Author's response to reviews

Title: Socio-cultural factors, gender roles and religious ideologies contributing to Caesarian-section refusal in Nigeria

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Author's response to reviews: see over
COVER LETTER

We would like to thank both reviewers for the time and energy spent in generating these insightful comments that are aimed at strengthening our paper. We wish to say that we have taken time to review the comments and have taken steps to reasonably respond to most of them by making specific/strategic amendments to the paper.

Below are our responses/amendments:

Reviewer: Chen-I Kuan

Major compulsory revisions:

1. We fully agree that anthropologists consider biomedical knowledge and practices as part of culture too. The reviewer suggests that we analyze how doctors/providers may also have their own value judgments toward childbirth, and toward TBAs and their clients as well so as to have a more balanced analysis. While we agree with this argument, we wish to say that data collected did not have this end in mind. Our data therefore does not allow us to fully analyze providers’ own value judgments toward childbirth, TBAs and their clients. Nevertheless, we have added some reflection on the cultural nature of biomedicine and its assumptions (see p 4 and Discussion P 23). We are indeed keen to avoid any dichotomy between ‘rational’ medical providers and ‘irrational’ women.

   We have also acknowledged this shortcoming in the study limitations (see p.24) and included examining biomedical and alternative providers’ perceptions and value judgements as suggestion for further research. We hope that the findings can serve as springboard for further investigations along these lines.

2. With regard to this comment, we have provided a concise description of qualities that define the alternative providers (TBAs and religious providers) (see p.5).

3. We appreciate the interesting observations made by the reviewer. We have changed our write up of the analysis (eg extract 19) to reflect an acknowledgement that accounts are not merely representing ‘facts’ and that speakers’ personal background may affect their narratives which is indeed perhaps most pertinent to providers’ accounts of alternative providers. We have also included some reflection on this in the Discussion section.

   However, the study design was not primarily tailored to capture first-hand accounts of women with C-section experience. Rather, it was meant to explore community-based norms, meanings and interpretations on C-section, hence the need for focus group discussions (FGD) as the main strategy of enquiry. Women with previous C-section experience were supposed to participate in one FGD (for women with C-section experience only) but it was not possible to find 4-5 eligible women in this category owing to various reasons like unwillingness to participate, medical reasons and the place/timing of the study. We therefore decided to conduct interviews for the two that
were eligible and willing to participate. Given our data, we are thus not able to provide more first-hand accounts of women. This, and the lack of opinions/perspectives of alternative providers in the study, has been recognized in the study limitations (see p.24).

Minor Revisions:

1. The reviewer notes that similar attitudes to vaginal delivery have been witnessed in cultural settings, though perhaps preference for vaginal delivery is particularly strong in Nigeria. This is an interesting hypothesis but seems to require more evidence and further study. We thus considered it best to not speculate on features of the socio-cultural environment in Nigeria which may intensify attachment to vaginal birth, though our observation that Nigeria is a deeply religious country perhaps begins to address this question.

2. 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. We now note this (in the discussion) and argue that this indicates that people may not have accurate/full information and over-estimate the potential negative consequences of C-section such as the possibility that C-section is an indication for another C-section.

Discretionary revisions:

1. We have incorporated some pertinent anthropological studies on reproduction and CS/medicalisation of birth.
2. We very much appreciate the suggestion to interview husbands, in laws and alternative providers. This would however require a new study— which we would be keen to conduct. Has been addressed as part of the study’s limitations (see p.24). Note that we do include data from a focus group with fathers/men.
3. Again, a suggestion which we much appreciate and would love to examine in future research. We have included it as suggestion of future research (see p24).

REVIEWER Jane Harries:

1. This is a very crucial comment and we understand that this is a limitation. In response, we have included an acknowledgement that the small sample size does not allow for firm conclusions. However we did not seek to use the quantitative data to establish cause-effect relationship (between c-section refusal and MM). We merely intended to give a sense of how common c-section is in our case study, how common c-sections are emergency c-sections and some indication of what proportion of women refuse c-section.
We have however added information about the indications for the C-sections in the hospital (see p.10) and this agrees with established medical reasons for a woman to have a C-section. More so, even though we cannot establish a causal link to maternal mortality, the study made a rigorous attempt to highlight socio-cultural and gender based issues that undermine effective implementation of internationally recognized strategies that reduce maternal mortality.

2. The issues on abbreviations have been addressed (see pp 3 and 4). Reference style has been amended.

3. See response to comment 1. The existence of gaps in the quantitative data made it necessary that further data be collected within the study period. Though the sample size of the prospective data is small, analysis indicates that most of the parameters seemed to conform with the 5-year retrospective data, hence the decision to examine it as we did.

4. The C-sections booked/performd were all for medical reasons (see p.10). In fact, most of them were emergency C-sections indicating that these women have been in labour elsewhere before coming to the hospital.