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ORIGINAL RESEARCH – QUALITATIVE

"It's Like a Disease": Women's perceptions of caesarean sections in Ghana's Upper West Region

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ABSTRACT

Problem: While caesarean sections in developing contexts act as a marker for access to skilled care, little is known about the health outcomes of caesarean sections. With calls for a more in depth understanding of women's perceptions of this procedure in resource poor settings, this paper explores women's perceptions and experiences of caesarean birth in the context of Ghana's Maternal Exemption Policy of the National Health Insurance Scheme in the Upper West Region.

Methods: A qualitative study using 10 focus group discussions and 30 in depth interviews of mothers and pregnant women were conducted. The results were thematically analysed.

Findings: Drawing on theories of feminist geography and embodiment, the results suggest most women perceive caesarean section birth as highly problematic, acting as a long term disease, which hinders their ability to engage in economic activities and care for their children. In the context of the Maternal Exemption Policy, caesarean section birth restricts a woman's ability to secure further health insurance for themselves and newborn child, leaving long term access to health care uncertain. Findings also suggest long term repercussions of caesarean sections may go beyond the physical health of the mother and child to include other socio-cultural and contextual challenges.

Discussion: Accordingly, caesarean sections position women in a multifaceted situation of vulnerability. This underscores the need for context appropriate maternal health programmes in developing countries.

Summary of Relevance:

Issue

- Rates of caesarean section birth are rising with little known about the impacts of such birth on maternal and neonatal health outcomes, especially in low and middle income countries.

What is already known

- Global caesarean section rates are exceeding the World Health Organization's recommended rate of 15%, leading to questions surrounding the benefits of the procedure on maternal and neonatal health outcomes.

What this paper adds

- The paper suggests that while rising rates of caesarean section birth allude to improvements in health access, such rates do not imply improvements in the long term health of women, particularly in rural subsistence environments.
- Maternal health policies should be cognizant of women's livelihoods when implementing services in order to ensure beneficial health outcomes.

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1. Introduction

Maternal mortality rates (MMR) represent the single largest health discrepancy between developed and developing populations, with nearly all (99%) maternal deaths worldwide occurring in developing countries.[1] Given that pregnancy and delivery are high risk events for women in many counties, the World Health Organisation (WHO) recommends skilled delivery for all women during this critical period, to ensure positive health outcomes.[2] Caesarean section delivery, performed by skilled health providers, act as a lifesaving procedure in high risk pregnancies in the event of serious pregnancy complications.[3] Defined as the birth of a foetus through incisions in the abdominal wall (laparotomy) and the uterine wall (hysterotomy),[3] caesarean section delivery aims to ameliorate complications of labour and delivery.

Globally, caesarean section deliveries have increased since the beginning of the millennia.[4] For the first time, findings from 150 countries reveal the number of caesarean sections worldwide has increased to 18.6%, exceeding the World Health Organization's recommendations of 15%.[5] While considerable increases have occurred in high-income countries, rates in developing countries have concurrently begun to increase.[5] With growing rates, experts have begun to question the benefit of these elective procedures on maternal and neonatal outcomes, especially in low- and middle-income contexts.[5,6]

While caesarean sections in developing contexts act as a marker for access to skilled care,[2,5] these deliveries in deprived settings have the potential to increase maternal and newborn risks.[6] In addition, there is limited information on why or how these rates are changing or whether increases are associated with health gains.[7] Further, data on caesarean section is often aggregated at the national level, with little opportunity to disaggregate data and examine the impacts of caesarean sections at the sub-national level. To address this gap, there have been calls for more in-depth, qualitative approaches to understand the health impacts and outcomes of caesarean section.[7] As such, this paper seeks to explore women's perceptions and experiences of caesarean sections in the Upper West Region (UWR) of Ghana. The research was framed within the context of the Maternal Exemption Policy (MEP) under Ghana's National Health Insurance Scheme (NHIS) and provides important evidence on the ways in which place specific factors intersect with women's ability to navigate the outcomes of caesarean section.

2. Context: Ghana

With growing calls for the reduction of global maternal mortality rates, Ghana implemented a Maternal Exemption Policy under its National Health Insurance Scheme, effectively granting free health services for all pregnant women for a one-year period.[8] Additionally, this policy provides the newborn child with health care services for three months after birth. This policy is especially important for women with no health insurance prior to pregnancy, as it offers a means to secure health care for themselves and the newborn child.[8] However, upon the three-month postnatal period, women previously not enrolled in the NHIS are no longer able to receive free health services. Additionally, if the mother did not enrol her child in the NHIS after birth, the infant cannot receive free health services.

The maternal exemption policy has made some modest gains since inception. For example, skilled attendance at birth in Ghana has increased over the past 20 years from 41% to 60%,[9] most of which has occurred since 2003 when the Ghana Health Service began fee exemption for delivery services.[10] According to the Ghana DHS survey,[11] the caesarean section rates have continued to increase from 6.4% to 17% between 2005 and 2014, with greater than 10-fold differentials in the rate by wealth quintile.[11] While paradoxically witnessing more than a 10-fold increase in caesarean sections over a decade, these figures are masked by spatially uneven development, which has translated into a health system with pervasive inequalities in access to health care between rich southern regions, and poor northern regions.[12]

3. Study context: Upper West Region Ghana

The UWR is one of the poorest, least developed regions in Ghana,[13] with only 16.3% of the total population characterised as urban compared to the national average of 51%.[13] Further, high illiteracy rates (68.8%) in the region sharply contrast the national average (38.8%) (14). Such high rates of illiteracy have effects on unemployment and economic opportunities within the region.[14] Many decades of political inattention towards the region partly explain why the region's literacy rates continue to be dramatically lower than the national rate.[15] This reinforces high levels of regional poverty, including poor health and nutritional status, which are the lowest in the country. For example, while 39.5% of Ghanaians live below the poverty line (defined as 90 Ghana cedis annual income or approximately $46 USD), 79–99% of the UWR population live below the poverty line.[16] Explanations for such diverse levels of national development are rooted in geographically uneven policies of the colonial state that exploited the northern regions as a labour reserve and broadly underfunded social services such as health care, a trend that has been perpetuated in independent Ghana.[15]

With regard to health care, most facilities in the region are underserved and poorly staffed. Currently, the UWR has six hospitals and only 21 of the country's 3061 physicians, representing both the lowest number of doctors in total as well as per population, with a ratio of one doctor to 9043.[12] This is 13 times worse than Greater Accra Region, which has a doctor patient ratio of 1:2744 inhabitants.[12] Furthermore, three quarters of households in the UWR live outside the recommended 8 km radius to a health facility.[13]

Against the backdrop of poor health infrastructure, limited sources of income, and impeding environmental degradation,[17] women face heightened challenges maintaining their health status, especially given the dual roles women assume. They must care for their children and they are expected to uphold the health and prosperity of their family. This becomes extremely challenging once they experience detrimental impacts on their personal health, such as in the situation of caesarean section delivery. Thus, women's health concerns in the UWR exist in concert with other important socioeconomic concerns and gendered roles. It is within the context of the above structural inequalities, gendered behaviour and prescribed roles, and the rapidly changing physical environments that we explore the impacts and long term health outcomes of caesarean sections.

4. Embodied inequality: processes, production and health

Understanding maternal health from the perspective of embodied epidemiology offers a useful framework for generating a holistic social and biological understanding of health, disease, and well-being.[18] Generally, embodied epidemiology expresses how human beings biologically, materially, and socially incorporate the world in which they live.[19] Krieger[19] advanced three critical claims central to the notion of embodiment. First, "bodies tell stories about- and cannot be studied divorced from- the conditions of our existence" [19, p. 350]. Secondly, "bodies tell stories that often – but not always – match peoples stated accounts" [19, p. 350]. Finally, "bodies tell stories that people

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