labor doesn't start. So, I would be happy if he give me a wide explanation when I talk to him”.* (39 wks. of GA woman who plan VBAC)

#### **IV. Wanting a supportive health care provider**

In mind the information about MOBs, women wish health providers to support them. As many participants expressed when women are planning or have in mind desired birth mode they want acceptance and support from healthcare providers. Women feel confident, wellbeing and encouragement when the health care providers share and support their desire. Altogether, women want health care providers to follow them closely, to identify things expected from women and update them everything. Although the support they get as their desire varies again. Some feel as they supported since the health care providers say “ok” by women's desire and some were unsatisfied and wish health care providers to give them a detail advice.

*“when I told them that I want to try labor, they said you can try. so I feel just like they helped me. They made me very happy since they shared my choice”.* (38 wks. of GA Woman who plan VBAC)

*“This is my decision. But I want them (health care providers) to identify any risk, to help me, to follow my condition and to do anything to be done. I want to finish everything with them.* (32 wks. of GA Woman who plan VBAC)

### **5.3. Conceptual framework emerged from the findings of this study**

Standing from the conceptual model used for this study (Dixon M, 2019), a modified conceptual framework below in figure 2 is developed based on the findings of the current study. The conceptual model adapted is along with stages showing how women make a decision on MOB following cesarean delivery. It also encompasses factors found to shape the decision making within each stage. The findings of this study also identified the process of decision making and factors affecting it. The decision making process of interviewed women in Tikur Anbessa specialized Hospital has a similarity with the process put on the theory developed in Loyola University Chicago(13). Because it contains all the stages women go through when making a decision. Such as: judging the experience, seeking information, knowing more, wanting VBAC or RCS, and searching for a supportive provider.

The difference in this finding is that, the order of the stages. The theory shows that women want VBAC or RCS after seeking information and knowing more about both options. But in this study women start to seek information and desire to know about birth options after they want VBAC or RCS based on their experience and attitude towards MOB. And even most women seek information only about one birth option they want. The other thing this study added is women's involvement in decision making and factors affecting it too. Based on the finding of this study factors that affect decision making process of involved women also found to affect the women's involvement (whether to involve or not).

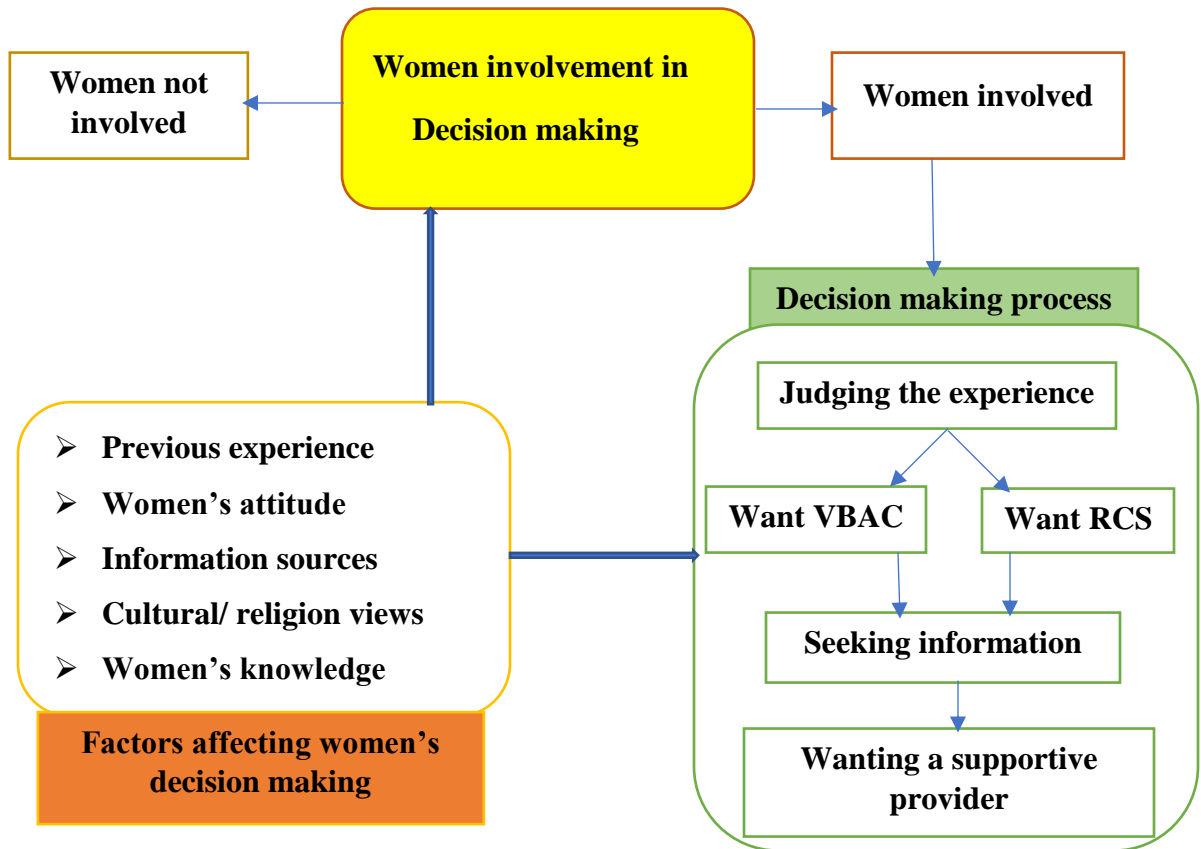


Figure 2: Modified conceptual framework of decision making process among pregnant women with previous CS in Tikur Anbessa Specialized Hospital, Addis Ababa, Ethiopia, 2023

## 6. DISCUSSION

This study aimed to explore women's decision making process on their MOB after previous CS in Tikur Anbessa Specialized Hospital. The findings of this study will reveal facts about women's decision making. This in turn will help as a guide for establishment of a strategy to promote or improve decision making. Women's decision making process has not previously been studied in Ethiopia; this study is the first to explore women's decision-making towards MOB and factors influencing.

The results of this study shows that all the study participants have information as they have two options of birth following CS. Most women have a desire to make or involve in a decision about MOB if given the chance. Based on this data three themes are identified: women's involvement in decision making, factors affecting women's decision making and women's decision-making process.

According to the study finding women have their own preference and plan towards one birth option. However their decision is only in their mind and not discussed with their ANC providers. Most participants express that health care providers both in the health center and in TASH were passive to discuss about the birth preparedness. This is in line with what previous studies concluded as decisions made with inadequate or no information about RCS and VBAC are a common concern in many countries (19, 25,28,29). The health care provider's contribution is only asking mother's interest rather than discussing and deciding together. Thus, antenatal education and SDM is very inadequate or unavailable at all. This opposes a SDM strategy and RCOG recommendations to all women with a previous CS to thoroughly informed about the risks and benefits associated with each MOB, and decide with health professionals (21-22). In the other hand, some women not were not concerned about decision making since they understand it as a hard to do. This finding indicates a need for health care providers to understand mother's desire and attitude towards decision making and to improve their culture of shared decision making.

The analysis of this data shows that in combination with women's previous experience and attitude towards MOB: information sources, cultural and religion views towards MOB and Women's knowledge about MOB appear to shape women to decide VBAC and RCS or to not decide at all.

Both birth experience and decision making experiences have a role in women's current decision making. As stated in other several studies (22, 25,28, 30, 32) the result of this study shows that women's previous birth experience has a significant influence in women's decision making. Women who experience only CS mostly want VBAC either because of experienced side effects or their intent to experience vaginal delivery. Indicates women want to experience vaginal delivery even if they had positive CS experience. This opposes other study findings concluded women who had a positive experience opted for the same MOB and women select a different MOB if they had negative experiences (22, 25, 30, 32). Based on the findings of this study women who have had both CS and labor experiences compare both to decide for now. Among women who plan RCS all have labor experience. Labor pain and procedures did to assist vaginal delivery are bad labor experiences which generate fear in women towards vaginal delivery. Indicates not only the CS experience affect women's decision making but also labor and vaginal birth experiences. This is similar with a finding in Taiwan (28).

Women's previous experience can also influence women not to make a decision. Doubt if reasons of previous CS happen for the current pregnancy hold women from making a decision. This is similar with a study finding in Taiwan and in Hawassa (28, 40). In addition, Women who didn't involve in their previous CS decision fail to decide now even if they have preference towards vaginal birth. Because they believe that the final decision will be the health care provider's. This disobeys the SDM strategy(21) and women's autonomy in health care decision-making (WHO, 2018). This finding is consistent with studies in Taiwan, Nigeria and a global qualitative evidence synthesis of 52 studies(24,28,30). This might be because of health professional's highest contribution behavior and negligence to women's capacity to choose.

Women's attitude towards both MOB's and decision making is another factor influence women's decision making. Some women have concerns like prolonged labor pain, stitch, and impact on child health associated with vaginal birth lead them to prefer RCS. This finding is consistent with several other studies (22, 24, 25, 28, 30). Not surprisingly, most mothers have favourable attitude towards vaginal birth related to natural and normality. To give birth without limit, to stand quickly and to regain daily activity are also some of the benefits of vaginal birth over CS many women perceived. This finding with similar with a study in Nigeria (39).

Women have also an attitude towards making a decision that limit them from choosing one birth option. Some believe that the time is early to decide. In addition some women understand making a birth mode decision is not their role. Thus, they are passive and ready to accept whatever the health care provider will say. This finding consistent with a study in US (29). In this study, women's attitude towards referral hospital is another thing holding women from making a decision. Women relate referral hospital with a cesarean delivery. This lowers their desire to decide on MOB since they claimed that their option is only RCS when joining a referral Hospital.

The other factor influencing women's decision making is the information and/or recommendation from health professionals, significant others and internet. Recommendation towards one birth option from health care providers who did the previous CS and/or ANC providers make women to desire that option. It is confirmed in previous researches that women trust their health providers and they comply with what the health care professional believes is best (20, 24). Regarding information the findings revealed that women receive a minimal and general or no information at all from professionals because of the health professional's negligence. Which make women to feel unconfident with their plan and/or to have no plan. This is consistent with a findings in Turkey and Italy (22, 32). In this study inability of women to be followed by one ANC provider found one reason for deficit of right information. Generally, this study revealed that women need a detail information from the health care providers to make a right decision. The WHO, 2018 also states "making the choice among the options easier and improving decision making are directly related to the routine provision of evidence based information and supporting women in their choice."

Oppositely, some participants in this study support the health care professional's limited information described knowing more about the risks and benefits will make them to worry about that. This opposes what several researches claimed the medical advice given by the caregiver, continuity of care with a midwife, SDM counseling sessions enhance a greater awareness of delivery modes and appropriate decision making (20,22,36).

As several other studies have concluded that others play a significant role in decision making process (20-25), the same thing in this study too. Information, recommendation, and birth experience from families, friends and/or society assisted most women's decision-making. Other's experience of VBAC (either successful or unsuccessful) influence women's hope towards VBAC. This is consistent with a finding in Peru (25). Moreover, women notice other's attitudes towards

MOBs and that influences their own attitude too. This study shows that our society's attitude towards MOBs skewed to the limitations of cesarean delivery which enhance women to prefer VBAC. However, there are also participants who support RCS based on other's perceptions toward CS. To escape: labor pain, stich, and breast feeding are some of advantages of CS other people perceived and push women to prefer RCS. This is in line with a study finding in Western Switzerland (20).

Religion and cultural views towards MOBs and children have also some part on women's preference to wards VBAC. Our culture and religion considers vaginal birth as natural law for being female. Conversely, CS is considered as a human made and technology. In addition having CS twice has a time limit and that is considered as against a religion since it is a limiting factor to one's reproductive careers. This finding is in line with findings in Nigeria and global review of 52 studies (24,39). These findings suggested that however women made the decision about their MOB themselves, their decisions were not based on thorough understanding of the advantages and disadvantages of vaginal versus cesarean delivery, rather on their previous experiences and their attitude in combination with other factors This suggests the need to support and improve women's decision making process by providing clear, appropriate and adequate medical education timely.

According to this study women's decision making process begins with judging their birth experience involves CS and labor and/or vaginal birth. Then, women claim to give birth by VBAC or RCS for next pregnancy based on their experience in combination with their attitude towards MOBs. In mind VBAC or RCS, women start to seek information to know more about the birth options desired. Which lead them either to be confident or to be confused. Having in mind the information about the birth option desired, women want health care providers to support them, to provide them a clear information and to follow them properly and update them conditions related with the pregnancy and birth mode. This has some similarity with a theory in Loyola University Chicago (13). The difference in this finding is that, women start to seek information and desire to know about birth options after they plan VBAC or RCS. And even most women seek information only about one birth option they desire. Suggests health care provider's to improve women's culture of decision making by educating them early and help them to decide after understanding risks and benefits of both.

## **7. STRENGTHS AND LIMITATIONS**

### **Strengths**

This is the first qualitative study regarding women's decision making process. This study tried to give an in-depth insight of the participant's desire towards MOB and practice of decision making by avoiding researcher bias during each interview. The interview comprised of women with different educational level, occupational status, and experience: this can give a depth insight of women's decision making practice and the factors influencing women's decision making. Nearly all the women come from different health centres of Addis Ababa and some from region and involve all the third trimester pregnant women. Thus, it may give a general overview of health care providers practice regarding decision making on MOB in Addis Ababa. The results also provided directions on how to improve decision making and point out the factors that influence women's decision making process.

### **Limitations**

Since this study only highlights prenatal interview it may not enable us to fully understand the ultimate process of decision making. Plus since the interview is only from women it may not enable us to capture the actual interactions between health care providers and pregnant women. In addition, this study consisted of women who had access to ANC and a facility providing VBAC. So further research is needed to better comprehend of the decision making process of rural women with a little access to maternity care. Finally, Criticism related to qualitative research like lack of generalizability and small sample size are also some of the limitations of the study.

## **8. CONCLUSION AND RECOMMENDATION**

### **8.1. Conclusion**

Three themes were identified: women's involvement in decision making, factors affecting women's decision making and women's decision making process. Women have a desire and plan towards one MOB and most put forward their plan for next pregnancy by themselves immediately following caesarean delivery. Among women who have a decision most plan to attempt VBAC. However their decision is only in their mind and not discussed with their ANC providers. The process of decision making involves judging the experience, wanting VBAC or RCS, seeking information and wanting a supportive health provider. Factors such as women's previous experience, attitude towards MOBs, information sources, cultural and religion views towards MOBs and Women's knowledge about MOBs appear to shape women's involvement or the decision making process of involved women as well. These findings offer the need for further investigation on decision making towards MOB. It is equally clear that increasing RCS while mother's preference is vaginal birth creates a question and it needs to be obtained from the health care provider's perspective.

## **8.2. Recommendation**

### **To Health institutions:**

It is recommended to the ANC unit be staffed with enough health care providers based on the number of women serviced in the unit. It would be beneficial if leaflets are prepared and avail for Mothers. In addition, it would be better if the institution evaluates the way the health care professionals providing a service and if trainings are held regarding to counselling and shared decision making.

### **To health care providers:**

ANC care providers are recommended to understand mother's right and desire as well to involve in a decision making. Thus, they should provide clear and adequate information timely, empower women to generate their idea and to make a right decision jointly.

### **To women:**

It is recommended the women's decisions should be based on comprehensive knowledge of the risks and benefits of vaginal versus Cesarean delivery than on other factors. It is recommended women should be active to ask questions and search for the right information about both birth modes from their health care providers.

### **To Researchers**

Future research to explore decision making on mode of birth which comprised of both prenatal and postnatal women is recommended to understand the ultimate decision maker and time. Also it is recommended to investigate dyadic decision making process of women and health care providers. It would also be beneficial to interview health care providers about their perspectives on decision making and factors influence health provider's decision making practice.

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## 10. ANNEXES

### 10.1. Annex-I: Participant Information sheet and Informed Consent Form

**Title of the Research Project:** women's decision-making process on their mode of birth among pregnant women with previous caesarian section in Tikur Anbessa Specialized Hospital, Addis Ababa, Ethiopia 2023: a qualitative study

**Name of Principal Investigator:** Mekdes Molla

**Name of the Organization:** Addis Ababa University College of health sciences school of nursing and midwifery department of midwifery.

**Name of the Sponsor:** Addis Ababa University College of health science

**Introduction:** This information sheet and consent form is prepared with the aim to explore women's decision-making process on their mode of birth among pregnant women with previous caesarian section in Tikur Anbessa Specialized Hospital, Addis Ababa, Ethiopia, 2023

**Purpose of the study:** This study aims to explore how mothers made decision on their mode of birth once they have had one previous cesarean delivery in Tikur Anbessa Specialized Hospital, Addis Ababa, Ethiopia, 2023. The findings of this study will help to identify any gap regarding decision making on mode of birth and to make necessary interventions.

**Procedure:** This study involves women who fulfilled the inclusion criteria. You are selected to be one of the study participants if you are willing to take part in this study and we kindly invite you to take part in our project.

#### **Participant Information:**

Thank you for making time to listen to me. My name is \_\_\_\_\_

I am studying master's degree in maternity and reproductive health nursing at Addis Ababa University College of health sciences. And I would like to talk to you about how you made decisions for your mode of birth following pervious cesarean section in Tikur Anbessa Specialized Hospital, Addis Ababa, Ethiopia. This study is for academic purpose and approved by Addis

Ababa University, College of health sciences, School of nursing and midwifery, in partial fulfillment of a master's degree in maternity and reproductive health nursing. Therefore, I need your honest and genuine response. The results of the study will hopefully serve as an important input for policy and intervention programs.

If you are willing to participate, we are so happy and we need you to clearly understand the aim of this study and show your agreement. I will do the interview and it will take about 30- 90 minutes. I will record the interview and take some notes because I do not want to miss your important responses and any of your comments.

**Benefits and Risks:** Your participation in the study has no risks. There is no direct short term benefit for participants. However, this study will in fact help to improve women's decision making for their health care and it may also be used by the health professionals as well as policy makers to evaluate the services provided by health institutions and to improve decision making.

**Voluntary Nature of the Study:** Please remember that you are under no obligation to participate in this interview. You can withdraw from the study at this point or end the interview at any point during the interview without explanation or consequences. You do not have to answer any question that makes you uncomfortable. Should we come to any question that you do not want to answer, just let me know and we will go to the next question.

**Confidentiality:** None of your answers will be available to anyone. I promise to treat all information collected from this interview as highly confidential and private by saving in a separate place where no one can see them. And it shall not be reported in a manner that identifies or links you with the results of the study. If you have any questions you can contact me any time, and you may ask at any time you want.

**Researcher's Address:**

**Name:** Mekdes Molla

**Phone:** +251913296758

**E-mail:** [mekmolla21@gmail.com](mailto:mekmolla21@gmail.com)

Do you have any questions regarding what I have just explained to you?

Would you be willing to participate in the study?

1. Yes                      2. No

**Informed consent form**

I, the under signed, acknowledge that, I, the undersigned, have been informed that this study is going to be conducted to explore how mothers once they have had one previous cesarean delivery made decision on their mode of birth in Tikur Anbessa Specialized Hospital, Addis Ababa. I understand the nature of the study and the means by which my identity will be protected and that the information I give will be kept. I have had the opportunity to ask questions and they were answered to my satisfaction. I understand that I am free to contact the researcher at any time to seek further clarification and information. My signature here also grants permission for the interview to be recorded.

Signature of research participant -----

Signature of researcher -----

Date -----

**10.2. Annex II: Semi-structured questionnaire for women in English**

A semi-structured questionnaire prepared to explore women’s decision making process on their mode of birth following previous cesarean section in Tikur Anbessa Specialized Hospital, Addis Ababa, Ethiopia, 2023.

- A. Approach: Explorative
- B. Sampling method: purposive sampling
- C. Data collection method: IDI

**Part I: sociodemographic form**

| Characteristics/variables | Response of reviewee | Remark |
|---------------------------|----------------------|--------|
| Code                      |                      |        |

|                                   |  |  |
|-----------------------------------|--|--|
| Age                               |  |  |
| Residency                         |  |  |
| Educational status                |  |  |
| Marital status                    |  |  |
| Occupational status               |  |  |
| Parity                            |  |  |
| Reason for previous CS            |  |  |
| Place where previous cs performed |  |  |
| Interval from previous birth      |  |  |
| Gestational age                   |  |  |
| No _of ANC follow up              |  |  |

## Part II: In-depth interview Guide

1. How would you describe your previous CS experience?

2. **Please tell me your current plan regarding MOB?**

**a. If not planned:**

- When and how you are going to decide?
- Which one do you think is better?
- Anything you know, any information you have about VBAC and/or RCS?

**b. If planned:**

❖ **How did you make this decision? (explain) [Probing questions may include the following]**

- When did you make this decision?
- What was it like for you to decide between VBAC or RCS?
- When did you first start thinking about making a decision between VBAC or RCS? (Prior to getting pregnant or during the pregnancy).
- How did you get the information first to assist you to make this choice?
- Then which one did you get appropriate for you VBAC or RCS? How do you choose?

❖ **Did your health care provider assist you to make this birth choice? (How)? [Probing questions may include the following]**

- When did your health care providers begin to talk to you about birth options?
- Please describe what you understand from your health professionals counseled you about VBAC or RCS?
  - VBAC risks & benefits?
  - RCS risks and benefits?
- Then who decide the final decision (your health care provider, you, jointly)?

**3. How would you describe your contribution in the decision to this MOB?**

**4. How would you describe your health care provider contribution and impact during the decision-making process?**

**5. What factors influence you to make decisions on your mode of birth? [Probing questions may include the following]**

6. How your previous CS experience influenced your current decision?
7. Have you ever had a vaginal birth before?
  - If yes how would you describe your experience (either positive or negative)?
  - How do you express your previous vaginal birth experience influence to make the decision now?
8. Do you have family member, friend, neighbor who underwent cesarean delivery?
  - Did they share their experiences for you?
  - How do you describe other's experiences influence to make this decision now?
9. What do your families and/or friends informed or recommend you towards MOB after cesarean section?
10. Have you ever search for information from internet?
  - If yes what did you get about MOB after previous CS?
  - How do you describe its influence to make this decision now?

**11. Are you stable and confident with your decision regarding MOB now?**

- **If not why? Please explain.**

**12. Is there anything else about your decision of VBAC or RCS you would like to share?**

**13. To the last; if you have questions?**

- Any suggestion or recommendations concerning decision making on MOB following CS for other women, would you tell us your suggestions in detail?

*Thank you very much for taking part in this study.*

**10.3. Annex III: ለተሳታፊ የሚሰጥ መረጃ እና የስምምነት ቅጽ**

**የጥናቱ ርዕስ :** ከዚህ ቀደም በቀዶ ጥገና የወለዱ ሴቶች ለሚቀጥለው እርግዝናቸው የመውለጃ መንገድ ውሳኔ አሰጣጥ ሂደት በጥቁር አንበሳ እስፕራሽን ሆስፒታል ፣ አዲስ አበባ፣ ኢትዮጵያ 2023

**ጥናቱን የሚያካሂደው ግለሰብ ስም:** መቅደስ ሞላ

**የተቋሙ ስም:** አዲስ አበባ ዩኒቨርሲቲ ጤና ሳይንስ ኮሌጅ

**የስፖንሰሩ ስም:** አዲስ አበባ ዩኒቨርሲቲ ጤና ሳይንስ ኮሌጅ

**መግቢያ:** ይህ የመረጃ ዝርዝር እና የስምምነት ቅጽ በአዲስ አበባ ከተማ በሚገኝ ጥቁር አንበሳ እስፕራሽን ሆስፒታል ውስጥ ከዚህ ቀደም በቀዶ ጥገና የወለዱ ሴቶች ለሚቀጥለው እርግዝናቸው የመውለጃ መንገድ ውሳኔ አሰጣጥ ሂደትን ለመመርመር ታቅዶ የተዘጋጀ ነው።

**የጥናቱ አላማ:** የዚህ ጥናት ዋና አላማ እናቶች ከዚህ ቀደም አንዴ በቀዶ ጥገና ከወለዱ በኋላ የሚቀጥለው እርግዝናቸውን የመውለጃ መንገድ እንዴት ይወስናሉ የሚለውን ለመመርመር ነው። የዚህ ጥናት ውጤት እናቶች ስለሚወልዱበት መንገድ ውሳኔ አሰጣጥ ሂደት ያሉ ክፍተቶችን ለመለየት ይህም ችግሮቹን ለመፍታታ አስፈላጊ እርምጃ እንዲወሰድ ያግዛል።

**የጥናቱ ሂደት:** በጥናቱ ውስጥ ለመሳተፍ የተካተቱትን መመዘኛዎች ያሟያሟሉ ሴቶች በጥናቱ ይካተታሉ። እርስዎም በዚህ ጥናት ለመሳተፍ በታላቅ አክብሮት ተጋብዘዋል።

**ለተሳታፊ የሚሰጥ መረጃ**

ለማዳመጥ ፍቃደኛ ስለሆኑ አመሰግናለሁ።

በዛሬው እለት ውይይታችንን የምመራው እኔ \_\_\_\_\_ ነኝ።

በአሁኑ ወቅት በአዲስ አበባ ዩኒቨርሲቲ በሚድኖር ትምህርት ክፍል የሁለተኛ ዲግሪ ትምህርቱን እየተከታተልኩ እገኛለሁ። የሁለተኛ ዲግሪዬን ለመጨረስ ይረዳኝ ዘንድ በአዲስ አበባ ከተማ በሚገኝ ጥቁር አንበሳ ሆስፒታል ከዚህ ቀደም በቀዶ ጥገና የወለዱ ሴቶች ለሚቀጥለው እርግዝናቸው የመውለጃ መንገድ ውሳኔ አሰጣጥ ሂደትን መመርመር በሚለው ርዕስ ጉዳይ ላይ ጥናት እያደረኩ እገኛለሁ። ጥናቱ በአዲስ አበባ ዩኒቨርሲቲ ጤና ሳይንስ ትምህርት ቤት በነርቪንግ እና ሚድኖር ትምህርት ክፍል የጸደቀ ነው። ውይይታችን የሚያተኩረው ከዚህ ቀደም በቀዶ ጥገና ከወለዱ በኋላ የአሁኑ እርግዝናውን የመውለጃ መንገድ እንዴት እንደወሰኑ ወይም እንደሚወሰኑ ያሉትን ልምድ እና አመለካከት እንዲያካፍሉ ነው። ስለሆነም ከላይ የተዘረዘሩት የጥናቱ ዓላማዎች ይሳኩ ዘንድ በእርስዎ በኩል በእውነታ ላይ የተመሠረተና ትክክለኛ የሆነ መረጃ እንዲሰጡኝ እጠይቃለሁ። እርስዎ ጥያቄ በመመለስ ቢተባበሩኝ ለጥናቱ መሳካት የራስዎን ጉልህ ድርሻ ተወጡ ማለት ነው። ለመሳተፍ ፍቃደኛ ከሆኑ፣ እኛ በጣም ደስተኞች ነን እናም የዚህን ጥናት አላማ በትክክል ተረድተው ስምምነትዎን እንዲያሳዩ እንፈልጋለን።

ውይይቱ በግምት 30-90 ደቂቃ ይወስዳል። ምንም እንኳን ማስታወሻ ብይዝም ድምጽዎትን ግን በመቅረጫ እቀርጻለሁ። ምክንያቱም የሚሰጡኝን የትኛውንም መረጃ ማጣት ስለማልፈልግ ነው።

**ጥቅማጥቅም ወይም ጉዳት:** በዚህ ጥናት ውስጥ መሳተፍዎ ምንም አይነት ጉዳት ወይም ቀጥተኛ ጥቅም አይኖረዎታል። ሆኖም ግን ይህ ጥናት እናቶች በጤናቸው ላይ የሚሰጡትን የውሳኔ አሰጣጥ ልምድ ለማሻሻል ያግዛል። እንዲሁም የጤና ባለሙያዎችም ሆነ ልሎች ህግ አውጪ አካላት በጤና ተቋማት እናቶች ስለሚደረግላቸው ህክምና እንዲወስኑ እየተሰጠ ያለውን የምክር አገልግሎት ለመፈተሽ እና ለማሻሻል ሊጠቀሙት ይችላሉ።

**ፈቃደኝነት (የመቃወም ወይም የመተዉ መብት):** በጥናቱ ላይ የመሳተፍ ግደታ የለብዎትም። የሚሳተፉት በፍቃደኝነት ስለሆነ ቃለመጠይቁን በፈለጉት ጊዜ ማቆም/ማቋረጥ ይችላሉ። ማንኛውም ለእርስዎ ምችት የማይሰጥ ጥያቄ ከሆነ አለመመለስ ይችላሉ ሆኖም ማንኛውም መመለስ የማይፈልጉት ጥያቄ ሲኖር ይነግሩኚና ወደሚቀጥለው ጥያቄ እናልፋለን።

**ሚስጥራዊነት:** ለቃለ መጠይቁ የሚሠጡኝ መልስ ግላዊ እና ስምዎን ያላካተተ ሆኖ በከፍተኛ ሚስጥራዊነት የሚጠበቅ ይሆናል። ከእርስዎ የተሰበሰበው መረጃ በኮምፒውተር ውስጥ ስምዎት ሳይኖር በሚስጠር ይቀመጣል። እንዲሁም ማንኛውም አይነት ጥያቄ ካልዎት በፈለጉት በማንኛውም ሊያገኙኝ እና ሊጠይቁኝ ይችላሉ።

**የተመራማሪው አድራሻ:-**

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ከላይ በተደረገው ገለጻ ላይ ጥያቄ አለዎት?

መጠይቁን ለመመለስ ፍቃደኛ ነሽ/ነዎት 1. አዎ 2. አይደለሁም

**የስምምነት ቅጽ**

እኔ ከታች ፊርማዬ የሰፈረው ፣ ይህ ጥናት እናቶች አንዴ በቀዶ ጥገና ከወለዱ በኋላ ለሚቀጥለው እርግዝናቸው የመውለጃ መንገድ እንዴት ይወስናሉ የሚለውን ለመመርመር የታቀደ መሆኑ ተነግሮኛል። የጥናቱን አይነት፣ ጥቅም፣ በፈቃደኝነት ብቻ የምሳተፍ መሆኑን ፣ የምሰጠው መረጃ ሚስጠራዊነቱ የተጠበቀ መሆኑን እና በማንኛውም ሰዓት ያለምንም አሉታዊ ውጤት ከጥናቱ መውጣት እንደምችል ተረድቻለሁ። ጥያቄዎችን ለመጠየቅ እድል ተሰጥቶኝ የነበረ ከመሆኑም ባሻገር በበቂ ሁኔታ ምላሽ ተሰጥቶኛል። በማንኛውም ጊዜ የበለጠ ማብራሪያ እና መረጃ ለማግኘት ብፈልግ ጥናቱን የሚሰራውን ሰው ለማግኘት ነፃ መሆኔን ተረድቻለሁ። እንዲሁም ከታች የተቀመጠው ፊርማዬ የማደርገው ቃለመጠይቅ እንደሚቀዳ መስማማቴን ይገልጻል።

የተሳታፊ ፊርማ: .....

ቀን: .....

**10.4. Annex IV: በክፍል የተዋቀረ መጠይቅ በአማርኛ**

ከዚህ ቀደም አንዴ በቀዶ ጥገና የወለዱ እናቶች ለሚቀጥለው እርግዝናቸው የመውለጃ መንገድ ውሳኔ አሰጣጥ ሒደትን ለመመርመር የተዘጋጁ በክፍል የተዋቀሩ መጠይቆች በ ጥቁር አንበሳ ሆስፒታል፣ አዲስ አበባ፣ ኢትዮጵያ፣2023

**ክፍል 1: መሠረታዊና ማህበራዊ ጥያቄዎች**

| ተ.ቁ                                 | ምላሽ | ማስታወሻ |
|-------------------------------------|-----|-------|
| መለያ                                 |     |       |
| እድሜ                                 |     |       |
| መኖሪያ ቦታ                             |     |       |
| የትምህርት ደረጃ                          |     |       |
| የጋብቻ ሁኔታ                            |     |       |
| የስራ ሁኔታ                             |     |       |
| በህይወት የተወለዱ ልጆች ቁጥር                 |     |       |
| ከዚህ ቀደም በቀዶ ጥገና የወለዱበት ምክንያት        |     |       |
| የተሰራበት ቦታ                           |     |       |
| በቀዶ ጥገናው እና በ አሁኑ እርግዝና መካከል ያለው ጊዜ |     |       |
| የቅድመ ወሊድ ክትትል ቁጥር                   |     |       |
| የ እርግዝናው እድሜ                        |     |       |

**ክፍል 2: ጥልቀት ያለው የቃለ መጠይቅ መመሪያ**

1. ከዚህ በፊት በቀዶ ጥገና ሲወለዱ የነበረውን ሁኔታ እንዴት ይገልጹታል?
2. አሁን በየትኛው መንገድ ለመውለድ አቅደዋል(በቀዶ ጥገና ውይይት በማህፀን)?

**ሀ: ካልወሰኑ:**

- መቼ እና እንዴት ነው የሚወሰኑት?
- የትኛው የተሻለ ነው ብለው ያስባሉ?
- ስለሁለቱም (በቀዶ ጥገና ውይይት በማህፀን) የሚያወቁትን ወይም የሰሙትን ማንኛውንም ነገር ይንገሩኝ?

**ለ: ከወሰኑ :**

❖ እንዴት ነው ይህን ውሳኔ የወሰኑት? ያብራሩልኝ። [የመመርመሪያ ጥያቄዎች የሚከተሉትን ሊያካትት ይችላል]

- መቼ ነው ይህን ውሳኔ የወሰኑት?
- የሚወልዱበትን መንገድ መወሰን ለ እርስዎ ምን ይመስል ነበር?

- የሚወልዱበትን መንገድ ለመወሰን ማሰብ የጀመሩት መቼ ነው? (ከማርገዝወት በፊት ወይስ በ እርግዝናዎት ወቅት)?
- ይህን ውሳኔ ለመወሰን የረዳዎትን መረጃ መጀመሪያ እንዴት ወይም ከየት ነው ያገኙት ?
- ከዛን ለእርስዎ የትኛው የተሻለ ሆኖ አገኙት? እንዴት ይህን መረጡ?

❖ **ይህን ውሳኔ ሲወስኑ የጤና ባለሙያዎች አግዘዎታል? በምን መንገድ? እባክዎትን ያብራሩልኝ።[የመመርመሪያ ጥያቄዎች የሚከተሉትን ሊያካትት ይችላል]**

- የጤና ባለሙያዎች (የቅድመ ወሊድ ክትትል የሚያደርጉሎወት) መቼ ነው ስለነዚህ የመውለጃ አማራጮች ከ እርስዎ ጋር መወያየት የጀመሩት?
- የጤና ባለሙያዎች ስለ ሁለቱም የመውለጃ አማራጮች የነገሩዎትን ወይም የተረዱትን እያንዳንዱን ነገር ያብራሩልኝ።

- ስለ ድጋሚ ቀዶ ጥገና ትቅም እና ጉዳት ?
- ከቀዶ ጥገና በኋላ በማህፀን ስለ መውለድ ጥቅም እና ጉዳት?

- ከዛን የመጨረሻውን ውሳኔ ማን ወሰነው (የጤና ባለሙያዎች እርስዎን በጋራ)?
- 3. በውሳኔ አሰጣጥ ሂደት ውስጥ የ እርስዎን አስትዋፅዖ እንዴት ይገልፁታል?
- 4. በዚህ ውሳኔ አሰጣጥ ሂደት ውስጥ የጤና ባለሙያዎቹን አስትዋፅዖ እንዴት ይገልፁታል?

- ያለውን ተፅዕኖ?

5. **የሚወልዱበትን መንገድ ለመወሰን ወይም ሲወስኑ ምን ምን ነገሮች ተፅዕኖ አድርጎብዎታል? ያብራሩልኝ። [የመመርመሪያ ጥያቄዎች የሚከተሉትን ሊያካትት ይችላል]**

- 6. ከዚህ በፊት በቀዶ ጥገና ሲወልዱ የነበረው ሁኔታ የአሁኑን ውሳኔ ለመወሰን ያለውን ተፅዕኖ እንዴት ይገልፁታል?
  - እርሱ አግዘኛል ብለው ያስባሉ?
- 7. ከዚ በፊት በማህፀን ወልደው ያወቃሉ?
  - አዎ ከሆነ የነበረውን ሁኔታ እንደት ይገልፁታል (ጥሩ ወይም ምጥፎ)?
  - እርሱ የአሁኑን ውሳኔ ለመወሰን ያለውን ተፅዕኖ እንዴት ይገልፁታል?
- 8. ከዚህ ቀደም በቀዶ ጥገና የወለደ የቤተሰብ አባል፣ጓደኛ ወይም ጎረቤት አለዎት?
  - ልምዳቸውን አካፍሎታል?
  - እነርሱ የነገሩዎት ነ
  - ገር ለአሁኑ ውሳኔዎት ያለውን ተፅዕኖ እንዴት ይገልፁታል?
- 9. ቤተሰቦችዎ በየትኛው እንዲወልዱ ይመክሩዎታል?
- 10. ከ ኢንተርኔት ላይ መረጃ አንብበው ያወቃሉ?
  - አዎ ከሆነ ያገኙትን ወይም የተረዱትን ያብራሩልኝ። ለአሁኑ ውሳኔዎት ያለውን ተፅዕኖ እንዴት ይገልፁታል?

11. አሁን በወሳኔዎች ላይ እርግጠኛ እና የተረጋጉ ነዎት?

- ካልሆኑስ ለምን? እባክዎትን ያብራሩልኝ።

12. ስለ እርስዎ ውሳኔ አሰጣጥ ሂደት ሊያጋሩን የሚፈልጓቸው ለሎች ነገሮች ካሉ ?

13. ማንኛውም ጥያቄ ወይም አስተያየት ካለዎት

- እንዲሁም እናቶች አንዴ በቀድሞ ጥገና ከወለዱ በኋላ ለሚቀጥለው እርግዝና የመውለጃ መንገዶችን በተመለከተ ለሌሎች ሴቶች የሚያስተላልፏት ሃሳብ አስተያየት ካለ በደንብ ሊነግሩኝ ይችላሉ?-

**በዚህ ጥናት ስላደረጉት የጎላ ተሳትፎ በጣም እናመሰግናልን!!!**