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SOCIOLOGICAL PERCEPTION OF FEMALE PREFERENCES OF CESAREAN SECTION IN SELECTED AREAS IN ILORIN METROPOLIS

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Abstract

Caesarean section has been part of human culture since ancient times and there are tales in both Western and Non-Western cultures of this procedure resulting in life of mothers and offspring. Yet, the early history of caesarean section remains shrouded in myth and is of dubious accuracy. Even the origin of Caesarean has apparently been distorted over time. In fact, caesarean sections are not without complications and consequences such as; maternal risks in the short term include hemorrhage, infection, ileus, pulmonary embolism, and Mendelson's syndrome. There is evidence suggesting decreased fecundity, increased risk of ectopic pregnancy, placenta praevia, and worse infant outcome in subsequent pregnancies, although the effect on non-reproductive health is unclear and contradictory. This is among the reason why this research work deemed it necessary to investigate the socio-cultural perception and female preference of Caesarean Section in Ilorin metropolis. The data were obtained from a list of 160 random people selected in four areas of Ilorin metropolis. The study further discovered that, there is relationship between age and the level of caesarean section and there is relationship between educational qualification and the level of caesarean section. The study concluded that, emergency obstetrics care, including caesarean section is seen as a key factors in reduction of maternal mortality in low and middle income settings but it is essential that service are available, affordable and accessible. Hence, the study recommended the need for information on what caesarean section is and what it is not, especially for women who are categorically unable to have a vaginal delivery so as to redress negative perceptions and enhance acceptance by communities. This would invariably be one way in which medical providers can address the socio-cultural experience of illness as well as diseases.

Keywords: Perception, Culture, Caesarean Section, Medical Providers

Introduction

Caesarean section has been part of human culture since ancient times and there are tales in both Western and Non-Western cultures of this procedure resulting in live mothers and offspring. According to Greek mythology Apollo removed Asclepius, founder of the famous cult of religious medicine, from his mother's abdomen. Numerous references to caesarean section appear in ancient Hindu, Egyptian, Grecian, Roman, and other European folklore. Ancient Chinese etchings depict the procedure on apparently living women (Martin et.al, 1987). The Mischnagoth and Talmud prohibited primogeniture when twins were born by caesarean section and waived the purification rituals for women delivered by surgery.



Source: The extraction of Asclepius from the abdomen of his mother Coronis by his father Apollo. Woodcut from the 1549 edition of Alessandro Beneditti's *De Re Medica* (National Library of Medicine, 2000).

Yet, the early history of caesarean section remains shrouded in myth and is of dubious accuracy. Even the origin of Caesarean has apparently been distorted over time. It is commonly believed to be derived from the surgical birth of Julius Caesar; however this seems unlikely since his mother Aurelia is reputed to have lived to hear of her son's



invasion of Britain. At that time the procedure was performed only when the mother was dead or dying, as an attempt to save the child for a state wishing to increase its population (Miller et.al, 1998). Roman law under Caesar decreed that all women who were so fated by childbirth must be cut open; hence, caesarean.

Sociologically, CS can save the life of the mother and newborn, but is also known to have the typical complications of any major surgery: hemorrhage, infection, venous thromboembolism and complications of anesthesia, sometimes leading to maternal death. Advances in care, antimicrobial and antithrombotic prophylaxis has improved the safety of CS (Sewell et.al 1990). During last decades, many obstetricians perceive the risks related to CS as being so low, that they are willing to perform a CS on relative medical indications, and even without medical indications. Some obstetricians emphasize the risks related to vaginal delivery (VD) - the risks of neonatal asphyxia and trauma and the risk for obstetric tears- to justify the liberal use of CS (Willson et.al, 1988).

Over the years, there have been several studies comparing severe maternal morbidity in different modes of delivery, and also comparing the risks related to elective CS with attempted VD (Liu et al. 2007, Villar et al. 2007, Kuklina et al. 2009, Van Dillen et al. 2010, Farchi et al. 2010). Risk factors identified by most studies are obesity and advanced maternal age, increasing the risk for CS and CS related complications. Severe maternal morbidity and even mortality (Deneux-Tharaux et al. 2006, Samuelsson 2007, Kuklina et al 2009, et al. 2010). The causes are unclear, but increased CSs increased obesity and an increased proportion of women giving birth in advanced age are among the causes suspected. The present study was planned to examine the maternal complications related to CS in a high-standard health care system and to determine the risk factors predisposing to complications.

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 labor resulting from obstructions 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 developing countries, caesarean section is still being perceived as a 'curse' of an unfaithful woman (Adeoye and Kalu 2011). Caesarean section was also seen among weak women.

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 death (Mboho et al 2013). Several studies have indicated how local beliefs have been identified as contributing to the delays in accessing appropriate skilled help when complications arise in labor (Okafor 2000).

Statement of the Problem

It can be observed that, long term morbidity including formation of adhesions, intestinal obstruction, bladder injury, and uterine rupture is often underestimated during subsequent pregnancy. There is evidence suggesting decreased fecundity, increased risk of ectopic pregnancy, placenta praevia, and worse infant outcome in subsequent pregnancies, although the effect on non-reproductive health is unclear and contradictory. Feelings of inadequacy, guilt, and failure in not completing a natural process may affect bonding between mother and infant, particularly if the operation was conducted under general anesthetic.

Risks of multiple caesarean sections - Serious maternal morbidity progressively increased as the number of previous caesarean deliveries increased. The rate of hysterectomy, blood transfusions, adhesions, and surgical injury all increased with increasing number of caesarean deliveries. In fact, constant risk of infant and neonatal death; high risk of diabetes after caesarean section delivery; risk of breathing problems; report of iatrogenic brain injury during emergency Caesarean Section especially when the baby was delivered it was found to be bleeding from an incised scalp wound with convoluted tissue exuding from the site (Durham, 1998).

A prospective study of caesarean operations (75 women) during 2000 revealed that 1.5 percent of the babies had skin lacerations (13 babies), seven



lacerated during emergency operations and six during elective ones. Only 7 of the 13 injuries were noted by the surgeon and four of the injuries were caused by one particular doctor, suggesting a fault in technique (Weiner and Westwood 2002). Prematurity - Research shows that one extra week in the womb makes a huge difference to risk of respiratory distress syndrome - and death. Some of the babies had been delivered by elective caesareans at 37-38 weeks instead of 39 weeks onwards, when their risk would be so much lower.

Objectives of the Study

The general aim of this research work is to investigate the socio-cultural perception and female preference of Caesarean Section in Ilorin metropolis.

However, the specific objectives are to: -

- i. Identify the socio-cultural influence of caesarean section among women in Ilorin.
- ii. Examine the perception of caesarean section preference in Ilorin.
- iii. Determine the effects of caesarean section among the subject of the study area.

Justification of the Study

This research is justifiable because of the significant importance that will be derived. This study will be conducted to explore pregnant women's preferences and perceptions regarding Caesarean delivery, that is, to determine the awareness of perception and attitude towards caesarean section. The Caesarean Section is ranked as the number one major surgical procedure performed in the industrialized world. Therefore, the study will be aimed at investigating the level of knowledge, attitudes and perceptions about Caesarean Section among women of child bearing age. There are many factors that contribute to Caesarean Section, Social factors, trauma, abuse and psychodynamic causes have been hypothesized. Fear of childbirth is usually expressed as fear of pelvic floor injury, of requiring emergency caesarean section, of losing the baby and of being left alone in labor. Tocophobia appears to be the most important reason for requesting caesarean section.

Nature, Perception and Causes of Caesarean Section (CS)

Caesarean delivery is the most widely performed major obstetric surgery globally and the incidence is rising. A caesarean section (CS) is a surgical procedure, which is performed whenever abnormal conditions complicate labor and vaginal delivery,

threatening the life of the mother or the baby. It is a form of abdominal surgery that is performed to deliver a baby via an incision made in the abdomen. A caesarean section may be planned in cases where it becomes evident during pregnancy that the procedure will be necessary or it may be performed as an emergency intervention.

In the work of Smith, Plaat and Fisk (2008), Caesarean Section (CS) is conceived as 'a most unnatural form of birth', a major abdominal surgery requiring an operating theatre. Caesarean deliveries were initially performed to separate the mother and the foetus in an attempt to save the foetus of a moribund patient. This operation according to the authors subsequently developed into a surgical procedure to resolve maternal or fetal complications not amenable to vaginal delivery, either for mechanical limitations or to temporize delivery for maternal or fetal benefit. The caesarean delivery has evolved from a vain attempt performed to save the foetus to one in which physician and patient both participate in the decision-making process, striving to achieve the most benefit for the patient and her unborn child.

Despite the adoption of more humanised procedures, how is it possible that C-section -defined by Fisk and his team as 'a most unnatural form of birth' (Smith et al 2008) - a major abdominal surgery requiring an operating theatre, the intervention of skilled personnel, the administration of anaesthesia and analgesics, and a hospital stay of several days, can be associated with 'natural childbirth'? To understand the paradoxical expression of 'natural caesarean', it is necessary to look back at the history of obstetrics and its techniques.

Indeed C-section, one of today's most common surgical operations in many European countries and North America (Jukelevics 2008), is now deemed a normal (ized) procedure, a routine practice that is not performed exclusively to save the life of the mother and of the baby, as it was originally conceived for, but also for various non medical reasons. According to the vast literature on the subject, several other causes have determined the high rate of C-section around the world (Souza et al 2010), such as convenience of the physician, hospital organizational constraints, economic benefit of health care providers and clinics, health inequalities and maternal request (Declercq et al 2011, Gamble et al 2007, Jacques 2007, Béhague 2002).



While in some countries it has become very frequent and relatively safe to give birth by C-section, it is impossible to deny that the material and emotional conditions under which it happens continue to be quite different. For instance, although the mother is generally under spinal anaesthesia, a technique that numbs only the lower part of her body, and thus is awake during the surgery, she will usually not see her baby coming out, because a drape separate her head from her abdomen. Moreover, she is under the effect of tranquillisers and analgesics to help her facing the frightening atmosphere of the operating theatre and the sensation of her body being opened. Also her partner finds himself in an uncomfortable position, he has to wear special clothes, a mask and a cap, has to stand in the operating theatre next to the upper part of his partner's body without interfering with the event going on, he is often nervous at the prospect of attending a surgical operation and is seldom able to accomplish the nowadays almost normative act of cutting the umbilical cord.

In developing countries however, CSMR is a minor player in contributing to increase rates of CS. If at all there is an increase, medical indications will dominate the list, because of the background, poor antenatal care services, fewer emergency obstetric care facilities and low numbers of Skilled Birth Attendants (National Population Commission, 2009; WHO Statistics Information, 2008). This is in addition to the negative perception of our women to Caesarean Section (Orji, Ogunniyi and Onwudiegwu, 2003; Ezechi, Fasubaa, Kalu, Nwokoro and Obiezie 2004). Caesarean section is costly and women play little role in decision taking particularly in emergency situations in some parts of Nigeria.

There are certain indications that call for Caesarean section which includes- previous Caesarean section, Cephalopelvic disproportion, foetal distress, failed induction, previous reconstructive vaginal surgery, abnormal presentation, multiple gestation, in excess of three and above, macrosomic baby, foetal abnormality, obstructive pelvic tumours, vulva herpes, retroviral diseases in PMTCT, several preeclampsia with unfavourable cervix, previous classical CS, major placenta praevia. Others include retained second twin, bad obstetrics history, patient's request, primigravida, breech, prematurity, cord prolapsed, abruption with live foetus.e.t.c (Jaiyesimi and Ojo 2003).

Common complications include endometritis, haemorrhage, injury to internal organs and neonates, wound infection, wound adhesions, urinary tracts infection, D.V.T and in very rare cases maternal death which might be due to complications that necessitate operation or to the risk associated with surgery. Jaiyesimi and Ojo (2003) also identified the following factors that propelled the increasing rates of Caesarean section- difficult vaginal deliveries, unbooked status of most patients, improper function or absence of facilities like vacuum extractor, induction of electronic foetal monitoring leading to over diagnosis of foetal distress, societal demands for improved foetal outcome and aspirations of the obstetrician to meet their demands. It has been estimated that 500 million women in developing countries are stunted as a result of malnutrition in childhood (Briggs, 2003). Many of these women have inadequate development of the bony pelvis, thus, increasing the risk of obstructed labour (Okafor and Onwusulu, 2000).

Health outcomes after a caesarean may be worse because medical problems may lead to surgery. This fact sheet, however, is based on research that determined excess harms arising from the surgery itself. In other words, women with a healthy pregnancy who have a caesarean rather than a vaginal birth are at increased risk for the following complications as are their babies: Compared with vaginal birth, women who have a caesarean are more likely to experience:

- Accidental surgical cuts to internal organs (Makoha, Felimban, Fathuddin, Roomi, & Ghabra 2004; Nisenblat, Barak, Griness, Degani, Ohel, & Gonen 2006).
- Major infection (Koroukian, 2004; Liu, Liston, Joseph, Heaman, Sauve, & Kramer 2007).
- Emergency hysterectomy (because of uncontrollable bleeding) [Kacmar, Bhimani, Boyd, Shah-Hosseini & Peipert 2003; Liu, Liston, Joseph, Heaman, Sauve & Kramer 2007].
- Complications from anesthesia (Goer, Saguly, Leslie & Romano, 2007).
- Negative psychological consequences with unplanned caesarean. These include: Poor birth experience, overall impaired mental health and/or self-esteem (Childbirth Connection, 2004); as well as death (Childbirth Connection, 2004; Deneux-Tharaux, Carmona, Bouvier-Colle & Breart 2006).

Health Belief Model (HBM)

Health Belief Model (HBM) was suggested, developed and modified originally by Rosenstock (1966) to explain health related behaviour. The two basic propositions of HBM are that individuals



differ in the way they perceive the personal benefits of a cure or effectiveness of a health care delivery system or the value of avoiding illness or getting well and their expectation that a specific action can prevent illness. The model is based on the assumption that the beliefs and attitudes of people are crucial factors determining their health-related behaviour (Tinuola, 2005). The model has four assumptions which include the following:-

Perceived Susceptibility: The belief that one is at risk of an illness is subjective. To one extreme is an individual who is in full denial of any risk while the other an individual who feels danger is certain. The area between contains those who admit the statistical possibility of contracting an illness, but do not fully believe they will.

Perceived Severity: The perception of the consequences of a negative health condition is also subjective. Beliefs of an illness causing pain, debilitation, social stigma or death are examples of perceived severity.

Perceived Benefits: Deciding on a course of action is shaped by the options accessible to the individual and the belief in their effectiveness. Action is thus dependent on having at least one course of action to prevent an illness from occurring while believing it will produce acceptable results.

Perceived Barriers: Despite a belief being established that a particular course of action may reduce a health threat, indecision may still take place. If readiness is low and negative aspects of the course of action are viewed as high, barriers are constructed preventing action.

The significance of the theory (Health Belief Model) in the explanation of the study cannot be underestimated because the study is a health-related issue. It could be deduced that HBM has two (2) basic propositions: (i) that individuals differ in the way they perceive the personal benefits or effectiveness of health behaviour or the value of avoiding illness, and (ii) their expectation that a specific action on the assumption that the beliefs and attitudes of people are crucial factors determining their health-related behaviour. Therefore, in the case of pregnant women during child birth or delivery, there are measures towards ensuring that they give birth naturally or through surgery.

Methodology

This section explains how the researcher conducted the research work because it allows the appropriate use of the research instrument in aiming the objectives of the study. In line with the above, a survey aimed at gathering primary data on the socio-

cultural perception and female preferences of Cesarian section of the respondents in the study area was conducted through the distribution of copies of structured questionnaire on sampled subjects of the study. As such, purposive and simple random sampling techniques were used for selecting the respondents, by selecting 40 people from four areas chosen ranging from Tanke area, Oke-oyi area, Taiwo area and Geri-alimi area respectively. A total of 160 respondents satisfactorily completed the copies of the questionnaire which formed the basis for the analysis. In analyzing the data collected from the researcher's field, the frequency counts, simple percentage and chi square were employed to analyze the major findings.

Results and Discussions

Table 1: Socio- Demographic Characteristics of the Respondents in the Study Area

Age	Frequency	Percentage (%)
Under 20	4	2.50
21-30	18	11.25
31-40	47	29.38
Above 41	91	59.87
Sex		
Male	89	55.62
Female	71	44.38
Religion		
Christianity	54	33.75
Islam	106	66.25
Marital status		
Married	123	76.87
Single	19	11.88
Others	18	11.25
Occupational status		
Unemployed	33	20.63
Civil servant	44	27.50
Self employed	43	26.87
Student	40	25.00
Educational Qualification		
Primary Education	3	1.88
Secondary Education	12	7.50
Tertiary Education	145	90.62
Income per month (#)		
10,000-19,000	30	18.75
20,000-29,000	18	11.25
30,000-39,000	20	12.5
40,000-49,000	32	20
Above 50,000	60	37.50
Total	160	100

Source: Author's Computation, 2017



The above table showed that, the highest age range of the respondent is above 40 since the majority amounted for 56.87%, followed by 31-40 years that clinched 29.38%. However, the lowest age range of the respondent is under 20 years since it amounted for 2.50%. As for gender, 55.62% were male, while the remaining 44.38% are females. 66.25% were Muslim and Christianity follows with 33.75%. 76.87% were married, followed by single with 11.88% and lastly other categories amounted for 11.25%. In occupational status, 27.50 were civil servant, followed by self employed respondents with 26.87%, then students with 25.00%. However, the lowest were unemployed with 20.63%. Educational status shows that, the majority have Tertiary Education because they occupied the highest percentage of 90.62, followed by Secondary Education with 7.50%, then the least has Primary Education which amounted for 1.88%. The respondents' income per month is above 50,000 since it amounted for the highest percentage of 37.50%, followed by 10,000-19,000 which amounted to 18.75%, then 40,000-49,000 amounted to 20%, 30,000-39,000 resulting to 12.5% and lastly respondents' income per month of 20,000-29,000 clinched 11.25%.

Table 2: Assessment of Caesarean Section

Response	Frequency	Percentage (%)
Respondents' View on Caesarean Section		
A most unnatural form of birth	41	25.62
Removal of baby from the womb through incision	34	21.25
None of the above	13	8.13
All of the above	72	45.00
Rampancy of Caesarean Section		
Highly rampant	37	23.12
Rampant	68	42.50
Fairly rampant	50	31.25
Not rampant	5	3.13
Major factor for Caesarean Section		
Foetal abnormality	44	27.50
Prematurity	36	22.50
Multiple gestation	18	11.25
All of the above	62	38.75
Implication of Belief System on Caesarean Section		
High	25	15.63
Very high	35	21.87
Low	80	50.00
Very low	20	12.50

Effect of Caesarean Section

Harms to the mother	36	22.50
Harms to the body	39	24.37
Harms to future pregnancy	15	9.38
All of the above	70	43.75

Source: Author's Computation, 2017

The result of the above table shows that the majority of the respondents viewed caesarean section encompassed around a most unnatural form of birth and removal of baby from the womb through incision. This is evident because 72 of the respondents which represent 45.00% choose the option 'All of the above' meaning that majority of the respondent viewed caesarean section comprises the above two mentioned. In term of rampancy, 42.50% choose the option very rampant, while fairly rampant amounted for 31.25%, followed by highly rampant with 23.12% and not rampant clinched 3.13%. It is evident that caesarean section can be described as rampant. More so, factors for caesarean section revolved around foetal abnormality, prematurity, and multiple gestations. This is evident because 62 of 38.75% of the respondents choose the option 'All of the above' meaning that majority of the respondent opined that caesarean section comprises the above three mentioned. With the implication of belief system on caesarean section, 80 respondents of 50% amounted for the highest, followed by very high with 35 respondents representing 21.87%, then followed by high which amounted for 25 respondents representing 15.63% and very low is the lowest pulling 20 respondents representing 12.50%. Thus, it is evident that the rate of implication of belief system on caesarean section is low. The effect of Caesarean Section revolved around harms to the mother, harms to the body and harms to future pregnancy. This is evident because 70 of the respondents which represent 43.75% choose the option 'All of the above' meaning that majority of the respondent viewed effect of Caesarean Section comprises the above three mentioned.

Test of Hypotheses**Hypothesis I**

- Ho there is no relationship between age and level of caesarean section
- Hi there is relationship between age and level of caesarean section

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**Table 3:** Cross tabulation of Respondents' Age and the Level of Caesarean Section

Age	Level of Caesarean Section				Total
	Increasing	Constant	Decreasing	I don't know	
Under 20	1	1	1	1	4
21-30	1	15	1	1	18
31-40	31	3	10	3	47
41 and above	66	18	3	4	91
Total	99	37	15	9	160

Source: Author's Computation, 2017

Chi square Calculated=54.4, Df= 9 Level of Significance=0.05 Chi =16.919

Therefore, $X^2_c=54.4 > X^2_t=16.919$, thus reject H_0 and accept H_1

Interpretation

The table above shows the cross tabulation of respondents' age and the rate of level of caesarean section. The calculated chi square from the table is $X^2_c=54.4$ with the degree of freedom of 9 at 0.05 level of significance and table $X^2_t=16.919$. Thus, there is significant relationship between age and the rate of level of caesarean section.

Hypothesis II

H_0 there is no relationship between educational qualification and level of caesarean section

H_1 there is relationship between educational qualification and level of caesarean section

Table 4.23: Cross tabulation of Respondents' Educational Qualification and Level of Caesarean Section

Educational qualification	Level of Caesarean Section				Total
	Increasing	Constant	Decreasing	I don't know	
Primary education	4	4	4	4	16
Secondary education	7	9	4	2	22
Tertiary education	88	24	7	3	122
Total	99	37	15	9	160

Source: Author's Computation, 2017

Chi square Calculated=33.42, Df=6 Level of Significance=0.05 Chi Square tabulated =12.592. Therefore, $X^2_c=33.42 > X^2_t=12.592$, thus reject H_0 and accept H_1

Decision Rule

The table above shows the cross tabulation of respondents' perception on educational qualification and level of caesarean section. The calculated chi square from the table is $X^2_c=33.42$ with the degree of freedom of 6 at 0.05 level of significance and table $X^2_t=12.592$. Thus, there is significant relationship between educational qualification and the rate of level of caesarean section.

Conclusion and Recommendations

Guide from the foregoing discussion so far, one can see that it has become increasingly common for people of all age, gender; women in particular and socio-economic, socio-cultural and biological factors influences incidence of caesarean section. Health Belief Model (HBM) by Rosenstock (1966) explained health related behaviour. The two basic propositions of HBM are that, individuals differ in the way they perceive the personal benefits of a cure or effectiveness of a health care delivery system or the value of avoiding illness or getting well and their expectation that a specific action can prevent illness. The model is based on the assumption that the beliefs and attitudes of people are crucial factors determining their health-related behaviour (Tinuola, 2005).

Comprehensive, emergency obstetrics care, including caesarean section is seen as a key factors in reduction of maternal mortality in low and middle income settings but it is essential that service are available, affordable and accessible. This research finding suggests that even when available and in principle affordable, socio cultural obstacles may hinder or delay women from accessing caesarean section especially in a system which includes powerful alternative providers who offer alternatives. It is only by recognizing and addressing some of these socio-cultural barriers that appropriate, timely and effective use of caesarean section services can be facilitated and that greater progress towards maternal health goal can be made.

Nevertheless, caesarean section costs should be reduced since they appear to underpin caesarean section refusal, marital instability post caesarean section and use of alternative providers. This may be particularly persuasive for poorer families who as reported make less use of caesarean section. Furthermore, it was found that people may not be fully aware of the reasons why a caesarean section may be advised or medically necessary. Moreover, vaginal birth after C-section (VBAC) is practiced in



Nigeria as long as a woman's medical history and clinical condition at the point of labour does not contradict that. More information on what caesarean section is and what it is not, and that is not merely for women who are categorically unable to have a vaginal delivery, may redress negative perceptions and enhance acceptance by communities and thus women. This would be one way in which medical providers can address the socio-cultural experience of illness as well as diseases. Such health education on caesarean section should target clients recommended for caesarean section and their relatives including their spouse; antenatal clients and the wider community.

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