

**Management of Labor and Women's Perception of Cesarean
Section Delivery in Two Ramallah Hospitals**

By



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Abstract

Background: High cesarean rate is an issue of international public health concern. Cesarean sections increase the health risks for mothers and infants as well as the cost of health care when compared with vaginal birth. Up to date there is no study or research attempt of looking into the justification of cesarean section in Palestine. Therefore, this study explored the question of cesarean section from different dimensions in two hospitals at Ramallah city, hoping to contribute to improving maternal health in particular and woman health in general. the study aimed at investigating the process of labor management so as to identify conditions entailing the performance of cesarean section at selected non-governmental and government hospitals in Ramallah city, while at the same time attempting to understand the women's feelings and experience of cesarean delivery. it is a hospital-based study that is descriptive explorative in nature, wherein both quantitative and qualitative data were gathered through the use of a combination of data gathering tools. The record review provided quantifiable data on aspects of labor management. The questionnaire about cesarean section was administered to women in order to understand their feelings and experience of a having a cesarean section. One hundred and Two medical records of cesarean women were reviewed. Only 97 cesarean women responded to the questionnaire. Thirty seven, 24, 14, and 8 cesareans were performed for previous cesarean, breech presentation, fetal distress, and failure to progress, respectively. The rest of cesareans were performed for miscellaneous reasons. Eighty eight women said that they suffered as a result of the operation, 62% of women felt that the pain of the incision was more than their expectation and 68% expressed negative feelings after the operation such as exhaustion, sickness and depression. Also

95% of women said that the operation affected their ability to breastfeed, while 21.6% said that it affected their ability to bond with their babies. Out of the total number of infants born by a cesarean section, only one newborn needed to be in a special care baby unit (SBCU) and 12 needed to be in incubators. This study demonstrated that many cesareans were unnecessary could have been avoided by paying greater head to appropriate indication. Besides that, many cesareans could not be justified in terms of indications.

ملخص

الخلفية: تثير المعدلات المرتفعة لحالات الولادة القيصرية قلق الأوساط الصحية الدولية، حيث يشكل هذا النوع من الولادات خطراً على حياة الأم، والطفل، علاوة على ارتفاع تكاليف العمليات القيصرية مقارنة بحالات الولادة الطبيعية. لا يوجد حتى يومنا هذا دراسة تبحث في مبررات إجراء العمليات القيصرية في فلسطين، ولم يحاول أحد أن يقوم بهكذا دراسة. لذا ركزت هذه الدراسة على التعرف على العمليات القيصرية من أبعاد مختلفة، وقد أجريت في مستشفيات في مدينة رام الله. على أمل أن تسهم في تحسين صحة المرأة عموماً، وصحة الأمهات خصوصاً. **أهداف الدراسة:** تهدف هذه الدراسة إلى التعرف على الكيفية التي تتم فيها عملية الإشراف على المخاض، لكي نتمكن من تحديد الظروف التي يتم في ظلها إجراء العمليات القيصرية، في مستشفى حكومي، ومستشفى آخر غير حكومي في مدينة رام الله. وفي الوقت ذاته هناك محاولة لفهم شعور وتجربة المرأة التي تخضع لعملية قيصرية.

المنهجية: تعتبر هذه الدراسة دراسة وصفية، استطلاعية. وقد أجريت اعتماداً على معلومات مستقاة مباشرة من المستشفيات. وقد تم تجميع البيانات النوعية، والكمية باستخدام عدد من أدوات البحث. فقد قدمت السجلات التي تمت مراجعتها كماً من المعلومات حول كيفية التعامل مع حالات المخاض، في حين تم توزيع استبيانات على النسوة بهدف فهم شعورهن بعد الخضوع لعملية ولادة قيصرية. **نتائج الدراسة:** تمت مراجعة 102 سجلاً من سجلات النساء اللاتي خضعن لعمليات ولادة قيصرية. بالمقابل أجابت سبع وتسعون امرأة على الاستبيان الذي تم توزيعه. وقد أجريت 37 عملية قيصرية لكون المرأة قد خضعت لعملية قيصرية مسبقاً، 24 عملية أجريت لأن وضعية الجنين ليست بالشكل الطبيعي، 14 عملية أجريت لكون الجنين كان منهكاً، و 8 عمليات أجريت لكون المخاض استغرق وقتاً طويلاً أو توقف. أما بقية العمليات القيصرية فقد أجريت لأسباب مختلفة. وقد أفادت ثمانية وثمانون امرأة أنهن

عائنين نتيجة العملية التي خضعن لها، في حين ذكرت ستون امرأة أن الألم الذي عانينه نتيجة الجراحة كان أكثر من المتوقع. في الوقت ذاته عبرت ست وستون امرأة عن شعور سلبي بعد خضوعهن للصلية. تمثل هذه الشعور بالإرهاق، والإعياء، والاكتئاب. وقد ذكرت اثنتان وتسعون امرأة على أن قدرتهن على إرضاع أطفالهن قد تأثرت بعد خضوعهن لعملية ولادة قيصرية، في حين أفادت إحدى وعشرون امرأة أن ارتباطهن العاطفي بأطفالهن قد تأثر بعد العملية. كما بينت الدراسة أن مولوداً واحداً من مجروح الأطفال كان بحاجة أن يوضع في وحدة العناية المركزة الخاصة بالأطفال، وأن اثني عشر مولوداً كانوا بحاجة إلى وضعهم في الحاضنة. **الخاتمة:** بينت الدراسة أن العديد من العمليات القيصرية غير ضرورية، ويمكن تحاشيها إذا ما أعرنا اهتماماً أكبر في تشخيص السبب المؤدي لعملية كهذه. إضافة إلى ذلك فإن العديد من العمليات القيصرية التي أجريت لا يمكن تبريرها اعتماداً على الأسباب التي تم تشخيصها.

Chapter One

1. Introduction

High cesarean birth rates are an issue of international public health concern. Cesarean section (CS) rates have risen from approximately 3% of all deliveries in the western world in 1960s to between 15 and 21 percent in 1990s. This trend of increasing rate stimulated many associations such as the American College of Obstetrics and Gynecology (ACOG) and the Society of Obstetrics and Gynecologists of Canada to develop specific guidelines in order to decrease the incidence of CS. In developing countries, a pattern of increasing rates is only beginning to emerge with Brazil and Chile reporting overall rates of 27 and 40 percent, respectively (Leung, Lam, Thach, Wan, and Ho, 2001).

CS is a major surgical procedure where a baby and placenta are delivered through incision made in the abdomen and uterus. It is used in cases in which vaginal delivery either is not feasible or would impose undue risks on mother or baby. Some of the indications are clear and absolute others are relative (Decherney and Pernoll, 1994). Also CS may be performed for non-medical reasons such as malpractice litigation, financial incentive, women's expectation and convenience (Enkin, Keirse, and Chalmers, 1991).

The origin of cesarean section is vague, but it was certain that Julius Caesar was not born by cesarean section in view of the probability of fatality associated with the procedure in ancient times. In the past, almost every woman who underwent a cesarean section died, and in many cases it was performed to save the baby. There are written reports of cesarean section performed in late 1500s, but survival of the mother and baby was not really feasible until the late 1700s and early 1800s (Depp, 1996).

CS increase the health risks for mothers and infants as well as the cost of health care when they are compared with vaginal birth (Leung et al., 2001). When a cesarean is determined, the risks and benefits of the operation need to be weighed. This includes looking at the added benefits and risks of delivering by cesarean or vaginally. Sometimes the benefits of the cesarean outweigh the risks, and sometime the vaginal birth benefits outweigh the risks of the cesarean (Decherney and pernell, 1994).

Various strategies for lowering cesarean section rate have been described. Sandmire and Demott described six measures to reduce cesarean section: 1- education and Peer review. 2- external review. 3- public dissemination of cesarean section rate. 4-changes in physician payment. 5-changes in hospital payment. 6- medical malpractice reform. (Sandmire and DeMott, 1994)



7. Conclusions and Recommendations

This chapter will try to accomplish the third objective of the study that is identifying specific measures that may help in avoiding unnecessary cesarean section.

The evidence presented throughout this study is that many cesarean sections could not be justified in terms of indications. This chapter concludes based on major findings and highlights a number of recommendations that may help in avoiding unnecessary cesarean section.

7.1. On the use of cesarean section

This study demonstrated that women suffer and express much pain after cesarean section. In addition, it showed that cesarean sections effect on the ability of the women to bond and breastfeed is significant. Therefore much effort must be paid to avoid as much as possible unnecessary cesarean sections so that every cesarean is a necessary one.

7.2. On the women informed choice

Women were found to be poorly or totally uninformed about the process of their labor and details concerning the performance of CS. Therefore, it should be requested from obstetricians and ward headnurses to make women fully informed about their health condition and the health of their babies. Women who request cesarean should be fully informed about the pros and cons of both cesarean section and vaginal delivery.

7.3. Enforcement of trial of labor in hospital protocols

This study demonstrated that more than one-third of cesareans were performed for previous cesarean, contrary to literature indications. If this continues population of women with multiple cesareans will increasingly grow. This study showed that the obstetricians tend to schedule women for cesarean once undergone a primary cesarean indicating no attempt of trial of labor. Bearing in mind the unnecessary costs of this on the woman herself, infant, family and the health system at large. hospitals must adopt a policy that enforces trial of labor for such women, with procedural and technical guidelines clearly stated in special protocols.

7.4. On fetal distress as indication for cesarean section

The study findings revealed subjective interpretation of electronic fetal monitoring in the studied setting. Limited preciseness must be taken seriously for the significant costly decision resting on it. Therefore, it is strongly recommended to maximize preciseness in interpreting the electronic fetal monitoring by:

1. Conditional exposure of all professionals involved in managing labor to regular, continuing training in interpretation and storing cardiotocographs.
2. Development and application of guidelines that include criteria for interpretation of suspicious and abnormal CTG traces.
3. Using intermittent auscultation for low risk pregnancy. If the intermittent auscultation identifies any abnormalities, the electronic fetal monitoring can be used to confirm these abnormalities.
4. Introducing fetal scalp pH test if available to help diagnose fetal distress
5. Periodic and regular auditing and reviewing of all CTG for diagnosed fetal distress.