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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Version: 3
Date: 14 May 2015

Author's response to reviews: see over
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. **In order to analyze how folklore beliefs and alternative practitioners influence women’s decision regarding CS, the authors draw on the approach of medical anthropology.** It should be noted that, while anthropologists emphasize medical system as cultural system, they also looked at biomedical knowledge and practices as part of culture. As such, the authors need to analyze how doctors/providers may also have their own value judgments toward childbirth, and toward TBAs and their clients as well. These assumptions may be also cultural, instead of purely scientific-based. It helps to avoid the dichotomy that medical providers as rational and women as irrational.

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) which now has a section that reads: It is important to note that, as Kleinman and other anthropologists have pointed out, biomedicine too, is a cultural system like ‘folk healing’. Anthropologists of reproduction have highlighted how the biomedical model of birth, although ostensibly derived and grounded in objective scientific facts, expresses particular cultural values [27]. Feminist anthropologists in particular have critiqued it for being technocratic, over-emphasizing technology and medical risks at the expense of a more holistic, naturalistic approach to birth which acknowledges the woman’s experience and allows her rather than the medical practitioner to be in control [27]. Differences between biomedical and ‘lay’ models of birth are not absolute. For instance, Makhlouf Obermeyer describes how in Morocco community members acknowledge health risks but refrain from taking preventative action because of practical barriers or because other risks such as receiving more disrespectful care are deemed more important [28].

The idea is further expressed in the DISCUSSION section in which the following has been introduced: The medicalisation of childbirth has been problematized by feminist anthropologists for decades [27]. Critique has centered on how medical interventions shift control from the woman to the often male medical practitioner, and the medical model’s prioritization of risks to health over and above social and personal risks [28]. As such, women’s refusal of CS could be seen as rejection of medical authoritative knowledge and display of agency, understandable within the specific socio-cultural context [51]. It is however important to note the potential detrimental consequences to women’s health and well-being. Furthermore, women who walk away
when advised to undergo CS appear to exert agency within restrictive circumstances confined by prevailing socio-cultural norms and gendered vulnerabilities, characteristic for socio-economic contexts where women’s economic and social survival may depend on their marriage and thus reproductive potential [48].

We are indeed keen to avoid any dichotomy between ‘rational’ medical providers and ‘irrational’ women. We have also recognised the need to examine alternative providers’ perceptions and value judgements as suggestion for further research in the discussion segment as reflected in this excerpt: …However, it is important that future research gains more direct access to alternative providers’ practices and views; we had to rely on providers’ and community members’ accounts...

We hope that the findings can serve as springboard for further investigations along these lines.

2. In order to give a more comprehensive context regarding the issue, it’s important for the authors to include more description of alternative practitioners or religious birth center. How do they practice childbirth? Where do they locate, urban or rural areas? Who go to them?

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) which reads thus:

Characteristically, TBAs are usually older women with inherited childbirthing skills and tend to practice in their local communities. Many of them do not have designated delivery rooms and their clients are usually women of relatively low socio-economic and educational status [37]……. Religious providers represent a diverse group of faith-based outlets ranging from birthing outlets linked to established churches and mosques to stand-alone small spiritual homes owned by individuals. These faith-based providers share a common feature of promising good delivery outcomes derived from divine/supernatural involvement.

3. To support their arguments, the authors use lots of interview data. However, in most of extracts, people talk about stories that they heard from their neighbors and friends. Very few are the self-narratives of women having or refusing CS. The authors may need to think about how these stories support their arguments. Instead of citing these data as objective facts, the authors may need to think about to what extent the story telling may be affected by personal interpretations of the speakers. By the same token, while citing provider’s observation on TBAs or religious leaders (such as extract 19), the authors also need to consider the standpoint of the doctors, and their tension with alternative providers. Meanwhile, is it possible for the authors to include more first-hand experiences of women in their article?

We appreciate the interesting observations made by the reviewer. We have changed our write up of the analysis (eg extract 19, now ext 20) to reflect an acknowledgement [‘this account suggests’ has been used to replace ‘It appears’ in the interpretation of the extract] 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 which now has a segment that reads thus:
.. several respondents spoke of the possibility that women refuse C-section although we were unable to collect first-hand accounts of C-section refusal. 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. The lack of opinions/perspectives of alternative providers in the study, have been recognized in the study limitations in which we have added the following: Another major limitation of the study hinges on reliance on the perspectives of biomedical staff without balancing it with the perceptions of other key players such as alternative providers. Accounts from hospital staff will be coloured by values and concerns of the cultural system of biomedicine. This may have led, for instance, to overly critical accounts of alternative providers. Thus, further research is required which examines the viewpoints and actual practices of all providers involved.

Minor Revisions:

1. The view that a real woman should have vaginal birth is widely heard from people in many cultures. But it seems that this value is particularly strong in Nigeria to the extent that women refuse medically necessary CS. The authors may want to talk more about the socio-historical origins of this idea and why it’s particularly strong in this specific culture.

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 (p.6) perhaps begins to address this question.

2. One reason for Nigerian women to refuse CS is that they believe the surgery would prevent them from having as many children as they want. This concern seems true if Nigerian doctors don’t practice Vaginal Birth after CS (VBAC). Do doctors there provide VBAC? If so, why do women think that they need to continuously have CS and thus limit the number of childbirths? If VBAC is not available in Nigeria, women’s concern about limited number of childbirth becomes reasonable.

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 - 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. It appears however that not everybody is aware
of this..) 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. In order to address socio-cultural factors behind refusal of CS, the authors draw on anthropological approach, mainly from Arthur Kleinman’s. It’s helpful for them to include anthropological study on CS which is well-researched in the field of Anthropology of Reproduction (such as works by members of Council of Anthropology on Reproduction). By responding to this body of literature, the authors can pursue a more in-depth analysis of gender and religious factors relating to the use of CS, and add to our knowledge of the complex relationships between gender and medical interventions in birth.

We have incorporated some pertinent anthropological studies on reproduction and CS/medicalisation of birth (see response to the first major compulsory revision).

2. In order to give a more balanced and comprehensive picture, the authors may want to also interview alternative practitioners, and women’s husbands and in-laws.

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. A segment in the study limitations/recommendations now reads: ... Thus, further research is required which examines the viewpoints and actual practices of all providers involved. Husbands’ and in-laws’ perspectives on CS and their role in CS decisions merit further attention too before we can make firm programmatic and policy recommendations. Note that we do include data from a focus group with fathers/men.

3. How medical information is given is crucial in shaping women’s idea of CS. For further development of this research, the authors may want to conduct observation on doctor-patient communication over the decision of CS. For example, how is the decision communicated? How do doctors frame the surgery? What term do they use? How do their clients react? What are the doctor-patient relationships? Do patient trust their doctors and feel free to ask questions? These doctor-patient interactions in the setting of hospital birth may significantly influence women’s understanding of CS.

Again, a suggestion which we much appreciate and would love to examine in future research. We have expressed this opinion in the Discussion segment: ...the tension between aversion and over-use needs to be explored in more depth since it raises additional concerns about the extent to which CSs are conducted with informed consent. Studies should be conducted into the practice of advising women to undergo CS, how decisions are reached and informed consent is obtained, and women's perceptions and experiences of the procedure...
REVIEWER Jane Harries:

1. My only concern is with the quantitative section. The sample size is small and collected over a short period of time. The key problem is that the link to maternal mortality in relation to not obtaining a CS cannot be convincingly made. The missing data as to reasons why a CS was indicated or received is a problem in terms of making that link.

This is a very crucial comment and we understand that this is a limitation. In response, we have included an acknowledgement in the ‘RESULTS” sections that the small sample size does not allow for firm conclusions: ..The sample size is small and does not allow for firm conclusions, but paints a picture of birth practices in our focal hospital...

However we did not seek to use the quantitative data to establish cause-effect relationship (between c-section refusal and Maternal Mortality). 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) as follows: The indications for the C-sections were mainly prolonged/obstructed Labour, foetal distress, preeclampsia/eclampsia, ante-partum hemorrhage and were consistent with standard medical indications for CS.

And these indications are consistent 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. Suggest that check that first time an abbreviation is introduced it is spelt out eg TBA on page 4 & NPC on page 6

Also ensure that the reference style of the Journal is consistent – in both the text and in the reference list. At the moment it is not.

The issues on abbreviations have been rigorously addressed (see pp 3 and 4). The in-text references have been numbered consecutively, in square brackets, in the order in which they appeared. For instance, the first in-text reference is presented thus; Sub-Saharan Africa alone accounts for 56%of the global burden [1]. The reference list has also been amended to reflect the journal style. The first on the list is presented thus:

3. Table 2: Delivery data: the missing data on refusal and Emergency CS is problematic—only provides a % of CS, is this the norm?—no convincing relationship between maternal mortality and refusal of CS. The prospective data (Table 3) is for 1 month only and thus not truly representative and not a large enough sample to be convincing.

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, as already acknowledged, 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. As already conceded, we clearly note in the “RESULTS” section of the study that: ..The sample size is small and does not allow for firm conclusions, but paints a picture of birth practices in our focal hospital...

4. The biggest gap is what were the indications for CS—this could explain refusal—was it for serious medical reasons or was it for other reasons such as financially motivated on the part of health care providers or medically unnecessary CS as reported in other countries including developing countries with a private health care system. as indicated that there are often economic motives why husbands would not support a CS (extract 14)

In the ‘RESULTS’ section, we have noted that, from the facility’s records, all the C-sections booked/performed were for medical reasons (see p.10... The indications for the C-sections were mainly prolonged/obstructed Labour, foetal distress, preeclampsia/eclampsia, ante-partum hemorrhage and were consistent with standard medical indications for CS.) In fact, most of them were emergency C-sections indicating that these women have been in labour elsewhere before coming to the hospital.