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Factors Influencing Decision for Cesarean Section: A View from a Gender Perspective

Atijosan, A.B [a], Kupoluyi, T.P [b], Fajobi, A [b]
[a] *Centre for Gender and Social Policy Studies, Obafemi Awolowo University, Ile-Ife.*
[b] *Faculty of Nursing Science, Obafemi University, Ile-Ife.*

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Abstract

Death resulting from pregnancy related causes continues to pose major maternal health issues in Sub-Saharan African countries such as Nigeria. Provision of caesarean section is one of the most effective means of reducing maternal mortality but social construction of gender roles constrains women's autonomy to make health related decisions. This study seeks to study and assess gender-based factors influencing women's decision for cesarean section (CS) in a tertiary health institution located in Ile-Ife, Osun State, Nigeria. The study employed a descriptive cross-sectional research design in which 156 pregnant women and 94 men (husbands) attending antenatal were recruited. Self-administered questionnaires were used and analysis was done using statistical package of social sciences (SPSS). The result of this study showed that 76.6 % male and 71.8 % female respondents believe that undergoing CS makes a woman less respected by the community. Also, majority of the respondents (69.1 % males and 67.9 % females) belief that CS leaves uterine scar. In addition, large percentage of the respondents' belief that decision to opt for CS can only be made by the husband and not the wife. Furthermore, 89.4% males and 80.1% females believe that CS affects household responsibilities. In conclusion, gender issues, and traditional myths still influence the decision to perform caesarean sections. There is an urgent need to provide more robust and gender inclusive information for pregnant women during antenatal clinics. Also, husbands of the expectant mother's involvement and participation should be encouraged during the information dissemination programs.

Introduction

Maternal mortality remains a serious problem in low- and middle-income countries (LMICs) as they still bear 99% of the burden of maternal mortality and the majority of deaths occur in sub-Saharan Africa [1]. Maternal deaths are clustered around labour, delivery and immediate post-delivery periods [2]. The World Health Organization identifies the availability of skilled birth attendants (SBA) and provision of Emergency Obstetric Care (EmOC) as two of the most essential ingredients of maternal mortality reduction programmes [1]. Caesarean section (CS) is a component of cEmOC and stakeholders agree that it should be universally available and accessible [3] as its provision to all who need it is one of the most effective means of reducing mortality [4,5].

Traditional Nigerian societies are characterized by patriarchy, that is, a society in which men tend to hold the positions of power, characterized by social stratification on the basis of sex [6,7,8,9]. The social system fosters gender inequalities by relegating women to domestic and reproductive roles and restricting their access to finance, and other entitlements such as land [7, 6, 10]. Hence, patriarchy and the social construction of gender roles in Nigeria constrain women's autonomy and access to resources [10, 7]. These gendered socio-cultural arrangements also limit women's capacity to make health related decisions, including their capacity to accept CS, thus increasing their risk of potentially life-threatening pregnancy complications [3, 11]. The prevailing socio-cultural pressures to achieve vaginal delivery are driving force behind some Nigerian women's use of additional providers in an attempt to achieve vaginal childbirth and avoid CS [3, 12]. In developing countries, there is an aversion for CS not withstanding its ability to save lives [13, 14, 15]. In most African communities including Nigeria, the decision to seek care, including the type of care, is culturally in the hands of the man [16, 13]. Nigeria's current maternal mortality ratio of 630/100,000 live birth is indicative that critical aspects of the health-care delivery continue to fail women [17, 14]. Women's autonomy in health-care decision making is extremely important for better maternal and child health outcomes [18, 14]. Many studies have looked at factors influencing women decision making for CS [14, 19, 20, 13, 3]. However, not many researches have been conducted to study the factors influencing women decisions for CS from a gender viewpoint. This study seeks to study and assess factors influencing women's decision for CS from a gender perspective. It uses a case study of women attending a tertiary health care institution in a semi-rural Nigerian community.

Method

Study design

A descriptive cross-sectional study was undertaken in a tertiary health care hospital. A structured pre-designed self-administered questionnaire was used to collect information from pregnant women and their husbands during antenatal clinic on the mode of birth and the factors that influence their preference based on the research objectives**.**

Sample size

Pregnant women and their husbands that attended antenatal clinic for booking at a tertiary health care hospital, were recruited for the study using a stratified random sampling method with proportional allocation based on gender. A sample size of 250 was determined using the Cochran, W.G formula.

Instrument for Data Collection

Standardized pre-designed self-administered questionnaire which consists of various sections addressing each of the research objectives was used for data collection**.**

Validity and Reliability of Research Instrument

The validity of the questionnaire was established through face and content validity technique by ensuring that the questionnaire measures what it was designed to measure. Each item on the questionnaire was assessed for clarity, coverage, consistence and relevance. Questions were structured in a precise manner.

Data Analysis

Data collected was analyzed using the statistical package for social sciences (SPSS) using descriptive statistics. In the knowledge section, a score of 1 will be awarded for the Yes options while a score of 0 will be awarded to the No options. The mean knowledge score was determined and used to classify respondents as having either Poor or Good Knowledge.

Ethical Consideration

Confidentiality was ensured by administering the questionnaires privately and anonymously. All records and relevant materials were kept safely and were accessed only by authorized personnel.

Results

This section presents a report on descriptive analysis as it analyses for the socio-demographic characteristics of the respondents and answer each research objectives of this study. The results are presented in frequency tables. The 250 questionnaires administered were returned and completed appropriately; these were used for analysis with a response rate of 100%.

Table 4.1: Socio-demographic Distribution of Respondents

Variables	Men		Women	
	Freq N=94	% (100)	Freq N=156	% (100)
Age (in years)				
30 and below	35	37.2	56	35.9
31 and above	59	62.8	100	64.1
Ethnicity				
Yoruba	65	69.1	129	82.7
Igbo	22	23.4	19	12.2
Hausa	2	2.2	8	5.1
Others	5	5.3	0	0
Educational status				
No formal education	9	9.6	8	5.1
Primary level	3	3.2	11	7.1
Secondary level	25	26.6	54	34.6
Tertiary level and above	57	60.6	83	53.2
Occupational status				

Not employed	31	33.0	39	25.0
Retiree	8	8.5	25	16.0
Self employed	14	14.9	29	18.6
Civil servant	41	43.6	63	40.4
Income (naira)				
10,000 and below	17	18.1	27	17.3
10,000 to 50,000	32	34.0	65	41.7
50,000 and above	45	47.9	64	41.0

Table 4.2: Knowledge of Caesarean Section

Knowledge items	Men		Women	
	Freq N= 94	% (100)	Freq N= 156	% (100)
Caesarean section is a surgical procedure made on the lower abdomen				
Yes	75	79.8	124	79.5
No	19	20.2	32	20.5
Caesarean section can be done to save the life of mother and the child?				
Yes	74	78.8	131	84.0
No	20	21.2	25	16.0
Is it possible for a woman to achieve vaginal birth after Caesarean section?				
Yes	59	62.8	101	64.7
No	35	37.2	55	35.3
Fetal distress, maternal distress, prolong labor, or bleeding from the vaginal can be an indication for caesarean section				
Yes	62	66.0	95	60.9
No	32	34.0	61	39.1
Do you think Caesarean section is riskier and more dangerous than vaginal delivery?				
Yes	41	43.6	58	37.2
No	53	56.4	98	62.8
Blood is loss during the operation, hence the need for blood transfusion				

Yes	74	78.7	123	78.8
No	20	21.3	33	21.2

From table 4.1, 62.8% of male and 64.1% of female fall within the age group of 31 and above; 60.6% of the male population had tertiary education compared with 53.2% of the female population; less than half were civil servants (43.6% men: 40.4% women); 47.9% of the male population and 41% of the female population receive 50,000 naira and above monthly.

Table 4.2 reveals that 79.8% of the male respondents and 79.5% of the women reported Caesarean section (CS) is a surgical procedure done on the lower abdomen; majority (84% men and 78.8% women) of the respondents agreed that CS can be done to save the life of the mother and baby; 64.7% of the female respondents and 62.8% of the male respondents agreed that it is possible to achieve vaginal birth after CS; 62.8% of the female respondents and 56.4% of the male respondents do not view CS as riskier and more dangerous than vaginal delivery; 78.8% of the female respondents and 74% of the male respondents acknowledged the need for blood transfusion due to blood loss.

Knowledge summary

Gender Mean score=10.9	Poor knowledge F (%)	Good knowledge F (%)
Male	23 (24.5)	71(75.5)
Female	44(28.2)	112(71.8)

A score of 1 was awarded for the Yes options while a score of 0 was awarded for the No options. The mean score was determined to be 10.9, respondents with scores below the mean were regarded as

having Poor Knowledge of Caesarean Section while those with scores higher than the mean were regarded as having Good Knowledge of CS. Cross tabulation was used to differentiate knowledge level in both male and female respondents.

Table 4.3 reveals that majority of the male and female respondents (76.6% men and 71.8% women) reported that CS makes women less respected by the community; 69.1% of the male respondents as well as 67.9% of the female respondents agreed that CS leaves uterine scars; 75% of the female respondents as well as 69.1% of the male respondents reported CS as too expensive; majority of the female respondents (77.6%) agreed that CS makes women's tommy big meanwhile 52.1% of the male respondents disagreed. Only 36.2% of the male respondents and 29.5% of the female respondent agreed that the decision to opt for CS can be made by the wife while the majority (63.8% male and 70.5% female) of respondents disagreed.

Majority (85.1%) of the male respondents reported that the decision to opt for CS can only be made by the husband, likewise 87.2% of the

female respondents reported same; almost all of the male respondents (89.4%) supported that CS affects household responsibilities and 80.1% of the female respondents agreed to this also. In addition, 81.9% of the male respondents and 86.5% of the female respondents reported that CS is not culturally acceptable while a small percentage (18.1% male and 13.5% female) of respondents reported that it is culturally acceptable.

Discussion

Findings of this study revealed that 76.6% of the male respondents and 71.8% of the female respondents believe that undergoing caesarean operation makes a woman less respected in the community. According to [21], it is traditionally believed that achieving a vaginal delivery portrays the woman's power and ability and also indicate failure for those who do not achieve it which may cause the woman to be looked down upon or disrespected in her community. The socio-cultural belief in normal birth is known to be a major factor that influence the mode of birth [19]. The origins of many of this beliefs stem from the strong patriarchal based belief system prevalent in sub-Saharan Africa [22], Nigeria inclusive. In order to increase their acceptance in the society many women therefore opt for natural birth. Majority of the respondents, (69.1% male and 67.9% female) belief that caesarean section leaves uterine scars. In Nigeria, like most developing countries in Africa, a lot of importance is laid on having a male child rather than a female child [14]. Women continue to have babies until they are able to have at least one male child, but preferably two. Therefore, a scar is seen as a limiting factor to their reproductive career [16, 14].

Also, 69.1% of male respondents and 75% of female respondent belief that caesarean operation is too costly to afford while 30.9% of male respondents and 25% of female respondent disbelief. This is in accordance with the study of [3] where it was observed that one of the reasons women refuse caesarean section was due to cost of surgery which many of them could not afford. Generally, in sub-Saharan Africa women are poorer than men due to socio-cultural constraints and they are the main victims of poverty [23, 21], and therefore constitute the bulk of poor people around [24]. This is a major influencer of women decision for CS especially for poor women and those living in rural areas.

Furthermore, majority of the respondents (85.1% male and 87.2% female) belief that the decision to opt for CS can only be made by the husband. This is because of the cultural belief that men are the head of the family and they are saddled with the responsibility of taking decisions including the decision to have a caesarian section performed on the woman [25]. The old-age belief in many sub Saharan Africa countries is that women and children belong to the husband [26]. The consequence is that women do not have enough power to participate in the decision-making concerning the household and their health [26].
Despite knowing what will benefit them, they are many times unable to take decisions because of sociocultural traditions and myths, which keep them subjugated and constrained into a dependency on men [25, 26, 27].

The finding also showed that 81.9% of male respondents and 86.5% of female respondent belief that caesarean section is not culturally acceptable while 18.1% of males and 13.5% of females have a contrary belief. Majority of our respondents believe that caesarean section is not culturally acceptable because culturally, it is believed that a real woman has to bear the pains of labor no matter how long it lasts and must subsequently give birth to a healthy baby by virginal delivery

method [14]. To these women, cesarean section signifies reproductive failure [25]. This explains why women in most Sub-Saharan African countries including Nigeria remain averse to CS even in the face of obvious clinical indications [14,25].

Furthermore, 89.4% of male respondents and 80.1% of female respondents reported that CS affects household responsibilities while only a few respondents (10.6 % males and 19.9% females) reported that CS does not affect household responsibilities. This is because in patriarchal societies like Nigeria, women bear a large disproportionately share of family responsibilities in terms of household work and care [28,29,30]. They are mainly branded with domestic responsibilities [6]. They have been identified as home makers making them to belief that CS will affect their household responsibilities as they will be restricted due to prolonged hospital stay.

Conclusion

This study shows that caesarean section is still surrounded by gender and sociocultural issues and myths. Until this gender issues are deconstructed and addressed, current knowledge and belief about CS will remain the same, thus posing a continually threat on the lives of pregnant women. Empowering women to take decisions that will be to the best of their interest is vital. Furthermore, men as important decision-makers in family life, should be involved in maternal health care as they are crucial in influencing the belief of women towards CS. This study recognizes that these gender and sociocultural issues are deep rooted and takes time to change. There is therefore a crucial and urgent need for integration of gender issues into information disseminated during antenatal clinics and more societal awareness on empowering women to take decisions that will be to the best of their interest especially pertaining to their health.

Limitation of the Study

The limitation of our study lies in the fact that we used a sample of convenience which involves all pregnant women who agreed to participate the study and were drawn from a single health facility in an urban setting. Despite this, all the respondents were from different socioeconomic classes and educational backgrounds. However, more extensive studies involving both urban and rural dwellers are needed to further confirm our findings.

Table 4.3: Gender issues on the choice of Caesarean Section as a mode of delivery

	Male		Female	
	Freq N= 94	% (100)	Freq N= 156	% (100)
Undergoing Caesarean section makes a woman less respected by the community				
Yes	72	76.6	112	71.8
No	22	23.4	44	28.2
Caesarean section leaves uterine scar				
Yes	65	69.1	106	67.9
No	29	30.9	50	32.1
Caesarean section is too costly to afford				
Yes	65	69.1	117	75
No	29	30.9	39	25
Caesarean Section makes women's tommy big				
Yes	45	47.9	121	77.6
No	49	52.1	35	22.4
Decision to opt for Caesarean section can be made by the wife				
Yes	34	36.2	46	29.5
No	60	63.8	110	70.5
Decision to opt for CS can only be made by the husband				
Yes	80	85.1	136	87.2
No	14	14.9	20	12.8
Caesarean section affects household responsibilities				
Yes	84	89.4	125	80.1
No	10	10.6	31	19.9
Caesarean section is not culturally acceptable				
Yes	77	81.9	135	86.5
No	17	18.1	21	13.5

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