

PERCEPTION OF NIGERIAN WOMEN TOWARDS CAESAREAN SECTION: A CASE STUDY OF WOMEN OF REPRODUCTIVE AGE IN AKWA LBOM STATE, NIGERIA.

Margaret Mboho

Department of Physical and Health Education, University of Uyo,
Akwa Ibom State, NIGERIA.

margaretmboho@yahoo.com

ABSTRACT

The main purpose of this study was to explore the perception of reproductive age women in Akwa Ibom State towards caesarean section. The research methods included structured face-to-face interviews and focus group discussion. Two sites in Akwa Ibom State-Etinan and Oruk Anam were used for the study. Thirty women of childbearing age were interviewed. Focus group discussions were held with five mothers-in-law of childbearing ages. The findings of the study indicate that caesarean section appeared to have various meanings for the respondents and that the procedure was not widely accepted in the communities. In addition, majority of the women that participated in the study had limited exposure to information, resulting in high level of ignorance, thus endangering their lives and those of the unborn babies. It was therefore recommended that provision of information during child birth is paramount to a satisfying birth experience. Furthermore, women should receive sufficient psychological and emotional support and encouragement from their husbands.

Keywords: Perception, Nigerian women, caesarean section, reproductive age women

INTRODUCTION

Maternal mortality represents the leading cause of death among the women of reproductive age in most developing countries including Nigeria (Mekonnen and Mekonnen, 2003; WHO, 2007). Furthermore, it is estimated that one third of all maternal deaths globally occur in just two countries, namely India and Nigeria (Mboho et al 2013). According to UNFPA (2012), in 2010, India was accountable for about 20% of global maternal deaths (56,000) and Nigeria, 14% (40,000). Meanwhile, disease, deformity and death are terms usually employed to describe the experiences of a vast majority of sub-Saharan African women during pregnancy and birthing (Harrison, 2001; Brookman-Amisshah and Moyo, 2004; WHO, 2004a). Similarly, the majority of African women are often viewed as being at high risk of infections, injury and death during pregnancy and the periods surrounding it (Izugbara and Ukwai, 2007).

In recent time women in Nigeria have expressed worries about choices of childbirth especially the issues surrounding vaginal birth. The joy of every woman is to deliver her baby normally. Some decades ago the most available or preferred option for most women was vaginal birth. Some of the women had their babies at home with traditional birth attendants but quite often with difficult labour resulting from obstruction and the women died before any meaningful interventions. Today, however, many babies have been delivered successfully through caesarean section. This success story is not without criticism.

Among women in the developing countries, caesarean section is still being perceived as a 'curse' of an unfaithful woman (Adeoye and Kalu 2011). The authors further assert that caesarean section is seen among weak women. In addition, caesarean section is surrounded

with suspicion, aversion, misconception, fear, guilt, misery and anger among the women of South Western Nigeria (Adeoye and Kalu 2011).

Furthermore, in most sub-Saharan African countries including Nigeria, caesarean section is being accepted reluctantly even in the face of obvious clinical indication (Adeoye and Kalu 2011). Despite the causes of maternal mortality often obstetric in origin, underlying cultural factors and beliefs also affect access to and use of health facilities and thus contribute to avoidable maternal deaths (Mboho et al 2013). Several studies have indicated how local beliefs and practices impact general health and childbearing. Some of these beliefs have been identified as contributing to the delays in accessing appropriate skilled help when complications arise in labour (Okafor 2000)

It is necessary to note that the issue of vaginal birth is not only peculiar to developing countries but also in some developed countries. Women still choose vaginal birth after having caesarean section even in the case of post dates slated for elective caesarean section (Clift-Mathews 2010). The author further highlighted the fact that women desperately wished to go into labour before their appointment dates because not giving birth vaginally was a sign of 'failure'. In addition; vaginal birth is something a number of women look upon as a rite of passage (Clift-Mathews 2010)

Obstetrics in modern America is a contentious subject in general (Ecker 2013). Usually childbirth and action surrounding it whether medical or otherwise normally evoke strong emotions where discussion is often framed ideologically as a matter of nature versus technology. Hence the issue of caesarean section in particular is much contested issue (Ecker 2013). Even so, caesarean section rates are on the increase as evident in a number of western countries such as the United States of America and United Kingdom (McAra-Couper, Jones and Smythe 2010).

In 1985, following the increasing disparity rate among nations in the number of caesarean births, the World Health Organisation (WHO) set out to determine an optimal rate of 15 percent as ideal. The postulated 15 percent by WHO would optimally prevent childbirth injuries and deaths. In addition, many women and babies would avoid unnecessary and potentially harmful surgery (Harvard magazine 2013). However, WHO has since modified this particular recommendation in 2009, stating that 'the optimum rate is unknown but asserts that both very low and very high rates of caesarean sections can be dangerous'. In other words, the procedure should be done only when it is absolutely necessary. The editorial team of Academic Research International of Harvard Magazine concluded that there is need for a balance to be reached, that is, women should be allowed to have normal vaginal deliveries with as little intervention as possible. However, at the same time, the families, obstetricians will be ready to address any unexpected emergencies.

AIM

The aim of this study was to explore the perception of reproductive age women in Akwa Ibom State towards caesarean section. Consequently, the question asked was: *What are the perceptions of women of reproductive age in Akwa Ibom State towards caesarean section?*

STUDY SETTING

The study was conducted in Etinan and Oruk Anam Local Government Areas of Akwa Ibom State. The need to select these areas was based on the accessibility and cost implications. In addition, the researcher had carried out intervention programmes earlier in these areas.

Sampling Principles and Procedures

Participation was restricted to women of reproductive age (15-49) who had given birth before. All participants were selected on the researcher's own judgement that they were the most suitable groups capable of providing information on childbearing practices in the community.

Ethical Considerations

The main areas of concern in ethical involvement with participants included the issues of privacy, anonymity and confidentiality. The researcher upheld the integrity of the participants and did her best to protect the rights of the research participants. Informed consent was obtained. Through informed consent, study participants were made to understand that participation was voluntary and they were counselled to freely opt out at any given time in the study.

Data Generation Method

Data were generated through topic-guided and in-depth personal interviews that took place in natural settings chosen by the participants. A total of thirty interviews were conducted with reproductive age women. Focus group interviews were carried out with five mothers-in-law of child bearing ages. The focus group was conducted in English, moderated by the researcher and audio recorded and transcribed verbatim. Ground rules for behaviour were agreed upon among the mothers-in-law at the start to facilitate discussion. On the whole thirty five women participated in the study.

Data Analysis

Thematic analysis of the data was undertaken following the principles of cross-sectional and categorical indexing delineated by Mason (2002). Analysis began with the process of familiarization with the data by listening carefully to interview tapes, reading and re-reading the data and making memos and summaries before the formal analysis began.

Credibility and Reliability

To enhance the credibility and reliability of the results further, an independent colleague analysed thirty (30 percent) of the scripts using the same process as the researcher. Comparable results were obtained. This offers additional confidence in the credibility of the results.

FINDINGS

Caesarean section appeared to have various meanings for the respondents. Although the women agreed that it was a procedure done in hospital to save the lives of women and that of their babies, the majority of them believed that it could be avoided if the individual was conscious of the activities of the 'wicked people'. Culturally, caesarean section was seen as a 'curse' and a 'failure of womanhood'. This view was well articulated during focus group discussions with mothers-in-law and during individual interviews with women of childbearing age.

I think it is a way of saving the lives of our women. However, women would prefer to die than go through a caesarean operation. Our belief is that if a woman undergoes the operation, her husband will accuse her of *ekpo nka owo* [infidelity]. With this in mind, some women would prefer to die rather than have a caesarean section (MIL 2).

We see caesarean section as a reproach for any woman. Women are expected to give birth normally through the vagina... God also promised women safe births, so we see

this as shameful and as proving that the woman must have done something wrong (MIL3).

One of the respondents who had previously had a caesarean section in hospital felt that the doctors were always in a hurry to send women for surgery. This is what she said:

I was still labouring with no obvious danger and was very strong... yet they took me to the theatre and operated on me. This has caused me a lot of problems with my husband and my mother-in-law. I am being accused of doing something wrong and wasting of my husband's money. I have not fully recovered from the pain and the incision scar (ORW 22).

Similarly, ERW 13, shared her own experience,

When I went to the hospital after my expected date of delivery, I was admitted for observation. After two days, nothing happened, so the doctor asked us to sign consent form for caesarean section. We refused—I mean my husband and I—and at night I absconded from the hospital to the church. I was in the church for the next three days and had a normal birth. You see, the doctors are always in a hurry to do a caesarean section, even when it's not necessary (ERW13).

Others believed that caesarean section was not the will of God and as such it was against their religious belief.

For me, I do not accept the idea of caesarean section. God promised women normal delivery and anything against the promise of God is totally rejected and not in conformity with my religious belief (ERW8).

For women who accept caesarean section, that is entirely their choice. The church usually prays against delivery through surgery. This is the work of the wicked people. I know of some pregnant women who previously had caesarean sections in the hospital but their subsequent births were here in the church and they were normal vaginal births (ORW 29).

During one of the observation sessions during the antenatal clinic in the home of a traditional birth attendant, a pregnant woman was sharply rebuked for coming into the session late. The TBA remarked:

You again, because you were stubborn in your last pregnancy... this resulted in caesarean section in the hospital. I thought you have learnt your lesson. I expect you to be the first to arrive in the home during this period of prayers and fasting. Next time you are late, I will send you away and you'll have to go back to the hospital for another caesarean operation (Field notes 1/03/10).

The pregnant woman quickly apologised and joined the session. Corroborating this perceived negative attitude to caesarean section is the report of a husband who is said to have divorced his wife after a caesarean section. ORW 23 narrated her experience:

He was a very difficult man who refused to understand what happened to me during the birth of my first baby girl. I had prolonged labour in the traditional birth attendant's home and was rushed to hospital where I had a caesarean section. I thank God that my baby and I survived. My husband was very angry with me to have caused him to spend so much money. He accused me of doing something wrong and then made him to spend so much money. Right from the day I returned from the hospital and until the day I left his house, I never had any peace. He accused me of ruining his business and in the end,

he asked me to leave his home. I am glad that he took that decision and now I am very happy with my present husband.

The decision to divorce the woman may not have been unconnected with the importance attached to male children; the birth of a male child would probably have mitigated the 'offence' of the caesarean section. Additionally, women who had had caesarean sections in the past reported having received abuse from their fellow women, making them unwilling to belong to the women's organization in the community. The data generated in the study indicates that women in these communities may have experienced a great deal of stress and trauma after undergoing a caesarean section. This view was corroborated by a mother-in-law

I have heard a young man abusing the mother when the mother cautioned the son for the wrong he did. The son told her that she had no right over him and that she was not his mother... She did not give birth to him, or if she did, why the scar on her abdomen? This experience would make other women afraid of going to the hospital, where their labour might end in caesarean section. Some women who have had caesarean section in the hospital would resort to traditional birth attendants for subsequent births (EMMW5).

The woman with caesarean section often receives abuse from other women... They are unable to give birth normally through the vagina. The woman is seen as a 'man' so she does not fit properly in the woman's world (ORW 20).

When this researcher asked whether any woman had been expelled from a women's organization for having undergone a caesarean section, this response was given:

Not really – you know women talk carelessly at times. There may be some issues for discussion; the contributions of such a woman may not be taken seriously, since it is believed that she has the features of a man, even though she is a woman... We believe that a woman should give birth to her children through the vagina and not through the abdomen. Her contributions in such meetings are viewed from the perspective of a man and not from the stance of a woman (ORW 20).

On the other hand, caesarean section was recognised by some respondents as a way of saving the lives of women and those of their babies.

Rather than a woman dying with her baby during childbirth and if caesarean section is the only option left for her survival, she should go ahead to have it. The pain of losing a woman during childbirth is great... I know there are many factors that hinder the acceptance of caesarean section in this community, but the benefits of staying alive outweigh the loss of the woman (ORW 18).

A mother-in-law narrated her experience:

I had all my children in the hospital normally but the last one was by caesarean section. That was my fourth child. During labour of my last baby I bled profusely with the baby still not delivered. I was taken to the theatre for caesarean section. I would have died if this delivery was at home. Caesarean section is a way of saving the life a woman and her baby. I think this fear of caesarean sections in this community is due to ignorance.

Other respondents in the study attributed the fear of caesarean section to the influence that the church has over women during pregnancy and childbirth.

DISCUSSION

The present study found that caesarean section was not widely accepted in the communities. Various meanings were associated with a woman who had undergone caesarean section. On

one hand, it was associated with infidelity on the part of the woman, while on the other; it was believed to be a sign of weakness and failure not to have a vaginal delivery. Furthermore, the majority of women found it repugnant to go to hospital, even in the case of life-threatening complications. This attitude was attributed to their fear of caesarean section and the belief that most doctors were usually in a hurry to carry out the procedure without any tangible reasons as well as to earn more money. It was also their belief that caesarean section would have negative consequences for future pregnancy and childbirth. In Northern Nigeria, Harrison and John (1996) noted that men were reluctant to grant permission for operative delivery in cases of difficult labour, because they perceived it as a mark of reproductive failure, and their actions have been known to have poor obstetric outcomes (Harrison and John, 1996). This supports the findings in this study that caesarean section was perceived in the study-communities as a failure on the part of the woman and attributed to infidelity.

In a previous study in Nigeria, 12 percent of women interviewed on their perception of caesarean section would not accept it under any circumstances (Aziken et al., 2007). The authors suggest that their non-acceptance might be due to cultural factors, fear of rejection or isolation in the community and women's lack of knowledge of obstructed labour and appropriate management of complications. The result was an increase in maternal deaths within the communities. Another study in Nigeria also indicated that TBAs were ignorant of maternal complications during childbirth and that there was a dearth of knowledge concerning management and treatment (Itina, 1997). The findings in the present study support the assertions of the above authors that some women and their families in the study communities viewed caesarean section as a mark of reproductive failure and as unacceptable, not being a natural form of childbirth. This reveals a high level of ignorance prevailing in the communities.

IMPLICATIONS FOR PRACTICE

It is evident that majority of the women that participated in the study had limited exposure to information, resulting in the high level of ignorance thus endangering their lives and that of the unborn child. However, it is not always recognised that a woman who has had a caesarean section has indeed undergone major surgery

Consequently, the decision to undertake a caesarean section should not be made lightly and each woman should be informed about the risks. These include: abdominal pain, bladder injury are short-term effects that occur much more commonly in women who gave birth by caesarean section compared to vaginal birth (Nice, 2004).

It is recognized that having an elective caesarean section is safer for a woman than undergoing an emergency caesarean section but vaginal birth is still viewed as the safest way of giving birth (Baxter, 2007)

In addition, there are significant numbers of women for whom caesarean is not an option, for instance, if the baby is breech for the women having their babies for the first time, or there is evidence of human immunodeficiency virus infection with a high viral load. Other cases are: type three and four placenta praevia, placenta abruption, obstructed labour, or cord prolapse.

RECOMMENDATIONS

Consequent upon the findings, the following recommendations are suggested;

Provision of Information

The provision of information during childbirth is paramount to a satisfying birth experience (Beake et al., 2005). Midwives should strive to ensure that women were familiar with the

advantages of caesarean section and also the risk associated with the procedure. As almost one in four women will give birth through caesarean section (Baxter, 2007). The information given will empower women to make informed choices either to have or not to have the surgery. Information can be provided for women and couples in group settings as part of a parent education programme during the antenatal period.

Vaginal Birth after Caesarean Section

Women who have had a previous caesarean section may have a strong need for information from their midwife and obstetrician during the antenatal period. Couples should be reminded of the reason why the previous caesarean section was necessary. They can use this information with their midwife and obstetrician to make decision about subsequent deliveries. Vaginal birth following caesarean section is safe and there are no absolute contraindications (Baxter 2007).

However, recommended practice is that it takes place in the hospital.

Provision of Emotional Support

Some women have been found to fear the prospect of undergoing caesarean as found in this study. Women still choose vaginal birth after having caesarean section even in the case of post dates slated for elective caesarean section (Clift-Mathews 2010). The author further highlighted the fact that women desperately wished to go into labour before their appointment dates because not giving birth vaginally was a sign of 'failure'. It is therefore, essential that women should receive sufficient psychological and emotional support and encouragement from their husbands.

Furthermore, in most sub-Saharan African countries including Nigeria, caesarean section is being accepted reluctantly even in the face of obvious clinical indication (Adeoye and Kalu 2011). Despite the causes of maternal mortality often obstetric in origin, underlying cultural factors and beliefs also affect access to and use of health facilities and thus contribute to avoidable maternal deaths (Mboho et al 2013).

LIMITATIONS OF THE STUDY

The main limitation of the study was the small number of participants. However, sample size in a qualitative study is determined by information saturation, meaning that the sampling was terminated when no new information was forthcoming and redundancy was the primary criterion. In addition, in purposive sampling in qualitative research, adequacy of sample size is a relative term, since the size depends on the purpose of the research. Furthermore, only the researcher can make decisions as to when to stop collecting information.

Selection bias may have occurred in recruiting participants as the researcher targeted participants based on her judgement of who participated in the study.

CONCLUSION

Caesarean section should be seen as life saving procedure. The procedure should be done only when it is absolutely necessary. However, in this study, it is quite obvious that caesarean section has been given various interpretations based on cultural and social factors. And unless, serious efforts are directed towards creating effective communication projects for behaviour change, the perception and attitude of the women of reproductive age in Akwa Ibom State, and indeed Nigeria towards caesarean section, may take a longer time before the much needed change occurs.

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