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Opinion of Women Giving Birth on Obstetric Interventions and Maternal Mortality at the General Provincial Reference Hospital of Kinshasa, Democratic Republic of Congo.

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ABSTRACT

Objective: *The aim of this study is to understand the opinion of women giving birth on obstetrical interventions and maternal mortality at the maternity ward of the provincial general hospital of reference in Kinshasa.*

Methodology: *It is a descriptive study of qualitative phenomenological type. Our approach has targeted women who have given birth who have themselves experienced these phenomena on various occasions when they attend maternity wards. We used the unstructured interview technique, the interviews being done on an individual basis using a face-to-face interview guide.*

Results: *From the main theme selected, the results of the thematic and categorical analysis revealed three subthemes in this study, namely: Perception of maternal mortality, Opinion of the new mothers on obstetrical interventions and Expectation of the new mothers in their care. charged. Maternal mortality is experienced by those who have given birth as a situation of deep concern; it is favored by Delay in the reference process; Lack of rapid intervention by the healthcare team; Bad fate of the family; lack of follow-up by the ANC. In the opinion of women giving birth on obstetrical interventions, they appreciate the care team in their work. However, they raised the demand for money as a difficulty during obstetrical interventions. In addition, they consider obstetrical interventions as early decision-making by the maternity team. Faced with the expectation of those giving birth in their care, they are asking for a reduction in the costs of interventions.*

Keywords :*Opinion, Women Giving Birth Births, Obstetric Interventions, Maternal Mortality.*

I. INTRODUCTION

The apparent increase in obstetrical interventions in recent decades and their standardization in the course of physiological deliveries perpetuates the impression that they provide greater safety for women and babies, and that the benefits outweigh the risks. However, current scientific research shows the opposite. The World Health Organization (WHO) even sets ceiling percentages beyond which interventions no longer provide health benefits **[1].**

These events have negative effects on both the woman and the newborn, in addition to constituting a violation of fundamental rights, a threat to their rights to life, to health, to physical integrity and to the absence of discrimination **[2].**

In this context, even if we are aware that these interventions are sometimes necessary to counter, prevent or respond to certain complications, we endorse the observation set out in the Policy, which specifies that "each time an obstetric intervention is performed, risks are associated with it, not to mention that recourse to an obstetrical intervention can trigger a cascade of interventions not indicated a priori **[1].**

In Quebec, recourse to obstetric interventions is frequent. For example, for the year 2009-2010, all pregnancies combined, the overall caesarean section rate was around 23% of deliveries, the pharmacological initiation rate 30%, epidural analgesia 69%, and 65% continuous electronic fetal monitoring. The 2008-2018 Perinatal Policy of Quebec, as well as its implementation document for the years 2008-2012, prioritize the promotion of physiological childbirth and the reduction of obstetric interventions. These orientations are the source of the mandate entrusted to the National Institute of Excellence in Health and Social Services (INESSS) by the Ministry of Health and Social Services **[3].**

These procedures are invasive and present risks for the parturient, the fetus and the course of labour. Therefore, the MSSS (2008) recommends training physicians and nurses on the non-pharmacological methods to be offered to parturients. **[4].**

Support must be offered continuously from the active phase of labor until delivery, by a person trained for this purpose. As caregivers, nurses must act with humanity and respect the natural physiological nature of labor and delivery (MSSS, 2008). In addition, they have a preponderant role in the support and progress of labor with the parturient. To do this, the nurse must provide an environment conducive to free choice, accompaniment and support for women during labor and delivery **[5].**

Thus, these risks and consequences, which must be less than the advantages associated with the intervention, that the subjects of these ci consider them around and through. Generally, the dissatisfaction is based on the norm, which considers vaginal birth as “normal childbirth” and promotes the feeling of not having lived “correctly” an essential event in their life as a mother **[6].**

In a study conducted in Quebec on the appreciation of obstetrical interventions, the participants were particularly concerned about the increase in obstetrical interventions resulting from the pathological vision dominating obstetrical practice.

The routine use of episiotomy and the increasingly frequent use of caesarean section (which had experienced a dizzying rise during the 1970s) were then especially criticized. Since then, the rate of instrumental vaginal delivery has decreased significantly, from 21% in 1981 to 16% in 2002 **[7].** In their review of the literature listing articles from 18 countries, including Canada and the United States, Bowser and Hill (2010) report the presence of physical abuse, care given without consent, care that violates confidentiality, care violating the dignity of the person, discrimination and negligence in obstetric care **[8].** .

These manifestations of mistreatment and disrespect have several consequences on women's health and their use of health care. Thus, it has been shown that women who have experienced this mistreatment will

be less likely to visit health services again during their next pregnancy or childbirth, contributing to an increase in the presence of neonatal mortality and morbidity.

Furthermore, one of the major challenges with which the human species is confronted daily is the safeguard of life. All of his actions directly or indirectly reflect his desire to prevent or cure illnesses that could lead to death. For a woman, giving birth should be a normal situation, a source of joy, and a means of human and social accomplishment. Unfortunately, it still happens that many women give life losing theirs, or keeping sequelae that can handicap them for the rest of their days on earth, due to numerous complications of pregnancy and/or childbirth. **[9].**

According to the World Health Organization (WHO), 303,000 women died worldwide in 2015 due to problems related to pregnancy or childbirth. About 99% of these maternal deaths occurred in developing countries, more than half of them in sub-Saharan Africa (57%) (WHO, 2015; United Nations Population Fund **[10].**

For several decades, the DRCongo has experienced major migratory movements. In large cities like Kinshasa, we are witnessing real demographic explosions which are characterized by several factors, in particular the plethora of health centres. The latter are no different from death homes, as they lack all the basic sanitary infrastructure and skilled labour. But ironically all these centers in their advertising posters claim to be able to perform all medical procedures including childbirth and gyneco-obstetric interventions.

This often leads to serious consequences, among others, the high maternal mortality in the city. To all this is added the alarming state of reference hospitals characterized by: water shortage, unexpected power cuts, absence of emergency services and specialized labor, repeated strikes doctors, the absence of paramedics for the rapid transport of pregnant women in a state of emergency to maternity wards, the state of the dilapidated and generally congested roads every day and does not allow rapid transport of pregnant women to hospital structures , etc

All of these are factors that contribute enormously to maternal mortality in the city of Kinshasa, but their magnitude and relative contribution to the occurrence of death in pregnant women during childbirth remains unknown.

When interventions are to be placed, ideally first level maternal and neonatal care should cover all useful interventions, including life-saving interventions. This is obviously impossible because it would then be necessary to have an operating room in each village. This is where the referral care provided by hospitals comes in: its purpose is to help the minority of women and newborns whose condition requires support. Health workers who provide first-line care must have recourse when faced with a problem that they are unable to solve because it is beyond their competence or because they lack necessary means.

Mothers need this resource to receive the care their condition requires, midwives (or their equivalent) must be able to count on it for their patients and to remain credible. Every pregnant woman needs to know that if things go wrong, her midwife will be able to fix the problem or, if not, get her transferred to a place where she can be cared for **[11].**

However, few works have evaluated the opinion or the perception of these interventions as well as of maternal mortality in our environment, this is what this study will try to find to complete the knowledge on these two phenomena.

The aim of this study is to understand the opinion of women giving birth on obstetrical interventions and maternal mortality at the maternity ward of the Kinshasa provincial reference general hospital. To achieve this goal, we have set ourselves the following specific objectives: Describe the socio-demographic characteristics of women who have given birth; Determine their opinion on the obstetrical interventions that carried out the maternity of the provincial general hospital of reference of Kinshasa; Raise their

perception on maternal mortality at the maternity ward of the provincial general hospital of reference in Kinshasa; Raise their expectation vis-à-vis these phenomena.

2. MATERIALS AND METHOD

2.1 Type of study and research setting

It is a descriptive qualitative phenomenological study. It responds logically to our study to understand the opinion of women giving birth on the obstetrical interventions they undergo and the mortality at the maternity ward of the Provincial General Reference Hospital of Kinshasa. This hospital is located in the Province of Kinshasa, capital of the Democratic Republic of Congo (DRC), commune of Gombe.

2.2 Target Population and Sample

Our approach has targeted women who have given birth who have themselves experienced these phenomena on various occasions when they attend maternity wards. We used the unstructured interview technique, the interviews being done on an individual basis using a face-to-face interview guide.

To carry out this study, we opted for the theoretical non-probability sampling technique. The selection is therefore of the primary type and will be made on the basis of the knowledge that the informant has of the subject of our research, thus admitting the advantage such that, while maintaining efficiency, the size of the sample is as small as possible.

As in all qualitative research, the size of the sample is determined by redundancy, that is to say when it is observed that there is repetition of the information collected.
In this work, our sample is 13 births.

2.3 Data Analysis Plan

The data analysis process was thematic, that is to say that from the themes that emerged, we retained subthemes supported by verbatim statements. This analysis was done following the steps below: the perception of the overall meaning of the research interview; the delimitation of the central theme; the analysis of the central themes according to the objectives of the research; the definition of the fundamental structure of the phenomenon studied.

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3.RESULTS

3.1Profile of respondents

Table 1: Sociodemographic profile of respondents

Characteristics	Workforce n=13	%
Age		
≤18 years old		
≥19 years old		
Average age 23 years (+-46)		
Marital status		
MarriedSingle	04 09	30.8 69.2
Study level		
PrimarySecondary	02 11	15.4 84.6
Residence Health Zone		

Residence in the Health Zone	03	76.9
Residence Outside the Health Zone	10	23.1
Profession		
Householdcut	10	76.9
and seam	01	07.7
Artist	01	07.7
Small business	01	07.7
Parity		
PrimiparousMultipara	10	76.9
	03	23.1

With regard to this table, we note that the age group of 19 years and over comes first with 69.2%, i.e. an average age of 23 years (+-46), more of the women who have given birth are single, i.e. 69.2%, from secondary level (84.6%); Most of the mothers interviewed come from municipalities outside the Kisenso health zone. These are women who have household chores (76.9%); the majority of women giving birth are primipara and primigravidae (76.9%).

3.2Results of thematic and categorical analysis

The main theme retained in this work is the opinion of women giving birth on obstetrical interventions and maternal mortality. From the central thematic analysis emerge three sub-themes in this study, namely:

1) Perception of maternal mortality
2) Opinion of women giving birth on obstetric interventions
3) Waiting for the new births in their care

From these sub-themes come different categories:

 First sub-theme: Perception of maternal mortality

The analysis of this sub-theme made it possible to identify two different categories below:

- Feelings about maternal mortality
- Factors/Causes of maternal mortality

 Second sub-theme: Opinion of women giving birth on obstetric interventions

The analysis of this second sub-theme made it possible to identify three categories:

- Judgment on the care team
- Difficulties during obstetric interventions
- Judgment of obsterical interventions

 Third sub-theme: Expectation of the new births in their care The analysis of this third sub-theme made it possible to identify a single category:

 Waiting for births vis-a-vis the hospital

These sub-themes emerge from the statements of the respondents. And each sub-theme brought out categories according to the responses of the respondents, faithfully reporting the significant descriptions or the full report otherwise called the verbatim.

Furthermore, we have organized these data by reducing their volume into smaller and more meaningful units called meaning.

Sub-theme 1: Perception of maternal mortality

- **Felt about maternal mortality**

Considering the declarations of the mothers, we notice that maternal mortality is felt by the mothers as a situation of deep concern. A few mothers explain their resentment in these terms: *R2: I really feel sorrow in my heart, especially when I see a woman come alive and suddenly she dies.R13: It's very heartbreaking, especially when you're still pregnant, it's a period when you're between life and death, and when you're in the delivery room, it makes you think a lot. And you are relieved only after childbirth*

- **Factors/Causes of maternal mortality**

In their statements, it appears that maternal mortality is favored by the Delay in the referral process; Lack of rapid intervention by the healthcare team; Bad fate of the family; lack of follow-up by the ANC. This woman approves: " *R2: women die because they come late to the hospital after having dragged a long time in other maternities… sometimes for lack of an intervention which requires blood, but because of lack of money "*

Sub-theme 2: opinions of women giving birth on obstetric interventions

•Judgment on the care team

Generally, the care team benefits from a good appreciation when they put in to perform an intervention. As this midwife attests: " *A7: they give us education on how to protect pregnancy and childbirth…they do their interventions well because they save both lives at the same time, of the mother and the baby. 'child.*

•Difficulties during obstetric interventions

Although appreciating the interventions of the nursing team, the mothers deplore the eRequirements of money before any intervention on the woman. Some say: *"R8: but here at Maman Yemo, they intervene first and then the money. It's a team that worries about saving human lives"… "R13: they receive us well and take care of us, but the problem is that they are very demanding in terms of money, they are expensive, you have to having a lot of money if not, it's difficult".*

- **Judgment of obsterical interventions**

Passing judgment on the way in which interventions are carried out, women deplore early decision-making by the maternity team among caregivers. They say it: *"R9: it's not good, you have to give the woman time to give birth normally vaginally, but here, as soon as you arrive, we do the vaginal examination and directly we decide on the cesarean. ". "R10: here at Maman Yemo, it's not good, because when we were transferred, as soon as we arrived, they decided to do a caesarean section without resorting to any other intervention".*

Sub-theme 3: expectation of new births in their care

Faced with the expectation of those giving birth in their care, they are asking for a reduction in the costs of interventions.

4.DISCUSSION

After our analyses, we notice that the trance aged 19 and over comes first with 69.2%, i.e. an average age of 23 years (+-46), more of the women who have given birth are single, i.e. 69.2%, from the secondary level (84.6%); the age of our respondents is closely aligned with the marital status. The mothers interviewed come from the communes of Kisenso, Kinshasa, Kitambo, Lemba, Linguala, Limete, Ngaliema, Mont ngafula, and Selembao; having as occupation the household task (76.9%); the majority of women giving birth are primipara and primigravidae (76.9%).

On the other hand, in a study conducted by Kabongo Muamba, et al (2017) on Cesarean section in rural Kasai Oriental (DR Congo): perceptions and experience in Kasansa and Tshilenge, the women interviewed were between 22 and 40 years old. (mean age 30.4 ± 5.9 years). The parity varied between 1 to 15 years (average parity 6.3± 4.1) **[12].**

- **Perception of maternal mortality**

Maternal mortality is experienced by those giving birth as a situation of deep concern. They say it: *R9: It's not good when a woman dies, because every woman is supposed to give birth normally.R13: It's very heartbreaking, especially when you're still pregnant, it's a period when you're between life and death, and when you're in the delivery room, it makes you think a lot. And you are relieved only after childbirth.* White Ribbon Alliance for Safe Motherhood (2011) goes on to say that the. This period of childbirth represents moments of intense vulnerability for women During these moments, women may feel judged and, seeking answers to their fears and worries, may find themselves faced with advice that seems experienced as a series of prohibitions and permissions **[13].**

In the statements of our respondents, it appears that maternal mortality is favored by Delay in the referral process; Lack of rapid intervention by the healthcare team; Bad fate of the family; lack of follow-up by the ANC. A few who have given birth speak: R7: *women who die are often kept in the maternities where they were admitted for the first time and the latter transfer them late.*

For WHO **[2].** , in terms of maternal mortality, the direct causes take the lion's share. These deaths are consecutive to complications of pregnancy and childbirth or can be caused by such or such intervention, oversight, therapeutic error or any other event resulting from these complications, including the complications of an unsafe abortion. There are four other major direct causes, namely: hemorrhage, infection, eclampsia, or obstructed labor. Maternal mortality will be more or less important depending on whether or not these complications have been taken care of correctly and in due time.

- **Opinion of women giving birth on obstetric interventions**

In the opinion of women giving birth on obstetrical interventions, they appreciate the care team in their work. In the study by **Saizonou et al [14].**on the quality of care for obstetric emergencies in referral maternities in Benin: The point of view of the "Echappées Belles" and their expectations, the objective of which was to assess emergency obstetric care and perceptions and expectations of women who had experienced being 'almost lost', in an effort to improve health in Benin, most women interviewed at the hospital were satisfied with the physical access, organization, operation and the environment.

However, excessively high costs and expense recovery requirements, flaws in the referral system, lack of empathy and discrimination on the part of nursing staff, lack of emergency resources, poor hygiene and comfort of the beginnings were underlined by the women interviewed at home.

However, the mothers in our study raised the demand for money as a difficulty during obstetrical interventions. This situation remains the same throughout the DRC. In the study by **Kabongo Muamba, et al (2017) [12].** on Cesarean section in rural areas of Kasai Oriental (DR Congo): perceptions and

experiences in Kasansa and Tshilenge, social tension caused by the expenses due to cesarean section: Fears of childbirth and in particular of cesarean section are inseparable from financial and medical constraints and social issues faced by women: "Most of the women we receive often arrive late. Knowing that the hospital is going to operate, the women prefer to first seek the solution elsewhere. Husbands' inability to pay cesarean costs has been the reason for some women being sequestered in hospital and rejected by the family. To pay the costs, the households resort to strategies such as the sale of products from the field, breeding, borrowing... The expenses incurred for the cesarean section further impoverish the households. The individual interviews with the women in their homes revealed that very few women say they know the cost of their caesarean section and that the expenses are, most of the time, supposed to be covered by the spouse.

In addition, they consider obstetrical interventions as early decision-making by the maternity team.

Moreover, the medical imperative is increasingly supplanted by other personal or organizational arguments; in the literature, the following reasons are cited for preferring a caesarean section in the absence of medical necessity: hospital planning, availability of the obstetrician who monitored the pregnancy, family organization at the time of birth (presence of the spouse, care of other children) or even the apprehension of future mothers faced with the pain and hazards of vaginal delivery. Yet, when caesarean section is not medically indicated, there is no evidence that it brings any health benefit to mothers or children.

In addition, the support of the parturient must be offered continuously from the active phase of labor until delivery, and this, by a person trained for this purpose. As caregivers, nurses should act with humanity and respect the natural physiological nature of labor and birth **.** In addition, they have a preponderant role in the support and the progress of labor with the parturient **[3].** To do this, the nurse must provide an environment conducive to free choice, accompaniment and support for women during labor and delivery **[5].**

- **Waiting for the new births in their care**

Faced with the expectation of those giving birth in their care, they are asking for a reduction in the costs of interventions. They themselves confirm this: *R6: only ask your authorities to help us with money. A13: Here at the hospital, we just want them to review the cost of procedures.*

5.CONCLUSION

Based on the main theme selected, the results of the thematic and categorical analysis revealed three subthemes in this study, namely: Perception of maternal mortality, Opinion of new mothers on obstetrical interventions and Expectation of new mothers in their care.

- ***Perception of maternal mortality*** : Maternal mortality is felt by those giving birth as a situation of deep concern; it is favored by Delay in the reference process; Lack of rapid intervention by the healthcare team; Bad fate of the family; lack of follow-up by the ANC.
- ***Opinion of the mothers about the obstetrical interventions*** : In the opinion of the mothers about the obstetrical interventions, they appreciate the nursing team in their work. However, they raised the demand for money as a difficulty during obstetrical interventions. In addition, they consider obstetrical interventions as early decision-making by the maternity team.
- ***Expectation of the new births in their care*** : Faced with the expectation of the new births in their care, they are asking for a reduction in the costs of the interventions.

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