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Daily Experience of Caesarean Deliveries on Their Care in the Maternities of the City of Kinshasa

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ABSTRACT

Objective: This study aims to understand the daily experience of caesarean births on their care in the maternities of the city of Kinshasa.
Materials and Methods: Our study is descriptive, opted for a qualitative estimate of the phenomenological type to study the daily experience of caesarean births on their care.
The direction chosen for this study is inspired by a phenomenological approach which aims to describe and understand phenomena based on the person's experience. The phenomenological survey method was used for data collection and the face-to-face semi-structured interview technique.
Results: After the analyses, in relation to the experience, the women who gave birth *before the caesarean have a Feeling of comfort after psychological preparation;* Caesarean section is perceived as a dangerous practice that exposes to death; *the caesarean represents a test of strength, binding but an act of rescue;* During their care, the midwives say that they had noticed a relaxation in the care following financial demotivation.
Conclusions: With regard to the expectation vis-à-vis the nursing staff, those who have given birth to caesarean sections want access to be given to their husbands for support during the caesarean section.

Keywords: Daily life, Births, Cesarean section, Support.

INTRODUCTION

The possibility of having a successful pregnancy and giving birth to a healthy child without compromising that of the mother is one of the priorities set out in the Sustainable Development Goals (SDGs) which recommend reducing maternal mortality. Similarly, the definition of reproductive health proposed by the Cairo Program of Action affirms "the right of access to health services that enable women to carry out pregnancies and childbirths and give couples, every chance of having a healthy child" [1].

In this perspective, the possibility of resorting to a certain number of obstetrical interventions such as cesarean delivery, is often associated with the improvement of reproductive health and, therefore, with respect for reproductive rights [2].

The practice of caesarean section has been the subject of controversy and discussion for several years. While its frequency has increased very rapidly in the medicalized countries of Europe and North America [2], but also in certain developing or emerging countries, for example Brazil where the figures reach or even exceed 50% [3].

These high frequencies have given rise to numerous evaluative studies around the world, in particular on the risks and benefits, the causes of inflation, the legitimacy of some of its indications, the differences between emergency caesareans and those which are programmed, the techniques of caesarean sections, the outcome of caesarean sections in terms of maternal and perinatal morbidity and mortality, not to mention the quality of care for women who suffer [4].

We could therefore congratulate ourselves on the progression of cesarean delivery which, practiced in the 1950s and 1960s, then progressed in a spectacular way in certain contexts. Although 16% of births are by caesarean section worldwide, this proportion masks very strong variations.

Rare in Africa (4%) or Southeast Asia (9%), delivery by caesarean section is now more common in the Eastern Mediterranean region (16%), in Europe (23%), in the Western Pacific region (24%) and especially in the Americas (36%) The differences between countries are very pronounced. The caesarean rate 3 is at least 1% in Niger and at most 52% in Brazil. These levels refer to different issues in terms of reproductive health [2].

In France, according to the 2010 national perinatal survey, the caesarean section rate has stabilized since the early 2000s. Caesarean section is the main etiology of uterine scarring in industrialized countries. In France, one in five women gives birth by caesarean section.

In less than half of the cases, the cesarean section is scheduled. The national average rate of scheduled caesarean sections in 2009 was 7.4%, with disparities between departments and according to the type of establishment considered. In this context, and in order to ensure an analysis of practices allowing the relevance of this act to be assessed, the College of the Haute Autorité Sanitaire recommends that health professionals provide the following information in the pregnant woman's file: indication, benefit/risk ratio and conditions for carrying out the act [5].

In Benin, to improve financial accessibility to caesarean section, the Government instituted free caesarean section which started in 2009. Since its application, the free policy has been the subject of two evaluations which focused on the process of its implementation, its effects on health services, on maternal and infant mortality.

It shows that despite the fact that caesareans are free, women continue to pay disproportionate costs, that relations with service providers still need to be improved in hospitals, that the policy is beneficial but that it is necessary to review the estimate of caesarean section costs in a consensual setting to avoid additional costs borne by women [6].

In addition, it should be noted that in the life of a woman, childbirth often represents a major event, both physically and psychologically. When we quote the word “childbirth”, the thought refers in most cases to childbirth by the natural ways or “vaginal way”. However, there is also another way of childbirth, more and more frequent: the cesarean section.

For several decades, medicine has recorded a considerable increase in the number of complaints from patients. Advances in recent decades have made failure less and less tolerable. This is particularly the case in obstetrics, where birth represents a strong and joyful moment and no longer a moment during which death is feared, for the mother and the child. As was still the case at the beginning of the 20th century [7].

The daily experience in itself is above all a subjective notion, it is therefore

specific to each woman according to her history, her culture, and the events that surround her. It depends on several factors, including the level of education, the quality of prenatal follow-up, the patient-provider relationship, the quality of psychological preparation before, during and after the intervention and the care received.

Women's reactions to the announcement of an imminent caesarean vary, sometimes it is panic that prevails, while for other women, it is rather relief after an interminable labor. The role of healthcare providers is to reassure, support and accompany women in order to have the best possible experience of the caesarean [7].

In Canada, a large majority of women in Quebec, between 84% and 86%, will experience childbirth during their lifetime. Despite the prevalence of this experience, the way in which childbirth is experienced by women is the subject of little social or political concern, as well as little concern on the part of the institutions that provide health care [8] .

In Mali, patients have some reservations about the announcement of the caesarean section and see in this mode of delivery a loss of femininity; even a failure. A psychic impact is observed in patients who think they have lost their feminine identity, which leads to a protest in some when the Caesarean section is announced. This situation leads to a varied experience for his patients. Some will have endless joy and happiness when they leave, while for others, the caesarean section will remain a bad memory [7].

In the Democratic Republic of Congo, especially in remote rural locations, performing a caesarean may simply not be possible. Transport to a well-medicalized and equipped structure can take many hours and the structure may not have a minimum technical platform or qualified personnel to carry out an intervention. In these conditions, fetal or neonatal survival is really a problem. In the event of prolonged obstructed labor, it is maternal survival that is at stake, as well as the risk of severe morbidity, in particular by vesico-vaginal fistula.

Women who gave birth by caesarean express less satisfaction with the birth experience; they more often suffer from loss of self-confidence; they feel frustrated because of the discrepancy between what they had imagined and reality. The dissatisfaction is based on the norm, which considers vaginal delivery as "normal childbirth" and promotes the feeling of not having lived "correctly" an essential event in their life as a mother [9].

Considering this, we will, within the framework of this study, understand the daily experience of the beneficiaries of this care in the maternities of the city Province of Kinshasa.

This study aims to understand the daily experience of caesarean births on their care in the maternities of the city of Kinshasa.

To achieve the goal, the specific objectives are:

1. Describe the characteristics of the cesarean women who participated in the study;
2. Explore their experience of receiving care during their stay in the maternity ward;
3. Raise their representation and perception of the caesarean section;
4. Raise their expectations of this care;
5. Identify their difficulties encountered;
6. Propose improvement strategies.

MATERIALS AND METHOD

2.1 Study estimate

Our study is descriptive, opted for a qualitative estimate of the phenomenological type to study the daily experience of caesarean births on their care.

The direction chosen for this study is inspired by a phenomenological approach which aims to describe and understand phenomena based on the person's experience.

2.2 Presentation of the environment

Within the framework of this study, the Reverend MBAKANI Evangelical Medical Center served as the framework. She is one of medical training of the medical work of the 23rd Evangelical Community of Congo. This Medical Center for which we conducted our research is located in the Democratic Republic of Congo, city of Kinshasa, district of Tshangu, Commune of N'djili , in Quartier Cinq (5), Avenue LUKAYA n°519.

2.3. Target Population, Sampling and Sample Size

In the context of our study, the target population is caesarean births from the Reverend MBAKANI Evangelical Medical Center. We have chosen the non-probability sampling method, precisely the theoretical sample by reasoned choice, this technique is based on the judgment of the researcher according to the typical character of the respondents, namely those who have had a caesarean section.

We retained the number of participants at the end of the data collection. Usually, the phenomenological study requires a small number of people which, according to Omanyondo (2013), is the study of the experience of an individual.

After data collection, we had reached only nine births who were present and who agreed to respond to our survey.

2.4 Data collection method, technique and instrument

The phenomenological survey method was used for data collection. And we used the face-to-face semi-structured interview technique, which has some advantages, namely:

- That of being in direct contact between the interviewer and the respondents;
- That of allowing uniform data collection for all respondents.

The instrument we used is the individual interview guide. This interview guide comprises two parts apart from the explanatory memorandum, the first part concerns information on the socio-demographic characteristics of the respondents and the second part concerns questions on the research topic. This individual guide consisted of open questions leading respondents to express their experience or experience in their own words. The questions were developed based on the objectives, the initial questions and the prior study of the literature.

While respecting the principle of informed consent, the information provided during the interview was recorded on SMART PHONE.

2.5. Data collection process

The interviews with the mothers took place around the questions contained in our instrument.

The purpose of this first contact was to explain the purpose of the study, to obtain a contact for their opinion on participation in the study. We then guaranteed the anonymity and confidentiality of their comments. From the outset, we introduced ourselves to our respondents. The interviews took place in a well-secured environment.

The place chosen was quite quiet, discreet and secure, with no risk of being overheard by a third party.

The average length of our interview was 10 minutes. The good transcription of the words of our interviewees was made possible because we obtained their authorization to record the interviews of each of them on a recording device.

At the end of the interview, we jointly proceeded to check the quality of the information provided and finally thanked the respondent for his availability and collaboration.

2.6. Data analysis plan

The data analysis was done by the method of phenomenological reduction. This method aims to bring out the hidden meanings inherent in the descriptions made by the subjects of the phenomenon studied. This step consisted in finding meaning or meaning in the data collected in the form of

verbatim and in demonstrating how they answer our research questions (OManyondo, 2015) This inductive analysis of the thematic contents, i.e. at the process of constructing categories based on the analysis of participants' comments.

The steps of this analysis are as follows:

- The full transcript of the interview material in the original language,
- Playing the material repeatedly,
- The choice of units of meaning or units of meaning,
- Identification of general themes,
- Categorization and classification.

As we collected the data, we noted the meanings, in order to avoid losing the thread of essential ideas and storing data that we will not be able to use later.

The collection of data was followed by the thematic and categorical analysis of the interviews, an operation which consists in cutting across what, from one interview to another, refers to the same theme. We therefore proceeded with the full transcription of the recorded speeches:

- ✓ For a 30-minute interview, it took an average of two hours of transcription after the hearing.

The transversal categorical analysis consisted of grouping the verbatim (in the form of ideas) with regard to categories and themes or a group of words from the verbatim of the interviewees.

We had to be attentive to listen to the cassette and reread the transcribed verbatim several times, to understand the words of the interviewees, to grasp the nuances in the speeches; then identify the significant expressions related to our subject.

The data analysis was solely centered on the discourse. The redundant verbatims were then grouped into nuance to bring out the categories. The meanings given to these categories allowed us to obtain the elements of the answers to the research questions under the different aspects that we wanted to address, eliminating repetitions.

To certify the results of our analysis, we compared part of the results of our data analysis with that carried out by a resource person (expert in qualitative research), to whom we gave the raw data for analysis.

We compared the two analyses, we ended up with almost the same results. Finally, we submitted the results of our analysis for verification to five of our respondents during a focus group to validate the relevance of the meanings given to the verbatim. They approved the meanings of the different categories that we have chosen for the study.

2.7. Ethical Considerations

The following ethical considerations were taken into account throughout the course of the study. After choosing a conducive and favorable environment for the interview and seeking free consent to participate in the study (see explanatory memorandum and attached consent form), we sought the agreement of the participants for the use of a recorder. In addition, all tapes and information collected will be kept and will be destroyed afterwards.

The participants were informed that they could withdraw from the study at any time if they so wished and finally, we guaranteed them the anonymity and confidentiality of the information they would provide.

RESULT

3.1 Results on socio- demographic characteristics

Box 1: Distribution of study subjects according to their socio-demographic characteristics

Initial	Age	Profession	Civil status	Parity
ACC1	33 Years	Household	Married	1 child
ACC 2	32 years	teacher	Married	3 children
ACC 3	30 years	Household	Married	2 children
ACC 4	41 years	Household	single	6 child
ACC 5	25 years	Nurse	Married	2 children
ACC 6	25 years	Household	Married	1 child
ACC 7	36 years	Household	single	1 child
ACC 8	29 years	Household	Married	2 Children
ACC 9	33 Years	Household	Married	4 children

By considering the data on socio-demographic characteristics, we find that the respondents who participated in our

study are mostly housewives, aged 25 to 41 with a parity of 1 to 6 children, whose marital status is dominated by Married.

3.2 RESULTS OF THE QUALITATIVE ANALYSIS

The categorical analysis consisted of grouping (by going back and forth) the verbatim (in the form of the words) with regard to the categories and themes in coherence.

After reading our transcriptions of the interviews recorded with Nine birth attendants, having used the syntactical analysis unit in a closed encoding of the interviews, according to a data analysis matrix at four levels: sub-theme, categories, verbatim and meanings. The central theme chosen is: "experience and expectation of the care of the caesarean section".

The syntactic unit is a sentence or a group of words from the verbatim of interviews or observation notes; that is, ideas expressed.

The data analysis was only centered on the speeches. II The redundant verbatim were then grouped together in a cloud to bring out the categories.

The analysis consisted in grouping the verbatim statements according to the corresponding category, to which we attributed hidden meanings, inherent in the descriptions that the interviewees made of the phenomenon studied. The meanings from each category constitute the results of this study.

From this central theme, two sub-themes flow, namely: experience of care and expectation vis-à-vis the nursing staff.

3.2.1. Sub-theme 1: experience of care

- **Category 1: Feelings of women giving birth before caesarean section**

By considering the declarations of midwives *before caesarean section, they have a Feeling of comfort after psychological preparation. Some testify:* ACC1: “I wanted to be operated on because I had no more strength, I was restless, I had to be operated on so that I could rest [....] it was a relief, a deliverance, everything you know and that my child came out alive”…. ACC4 : " I started with the center after many hours spent with the IT (Titular Nurse) it was not possible to give birth vaginally, I myself felt that with the experience I couldn't take it anymore, I asked the IT to take me to the hospital, I risked losing my child”… ACC6: “The doctors informed me of the operation, I didn't I was not afraid because I myself wanted it given the pain I was feeling,[...] I preferred to have an operation, especially when I was transported on the motorcycle to take me to the hospital, I suffered very badly”

- **Category2: Perception of caesarean section**

Caesarean section is perceived as a dangerous practice that exposes to death. The stories below are the expressions of women giving birth to this perception: *ACC2:* "[...] I was very afraid, like any human being faced with such an ordeal for the first time in life, but I was encouraged by the nurse. I was scared because I didn't know if 'I was going to die or not'. ACC5: “While I was pregnant, I had heard women say that women were killed during caesarean section and especially when I remembered those who died following caesarean section.[...] When the operation was announced, I was very scared. But I was encouraged by the doctor and the nurses who reassured me that I will be saved as well as my child…. ACC1 : " [...] when I was informed that I was going to be operated [...] I was very, very scared and I started to cry [...] but the doctor took me encouraged [...] by telling me that it was necessary to operate to save both me and the child. [....] but I was very afraid of dying [...] you know that in this story there is a cross at the head and a cross at the feet (high probability of dying).

- **Category 3: Representation of the caesarean section**

The caesarean represents a test of strength, binding and an act of rescue at the same time.

On the one hand, the mothers express this constraint by saying: ACC2 8: I had a completely normal pregnancy, even escaping the famous nausea of the first trimester. Immune to toxoplasmosis, I also avoided a strict diet, while gaining only ten kilos. Neither gestational diabetes, *nor severe fatigue forcing me to take* pathological leave . *All blood tests were good. I even cycled more than 10 km during my eighth month, during our weekend, but I was surprised to have the announcement that I had to have surgery.*

On the other hand, listed it is an act of rescue, here is what they say about it: ACC2 "... in my case, there were pregnancies that went well but for the last two finished by caesarean section, it was a difficult problem [...] *ACC7* "[...] I was very afraid, like any human in front of such an ordeal for the first time in life, but I was encouraged by the nurse. I was scared because I didn't know if 'I was going to die or not'.

- **Category 4: difficulties encountered in care**

During their care, the midwives say that they had noticed a relaxation in the care following financial demotivation. The following mothers expressed this difficulty in these terms: ACC2: "The expenses were paid in part, as my husband had no more money, I was abandoned, so I began to notice a little negligence and to leave go in the way of healing us. I resorted to family members, those of my husband's family said that as I am small that she cannot give birth normally, their son will suffer by supporting each time the cesareans, so I was abandoned.

ACC2, ACC4, ACC7 " *…We don't have the courage to pose the problems; if you respect yourself you are obliged to undergo their treatment* ", " *It is some who destroy what the others do of positive. If you come across those who shout, you no longer have the courage to raise your problem. Others are very nice too, I recognize that…* " but all this happens when you haven't paid well.

3.2.2 Sub-theme 2: expectation vis-à-vis healthcare personnel

The analysis of this second sub-theme has brought out a single category, namely:

- **Category 1: expectation vis-à-vis healthcare personnel**

As an expectation, caesarean women are advocating for access to their husbands for support during the caesarean section. One of them complains saying: ACC5: My caesarean was not planned at all. I overstayed, and as the labor was very long, after 11 hours, the baby's heart got tired. So in an emergency, I was admitted to the operating room for the caesarean section. I understood that it was not going to happen as planned… I was panicked, in addition my husband who was far from me. I wish she was there….ACC7: We see elsewhere in youtube videos that women are always accompanied by their husbands even in the delivery room, but here it is the opposite.

DISCUSSION

4.1 Results on socio- demographic characteristics

By considering the data on socio-demographic characteristics, we find that the respondents who participated in our study are mostly housewives, aged 25 to 41 with a parity of 1 to 6 children, whose marital status is dominated by Married.

These results corroborate with those found in the study Kabongo et al (2018) [9]. which show for the population profile, the women interviewed were between 22 and 40 years old (mean age 30.4 ± 5.9 years). Parity varied between 1 to 15 years (average parity 6.3 ± 4.1).

4.2 Results of the qualitative analysis

4.2.1 experience of treatment

- **Feelings of births before caesarean section**

By considering the declarations of midwives *before caesarean section, they have a Feeling of comfort after psychological preparation.*

Generally, the emergency cesarean, during or outside of labor, can be described as unplanned, unlike the planned cesarean. Indeed, in the latter case, the women know what awaits them, so they have not idealized a "normal" vaginal birth. The shock is sometimes brutal when a caesarean section has never been even considered. [7].

Many women testify to an impression of being spectators and not actors of their childbirth, our respondents affirm here: ACC1: "I wanted to be operated on because I had no more strength, I I was agitated, I had to be operated on to rest [....] it was a relief, a deliverance, everything you know and that my child came out alive "

This assurance was produced by preparation. All these explanations reassure patients and play a role in reassuring patients and play an important role in the experience of the cesarean section. [7]. ACC4 : " I started with the center after many hours spent with the IT (Titular Nurse) it was not possible to give birth vaginally, I myself felt that with the experience I couldn't take it anymore, I asked the IT to take me to the hospital, I risked losing my child"

According to several authors, caesarean section would be associated with high anxiety as well as a greater risk of postpartum depression. In addition, the sometimes intense pain after a cesarean section could have negative consequences on the morale of the young mother [10].

The different reactions can be explained by the fact that despite advances in caesarean section, this intervention is still poorly perceived by the majority of the Malian population. Indeed, many see women who have had a caesarean section as incapable of giving birth vaginally, women who don't want to put in a lot of effort or who don't want to bear the pain.

For some, a person operated on is a permanently diminished person and for others, a caesarean section is an easy solution for health personnel. The feeling of relief reported by some patients is explained by the fact that more often than not most of them had passed through the first level structures before being evacuated to our center [7].

- **Perception of caesarean section**

Caesarean section is perceived as a dangerous practice that exposes to death. The mothers reassured this in these terms: ACC5: "While I was pregnant, I had heard women say that women were killed during caesarean section and especially when I remembered those who died following caesarean section.[...] when the operation was announced, I was very scared. But I was encouraged by the doctor and the nurses who reassured me that I will be saved as well as my child" ACC8: "Delivering is good, but you can die during delivery [....] or die after giving birth and leaving the child [....] it's scary, very scary"

Kabongo et al (2018) [9] explain that the discourse relating to fears reflects a crisis of confidence in this medical act and the effects it can have on health. Fears of death, fears of side effects clearly convey the content of a distrust of the care offered. We are therefore a long way from a social trivialization of caesarean sections. As such, the question of acceptance can be posed in terms of multiple risks. This is one of the reasons that led the women interviewed in our study to fear the future of motherhood.

- **Representation of caesarean section**

For midwives, caesarean section represents a test of strength, binding but an act of rescue. This midwife testifies by saying: ACC2 8: I had a completely normal pregnancy, even escaping the famous nausea of the first trimester. Immune to toxoplasmosis, I also avoided a strict diet, while gaining only ten kilos. Neither gestational diabetes, *nor heavy fatigue forcing me to take* pathological leave. *All blood tests were good. I even cycled more than 10 km during my eighth month, during our weekend, but I was surprised to have the announcement that I had to have surgery.*

Another study carried out on 25 women in France a few days and then one to two months after an emergency cesarean section. Nineteen women who gave birth really experienced the caesarean section as a traumatic event [11].

- **Difficulties encountered in the care**

During their care, the midwives say that they had noticed a relaxation in the care following financial demotivation.

They say this: ACC2, ACC4, ACC7 " *…We don't have the courage to pose the problems; if you respect yourself you are obliged to undergo their treatment* ", " *It is some who destroy what the others do of positive. If you come across those who shout, you no longer have the courage to raise your problem. Others are very nice too, I recognize that…* " but all this happens when you haven't paid well.

The implications on the economic side are no less. Caesarean section entails significant financial costs for rural domestic units. Even in situations where there is a system for alleviating financial costs, these remain significant for families and in particular for men who provide social support for health expenses. There is therefore often a feeling of guilt on the women's side: that of having been the source of additional expenses, the cause of the impoverishment of the household [9].

The experience is above all a subjective notion, it is therefore specific to each woman, according to her history, her culture, the events that surround her... The information received or not received before and after the pregnancy, the presence of the spouse, the accompaniment and support by the medical team appear to be essential factors.

The reactions to the announcement of an imminent caesarean are diverse, sometimes it is panic that prevails, while for other women, it is rather relief after an interminable labor. The nursing staff plays an important role with the mother, whether in the operating room or after birth. His presence is paramount, as much for comfort, listening and support as for help with daily care, especially during the first 48 hours. [12].

4.2.2 Expectation vis -à-vis healthcare personnel

As an expectation, caesarean women want access to be given to their husbands for support during the caesarean.

This is expressed by this mother: ACC2: My Baby was triggered 4 days after term, because he had not decided to come out. After 24 hours without effective labor, despite 2 triggers and the pierced water bag, the cervix was only at 1, and the baby's heart rate began to weaken. The doctor therefore considered an emergency caesarean section.

I admit that I was not sufficiently prepared and I panicked, we had to leave my husband in the operating room, unfortunately they did not want your request to be accepted depending on the obstetricians.

All the literature around the world agrees that the accompaniment of the woman during pregnancy by her husband ceases to be a simple help but a medical obligation.

CONCLUSION

After the analyses, in relation to the experience, the women who gave birth *before the caesarean have a Feeling of comfort after psychological preparation;* Caesarean section is perceived as a dangerous practice that exposes to death; *the caesarean represents a test of strength, binding but an act of rescue;* During their care, the midwives say that they had noticed a relaxation in the care following financial demotivation.

With regard to the expectation vis-à-vis the nursing staff, those who have given birth to caesarean sections want access to be given to their husbands for support during the caesarean section.

In view of this experience, the role of the nursing staff who accompanies the pregnant woman or in labor is therefore to

relieve them of their guilt and not to hesitate to talk about the cesarean section and its feelings. It is also essential to promote the acceptance of caesarean section, to value these women and to emphasize that they are mothers in the same way as the others. Although the caesarean section is a surgical intervention, it remains above all a birth of the newborn, even if the memory is more often that of an operation than of a childbirth.

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Conflict of Interest Statement

The authors have no conflict of interest to declare.

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