JHWCR JOURNAL OF HEALTH, WELLNESS AND COMMUNITY RESEARCH 3007-0570

DOI: https://doi.org/10.61919/ew7yyy83

Original Article

Exploring the Emotional and Postoperative Experiences of First-Time Mothers Following Emergency Cesarean Section in Faisalabad, Pakistan: A Qualitative Study

Hafiza Maira Umar[1], Mustafa Khattak[2], Sehar Mudassar[3], Laiba Zahid[4]*, Afida Wajid[5], Rafia Ali[5]

[1] Student, Department of Health Professional Technologies, Faculty of Allied Health Sciences, The University of Lahore, Lahore, Pakistan
[2] Master's Student, Uppsala University, Uppsala, Sweden
[3] Senior Lecturer, Al-Shifa Institute of Health Sciences, Narowal, Pakistan
[4] Lecturer, Department of Health Professional Technologies, Faculty of Allied Health Sciences, The University of Lahore, Lahore, Pakistan
[5] Demonstrator, Department of Health Professional Technologies, Faculty of Allied Health Sciences, The University of Lahore, Lahore, Pakistan

***Corresponding author: Laiba Zahid, laibasheikh780@gmail.com**

"Cite this Article" Received: 30 January 2026; **Accepted**: 19 June 2026; **Published**: 16 July 2026

Author Contributions: Concept: HMU, LZ; Design: HMU, SM, LZ; Data Collection: HMU, AW, RA; Analysis: HMU, MK, LZ; Drafting: HMU, MK, SM, LZ, AW, RA. **Ethical Approval**: The University of Lahore, Lahore, Pakistan. **Informed Consent**: Written informed consent was obtained from all participants; **Conflict of Interest**: The authors declare no conflict of interest. **Funding**: No external funding; **Data Availability**: Available from the corresponding author on reasonable request; **Acknowledgments**: NA

ABSTRACT

Background: Emergency cesarean section is a potentially life-saving obstetric intervention but may cause considerable fear, uncertainty, and emotional distress, particularly among women experiencing childbirth for the first time. Objective: To explore the emotional and postoperative experiences of first-time mothers following emergency cesarean section in Faisalabad, Pakistan. Methods: A qualitative descriptive study was conducted over four months at Mujahid Hospital, Faisalabad. Fourteen first-time mothers aged 18–40 years who had undergone emergency cesarean section were recruited through purposive sampling. Data were collected through private, semi-structured, in-depth interviews lasting approximately 30–45 minutes. Interviews were audio-recorded, transcribed verbatim, and analysed manually using Braun and Clarke's six-phase thematic-analysis process. Results: Three interrelated themes were generated: anticipatory threat and uncertainty, disrupted birth expectations and emotional distress, and postoperative recovery and positive reinterpretation. Participants described fear of anesthesia, surgery, maternal or newborn harm, and uncertain recovery. The unexpected transition from anticipated vaginal birth to surgical delivery produced disappointment, helplessness, and emotional distress. During recovery, reduced physical discomfort and perceived maternal and newborn wellbeing contributed to relief, optimism, gratitude, and greater acceptance. Conclusion: Emergency cesarean section was experienced as both a clinically necessary intervention and a psychologically significant event. Clear communication, respectful emotional support, and appropriate postpartum assessment may help women adjust following an unexpected surgical birth. Keywords: Emergency Cesarean Section; First-Time Mothers; Emotional Experiences; Postoperative Recovery; Qualitative Research; Thematic Analysis.

INTRODUCTION

Childbirth is a major life event shaped by the interaction of clinical circumstances, psychological expectations, interpersonal support, and sociocultural beliefs. Women generally value safety, respectful treatment, effective communication, emotional support, and involvement in decisions affecting their care during childbirth (1). Cesarean section is an essential obstetric intervention that can prevent serious maternal and neonatal complications when medically indicated. Although cesarean delivery rates have increased internationally, the World Health Organization emphasizes that the procedure should be performed according to clinical need because increasing population-level rates beyond approximately 10% has not been associated with further reductions in maternal or neonatal mortality (2).

Emergency cesarean section differs substantially from a planned cesarean delivery because the decision is usually made in response to an unexpected maternal or fetal complication and may allow little time for psychological preparation. Although the procedure can be life-saving, women may experience fear of anesthesia and surgery, concern about their own survival or the safety of their newborn, physical pain, uncertainty, and loss of control over the birth process. Qualitative evidence has shown that cesarean delivery experiences are influenced not only by the surgical procedure itself but also by women's understanding of the clinical situation, expectations regarding childbirth, communication with healthcare professionals, and the support available during and after delivery (3). Perceived threat, helplessness, lack of control, and unexpected intervention during childbirth have also been associated with subsequent psychological distress and trauma-related symptoms (4,5).

Women experiencing childbirth for the first time may be particularly affected by an emergency surgical delivery because they have no previous personal experience against which to interpret labor, operative birth, or postoperative recovery. Many enter childbirth with expectations regarding vaginal delivery that are informed by family members, healthcare professionals, antenatal information, and wider cultural beliefs. When an emergency cesarean becomes necessary, the abrupt disruption of these expectations may produce disappointment, fear, uncertainty, or a sense of personal loss, even when the procedure results in a favourable maternal and neonatal outcome. Women's views of cesarean delivery are therefore complex and may include both negative reactions to surgery and positive interpretations related to safety, predictability, or avoidance of further uncertainty (6).

Previous qualitative research involving women who underwent emergency cesarean delivery has identified shock, fear, disappointment, emotional distress, and lack of preparation as important features of the experience (7). However, experiences are not uniformly negative. A study comparing childbirth experiences among primiparous women reported more positive experiences among some women who delivered by cesarean section than among those who delivered vaginally, indicating that mode of delivery alone does not determine how childbirth is evaluated (8). Perceived safety, respectful communication, continuous support, and the extent to which women feel informed and involved may substantially influence whether an emergency surgical birth is interpreted as traumatic, necessary, protective, or ultimately acceptable (1,9).

Despite growing international evidence, the emotional meaning and postoperative experiences of first-time mothers undergoing emergency cesarean section remain insufficiently described within Pakistani maternity-care settings. Local understanding is particularly important because women's interpretations of childbirth may be influenced by healthcare practices, family involvement, religious coping, expectations regarding vaginal birth, and access to psychological and postpartum support. Exploring these experiences can identify aspects of maternity care that may reduce distress and support physical and emotional adjustment following an unexpected surgical delivery. Therefore, this study aimed to explore the emotional and postoperative experiences of first-time mothers following emergency cesarean section at a hospital in Faisalabad, Pakistan.

MATERIALS AND METHODS

A qualitative descriptive design was used to obtain detailed accounts of the emotional and postoperative experiences of women undergoing childbirth for the first time through emergency cesarean section. The study was conducted over four months at Mujahid Hospital, Faisalabad, Pakistan. A qualitative approach was considered appropriate because the study sought to understand how participants perceived, interpreted, and responded to an unexpected surgical birth rather than to quantify the prevalence of predetermined symptoms or test a causal hypothesis.

Fourteen first-time mothers who had undergone emergency cesarean section were recruited through purposive sampling. Purposive recruitment was used to select participants who had direct experience of the phenomenon under investigation and could provide relevant, information-rich accounts of

emergency cesarean delivery and postoperative recovery. Women aged 18–40 years who had experienced emergency cesarean delivery, were willing to participate, and provided written informed consent were eligible. Potential participants were identified with the assistance of personnel from the obstetrics and gynecology department after confirmation of their eligibility. Eligible women were approached individually and informed about the purpose of the study, the interview procedures, audio recording, voluntary participation, and their right to decline participation.

Data were collected through individual, semi-structured, in-depth interviews guided by questions developed from the study objective and relevant literature. The interview format allowed the same principal areas to be explored across participants while providing sufficient flexibility for women to describe their experiences in their own words and elaborate on issues that were personally meaningful. Interviews explored participants' emotional responses to the decision for emergency surgery, concerns regarding anesthesia and operative delivery, perceptions of maternal and newborn safety, reactions to the unexpected change in the anticipated mode of birth, and experiences of pain, mobility, recovery, relief, and adjustment after surgery. Follow-up prompts were used to clarify responses and encourage fuller descriptions where required. Interviews were conducted at a time convenient for each participant in a private and quiet room within the hospital to support confidentiality and reduce interruption. Each interview lasted approximately 30–45 minutes and was conducted in the participant's preferred language. With the participant's permission, interviews were audio-recorded to preserve the content of the account and facilitate detailed analysis. The recordings were transcribed verbatim with the assistance of TurboScribe.ai. The resulting transcripts were repeatedly reviewed by the research team before coding to develop familiarity with the data and identify sections relevant to the study objective. Participants were represented by numerical identifiers in the analysis and reporting of quotations.

The data were analysed manually using the six-phase thematic-analysis process described by Braun and Clarke (10). Analysis began with repeated reading of the interview transcripts to achieve familiarity with the content and context of participants' accounts. Meaningful segments of text relating to emotional reactions, perceived threats, birth expectations, surgical concerns, recovery, and postoperative adjustment were assigned initial codes. Codes reflecting related ideas were compared and grouped into preliminary categories. These categories were subsequently examined for broader patterns of shared meaning and developed into candidate themes and subthemes. The candidate themes were reviewed against the coded extracts and the complete dataset to assess whether they were internally coherent, conceptually distinct, and adequately supported by participants' accounts. Theme boundaries and labels were then refined to ensure that the final thematic structure accurately represented the emotional and postoperative experiences described by the participants. Credibility was supported through repeated engagement with the transcripts, comparison of coded material across interviews, and discussion of coding and theme development among members of the research team. Alternative interpretations were considered during these discussions, and the final themes were agreed after iterative review of their content, boundaries, and relationship to the study objective. The use of a semi-structured interview guide, audio recording, verbatim transcription, participant identifiers, and team-based review provided a systematic record of the progression from interview data to codes and themes.

Ethical approval and written permission to undertake the study were obtained from the departmental Research Committee of The University of Lahore before participant recruitment and data collection. All participants received information regarding the purpose and procedures of the study and provided written informed consent before the interviews. Participation was voluntary, interviews were conducted privately, and identifying information was excluded from the presentation of findings.

RESULTS

Fourteen first-time mothers who had undergone emergency cesarean section participated in the study. Thematic analysis generated three interrelated but conceptually distinct themes: anticipatory threat and

uncertainty, disrupted birth expectations and emotional distress, and postoperative recovery and positive reinterpretation. These themes represented participants' experiences surrounding the emergency decision, their immediate emotional responses to an unplanned surgical birth, and their subsequent physical and emotional adjustment during recovery.

Table 1. Thematic Structure of the Emotional and Postoperative Experiences of First-Time Mothers Following Emergency Cesarean Section

Theme	Analytical focus	Subthemes
1. Anticipatory threat and uncertainty	Perceived risks and uncertainty associated with the emergency surgical procedure before and during cesarean delivery	Fear of anesthesia and surgery; concern for maternal and newborn safety; uncertainty regarding postoperative recovery; acute stress and anxiety
2. Disrupted birth expectations and emotional distress	Emotional consequences of the unexpected transition from anticipated vaginal birth to emergency surgical delivery	Emotional reaction to the emergency decision; disappointment over not having a vaginal delivery; helplessness and reduced sense of control
3. Postoperative recovery and positive reinterpretation	Physical improvement and emotional adjustment following successful surgery and favourable maternal and newborn outcomes	Relief from pain and physical discomfort; optimism during recovery; gratitude and retrospective acceptance

Table 2. Representative Participant Quotations Supporting the Principal Themes

Theme	Subtheme	Participant	Illustrative quotation
Anticipatory threat and uncertainty	Fear of anesthesia and surgery	P2	"I feared the anesthesia and the surgical process."
Disrupted birth expectations and emotional distress	Emotional distress following the unexpected decision	P2	"It was not my planned delivery, and I felt depressed."
Disrupted birth expectations and emotional distress	Disappointment over not having a vaginal delivery	P9	"I wanted a normal delivery, but it did not happen."
Postoperative recovery and positive reinterpretation	Relief from pain and physical discomfort	P1	"After surgery, I felt less pain and better."
Postoperative recovery and positive reinterpretation	Gratitude for maternal and newborn wellbeing	P9	"I am thankful to Allah for my recovery and my baby's health."

P, participant.

Anticipatory Threat and Uncertainty

The first theme reflected participants' perceptions of threat and uncertainty after being informed that emergency cesarean delivery was required. Their concerns centred on anesthesia, the surgical procedure, possible complications, and uncertainty about what would happen during and after the operation. For women experiencing childbirth for the first time, the emergency nature of the decision appeared to intensify apprehension because they had limited time to understand or psychologically prepare for surgery. One participant expressed this concern directly:

> *"I feared the ANESTHESIA and the surgical process." — P2*

Participants' accounts also reflected concern about their own safety and the wellbeing of their newborns. These concerns were closely connected to uncertainty regarding the outcome of the operation and the expected course of postoperative recovery. Fear was therefore not limited to the procedure itself but extended to possible maternal or neonatal harm, postoperative pain, and the length and difficulty of recovery. Feelings of nervousness, stress, and helplessness accompanied this uncertainty during the period surrounding the emergency decision.

Disrupted Birth Expectations and Emotional Distress

The second theme described the emotional consequences of the unexpected transition from an anticipated vaginal birth to emergency surgical delivery. Participants reported disappointment, sadness, anxiety, and emotional distress when the planned or expected mode of delivery could no longer proceed.

The emergency decision was experienced not only as a clinical intervention but also as an abrupt disruption of participants' expectations regarding childbirth.

One participant described the emotional effect of the unplanned surgical delivery:

> *"It was not my planned delivery, and I felt depressed." — P2*

The term "depressed" represented the participant's own description of her emotional reaction and was not interpreted as a clinical diagnosis. Participants' distress appeared to arise from the sudden change in the birth plan, limited preparation for surgery, concern about possible adverse outcomes, and a reduced sense of control over the childbirth process.

Disappointment regarding the loss of an anticipated vaginal birth was also evident:

> *"I wanted a normal delivery, but it did not happen." — P9*

For these participants, vaginal delivery had formed part of their expectations of first-time motherhood. The requirement for emergency surgery created a sense of loss and disappointment, even when participants understood that the procedure was necessary. The emotional response therefore reflected both fear of the surgical intervention and grief over a childbirth experience that differed from what they had expected.

Postoperative Recovery and Positive Reinterpretation

The third theme represented the gradual shift from immediate surgical distress towards physical relief, optimism, and gratitude during postoperative recovery. Participants described improvement in pain and physical discomfort after surgery and reported feeling better as their condition stabilized. One participant stated:

> *"After surgery, I felt less pain and better." — P1*

Physical improvement appeared to contribute to greater emotional reassurance. As participants recovered and became aware of favourable maternal and newborn outcomes, their initial fear was increasingly accompanied by relief and optimism. Recovery was therefore experienced as both a physical process and an emotional adjustment to the outcome of the emergency delivery. Gratitude was particularly evident when participants reflected on their own recovery and the wellbeing of their newborns:

> *"I am thankful to Allah for my recovery and my baby's health." — P9*

This account illustrates how religious gratitude contributed to the interpretation of a successful outcome following an initially distressing experience. Although emergency cesarean delivery was described as frightening and inconsistent with participants' expectations, successful surgery, reduced pain, and reassurance regarding the newborn allowed some women to reinterpret the experience more positively.

The findings consequently indicated that negative emotional reactions and positive postoperative evaluations could coexist within the same childbirth experience.

Overall, participants experienced emergency cesarean section as a progression involving initial threat and uncertainty, emotional distress associated with disrupted birth expectations, and subsequent physical and emotional adjustment. The recovery process did not eliminate the disappointment or fear associated with the emergency procedure; rather, relief, optimism, and gratitude developed alongside participants' recognition that the intervention had resulted in favourable maternal and newborn outcomes.

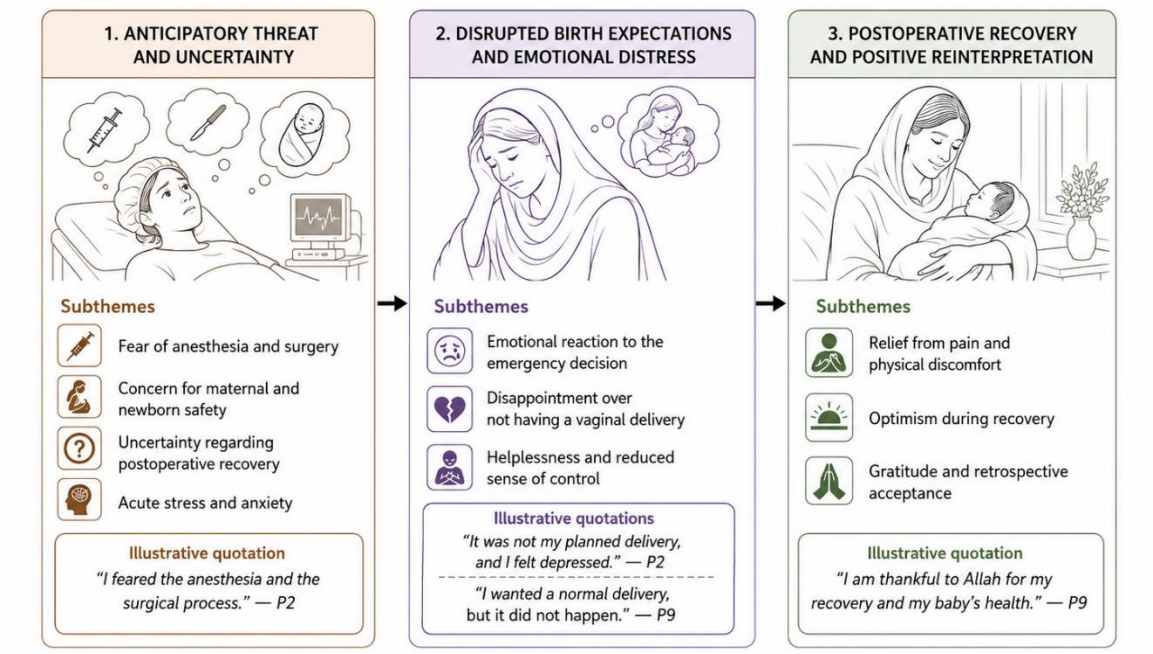

Figure 1 Thematic model of first-time mothers' emotional and postoperative experiences following emergency cesarean section. The figure presents a three-stage thematic progression beginning with anticipatory threat and uncertainty, characterized by fear of anesthesia and surgery, concern for maternal and newborn safety, uncertainty regarding recovery, and acute anxiety. The second stage illustrates emotional distress arising from disrupted birth expectations, including disappointment over the loss of an anticipated vaginal delivery, emotional reactions to the emergency decision, and a reduced sense of control. The final stage represents postoperative recovery and positive reinterpretation, reflected in pain relief, optimism, gratitude, and retrospective acceptance following favourable maternal and newborn outcomes. Directional arrows indicate the experiential transition across these stages, while participant quotations provide illustrative support for each major theme.

DISCUSSION

This qualitative study explored how first-time mothers experienced an emergency cesarean section emotionally and during postoperative recovery. The findings showed that participants' experiences were characterized by three connected processes: perceived threat and uncertainty surrounding the emergency procedure, emotional distress related to disrupted birth expectations, and subsequent physical recovery accompanied by relief, gratitude, and more positive reinterpretation. These findings indicate that emergency cesarean delivery was experienced not only as a surgical intervention but also as a psychologically significant event shaped by uncertainty, expectations regarding childbirth, concern for maternal and newborn safety, and perceptions of recovery.

Fear of anesthesia, surgery, possible complications, and maternal or newborn harm was particularly evident around the emergency decision. The limited time available to understand and prepare for surgery appeared to intensify uncertainty among participants who had no previous childbirth experience. Similar emotional reactions, including fear, shock, helplessness, and loss of control, have been described among women undergoing emergency cesarean delivery in other settings (7). Evidence from childbirth-trauma research also indicates that perceived threat, unexpected clinical intervention, and reduced control during childbirth may contribute to persistent psychological distress (4,5,11). The

present findings do not establish that participants developed a psychological disorder; rather, they demonstrate that the emergency surgical context produced considerable situational fear and emotional vulnerability.

Disappointment regarding the loss of an anticipated vaginal birth represented a separate but closely related dimension of participants' experiences. For some women, the emergency procedure disrupted expectations regarding how their first childbirth would occur and created a sense of sadness or personal loss. Previous qualitative studies have similarly shown that women may evaluate cesarean delivery negatively when it is unexpected, insufficiently explained, or inconsistent with their preferred birth plan (3,7). Nevertheless, childbirth experiences are not determined by mode of delivery alone. Some women undergoing cesarean delivery have reported positive experiences when they perceived the procedure as necessary, safe, or protective, indicating that clinical circumstances, expectations, communication, and perceived involvement may be more influential than the surgical procedure itself (6,8).

The participant statement that she "felt depressed" should be interpreted as a description of immediate emotional distress rather than evidence of clinically diagnosed depression. No standardized psychological assessment was conducted, and the study was not designed to estimate the prevalence of postpartum depression, anxiety disorders, or post-traumatic stress disorder. The findings instead emphasize the importance of recognizing women's own descriptions of sadness, helplessness, fear, and disappointment following an unexpected surgical birth. Where such feelings persist or interfere with maternal functioning, postpartum assessment and referral may be clinically appropriate.

Postoperative improvement contributed to a more positive evaluation of the experience for some participants. Relief from pain and physical discomfort, together with perceived maternal and newborn wellbeing, appeared to reduce initial fear and support emotional adjustment. This pattern is consistent with evidence indicating that women may retrospectively interpret an emergency intervention more positively when they understand its protective purpose and experience a favourable outcome (1,3). Continuous support, reassurance, and respectful care may further improve women's sense of safety during childbirth and reduce negative emotional experiences (1,9). However, positive reinterpretation should not be viewed as eliminating the earlier fear or disappointment; both negative and positive meanings may coexist within the same childbirth experience.

Religious gratitude was also evident in one participant's reflection on her recovery and the health of her newborn. This suggests that faith may serve as a personal meaning-making or coping resource following an initially distressing delivery. Because this interpretation was supported by a limited number of accounts, it should not be generalized to all participants or to Pakistani mothers more broadly. Further qualitative research could examine how religious beliefs, family involvement, communication practices, and local expectations regarding childbirth influence women's adaptation following emergency obstetric intervention.

The findings have several implications for maternity care. When clinical urgency permits, healthcare professionals should provide a brief and comprehensible explanation of why emergency cesarean delivery is required, what the procedure involves, and what the mother can expect during early recovery. Communication should acknowledge both clinical safety and the emotional impact of an abrupt change in the planned mode of birth. Postoperative care may also include opportunities for women to discuss the delivery, clarify unanswered questions, and express concerns about recovery or newborn wellbeing. Women reporting persistent distress may benefit from structured psychological assessment and appropriate referral. These implications should be regarded as practice considerations arising from participants' experiences rather than interventions whose effectiveness was tested by the study.

A strength of this study was its focus on the experiences of first-time mothers, whose emotional responses to emergency cesarean delivery may differ from those of women with previous childbirth experience. Individual, semi-structured interviews also allowed participants to describe fears,

disappointment, recovery, and gratitude in their own words. However, the findings should be interpreted in light of several limitations. Participants were recruited from a single hospital through purposive sampling, which limits transferability to other maternity-care settings. Interviews conducted within the hospital may have increased social-desirability bias or discouraged criticism of care. The available participant characteristics were limited, and the influence of age, socioeconomic position, obstetric indication, neonatal condition, and postpartum timing could not be examined. Translation and automated transcription may also have affected the wording or cultural nuance of participants' accounts, although transcripts were reviewed before analysis. Finally, the cross-sectional interview design captured experiences at one stage of recovery and could not determine how emotional responses changed over the longer postpartum period.

CONCLUSION

Emergency cesarean section was experienced by first-time mothers as a complex emotional and postoperative process involving fear of surgery and possible harm, disappointment associated with disrupted birth expectations, and subsequent relief, gratitude, and positive reinterpretation during recovery. These findings indicate that emergency maternity care should address women's informational and emotional needs alongside clinical safety. Clear communication, respectful support, postoperative discussion, and attention to persistent psychological distress may help women process an unexpected surgical birth and adjust more positively during the postpartum period.

REFERENCES

1. World Health Organization. WHO statement on caesarean section rates. Geneva: World Health Organization; 2015.
2. Elmir R, Schmied V, Wilkes L, Jackson D. Women's perceptions and experiences of a traumatic birth: a meta-ethnography. J Adv Nurs. 2010;66(10):2142-2153.
3. Ayers S, Bond R, Bertullies S, Wijma K. The aetiology of post-traumatic stress following childbirth: a meta-analysis and theoretical framework. Psychol Med. 2016;46(6):1121-1134.
4. Bohren MA, Hofmeyr GJ, Sakala C, Fukuzawa RK, Cuthbert A. Continuous support for women during childbirth. Cochrane Database Syst Rev. 2017;(7).
5. Downe S, Finlayson K, Oladapo OT, Bonet M, Gülmezoglu AM. What matters to women during childbirth: a systematic qualitative review. PLoS One. 2018;13(4):e0194906.
6. Begum T, Ellis C, Sarker M, Rostant K, Rahman A, Anwar I, et al. Women's experiences of caesarean section in rural Bangladesh: a qualitative study. BMC Pregnancy Childbirth. 2018;18:1-10.
7. Cook N, Ayers S, Horsch A. Maternal posttraumatic stress disorder during the perinatal period and child outcomes: a systematic review. J Affect Disord. 2018;225:18-31.
8. Novita RVT. Caring experience of childbirth primipara undergone emergency cesarean section: a systematic review. Jurnal Ilmu Keperawatan Maternitas. 2019;2(1):25.
9. Ikram B, Zakiya Rubab M, Jan A. Local perception about caesarian section among post caesarian section women in Pakistan. OJS. 2021;4(2):299-308.
10. Malik M, Prescott K, Khalid M, Hashmi A, Kiani A. Expectations and experiences of women regarding maternal healthcare services in Pakistan: challenges and lessons to be learnt. J Pharm Policy Pract. 2021;14(1).
11. Tariq A, Raza A. Social context of post-cesarean stress management by young mothers in Lahore. Pak J Soc Res. 2022;4(2):363-369.

12. Nuampa S, Ratinthorn A, Lumbiganon P, et al. Because it eases my childbirth plan: a qualitative study on factors contributing to preferences for caesarean section in Thailand. BMC Pregnancy Childbirth. 2023;23:280.

13. Rodriguez J, Moro MR, Radjack R. Migrant mothers' experiences of caesarean section: a transcultural qualitative study. Front Psychiatry. 2023;14.

14. Michael TO, Agbana RD, Naidoo K. Exploring perceptions of cesarean sections among postpartum women in Nigeria: a qualitative study. Women. 2024;4(1):73-85.

15. Orovou E, Antoniou E. Voices of women with emergency cesarean section experience: a qualitative approach. Cureus. 2024;16(2).

16. Saansong AOA, Adoma PO, Nkrumah J, Gbagbo FY. Experience and perceived impact of anxiety and depression on quality of life following emergency caesarean section among women in Ghana: a qualitative study. BMJ Open. 2024;14(11):e086069.

17. V E. Qualitative study to explore the lived experiences of postpartum depression among caesarean section mothers. REDVET. 2024:34-40.

18. Afshar F, Pakseresht S, Jafarzadeh-Kenarsari F, Maroufizadeh S. Comparison of childbirth experience and related factors in primiparous women with normal vaginal delivery and cesarean section from northern Iran. J Holist Nurs Midwifery. 2025;35(1).