New Reproductive Techniques: The Case of Caesarean Births in Nairobi

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BY

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DECLARATION

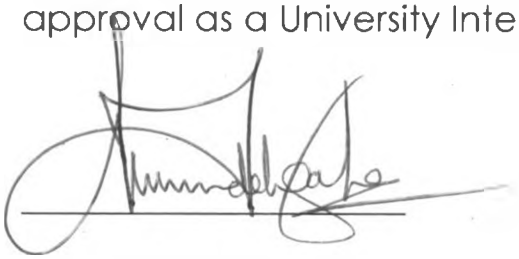
This project is my original work and has not been submitted for a degree to any other University

17-08-06

Ogola, Owuor Samuel

Date

This project has been submitted for examination with my approval as a University Internal Supervisor



17. 08-06

Mr. Owuor Olungah

Date

DEDICATION

To Juanita, Mary, Aggie, Bella, Ashley, Moriah, Unnie and Christine: special women in my life whose reproductive health must be informed by New Reproductive Techniques.

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ACKNOWLEDGEMENTS

My deep and sincere appreciation goes to all those who contributed to the success of this project. It is impossible, however, to thank all of them individually.

My special gratitude goes to my supervisor, Mr. Owuor Olungah who guided me at every stage of this project and always had a word of encouragement whenever things looked gloomy.

My appreciation also goes to the management of Kenyatta National Hospital, Pumwani Maternity, Nairobi Hospital and the Aga Khan Hospital: Without your collaboration and good will, not much could have been achieved.

I cannot forget my dear friends Christine Ochieng and Mary Okioma for their useful comments on earlier drafts of this work.

Special regards go to Annie and Vanessa for their labours in the field while gathering data.

May the Almighty God bless all of you and increase your capacity to be a blessing to many more researchers.

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LIST OF ABBREVIATIONS

ANC	Ante natal care
CEDAW	Convention on the Elimination of all forms of Discrimination against Women
CDT	Cognitive Dissonance Theory
CPD	Cephalo Pelvic Disproportion
C/S,	Caesarean Section Births
FCI	Family Care International
FGDs	Focus Group Discussions
HIV	Human Immuno Virus
IVF	In Vitro Fertilization
KDHS	Kenya Demographic and Health Survey
NRTs	New Reproductive Techniques
PEP	Perinatal Education Programme
TBAs	Traditional Birth Attendants
UN	United Nations
VBAC	Vaginal Births After C-sections
WHO	World Health Organization

ABSTRACT

This study investigated the role that New Reproductive Techniques (NRTs) play in widening the scope of women in enjoying reproductive health and rights. Some of these NRTs include in vitro fertilization (IVF), cloning, genetic screening, and anaesthesia management. Specifically, the study examined the social and cultural environment in which caesarean section births take place in Nairobi, exploring the decision makers in reproductive health, while questioning some usage of NRTs with regard to ethical considerations.

The study used cognitive dissonance theory as posited by Leon Festinger. Two public and two private hospitals were purposively selected for the study in Nairobi. A sample of forty respondents (32 women and 8 men) was also randomly selected. An interview guide with open ended and close ended questions, key informants and focused group discussions were the major methods used to generate data for this study. Additional data was gathered through the use of informal conversations. The data was analysed using both qualitative and quantitative techniques.

The findings of the research indicate that there are many factors that women consider in order to arrive at the decision to give birth vaginally or through c-sections. The study further reveals that most women in Nairobi do not have sufficient information that can help them make reproductive health choices that face them when pregnant. The study acknowledges the critical role that NRTs play in the management of women's reproduction, while at the same time asserting that NRTs can be applied for self gain and other reasons other than strict medical indications

The study recommends that c-sections (especially emergency c-sections) be made readily available to all women who may need it, in order to reduce maternal mortality in the country. The study further recommends that many more lives could be saved by improving training in anesthesia and postoperative surveillance.

CHAPTER ONE

1.1.0 Introduction

The world's reproductive landscape is fraught with numerous technological breakthroughs (Robertson, 1996). Cloning, genetic screening, embryo freezing, in vitro fertilization (IVF), Norplant, and RU486 are some of the technologies revolutionizing our reproductive perspectives.

Through an understanding of procreative liberty (meaning both the freedom to decide whether or not to have children as well as the freedom to control one's reproductive capacity), this study explores the role of New Reproductive Techniques (NRTs) in the management of pregnancy, and pregnancy related morbidity, and specifically examines social controversies surrounding the use of cesarean sections (C-sections) in the wake of rising reproductive technologies.

Today's consumer-driven, desire-for-perfection society has constructed pregnancy and childbirth as a very risky business. Women are bombarded with all sorts of warnings about the hazards of pregnancy and childbirth, and the inherent faultiness of their bodies (Singer, 2004). This preys on the concerns and anxieties of pregnant women, making them acutely aware of all the things that could possibly go wrong, and the need to plan against those risks (Holmes, 1981). As a result, the expectant woman more readily engages with the myriad of prenatal screenings, medical tests and other medicalized birthing choices, to help ease her fears (Graham et al. 1999). Increasingly, we are seeing women opt for invasive procedures because it's viewed as acceptable, responsible and a kind of insurance policy against possible prenatal, delivery or postnatal problems (Debra et al. 2000).

Presently, the world witnesses a reproductive revolution potentially more significant than the industrialization, nuclear power or the computer[1]. At the moment, in vitro fertilization (IVF), the laboratory production of test-tube babies, has become fairly commonplace since the birth of Louise Brown in 1978. Our own Kenyan test-tube babies have been delivered in 2006, giving hope to thousands of infertile couples around the country[2].

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[1] ASSISTED CONCEPTION: ETHICAL AND SOCIAL PROBLEMS, by Fr Anthony Fisher, O.P.

http://www.ewtn.com/library/PROLIFE/IVF_LIFE.TXT August, 2006

[2] The Daily Nation 11th May, 2006

All human societies attach great value to having children. However there are many social and cultural differences as regards to the reasons for having children, the ideal number of children, the importance of sons and daughters, and also about childlessness whether voluntary or involuntary. Involuntary childlessness often leads to devastating personal and social-economic consequences for the concerned men, and especially the women (Inhorn et al. 2002).

Unfortunately, most of these NRTs are prohibitively expensive and difficult to implement in many parts of the developing world. Not surprisingly, these technologies are rapidly globalizing to pronatalist developing societies, where children are highly desired, parenthood is culturally mandatory, and childlessness socially unacceptable (Inhorn et al. 2002).

With the high rates of intervention during pregnancy and childbirth, particularly among women from wealthier socio-economic backgrounds, caesarean section births continue to be perceived as the ultimate mode of birth (FCI, 1998). Caesarean section has become the most commonly performed surgery the world over (Flamm, 2000), even though its outcome over the vaginal delivery for the mother or the baby is still under investigation. Caesareans can be life-or-health-saving for many mothers and babies. But a c-section remains a major abdominal surgery so avoiding unnecessary ones also is important (Hannah, 2004). Caesarean births carry a death rate for mothers that are three to seven times greater than vaginal births, differing among studies (WHO, 2002). In Africa, not all deserving cases for c-section get the attention they deserve due to inadequate resources and lack of skilled professionals (WHO, 1985).

In elective c-section, a woman chooses birth by surgery to avoid labour or be able to schedule a birth at her convenience or that of her doctor[3]. Many obstetricians think that women should be given a choice on this issue (Gupta, 1998). But this raises ethical as well as philosophical questions: is their right to choice a more helpful or harmful mode of delivery? Is it ethical to even offer the choice or is it ethical to be silent? Pregnancy, labour and vaginal delivery are normal physiologic processes, is it in order that we pathologize them (Lomas et al. 1991)?

As childbirth therefore enters the high-tech, medicalized, high-speed world, many women are faced with critical medical, ethical, and social decisions regarding the benefits and risks involved in vaginal delivery, caesarean delivery or vaginal delivery after c-section(Debra et al. 2000).

[3] Our bodies, Ourselves (Boston Women's Health Book Collective) www.ourbodiesourselves.org/issues.htm June 16, 2006

The choices are difficult to determine due to lack of proper medical advice, lack of a regulatory framework that can raise guidelines (Lomas et al. 1991), money driven practitioner orientation, and the emerging social class that feels too posh to push (Klein, 2004).

Maternal and child health reflects both a society's level of development as well as the performance of the healthcare delivery system (FCI, 1998) In Kenya, 90 % of women receive antenatal care from a medical professional (18% from a doctor, 70 % from a nurse or midwife, and 2% from Traditional Birth Attendant (TBA)). 10 % of women receive no antenatal care at all (KDHS, 2003).

When it comes to delivery assistance 11% of women in Kenya are assisted by doctors; 30% of them are delivered by nurses or midwifes; 28% of the women are assisted by TBA; 22% are assisted by relatives and friends, while the remaining 8% go through birth without any assistance from anyone (KDHS, 2003).

1.2.0 Statement of the Problem

Despite strategies put in place to achieve the 5th millennium goal of improving maternal health, mothers' reproductive health continues to be a global challenge (FCI, 1998), and in many developing countries, maternal mortality is high, and women's chances of dying of pregnancy related complications are almost 50 times higher than in developed countries (Millennium Project, 2005).

It has been difficult to hold African governments accountable for protecting women's human and reproductive rights as stipulated in regional and international covenants (for instance, the Convention on Elimination of all forms of Discrimination against Women (CEDAW), and the Protocol to the African Charter on Human and Peoples' Rights). However, the Women's Rights Protocol is the first regional human rights instrument in Africa to specifically address women's human rights, including explicit protection for women's sexual and reproductive rights. Kenya is not yet a signatory to this charter, and the apparent gains for women's reproductive rights may not easily reach them.

Having the ability to make strategic life choices is central to women's reproductive health (Corea, 1990a; Gupta, 1998; Graham et al. 1999). Questions are emerging on the relative safety of caesarean births as compared to vaginal births (Flamm, 2000; Hannah, 2004). Mothers need to know from a scientific perspective whether to give birth vaginally or

through caesarean sections, and to establish the extent to which they can trust the new reproductive technologies (Gupta, 1998).

The social-demographic data reveal that Nairobi Hospital has a caesarean section birth prevalence rate of 28.2% (Nairobi Hospital Proceedings, 2003). At the moment, concern is being registered by women organizations whether the increasing cases of caesarean section births are driven by reasons other than strict medical indications (Debra et al, 2000) or by mothers themselves asserting their agencies in pursuit of greater reproductive rights and gains (Lomas et al. 1991).

Ten years ago, the most common form of caesarean section births was the emergency caesarean births (Singer, 2004). But now, elective caesarean births are readily available to women who belong to a specific socio economic class (Inhorn et al. 2002), raising ethical and legal concerns, and creating doubt whether women in Kenya are making informed consent to the pieces of advises received from reproductive health practitioners (Flamm, 2000).

While some feminists feel that women should be given a free hand to make decisions regarding their reproductive health (Gupta, 1998; Corea, 1990a; Graham et al, 1999), others are insisting that the medicalization of a natural process only serves to dis-empower women (Corea, 1985a). The problem facing us is the attempt to balance medical ethics, patient demand, mothers' right to choice, and the inherent risks involved in a major surgical procedure (Rowland, 1991). Even though caesarean birth is not new, the increasing demand for the service is new (Klein, 2004) and calls for a closer examination in order to ensure that women enjoy greater reproductive rights in a safe and secure environment (FCI, 1998).

1.3.0 General Objective

To explore the reasons and circumstances that mothers consider in making the decision on the type of birth they should undergo in the context of the New Reproductive Techniques (NRTs), and to examine whether the application of these NRTs increase or reduce women's reproductive rights and choices in the enjoyment of better reproductive health, with specific regard to caesarean section births in Nairobi.

1.4.0 Specific Objectives

1.4.1 To explore factors that lead to caesarean section births.

1.4.2 To identify key decision makers in caesarean section births.

1.4.3 To asses the role of NRTs in mothers' reproductive health and rights.

1.4.4 To provide data that will inform medical health policies in the management of pregnancy related morbidity.

1.5.0 Study Assumptions

1.5.1 NRTs are treated with a lot of suspicion and are only applied when other options are not available

1.5.2 C-sections are largely emergency related in both public and private hospitals.

1.5.3 The mother to be makes an independent decision without coercion for or against New Reproductive Techniques

1.5.4 NRTs have widened the scope in the enjoyment by mothers of greater reproductive rights

1.5.5 Most NRTs are out of the reach of many women in Kenya

1.6.0 Study Justification

The average c-section rate in Kenya is 4%. This figure varies from one province to another (Nairobi 10.3%; Central 6.2%; Coast 4.3%; Eastern 4.2%; Nyanza 1.9%; Rift Valley 3.8%; Western 2.2%; and North Eastern 2.5% (KDHS, 2003)) This is well below the maximum ceiling recommended by the World Health organization (15%).[4] However, records from Pumwani maternity Hospital indicate a prevalence rate of 16%, while that of Kenyatta National Hospital stands at 18%.[5] The trend for elective caesarean section is on the rise. This study has examined very closely the question on whether the increasing cases of caesarean sections births have improved maternal health by granting mothers greater reproductive rights.

While many women are socialized that birth is a natural process which should be left to take its own course and that vaginal births and the subsequent pang of pain is the ultimate realization of true motherhood

[4] Kenya Demographic Health Survey, 2003

[5] Nairobi Birth Survey, 1993

(Graham et al. 1999), the new reproductive technologies have been able to reduce the risks hitherto inherent in giving birth through c-section (Rowland, 1991). This study therefore explored the improvements brought by NRTs and the levels of empowerment they offer to mothers to be.

Given the high Perinatal Mortality Rates (52% for Kenyatta National Hospital), the study found that women need quality information supported with requisite statistics to be able to make informed choices in the management of their reproductive health.[6] The findings of this research therefore, provided patients, healthcare providers, administrators and policy makers with the information they need to improve the delivery of caesarean section births in Kenya. The findings have both theoretical and practical implications for the future of maternal and child health in this country. Theoretically, the study contributes to the advancement of knowledge and should practically influence and inform the policy formulations by the government and international bodies on issues affecting women's reproductive health in Kenya.

1.7.0 Scope and Limitations

The subject of study was highly personal and some respondents felt shy in sharing what they consider very private and personal information. The researcher however tried to overcome this problem by engaging a female research assistant who was able to re-assure participants.

In the initial focus group discussion, it became very clear that women participants could not discuss issues of sexuality and reproduction freely in the presence of male participants. The researcher therefore rescheduled the discussion and later held separate discussions with women and with men.

Some respondents' reactions indicated the need to satisfy what they thought the researcher was after and not necessary how they truly felt. The researcher used the technique of probing and rephrasing the same inquiry until clarity was achieved.

1.8.0 Operational Definitions

1.8.1 Caesarean section (c-section) is the surgical delivery of a baby through an incision in the mother's abdomen and the uterus.

[6] Perinatal Mortality is the pregnancy losses occurring after seven completed months of gestation (stillbirths) plus deaths to live births within the first seven days of life (KDHS, 2003)

1.8.2 Elective c-section - a mother's decision to give birth surgically even though it may not have any medical indication.

1.8.3 Emergency c-section - a complication arises during labour, which requires immediate surgical delivery.

1.8.4 Informed consent - the mother to be is conscious of the implications of both vaginal births and c-section births and makes a choice for one or the other.

1.8.5 New Reproductive Technologies (NRTs) -traditionally refers to a range of devices and procedures for assisting, preventing and/or manipulating contraception, fertility and reproductive practices.

1.8.6 In vitro Fertilization (IVF) – a procedure in which a woman's eggs are removed and fertilized in a laboratory.

1.8.7 Surrogacy – an arrangement where a woman (the surrogate) bears a child for another person.

1.8.8 Cloning – the creation of an exact copy of existing genetic material

CHAPTER TWO

2.0.0 Literature Review

2.1.0 Introduction

Doctor to patient ratio in Kenya is 1:4000 (KDHS, 2003). This means that very few women are attended to by doctors, and in cases where they are attended, the doctor patient interaction is very brief (Onyango-Ouma et al. 2001). In spite of this fact, the number of women seeking birth interventions through the c-section is increasing, and paradoxically commanding a big share of doctors' attention (Al-Mufti et al. 1996). Some people feel that this scenario is demand driven, rather than medically driven (Hannah, 2004). Others assert that medical practitioners are encouraging this trend to make quick cash and to gain surgical skills (Debra et al, 2000). The ensuing c-section debate mixes together a number of issues of women's autonomy verses professional judgement (Corea, 1990a), of the apparent interests of the expectant mother versus those of her child (Gupta, 1998), of 'natural' versus medicalized childbirth (Holmes, 1981). In all of this, what tends to get lost is the issue of what is best for a woman or her child.

The maternal mortality ratio in Kenya was estimated to be 414 deaths per every 100,000 live births (KDHS, 2003). Bearing on average 4.7 children, a Kenyan woman has 1 in 36 chance of dying from maternal causes during her life time. The chance of death increases when the mother gives birth through a caesarean section (FCI, 1998).

2.2.0 Accounting for emergency caesarean sections

C-section can be a lifesaving operation when either the mother or the baby faces certain problems before or during labor and delivery. Some women who deliver surgically do not expect it. Singer, (2004) suggests that a cesarean section delivery is major surgery and should be done only when the health of the mother or baby is at risk. It should not be considered an option for the convenience of the doctor or the parents, or for any non-medical reason.

According to Minkoff (2003), the conditions that create a higher-risk pregnancy that may require Caesarean delivery include: prolapsed cord, placenta praevia, abruptio placenta, cephalopelvic praevia, breech birth, multiple pregnancies, and previous surgery on the uterus, foetal distress and maternal illnesses.

Recent researches reveal that for a pregnant woman who already has had one c-section, an attempt at vaginal delivery is more dangerous for both mother and baby than a second c-section, because it can cause a ruptured uterus and such complications as endometritis. Such Vaginal Birth after Caesarean (VBAC) is more dangerous for the baby, and can cause serious brain damage.[7]

A Brazilian study (Belizan et al. 1999) reveals that emergency c-section is often done mostly to poor women with low levels of education or teenage mothers while elective c-section is mostly done to women who are well educated and therefore able to afford it. To the latter it becomes a lifestyle choice, and to the former a matter of life or death.

2.3.0 Reasons for elective caesareans

Requests for elective c-section present obstetricians with a clinical and ethical conundrum. Do considerations such as avoidance of pain, fear of labour, worries about maternal complications and risks to the foetus, or the convenience of the mother, and the preservation of vagina justify the risks of "unnecessary" abdominal surgery? How far should patient choice in the birthing process extend?

The permissive attitude toward elective c-section runs counter to international recommendations. The International Federation of Gynecology and Obstetrics guidelines state that "Because hard evidence of net benefit does not exist, performing c-section for non-medical reasons is ethically not justified." Similarly, the World Health Organization states that a c-section rate of over 15% indicates inappropriate usage." (Anderson, 2004)

There is some controversy about the number of caesareans performed: the total is rising year in year out, and it is generally agreed by professional organizations and parents groups (Hannah, 2004) that many are not necessary. The climate of 'over-medicalization' of childbirth and fear of vaginal delivery are some of the reasons for the rising trend (Gupta, 1998). In Kenya, the rate of C-sections may be lower than the upper limit recommended by the UN[8], but the concern is already registered by mothers as evidenced by the number of inquiries made by pregnant women to the reproductive health practitioners.

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[7] "The lure of caesarean section", by Thomas G Dolan in a publication called "For the Record", vol. 17 No. 18 P. 36 of August 29, 2005.
[8] Nairobi Hospital proceedings (2003)

The view that the rising c-section rate is fuelled by consumer demand has taken hold strongly in the medical literature (Hannah, 2004), and an increasing number of women are pressurising obstetricians to use their surgical skills. Apparently, women are losing confidence in the ability of their bodies to birth vaginally or naturally. Perhaps an examination of shortcomings in the existing maternity services would generate some data on why women are genuinely frightened or traumatised with the prospect of natural birth (Hannah, 2000).

There is no question regarding the place of medically justified c-section. Nature is not perfect and sometimes needs a helping hand. But a planned elective caesarean delivery constitutes an intervention in a natural event which, in most cases, would have occurred without any complication (Gupta, 1998). Could it be that conventional birth in our contemporary hospital settings (that include inductions, long labours, continuous electronic foetal heart monitoring, augmentation, epidurals, forceps, episiotomy, multiple caregivers) has become so medicalized, that we no longer consider it "natural" (Hannah, 2000)?

Patient's requests for caesarean sections in the absence of clear biological risks may seem irrational. What seems to underlie the fear of vaginal delivery is not simply a lack of information on how to prepare for a vaginal birth, but real issues relating to class based differences in the quality of health-care provision[9]. Indeed, many of the factors influencing maternal behaviors, such as fear of pain, are meaningful precisely because they are understood to differ by socio-economic status and to be embedded in discriminating practices (Peterson-Brown, 1998).

Many women choose c-sections because of lifestyle reasons (Sachs et al, 1999). There is a need for a distinct shift in emphasis to ensure that elective c-section as a lifestyle choice are not supported by the health services and that c-section should only be undertaken when medically or psychologically necessary, and after appropriate support and counselling. This view, however, contradicts the assertion by the pro-choice proponents e.g. Millet (1993a), who insists that women have the right to choice regardless of the circumstances, and women's reproductive choices should not be limited especially if they can afford it.

While many delicate and rich women who feel "too posh to push", get criticized for choosing to go under the knife to protect their work commitments, sex lives, and continence, some writers (Anderson et al.

[9] Healthy people 2000: National health promotion and disease prevention objectives. Washington: Government printing office, 1990

1982; Singer, 2004; Berkowitz, 1990) regard this as women's liberation, and a sign of empowerment.

A vaginal birth is considered a risky and negative experience while caesarean section represents the best quality care (Inhorn, 2002). When asked why they preferred c-section in a study done by Dr Kitzinger, many patients recounted problems with foetal distress and mortality, excessive pain, or trauma to the vagina. Women no longer want to spend two to three days in labour and delivery or wait weeks past their due date for labour to begin, like their mothers and grandmothers (Belizan et al. 1999).

Women not only seek c-section because they want to keep their vaginas 'honeymoon fresh', but also because c-section is being positioned as the safe and ultimate option available in delivering a baby.[10]

However, the argument of keeping vaginal muscles firm tends to be a serious consideration to some women. The debate that follows is whether the keeping of vagina firm adds any value to the woman's sexual life. Patriarchy is once again pushing women to seek extreme actions in order to satisfy the whims of men (Hannah, 2000), because it is men who enjoy and appreciate a firm and tight vagina. In-fact, a tight vagina might be harmful to the woman in a sexual encounter.

A successful vaginal birth is beneficial to the mother as it is generally associated with less bleeding, less blood transfusion, less infection, faster recovery with shorter hospital stay and less post-delivery pain and complications (FCI, 1998). Successful Vaginal Birth after C-section (VBAC) has also no proven adverse effect on the baby. In terms of cost, a successful VBAC is cheaper than c-section birth (Minkoff et al. 2003).

2.4.0 Caesarean sections and women's rights

With the development and application of New Reproductive Techniques (NRTs), the notion of a 'woman's right to choice', a slogan coined by feminists during the abortion movement has become problematic. Increasingly, these NRTs have become a subject of controversy even among women. Some feminists (Rothman, 1984b) have pointed out that while certain technologies have widened women's choices, some have also curtailed the same.

Other feminist scholars (Millet, 1990a; Gupta, 1998) welcome these technologies as scientific and progressive, believing that it is the use to

[10] Women's Health Watch: A Women's Health Action Trust, edited by Sandra Coney. September, 1998.

which they are put which makes them good or bad, empowering or disempowering. They further see new technologies as the extension of women's reproductive rights and self determination, for which reason all women should have access to them. They support women's right to reproductive choice, looking upon women as active agents rather than passive victims (Gupta, 1998).

Other feminist scholars like Akhter (1990), Corea (1985a), Hanmer et al. (1987), Klein (2004) and Mies (1983) see NRTs as enhancing patriarchal and technological control over women because they remove reproduction altogether from women and put it into the hands of medical reproductive engineers, because they violate the integrity of the female body, since they industrialize reproduction for the sake of profit and because they are sexist, racist and eugenic per se (Gupta, 1998).

Given the current level of medical technology, we should not be surprised that some high profile obstetricians advocate c-sections or some women are beginning to view surgical birth as a better, safer, option. The question at hand is whether this comes from a free and informed choice, even for that minority, when childbirth is being increasingly presented as highly risky and so little is being done to offer women the conditions and support that will enable them to give birth physiologically, without trauma and fear (Paterson-Brown, 1998).

Most women prefer to plan for a vaginal birth. However, if a woman without an accepted medical indication requests delivery by elective cesarean section and, after a thorough discussion about the risks and benefits, continues to perceive that the benefits to her and her child of a planned elective cesarean outweigh the risks, then most likely the overall health and welfare of the woman will be promoted by supporting her request (Hannah, 2004).

The notion that women must be dissuaded from c-sections, whatever the cost to their pain or peace of mind - as though the woman's wellbeing during childbirth is of less importance than the precise method of her labour is not acceptable to many women and tends to infringe on their right to choice in enjoying better reproductive health (Corea, 1990a).

2.5.0 Decision makers in the in the use of NRTs

Beijing and its five-year review upheld the right of decision-making over one's "sexuality, including sexual and reproductive health, free of coercion, discrimination and violence," (FCI, 1998).

Reproductive decisions are never made in isolation (Graham et al, 1999), but take into consideration the societal context in which it is made. Elective c-section is a choice that the pregnant woman makes. She is driven into this decision by a variety of concerns (real and imaginary), with the express aim of taking advantage of the improved NRTs[11]. Emergency c-section, on the other hand is unexpected and treated as the last resort to save lives.

Of all the areas of a woman's reproductive life, childbirth is the one over which she has the least control - the baby has to come out, somehow, about nine months after it was conceived. Yet the limited range of choices that a woman does have about the precise method of the birth has become a battleground, upon which a range of political and moral disputes are fought.[12]

If the physician believes that cesarean delivery promotes the overall health and welfare of the woman and her foetus more than vaginal birth, s/he is ethically justified in performing a c-section. Similarly, if the physician believes that performing a c-section would be detrimental to the overall health and welfare of the woman and her foetus, s/he is ethically obliged to refrain from performing the surgery. [13]

However, the high death rates that result from the c-sections in most district hospitals tend to suggest that some doctors are quickly looking out for any excuse to put the patient under the knife so that s/he can gain surgical skills (at the expense of human life), this trend is worrying and calls for further research (Inhorn, 2002).

According to Hubbard (1984), the symbiosis between a pregnant woman and the living relationship by which the life of both is preserved-is disrupted by the NRTs. This may create a situation where foetal rights are placed versus a pregnant woman's rights to her own body. The language of foetal rights (e.g. in foetal distress) is a language of social control.

A healthcare organization's financial status may also play a role in the decision-making process. Obstetricians and hospitals have found that a high-intervention birth warranted or not, is very profitable. So there is a tremendous financial incentive to bypass the clinically optimal approach, and opt for convenience and profit. According to Tonya Jamois, many

[11] World Health Organization: Appropriate technology for birth. Lancet 1985;2:436-7

[12] 'Whose c-section is it any way?' by Jennie Bristow in April, 2004.

[13] Ethics Committee of the Society of Obstetricians and Gynaecologists of America, 2004.

hospitals have eliminated facility-based midwifery practices simply because the low-intervention approach, while clinically sound, does not bring in as much money.[14]

The primary duty of health care providers is to maintain, or restore as best as they can, the physiological functions of patients. In doing so, they should a priori respect the plans of "Nature", assuming, as Aristotle (353 BC)[15] stated, that: "Nature does nothing in vain." During pregnancy, labour, birth and the immediate postnatal period, a complex array of events takes place to allow the harmonious construction and survival of a new human being. When asked about their birthing experience, women who had a c-section often mention they feel as if "something is missing Nissen et al. 1996. Maybe part of the answer lies in the regulation of affiliation relations with the newborn. As demonstrated by Nissen et al (1996) a natural flow of oxytocin occurs in the mother's blood, and presumably in the brain also, during the first post partum hour. Oxytocin is best described as the "hormone of love" as it provokes a nurturing drive in animals and humans. This surge of oxytocin seems to be blurred in the breastfeeding mother who has had a surgical delivery. Furthermore, many studies show that c-sections disrupt the proximity between mother and child and delays breastfeeding (Nissen et al. 1996).

The use of NRTs is not an individual affair alone, but takes place within the context of certain ideologies and policies, among which the ideology of motherhood and that of population control and the mode of birthing is very strong. C-section has emerged as a critical women's issue, a topic for debate and a target for professionally endorsed guidelines (Lomas et al. 1991).

Historically, as c-section rates rose and crossed the 15% mark that the World Health Organization had suggested as an upper limit, research has focused on determining the extent to which the increase was driven by medical indications. The medical profession defined approaches to care that would reduce or limit the rise in caesarean section, and systematic efforts were made to implement these strategies in America and other European countries. In Kenya, such guidelines are largely missing, calling for an urgent formulation of a regulatory framework.

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[14] "The lure of caesarean section", by Thomas G Dolan in a publication called "For the Record", vol. 17 No. 18 P. 34 of August 29, 2005.

[15] The Works of Aristotle the Famous Philosopher, by Aristotle: 353 BC

Dr Althabe comments that the implementation of a mandatory second opinion policy in public hospitals on an indication of intrapartum c-section could prevent 22 caesarean sections for every 1000 women in labour without harmful effects on the baby or the mother. Maureen Porter from the University of Aberdeen, UK, concludes: "Althabe and colleagues' trial is important because it suggests a sense of corporate responsibility on the part of the participating countries to tackle spiralling rates of caesarean sections where the problem is most pressing. Their study joins the ranks of only three reported trials in this clinical area, and opens up possibilities for others that aim to reduce maternal exposure to unnecessary surgery". [16]

2.6.0 Caesarean section and informed consent

Within medical settings, as in health legislation and medical ethics, the term "informed consent" is commonly used to express the patient's willingness to under-go an examination (or other medical treatment) It is important to note that a person can only agree to undergo a medical examination after having acquired sufficient knowledge and understanding of all elements and implications of the examination so as to enable him/her to make a carefully considered decision. The person concerned can only give his/her voluntary consent when s/he can exercise free power of choice without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion. Moreover, the individual should also have the legal capacity to give consent (Klein, 2004).

There is a rising concern that women are making important reproductive decisions without proper information (Graham, 1999). Sound medical practice demands that patients must be fully informed and make a choice from a broad spectrum of options, including birthing support from birth attendants, nurses and midwives. C-section should be at the end of the line, not at the top (Anderson, 2004).

The historical role of the doctor acting as the informed agent for the patient has changed, thanks to the increasing reliance on a model where the patient is seen as the consumer and the doctor as supplier of services (Onyango-Ouma, 2001).

Suppliers may find it difficult to ignore consumers' demands. Patients preferences have an important role in informed decisions, but these preferences can be expressed fairly only in the context of the best

[16] This Research on the Role of Second Opinion was done in Latin America, and reported in the "Medical Procedure News" of THE LANCET, on June 11, 2004.

evidence on risks and benefits, and doctors should not be expected to provide services that are of no clinical benefit or potentially harmful[17].

Without solid evidence on the risks and benefits of c-sections versus vaginal delivery, making informed decisions with individual patients is difficult (Klein, 2004). Jane Thomas argues that women should be guided to make informed choices. They have to be told about the risks and benefits about the decision they make because they are often fearful about giving birth. These fears must be addressed as they arise.[18]

Dr. Rudolph Fedrizzi (Stein, 2005) asserts that patients must have full informed consent before any surgical intervention. He further argues that since it is the women who will bear the brunt of the outcome, whether good or bad, it's necessary that they participate fully in the decision-making. It's owed them. Medicine, for him, is a service. It should be done with people, not to people hence the concept of democratizing medicine[19]

According to Michael Bradley, a research published in the British Medical Journal that surveyed 283 women three years after they had undergone either a vaginal delivery or c-section revealed that doctors maybe underestimating the psychological impact of c-section on first time mothers. The survey found out that 42% of women who had c-sections were avoiding further pregnancy due to the fear of childbirth.[20]

For a woman who requests an elective caesarean delivery to be fully informed, substantial time must be set aside for sharing the important information with her. However, the obstetrician who counsels the woman must do more than recite a litany of risks and benefits[21].

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[17] WHO: Appropriate Technology for birth. Lancet:1985 (Feb, 2006)

[18] BBC News, @ http://news.bbc.co.uk/go/pr/fr/-/1/hi/health/3663479.stm (Oct 23, 2005)

[19] "Un informed Consent", by Loren Stein, appearing in Metroactive Features Cytotec http://www.metroactive.com/papers/metro/03.21/covert/cytotec1-0212.html (Feb 14, 2006)

[20] "Hidden scars of Caesarean Section", by Michael Bradley (2005) http://www.smh.com.au/articles/2004/01/14/1073877902421.html (May 10, 2006)

[21] International Federation of Gynaecology and Obstetrics (2005)

2.7.0 NRTs and women's reproductive health and rights

All people have a fundamental right to health, which the World Health Organization (WHO) defines not just as the absence of disease but as a state of complete physical, mental and social well-being. In the area of reproductive health, this right entails the ability to have a satisfying and safe sex life and to make free and informed decisions about reproduction, including whether and when to bear children and how to deliver them[22].

The realization of women's sexual and reproductive health and rights, including ensuring access to appropriate reproductive technologies, has been a cornerstone in the fight for women's human rights and freedoms. Not only are these technologies being used to manipulate contraception, fertility and reproductive practices, but they are creating new ways to have and influence characteristics of potential children[23].

Some bioethicists have proposed a global treaty to ban enhancement technologies as "crimes against humanity." But defenders of NRTs argue that the use of NRTs is a fundamental human right, inseparable from the defense of bodily autonomy, reproductive freedom, free expression and cognitive liberty. While acknowledging real risks from genetic, prosthetic, and cognitive NRTs, they believe that bans on the consensual use of new technologies would be an even greater threat to human rights[24].

Health care, disability and reproductive rights activists have argued that access to technology empowers full and equal participation in society. Yet, what, if any, limits should be considered to human reproductive technologies? On what grounds can citizens be prevented from modifying their own genes or brains? How far should reproductive rights be extended? Might enhancement reduce the diversity of humanity in the name of optimal health? Or, conversely, might enhancements inspire such an unprecedented diversity of human beings that they strain the limits of liberal tolerance and social solidarity? Can we exercise full freedom of thought if we can't exercise control over our own brains using safe, available technologies?[25]

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[22] http://www.ipas.org/english/womens_rights_and_policies/default.asp June 14, 2006

[23] Young Women and Leadership: Gender Equality and New Technologies. Awid No. 8, June 2004 http://www.awid.org/publications/primers/factsissues8.pdf

[24] Institute for Ethics and Emerging Technologies: Human Enhancement Technologies and Human Rights, Stanford University http://ieet.org/index.php/IEET/HETHR June 23, 2006

[25] ibid.

Between the ideological extremes of absolute prohibition and total laissez-faire that dominate popular discussions of human reproduction, there are many competing agendas, hopes and fears. How will new technologies transform the demands we make of human rights?[26]

Technology has dramatically changed women's social options and social roles, e.g. contraception, In Vitro Fertilization or Pre-Implantation and Genetic Diagnosis. Technology can both liberate and enslave women[27]. The risks to women are growing and they include the following:

Inappropriate experimentation on women and deficient laws regarding reproductive and genetic technologies, viewing women merely as vessels to produce healthy babies, or in the future embryos or foetuses for stem cell therapies; for decades, the social policy has regulated women's reproductive behaviour to control their sexuality and to attempt to create more worthy children; there appears to be a growing social interest in subjecting a woman's pregnancy to public control, a process that has been called the "publicization" of pregnancy; changing societal norms to devalue differences among people and discriminate against people based on their gene types; on the one hand, these techniques offer a woman further control over her fertility and provide greater choice in establishing alternative family structures; on the other hand, many of these technologies further medicalise the process of conception, pregnancy, and birth, potentially lessening the woman's control over reproductive functions[28].

NRTs also include any therapy directed towards improving the chances of conception for an infertile couple and the mode of delivering the conceived babies[29]. Many of the procedures are questionable, and many of the drugs used in these procedures put women's health and lives in jeopardy (Debra et al, 2000).

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[26] WHO: Appropriate Technology for birth. Lancet, 1985

[27] Network for European Women's Rights www.NEWR.bham.ac.uk June 2, 2006

[28] Second workshop on Reproductive Rights in Women: University of Basque Country 6th and 7th Feb, 2004 http://www.newr.bham.ac.uk/pdfs/Reproductive/Report%20from%20Donosti.pdf .Downloaded on August 24, 2005.

[29] An article by Marie Anderson M.D., and John Bruchalski M.D.: Assisted Reproductive Technologies are anti women (www.usccb.org/profile) July, 2006.

To protect women's rights, it is important to incorporate the global nature of business, international institutions, governments, and science and technology into the analysis of NRTs, keeping in mind how women in differing realities and locations are exposed to technology. Other issues to consider are the profitability of technology, and the complexity of decision-making processes - that is, how and why decisions are made to introduce and promote NRTs in the communities[30].

As the result of many women increasingly turning to NRTs to have children, the cost of treatment in IVF and c-sections has increased tremendously, blocking a certain category of women from accessing it (Al-Mufti et al, 1996). An emerging concern is whether NRTs should be made to address the needs of women who can afford them, or whether the pursuit for NRTs should be stopped because they cannot meet the needs of women from all socio-economic classes (Al-Mufti et al. 1996).

Medical practitioners argue that NRTs have drastically improved abortions, making them safe and reliable. To this end, therefore, NRTs improve the enjoyment by women of greater reproductive health. Even anti abortionists would concede that NRTs make it much easier for women who legally must have access to abortions as the result of rape, incest or illness.[31] Where abortion is safe and widely available, and other reproductive health services are in place, rates of abortion tend to be low. The simple conclusion is: better contraceptive services for all people will reduce abortion.[32]

Ethical concerns are also manifest in the operationalization of NRTs for example; cloning is dehumanizing to the person cloned, whether for reproductive or research purposes[33]. In this process, an egg is surgically taken from the woman's ovary which has been hormonally manipulated. The nucleus is removed from the egg, and the nucleus from a body cell of the individual to be cloned is transferred into the empty egg and fused with an electric current. The donor of the somatic cell then becomes the genetic parent of his or her own identical twin (Nicholas et al, 2003).

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[30] New Reproductive Technologies and the Indian Woman www.hsph.harvard.edu/Organizations/healthnet/SAsia/suchana/0400b/h022.html. Date downloaded July 17, 2006)

[31] Voices of Choice http://www.voicesofchoice.org/ June 22, 2006

[32] The state of world population: Rights for sexual and Reproductive Health, 1997

[33] Center for Genetics and Society www.genetics-and-society.org June 17, 2006

Most pro choice advocates in the reproductive health debate insist that New Reproductive Techniques (NRTs) that intervene in women's reproductive processes provide an important tool for the management of human reproduction (Debra et al, 2000), especially when the life of the mother or the foetus is threatened.

The anti choice advocates argue that pregnancy is a natural process and unless there are complications, one may ask if it would not be better for a successful pregnancy to take its natural course, and that the woman be left to go through the pregnancy on her own strength, rather than be made to undergo medical interventions. Accordingly, NRTs are used by doctors to play upon the anxieties and uncertainties of the pregnant woman, who then learns to trust the technology (machine) more than herself (Gupta, 1998). This goes on to deny women agency.

According to Gupta, the proliferation of prenatal diagnosis technologies in the management of pregnancy has resulted in the indiscriminate use and loss of the traditional ways of looking at pregnancy as a natural process. Instead, every pregnancy is treated as suspect, or as a disease, which needs high tech management. The new technology in the hands of doctors destroys the old knowledge in the hands of women and midwives (Gupta, 1998). In the Kenyan context, the point raised by Gupta is important because the vast majority of pregnant women rely on Traditional Birth Attendants (TBAs), since the government has no capacity to intervene in all births.

Most NRTs are developed within a Western based model consisting of the medical, male, rational as the expert who designs ways to control women's bodies - mostly in relation to fertility control. Historically, women have been seen as irrational; their bodies to be tamed, controlled or colonized. The development and marketing of NRTs is moving control of procreation, not just contraception, further into this male, rational and controllable world. In the meantime, women's wombs are becoming laboratories for invasive and often risky reproductive technological interventions[34].

NRTs both improve and hinder women's rights. When women have access to them, NRTs enhance women's reproductive freedom, allowing them to further control their own fertility. But when NRTs are used as a part of

[34] Young Women and Leadership: Gender Equality and New Technologies, June 2004 http://www.awid.org/publications/primers/factsissues8.pdf Date downloaded June 13, 2006

population control policies and forced sterilizations, women's rights are certainly violated. Women's rights are also hindered when their bodies are used as testing sites for new reproductive technologies without adequate protection for their rights, health, and for prior informed consent. NRTs are increasingly able to help manipulate the very characteristics, ways and qualities for which eggs, embryos, and eventually children are created and selected[35].

2.8.0 Conceptual Framework: Cognitive Dissonance Theory

This conceptual framework was developed by Leon Festinger (1957, 1959) in his analysis of the consistency between cognition and attitudes or behaviours (dissonance). The Cognitive Dissonance Theory postulates that individuals, when presented with evidence contrary to their worldview or situations in which they must behave contrary to their worldview, experience cognitive dissonance (Festinger, 1957). Dissonance can be simply understood as an "unpleasant state of tension." A person who has dissonant or discrepant cognitions is said to be in a state of psychological dissonance, which is experienced as unpleasant psychological tension (Berkowitz & Cotton, 1984). This tension state has drive-like properties that are much like those of hunger and thirst. When an individual has been deprived of food for several hours, he/she experiences unpleasant tension and is driven to reduce the unpleasant tension state that results (Berkowitz &Cotton, 1984).

The general sequence of a psychological tension is as follows: conflict-decision - dissonance - dissonance reduction (O'Keefe, 1990). The theory explains the tendency for individuals to seek consistency among their cognitions (i.e., beliefs, opinions). When there is an inconsistency between attitudes or behaviors (dissonance), something must change to eliminate the dissonance. In the case of a discrepancy between attitudes and behavior, it is most likely that the attitude will change to accommodate the behavior (Brehm, J. et al, 1962).

The focus of Cognitive Dissonance Theory is an attitude change. According to the Social Judgement Theory (which complements this theory in this study) developed by Muzafer et al[36], once we judge a

[35] Our Bodies, Ourselves
http://www.ourbodiesourselves.or/issues.htm Feb, 2006

[36] Muzafer, Caroline Sherif and Roger Nevergall (2005): The theory states that we judge and place incoming information in an 'attitude scale' in our minds in three zones:- latitude of acceptance, latitude of rejection and latitude of noncommitment

message, we will adjust our attitude to accommodate the new input (Griffin, 1997).

Festinger proposed three hypotheses to elaborate upon Cognitive Dissonance Theory (Berkowitz & Cotton, 1984), which were helpful in this study:

Hypothesis 1: Selective exposure Prevents Dissonance People avoid information that is likely to increase dissonance, and hung around like minded company. In application, pregnant women (and women generally) expose themselves only to used, familiar and tested technology, avoiding techniques and information that is not favourable to their beliefs (Berkowitz & Cotton, 1984). This may explain why Traditional Birth Attendants (TBAs) are still treated with a lot of respect in most parts of Kenya. When it comes to giving birth, and in order to prevent any chance of discomfort, these women will avoid using new technology that causes dissonance, even if that technology offers the best in terms recovery (Griffin, 1997).

Hypothesis 2: Post decision Dissonance Creates a Need for Reassurance In application, many mothers to be make a rush decision to go for/against c-sections. Meanwhile, they begin to wonder if this decision is worth the effort. The second thoughts following a decision motivate women to seek re-assuring information and social support for their position (Griffin, 1997). This is the stage that they begin to rationalize in search of reassurance (Berkowitz & Cotton, 1984). They may remind themselves of friends who went through c-sections and came out fine. They begin asking themselves: what is the harm of using new technology if it can reduce labour pains? All of this reassurance makes them feel better about their decision, thereby reducing dissonance (Griffin, 1997).

Hypothesis 3: *Minimal Justification for Action Induces a Shift in Attitude* This hypothesis deals with the difference between public compliance and private acceptance. If one wanted to obtain private change in addition to mere public compliance, the best way to do this would be to offer just enough reward or punishment to elicit overt compliance (Griffin, 1997). Following Griffin's argument, one would say that once determined that using NRTs was the safest option available, pregnant women choose to go for it. In other words, many women do have unresolved issues and concerns about NRTs but the potential benefits (e.g. In Vitro Fertilization for infertile couples) far outweigh their concerns for safety and the guilt that they may feel (Berkowitz & Cotton, 1984).

Dissonance theory applies to all situations involving attitude formation and change. It is especially relevant to decision-making and problem-solving, which is a key objective of this study. This theory has been one of the most influential and widely debated theories in social psychology (Jones, 1985). It has spurred many studies that aim to better understand what determines an individual's beliefs, how they make decisions based on those beliefs, and what happens when those beliefs are brought into question (Harmon-Jones et al, 1999).

An important application of cognitive dissonance theory is research on attitude change (Lindzey et al, 1985). The significance of the dissonance theory has been researched in depth by Gerard (1967), Adams (1963) and Pallak and Pittman (1972) among others. Much of the cognitive dissonance research being done today centres on experiments which try to prove or disprove a link between physiological arousal in motivating a person to change his/her attitude in the presence of dissonance.

Aronson (1997) uses research by Swann and Read (1981) to show that people try to persuade others to behave in a way that will justify their own belief systems. Aronson asserts that this is a manifestation of Festinger's original theory wherein Festinger claims that one way to preserve one's consonance is by changing an environmental cognitive element (Aronson, 1997). Jack Brehm's famous experiment looked at how housewives, after making a decision, favoured the alternatives which they had selected more strongly (Brehm, 1956). This can be explained in dissonance terms - to go on wishing for rejected alternatives would arouse dissonance between the cognitions "I chose something else" and "I preferred that option".

This theory helped to explain my data by clarifying why some pregnant women preferred some NRTs, while others rejected them. It also helped in clarifying the decision making process in favour of c-sections or vaginal births, since reproductive decisions are made in fluid environment. The theory was also helpful in establishing the minimal justifications that women need in making reproductive health choices. In emphasizing selective exposure, the theory helped to explain why women in different socio-economic groups respond differently when faced with the same problem, using different NRTs and different birthing procedures in achieving the same objectives. Finally, by insisting that Post decision Dissonance Creates a Need for Reassurance, the theory greatly assisted in understanding why and how some women are taken advantage of by doctors, midwives, hospitals, religious groups and even relatives in the

attempt to seek reassurance once a decision has been made for or against specific medical procedure.

CHAPTER THREE

3.0.0 METHODOLOGY

3.1.0 Research Design

This was an exploratory study that took keen interest to ensure that the objectives of data collection process were achieved. The major aim of this study was to elicit qualitative data. Research assistants were trained on data collection techniques, contents of questionnaires, and note taking. Data collected was edited and coded immediately.

3.2.0 Sample Selection

The selection of Nairobi as the study site was purposive and intentional. The city exhibits a physical environment suitable for this study. The high concentration of both public and private hospitals in the city was considered. The concentration of NRTs in the city hospitals was also important.

Four hospitals were selected for this study: Nairobi hospital; Kenyatta National Hospital; Pumwani Maternity hospital and the Aga Khan hospital. The four hospitals were chosen not only because they provide antenatal care to the largest number of women, but also because of their application of new reproductive techniques.

3.2.1 Study Site

The study was carried out in Nairobi. The city is quite representative in terms of the concentration of hospitals that serve women from different socio-economic backgrounds. The use of NRTs is more pronounced in Nairobi than other parts of the country.

3.3.0 Unit of Analysis

The individual was the unit of analysis in this study. This is primarily because the over arching aim of this research was to capture the perceptions of individual women and men in their usage of NRTs, the factors that influence their decisions on modes of birth and to establish whether their rights to reproductive health are increased or reduced.

3.4.0 The Target Population

In the research, the population consisted of forty participants. Thirty two were women who had given birth either vaginally or through c-sections, or who knew of relatives and friends who had past experience with c-sections. The last eight included medical doctors, nurses, and healthcare

system managers, who mainly participated in key in depth interviews and focus group discussions.

3.5.0 Methods of data collection

3.5.1 Documentary Sources

This technique was used to supplement primary data and to inform the orientation of the problem under study. The available literature on NRTs and the decision making processes as well as rights issues in application of NRTs were examined before embarking on the fieldwork. In fact, most of the relevant documents from books, the internet and magazines were made use of through out the entire period of the study. The literature on NRTs with Kenyan perspective was however, very scanty. Recorded patterns of reproductive decisions were also hard to come by.

3.5.2 Structured Interviews

A semi-structured interview guide was developed and administered to the forty respondents. The questionnaire had both open-and-closed-ended questions. The open ended questions empowered the respondent to freely air her/his views. This enabled the researcher to elicit subjective and personal views of the respondent on sexual and reproductive practices. This prompted some unanticipated responses that were further probed and investigated (e.g. the assertion that mothers feel more love for children born naturally than those delivered through c-sections).

Two questionnaires were used in this study. One in-depth interview guide and one focus group discussion guide were formulated.

Two female research assistants were trained to be conversant with the structure, content and form of the research instrument to be able to assist the researcher in administering the questionnaires. The direct interactions between the interviewers and the respondents allowed for the modification of the questions to absorb the emerging scenario. For instance, some doctors were reporting breakthrough in Kenya's medical history in the use of in vitro fertilization. This line of questioning had not been considered initially. Pre testing technique was therefore used in a very limited way.

3.5.3 Unstructured Interviews

This method was used to complement and reinforce the structured interviews. As Mandelbaum (1982), Burgess (1991), and Pelto and Pelto (1987) all agree, it mainly took the form of conversational interviews. These interviews were held in informal settings with members of the households living in the same neighborhood as the researcher. They were men and

women who previously had experienced c-sections, or who knew of relatives and friends who had undergone the procedure. They took place mostly in the late afternoons and early evenings.

It was absolutely important to make use of this technique so as to obtain data in less controlled research settings that could provide insights into the subjective views of the informants concerning the research topic. As a result, some pertinent concerns were tactfully clarified during such occasions. This research technique elicited response on topics such as the expression of mothers' love to children born vaginally as compared to babies delivered through c-sections; the preferred mode of birth for the next pregnancy; determining whether vaginal births interfere with sexual intimacy; clarifying whether NRTs increase/restrict the scope of women's reproductive health rights; and insights into the perceived differences between elective c-sections and emergency c-sections. The responses were recorded in a field note book to help in the analysis of the data.

3.5.4 Key Informant Interviews

This category of respondents were considered specialists, articulate, knowledgeable and experienced in the area of reproductive health, New Reproductive Techniques and Women's Human Rights. They were intentionally and conveniently selected on the basis of the following set criteria: their advanced qualifications in reproductive health; their vast experience in the management of women's health; their use of NRTs; and their high social status in the community. They included two medical doctors, two mid wifes, two nurses and one laboratory technologist and one priest. They provided both in-depth and FGD data that enabled the researcher to gauge the impact of NRTs on women who seek reproductive health interventions. The total number of key informants engaged in this study was eight, forming part of the forty target population.

3.5.5 Focus Group Discussions (FGDs)

Four FGDs, each consisting of between eight to ten respondents were held. Participants were drawn from health care management professionals (doctors, nurses, midwifes, laboratory assistants e.t.c.), women who have undergone some procedures in NRTs, women who have given birth through c-sections or who knew of relatives and friends who had past experience with c-sections or who had undergone some kind of assistance in conception and birth. They also included men who are married with wives who have undergone c-sections and other aid in conception and delivery.

Separate sessions were held for women and men (three sessions for women and one for men) to give everyone the chance to feel free to explore and express their deepest thoughts on sexuality and reproductive health procedures. FGDs generated rich data within a very short time and provided a great deal of varied experiences and opinions that could not otherwise be learned from individual interviews. For instance, the thoughts on preserving the firmness of the vagina to pre birth status through the use of c-sections in delivering babies, and the special love felt for children delivered vaginally.

3.5.6 Data Analysis

Qualitative and quantitative methods of data analysis were used. They included frequency tables, averages and percentages which are very pertinent in descriptive studies of this nature. Cross-tabulations were made to aid better understanding of the results. Content analysis was also done.

3.6.0 Ethical considerations

The researcher bears responsibility for all procedures and ethical issues related to the project. The research gave due consideration to the integrity of the research processes (Barnes, 1984). The researcher considered the effects of his work, including the consequences or misuse, both for the individuals and groups among whom he carried out the fieldwork; he therefore carried out debriefing sessions for all the respondents. The research was carried out in full compliance with, and awareness of, local customs, standards, laws and regulations (Jowell, 1986).

The research avoided undue intrusion into the lives of the individuals that were studied. The welfare of the informants was given the highest priority; their dignity, privacy and interests have been protected at all times. Freely given informed consent was obtained from all respondents. Participants were informed in a manner and in languages that they understand. The context, purpose, nature, methods, procedures, and sponsors of the research were clearly explained to them. Participants were fully informed of their right to refuse, and to withdraw at any time during the research[37].

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[37] Ethical Guidelines for International Comparative Social Science Research in the framework of MOST http://www.unesco.org/most/ethical.htm July 2006

Participants were offered access to research results, and it has been presented in a manner and language they understand.

CHAPTER FOUR

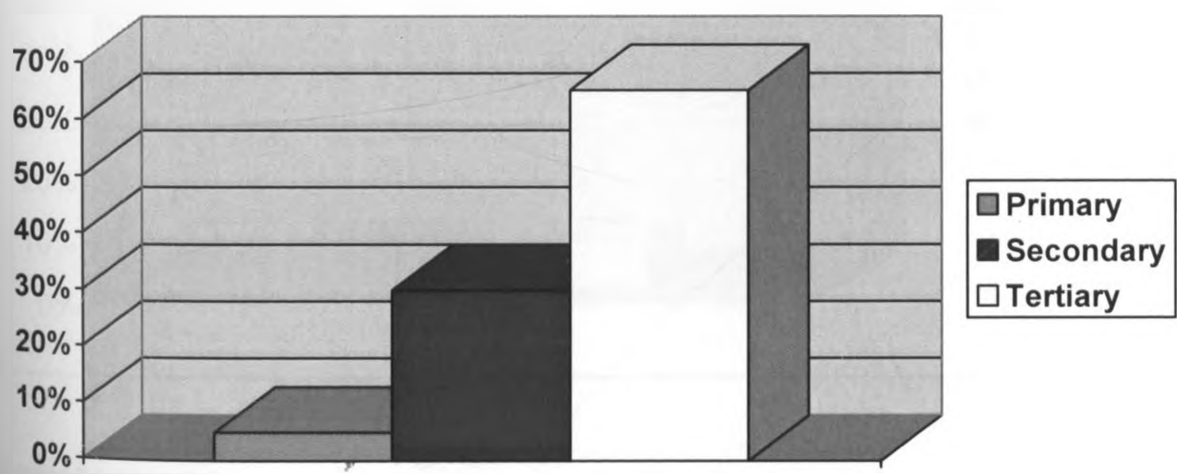
4.0.0 RESULTS

4.1.0 Introduction

In this section, the researcher presents the findings on the various themes of the study. The first part presents the demographic characteristics of the forty respondents (thirty two women involved in the study and eight key informants). The rest of the chapter presents the findings on the objectives of the study and the discussion on the implications. As much as possible, the researcher tries to use the words and expressions of the respondents and their perspectives on the subject under study.

The study interviewed 40 respondents, eight men and 32 women of ages ranging from 21 – 50 years. The demographic characteristics and highlights of findings are depicted in the following diagrams:

Table 1 Respondents level of education

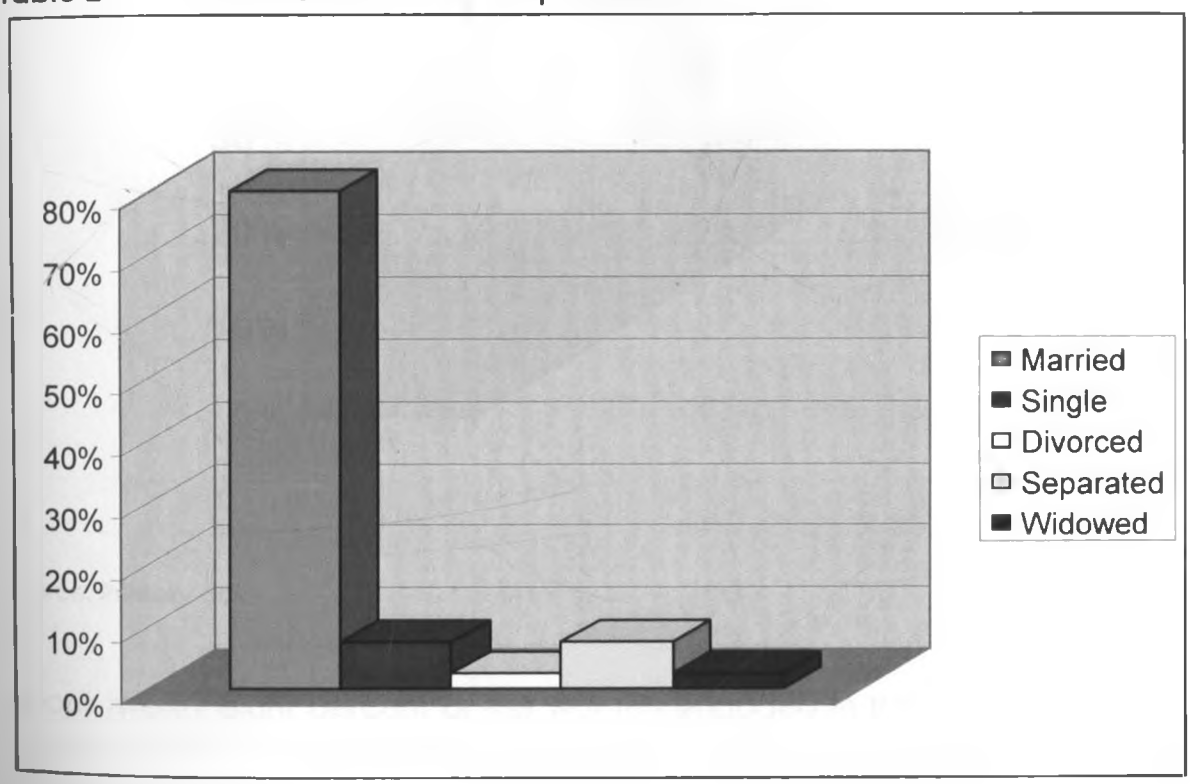


Source: Primary data

The thirty two women that were examined in this study were all educated, but at different levels. Less than five percent of them had primary education; thirty percent of them had secondary school education, while the majority (over sixty percent) had tertiary level of education.

The study shows that the lower the education of the mother, the lesser the use of new reproductive technologies. The exception comes when an emergency situation arises, and the mother is rushed to the theatre (for instance, the case of emergency c-sections). Some of these women heard the term c-section for the first time when being rushed to the theatre. On the other hand, the higher the education level and the earnings of the mother, the greater the use of new reproductive techniques (for instance contraceptive methods, termination of pregnancies and fertility enhancement methods). Most of the mothers with tertiary level of education were familiar with such terms as IVF, Surrogate motherhood, cloning etc.

Table 2 Marital Status of the Respondents

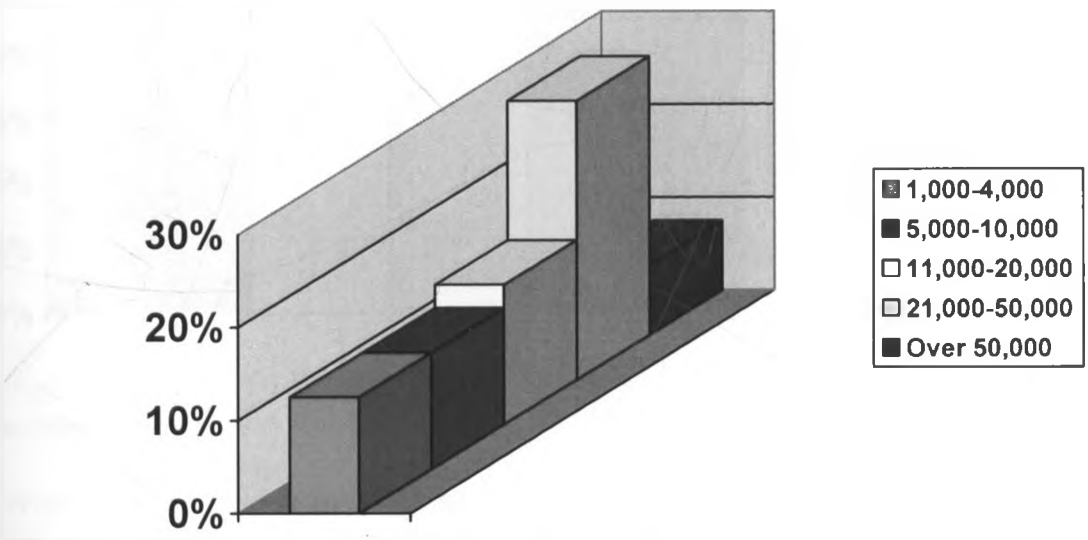


Source: Primary data

Close to eighty percent of the respondents are married, leaving the twenty percent to singles, divorced, separated and widowed individuals. Those who are married pointed out that their partners also influence the kind of technology used in reproductive health. The other social

categories revealed that their use of reproductive technologies depended on advice from relatives, friends and doctors.

Table 3 Respondents' income brackets

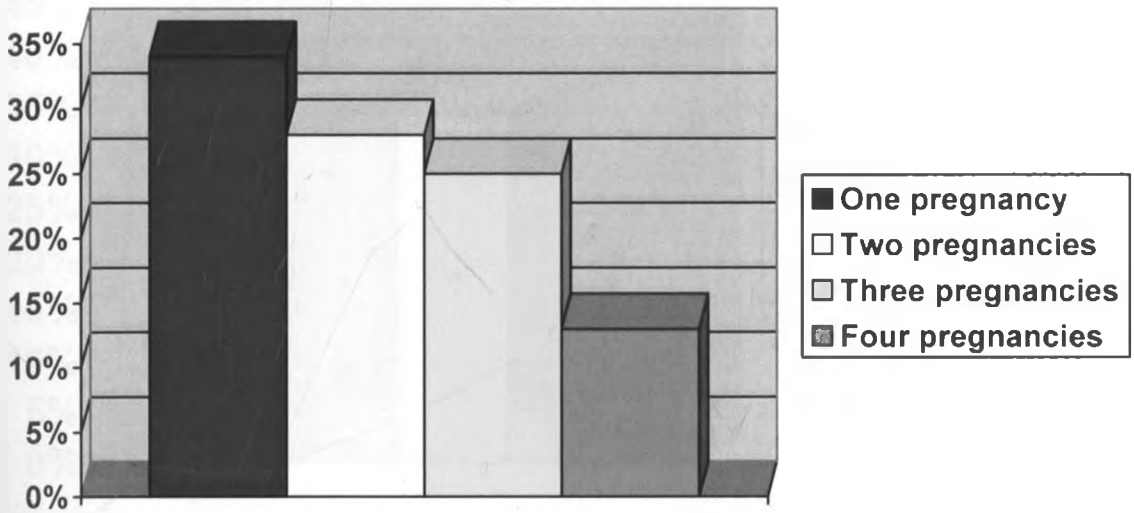


Source: Primary data

About twenty eight percent of the women engaged in this studied earn more than fifty thousand shillings per month. Twelve percent of them earn over eleven thousand shillings while the least earn less than four thousand.

The study establishes a link not only between the level of income and the visit to the ante natal centres, but also with the choice of reproductive technology. For instance, both mothers that used elective c-sections in this study reported their income to be above fifty thousand shillings.

Table 4 Respondents' number of pregnancies

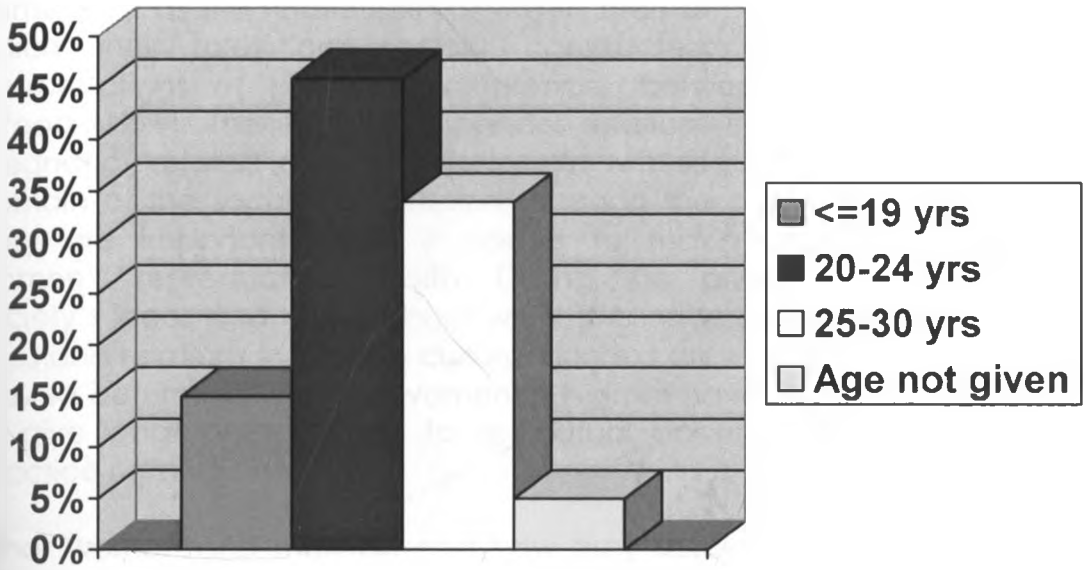


Source: Primary data

The women that reported higher number of pregnancies were more mature than those that reported lower pregnancies, indicating the increased number of years in a marriage relationship. The highest number of pregnancies was also reported in the lowest income and education brackets.

The data in this study reveals that the first pregnancies had more reported complications than subsequent pregnancies. These complications include prolonged labours, acute labour pains, and ruptured uterus.

Table 5 Respondents' age at first pregnancy



Source: Primary data

According to the study, the most common age bracket at first pregnancy is twenty to twenty four years (this seems to agree with the national figure of age at first birth (25-29 years))[38], followed by twenty five to thirty brackets. At these age brackets, women's reproductive organs are mature. Women of lower and higher age brackets face complications related to immature organs (pelvis, womb) and menopausal distresses (hormones, bone problems and infertility).

[38] KDHS, 2003

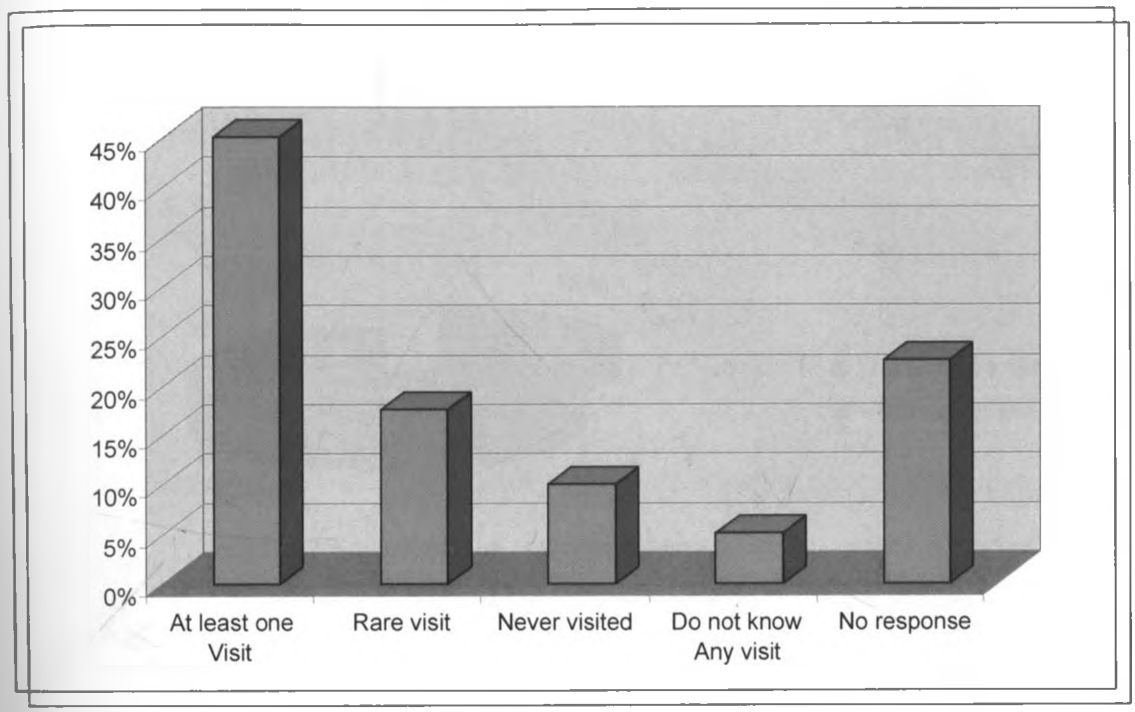
4.1.1 Demographic characteristics

Demographic characteristics refer to age, gender, residence, education and means of earning a living among other variables. Gender is considered as the relationship between men and women in the ways in which their roles are socially constructed and to the cultural interpretations of biological differences between men and women (Wood, 1999). The impact of gender relations in the management of pregnancy related concerns, especially with regard to NRTs is still in the domain of the social constructions through the process of socialization. They are important when it comes to making decisions regarding women's reproductive health. During the process of socialization, society's ideas and ideals about what is considered appropriate gender roles and relations in a given cultural context are defined, this goes along way to determine whether women in Nairobi have the cultural capacity to give what doctors refer to as mutual consent with regard to the practice of medicine.

What women and men do and how they relate socially are important aspects of gender systems and reflect cultural interpretations of female – male differences (Adepoju and Oppong, 1994). Women are socialized to derive their identity through marriage, motherhood, reproduction and other self-actualizing roles whose values are still deeply rooted or ingrained in the culture and which are strongly safeguarded. The traditional authority structure tends to give to the society the management of diseases, denying women agency and rights as individuals.

4.2.0 Accounting for emergency c-sections

Table 6: Pregnant women's number of visits to ante natal facilities

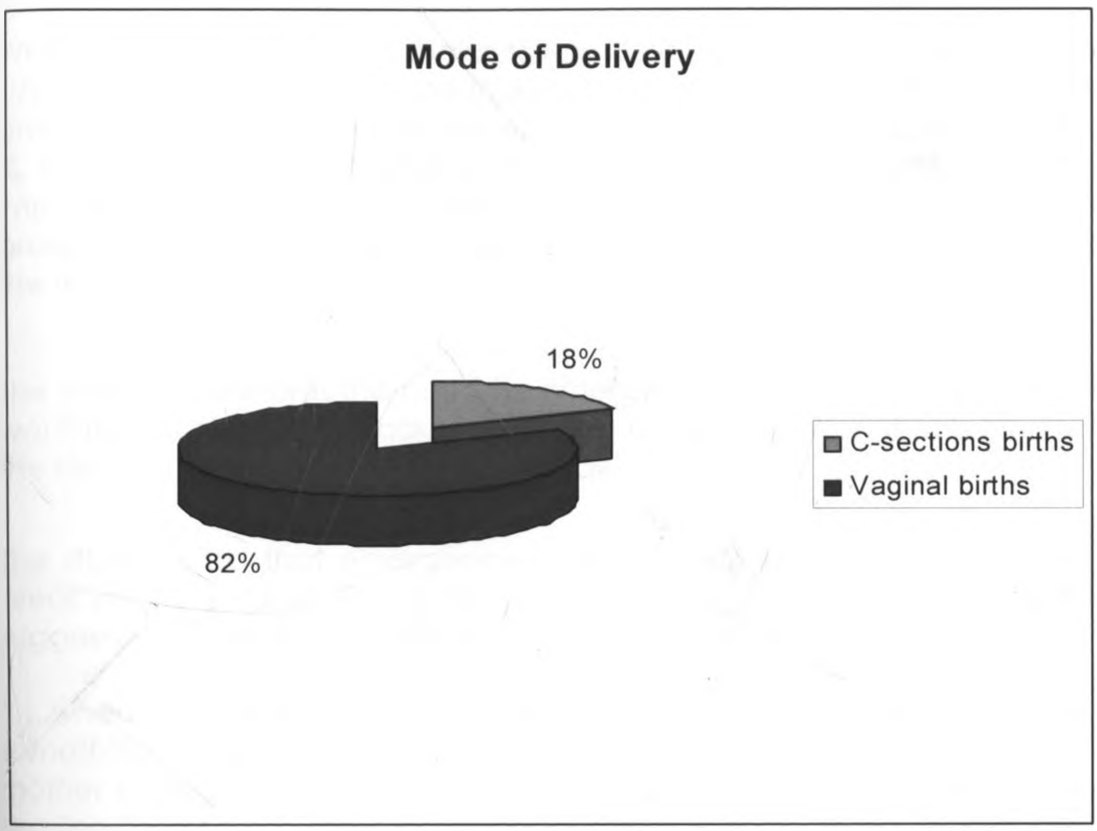


Source: Primary data

The bar graph clearly shows that less than fifty percent of pregnant women in the study regularly consulted a health facility during their pregnancy. This shows that pregnancy is not regarded by many mothers as a serious concern worthy of regular medical attention. This also implies that early indications that doctors can use to prepare mothers for elective c-sections go unnoticed. The result is that when labour sets in, the delivery becomes a c-section emergency.

The study indicates that most emergency c-sections are the result of ignorance on the part of pregnant women who tend to disregard ANCs because their other births have never had complications. Some pregnant women, according to the study simply attend ANC once to book their names in the register, so that they are not treated as new cases when labour sets in.

Table 7: Methods used to deliver the babies.



Source: Primary data

Five of the women that registered the eighteen percent c-section births also reported birth complications arising out of foetal distress, loss or lack of blood and an oversize baby. These complications were however not reported to the doctors in good time, hence creating an emergency situation. Two of the c-sections were elective in nature.

According to the study, emergency c-section is the most prevalent form of c-section. The study reveals that it affects mostly the low income section of the population in Nairobi. The greatest numbers of emergency c-section births are realised at Pumwani Maternity Hospital in the outskirts of Nairobi.

The study indicates that some mothers only get to know of c/s when complications arise and they are asked to sign consent forms. The reasons that help to explain this situation according to the study are poor

education, poverty, unstable public health policy in Nairobi and cost sharing measures put in place by the government.

When compared to other major towns in Africa, the prevalence rates of c/s in Nairobi is quite low, an indicator of a serious reproductive health practices in the country. The acceptable rates according to WHO is 15-20 %. In Nairobi, the study found a c/s prevalent rate of 13 %. This means that important messages in reproductive health do not reach the target group; it is assumed that they continue to suffer serious consequences as the result of this gap.

The study underscores the need for emergency c/s to be available to any woman who needs it; because it is a life saving operation that is critical to the life of both the mother and her baby.

The study noted that emergency c-sections are more prevalent in rural areas and the slums. One nurse who gave an in-depth expert interview suggests some reasons for this trend:

"....when a mother is attending Ante Natal Clinic (ANC), there is something called trial labour, and this looks at the possibilities of the mother having a normal delivery. In the rural areas though, the hospitals are too far that trial labour isn't conducted. As such, when labour sets in, the woman who might have had a complication that was never detected ends up having an emergency c-section. The few hospitals in the rural areas are having poorly trained personnel who don't know when a condition is termed risky.... above all, there is very poor infrastructure hence any case gets delayed for proper attention to be accorded."

The study established that more than half the women in Nairobi do not attend ANC due to poor knowledge on reproductive health issues. Those who attend are likely to have an education, and the most regular attendees are first time mothers or mothers in advanced age groups. This helps to explain why most c-sections end up being emergency related. Women from the lower economic group go for ANC not because they are necessary but because they do not want to be turned back when labour sets in. One pregnant mother, while contributing to this debate in a focussed group discussion suggested that:

"..... a woman will go for ANC in her eighth month of pregnancy, not because she cares about the baby she is carrying but because she wants

to book herself a place in the clinic or hospital so that when labour sets in, she will not be termed as a new case but she will already have a file in the health facility....."

The study also attributes the emergency led c-sections to the medical personnel who do not diagnose the range of problems that pregnant women face. In one in-depth interview, a male nurse had the following to say:

"....some paramedics do not recognize some of these indications. This means that a woman will probably not think of undergoing c-section if her doctor has not proposed the same. If we would compare low c-section cases and high death rates, we would talk of high rates of ignorance but since this is not the case, it means our women are having normal deliveries. Geographically, there are regions where women have narrow pelvises and as such majority undergo c/s but since in Kenya, the cases of c/s are low, this would therefore, mean that our women have good body structures....."

The study also attributes most emergency c-sections to sheer ignorance on the part of pregnant women and mothers. A social worker in a focussed group discussion insisted that women needed to be sensitized on how to take care of their pregnancies. She added that:

"....due to ignorance, some women do not know the importance of Ante-natal care. A woman assumes that since she feels no pregnancy related discomfort, everything is fine. ....this being the case, complications that would have been avoided do arise, prompting an emergency c/s.....in a nutshell, ignorance accounts for almost all emergency c/s in Nairobi..."

The above position may only serve to explain a small percentage of emergency c-sections, since many other situations are known to account for the same (for instance high blood pressure, baby lying in a breech position etc).

The study was able to connect poverty to emergency c-sections. It emerged that women do not have the time to engage in what they call luxury hospital visits. It emerged that for poor women, putting food on the table is far more important than visiting a clinic for reason of being pregnant. One mid wife in an in-depth interview had the following to say:

"....Kenyan women from poor background still have poor communication with doctors or nurses who are supposed to teach them the importance

of ANC...this has led to some women giving birth at home or on their way to the hospital. ...all these are signs of poverty....the woman cannot leave home to meet the nurses or doctors at the expense of looking for food for their families....being a mother of three, I have never enjoyed attending ANC and also during that period I was not prepared for the danger signs in pregnancy or in labour.... I was only told that the baby was o.k., I was not told why they are doing tests on me..... I knew the reasons of taking my history was in case my baby died and in case I ran away after delivery, then they could reach me....."

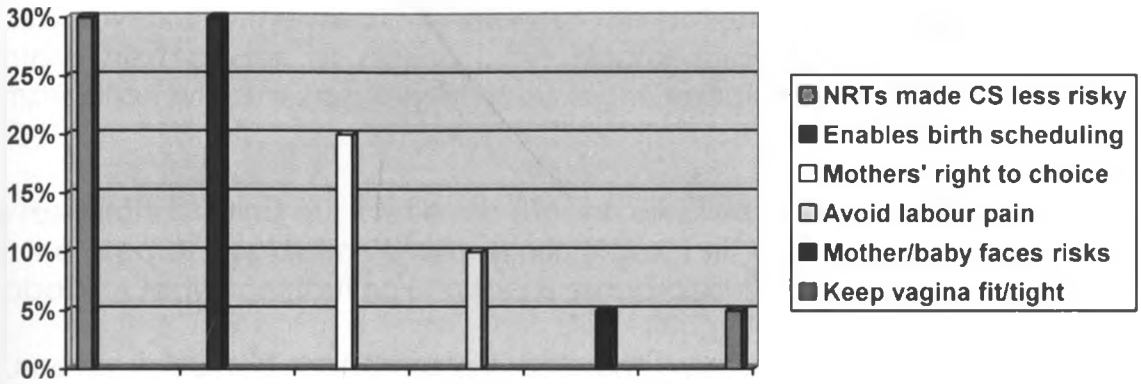
4.3.0 Reasons for elective c-sections

In elective c-sections, there is prior counselling and preparations, a mother makes an informed consent whereas in an emergency c-section, there is no time to prepare, counsel or make an informed consent. She either undergoes a c-section or loses her baby, her life or both.

According to the respondents, the main reasons that women seek elective c-sections are because:

NRTs have made c-sections less risky; Enables the scheduling of birth at personal convenience; Mothers' right to choice; In order to avoid labour pain; In the event that mother/baby faces some risks and finally to keep the vagina fit and tight for the enjoyment of the sexual act.

Table 8: Reasons for Elective C-Sections



Source: Primary data

Some technologies that were considered to make c-sections safe include relaxation and breathing techniques; intravenous anaesthesia (which causes excellent pain relief); less drowsiness with almost no side effects on the baby.

The study examined reasons why there is an upward trend for elective c-sections in Nairobi. It emerged that doctors played a very important role in elective c-sections. Some respondents even suggested that doctors were looking for personal gain, and therefore, attribute the rising cases of elective c-sections to doctor driven and not need driven indications. One doctor respondent however dismisses this assertion and argues that:

'...it is incorrect to say so....a doctor does not just recommend a c-section... he must have reasons to back-up his recommendation....there might be student interns who may recommend a c-section when they just want to complete their rotations and move on to the next case due to exhaustion of follow-ups. ...the only time you might say for sure the c-section was doctor driven is when we are referring patients to private practitioners who are commercially based but proof is still needed that they were after money...."

According to another doctor who contributed in an in-depth interview, there is some truth that the rising rates of elective c-sections are doctor driven to the extent that:

..... a c-section case is chosen from people with bad obstetric history or those with scars...also, we have medical interns who will recommend a c-

section not because it is necessary but because they want a case study for academic reasons ...although some patients think that c-sections are doctor driven, it is the medical history of the patient that determines the doctor's next course of action ...the doctor might have detected a complication which is not very obvious e.g. Cephalo-pelvic-disproportion (CPD)'

The researcher found out that even though elective c-sections are on the rise, the greater population of women in Nairobi still do not know what it is all about. A lady contributing in a focus group discussion had this to say:

"....I never imagined that there are different types of c-sections. Women must be made to appreciate this difference. As for me, elective c/s is important for those who are HIV positive. If that is the case, then we need to teach these women not by abusing them but by showing them love. If given good knowledge, then they will not go with the word of the doctor, but rather for their own needs..."

It appears that some women prefer c-sections so that they do not disrupt sexual encounters with their partners for long. A nurse who participated in one of the focus group discussions gives the following advice:

"...a man should not force his wife to have sex with him immediately after birth, this could cause bacterial infections and slow down her healing process...if the woman gets infected, sexual life will be different and while the couple might blame it on having a vaginal birth, its actually on the part of the couple being irresponsible."

It emerged that some women fear that their husbands could have adulterous liaisons with other women if they take too long to recover before sex. The pressure not to disrupt sexual relationship is real and leads some mothers to prefer elective c-section. One mother had this to say during one of the FGD sessions:

'....some men really pin down their wives on declining sexual performances after giving birth vaginally. They do not realise that a woman has to heal properly before engaging in sexual act. Sometimes the woman is forced to succumb to sexual pressure to ensure that the husband does not stray ...."

The study reveals that vaginal birth will only interfere with sexual performance if the woman does not follow her doctor's advice. But the situation is complicated for women who do not value the doctor' advice

or those who do not attend ANC sessions. A lady participant in one of the FGDs had this to say:

"...a woman will be told to rest for a certain period of time not to do certain things e.g. lifting heavy loads and not walking or carrying her baby before certain times but if she ignores all these, she will end up not recovering fully, so her body apart from lacking the strength it should have regained, her performance in sexual acts will be minimal since her muscles will not have recovered fully....."

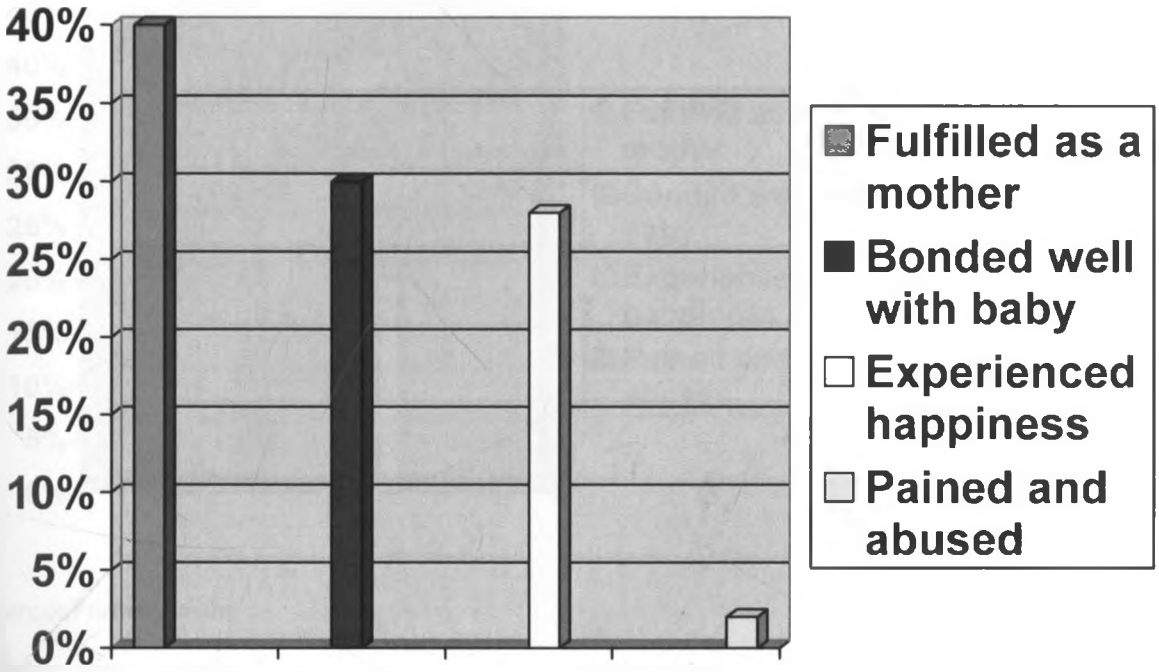
Therefore, we can say that for good sexual performance to be realized, a couple should follow a doctor's advice to the letter.

The study found out that some women prefer elective c-sections to preserve their vaginal muscles and avoid vaginal stress. One respondent in the structured questionnaire who said she was talking out of experience explains further:

'....vaginal birth leaves the woman feeling raw and pained. The vaginal muscles are stressed and strained ....'

When asked how they felt after giving birth vaginally, some mothers reported experiencing a sense of fulfilment, others felt they bonded quite well with their new babies, some experienced a sense of true happiness, while a few of them felt abused and pained in the whole process.

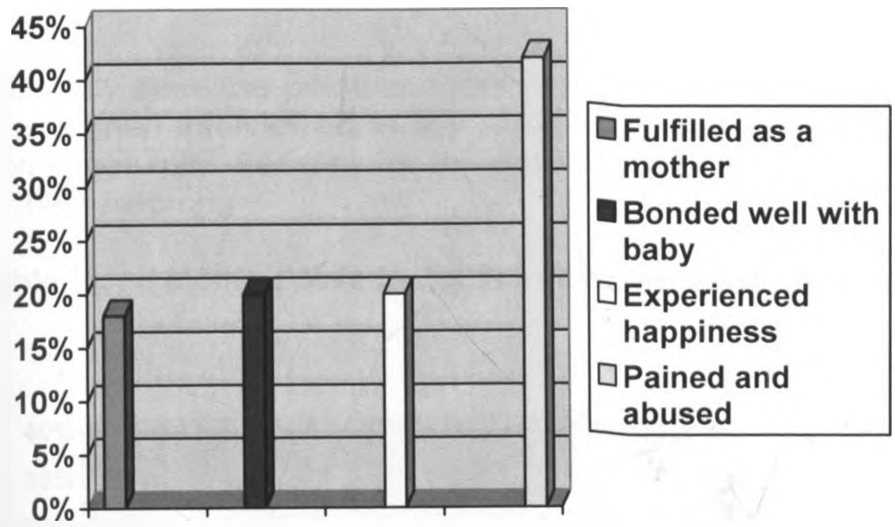
Table 9: Mothers' response to vaginal births



Source: Primary data

Table 9 above indicates that 40% of women interviewed experienced fulfilment as they achieved motherhood. 30% of them reportedly bonded well with their babies, 28% of them experienced true joy and happiness, while only 3% of them felt pained and abused.

Table 10: Mothers' response to c-section births



Source: Primary data

Table 10 above shows that more women found c-section births very distressing. The bonding between mother and baby is also reported higher in vaginal births than c-section births. More mothers experienced joy and happiness after vaginal birth than in c-section births.

The nine mothers in the target population who had the experience of giving birth through both the c-section and vaginally were asked to express the level of love they felt for the children they gave birth to vaginally and through c-sections. One mother had this to say in an FGD session:

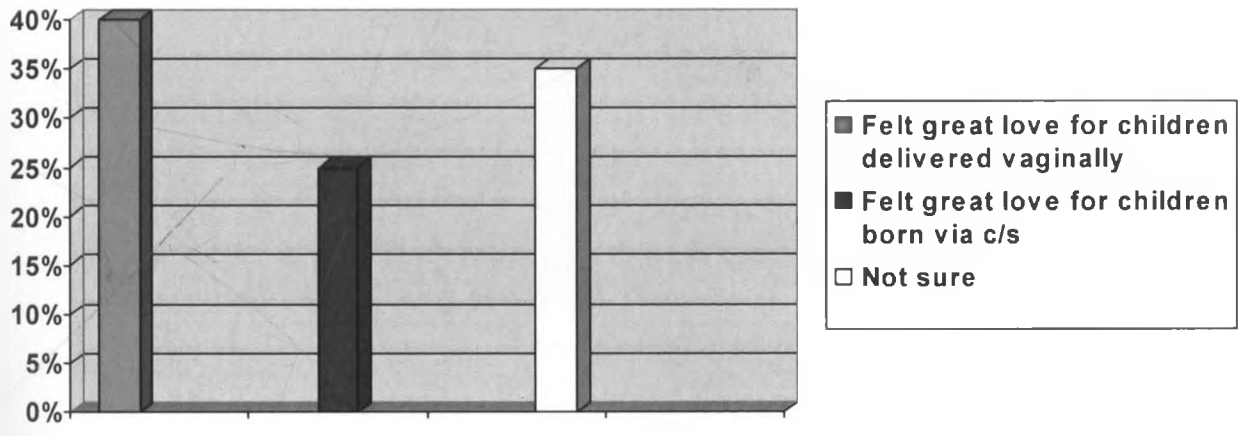
'Huyo mtoto wangu wa pili, wacha yeye kabisa. Huyo mtoto ndiye ange niua. Niliteseka na huyo mtoto mpaka hua sitaki mtu amguzee. Kumpenda, nampenda kipekee. Huyo mtoto nilimzalisha kwa njia wa kawaida. Huyo wa kwanza siku elewa jinsi aliyezaliwa. Nili amka tu nika ambiwa huyu ni mtoto wako. Nampenda pia, lakini sio kama huyu mtoto wangu wa pili '

(Leave alone my second born. That baby could have killed me during birth. The way I laboured for that baby, I do not allow people to mess up

with him. I love him in a very special way. I gave birth to him normally. I really do not know how my first baby was delivered. I just woke up and was told that the baby was mine. I love him too, but not like my second born).

This study therefore points out that mothers love their children differently. The women interviewed in this study expressed more love for children borne naturally. Reasons for this should probably be the foundation for further research.

Table 11: Mothers' love for babies delivered via different methods



Source: Primary data

Table 11 above confirms that many mothers reported great love for children born vaginally than those born through c-sections. The researcher attributed this to the probable cause of the chemical oxytocyn, a love chemical abundantly available in natural birth that serves to unite and bond the mother and the baby.

A nurse in an in-depth interview suggests that there is no reason for pregnant women to use vaginal stress as a reason foe c-section because the body has a way of healing itself. This is how she puts it:

'....physiologically, the body is under hormonal influence..... so even when labour sets in, the body is prepared by muscles getting dilated and normal delivery is realized. With time, after delivery, the body gets reorganised hormonally. Therefore, those who advocate for c-sections thinking they will achieve better sexual performances are misled; nature is in charge of all these physiologic processes..."

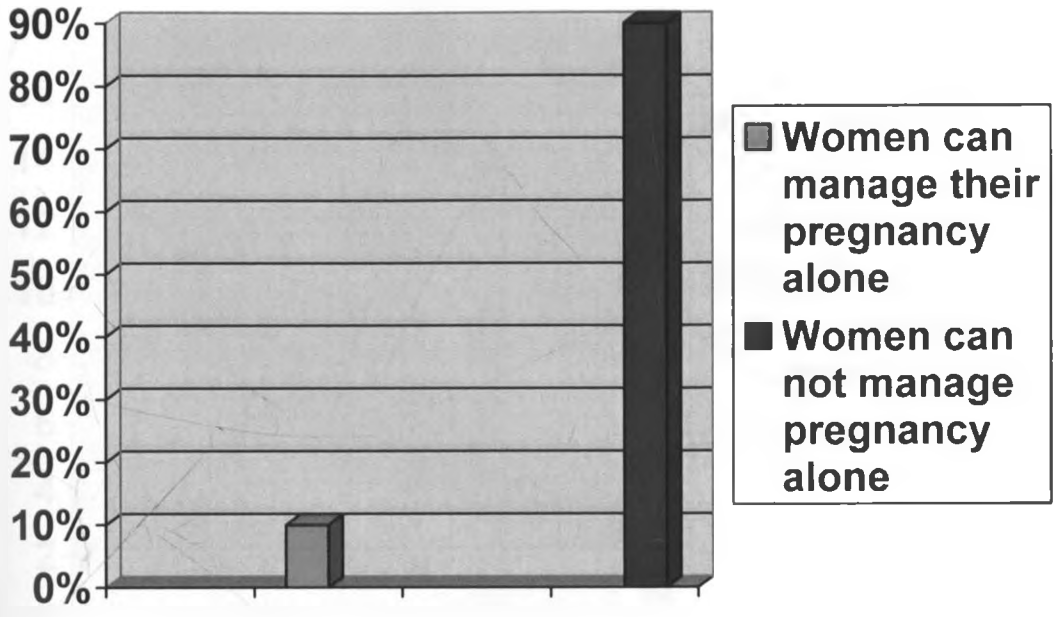
Culture also plays a role in determining the mode of birth a woman undergoes. Religion is also instrumental in shaping the preferences for birth. In the male FGD, one man pointed out that:

"...there are some religions that do not allow their women to do family planning...while in some cultures, women are encouraged to give birth naturally, which is considered the ultimate way of attaining motherhood."

4.4.0 C-SECTIONS AND WOMEN'S RIGHTS

When asked whether pregnant women and mothers should be left alone to manage their pregnancy, four respondents agreed while thirty six respondents refused.

Table 12: Women and management of pregnancies



Source: Primary data

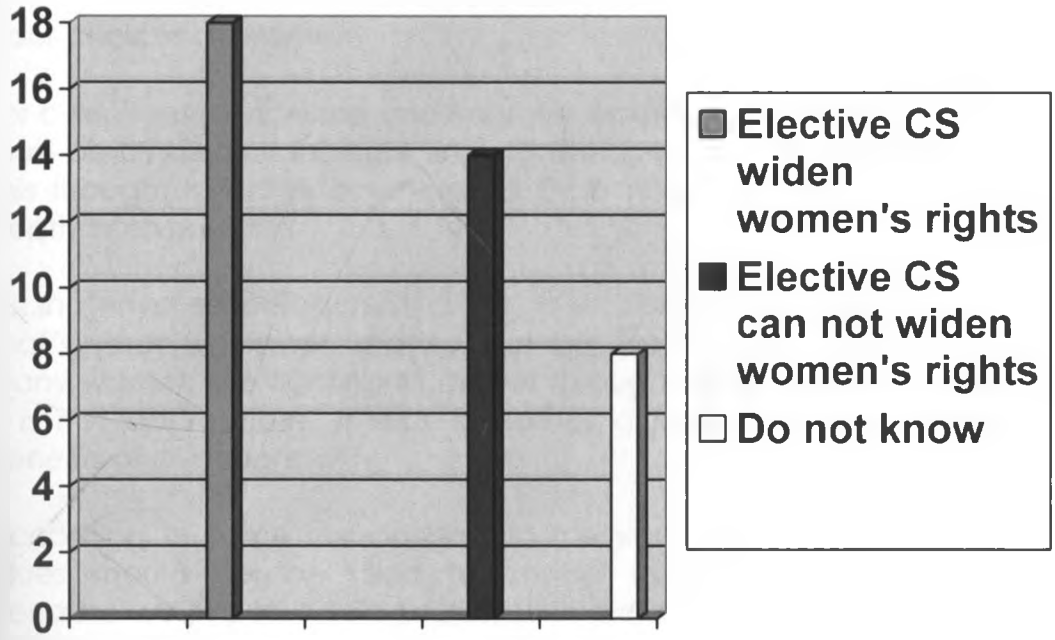
Table 12 above indicates that 90% of the 40 respondents firmly believe that women should not be left alone to manage their own pregnancies. The remaining 10% believe that women should be left alone to manage their pregnancies without the interference from anywhere.

According to the study, elective c-section is the preserve of women of certain status and income within Nairobi. The study reveals that only those respondents with secondary education and above can establish the difference between emergency and elective c-sections.

Opinion is divided among respondents whether both emergency and elective c-sections should be freely available in public hospitals. It emerged, however, that elective c/s is a choice that a woman makes out of other available choices. This individual choice should not burden tax payers in general. When asked whether elective c-sections are justifiable if

they serve to widen the scope of women's reproductive rights, eighteen respondents supported elective c-sections, fourteen rejected elective c-sections, while the remaining eight did not have a clear stand.

Table 13: Elective C-Sections and women's reproductive rights



Source: Primary data

Table 13 shows that the majority of respondents firmly believe that NRTs (c-sections) do indeed widen the scope of women's reproductive rights. Some of them (14) however feel that NRTs(c-sections) can not widen the scope of women's reproductive rights, while eight of them do not have a clear position.

The study underscores the fact that c-sections, especially emergency c-section is a life saving operation that prevents a likely death. To that extent, we can argue that c-sections indeed widen the scope of women's reproductive rights. The main arguments in favour of c-sections increasing women's rights are exemplified when women are given space to express personal preference. When mothers go for c-sections to avoid labour pains, they exercise discretion on choices for personal fulfilment, a personal need is realized and this builds their confidence in taking charge of their reproductive health concerns.

On the other hand, the study also revealed that c-sections as a manifestation of the broader NRTs can restrict women's rights because women in Nairobi have limited knowledge on reproductive health, and the onus is left to doctors to give requisite advice, and some of the doctors take advantage of these women. Most of these mothers to be are not conscious of possible future complications. This increases morbidity among mothers. The lack of adequate information may lead to making of poor choices by women.

For c-sections to increase and improve women's rights, proper information must be availed at the right time, in the right mode and at the right fora. This thought is further enumerated by a nurse who responded in an in-depth interview:

"...in Kenya especially rural areas, c-section is the last resort or solution. That's what we know, that's what our women and mothers know. So many women are fighting to deliver through the vaginal way even when it is not appropriate. It thus becomes difficult for one to accept the benefits of c-sections..."

According to some respondents in the various interviews, human rights issues should not be used to control reproductive health concerns because we live in a fluid society with extreme inequalities. A laboratory technologist in an FGD captures it this way:

"....a person may consider it a right for certain things to be done to them because they belong to an elite group, without considering the consequences associated with their actions. When somebody requests for a c-section for fear of going through the pain associated with natural child-birth, what she terms a right to her body is fear driven because her mind is not free.....a right, to me is when you agree unto something without a compelling thought, or without being coerced by a certain fear from other people's experiences....to me then, NRTs restrict women rights because the information given is biased compared to what is correct..."

A pregnant woman might get a doctor who tells her that it is her right to undergo a c-section, but in the real sense the doctor is after huge monetary gain. C-sections will only benefit the reproductive health of a woman if there are indications that vaginal birth is harmful to the mother or to the foetus. A doctor respondent in an FGD puts it this way:

".....the fact that an elective c-section is planned does not necessarily say one had a right to undergo it...a doctor might approve an elective c-

section because of some minor or not very threatening medical conditions, in such case, the woman can undergo a normal delivery but there is an option of an elective c-section....Some of these medical conditions include cephalo-pelvic disproportion, diabetes or a heart condition..."

Therefore, as much as the woman might prefer one process over the other, she should consider the doctors advice, and indeed if this choice makes her realize that it is a right, then so be it as long as her reproductive and sexual needs are adequately met.

Other people argue that c-sections do not expand women's rights, but indeed deny them their agency in the management of a normal physiologic process. It is however true that c-section may in fact expose these women to other risks and hence restrict the enjoyment of their other rights by increasing morbidity. A clinical officer in an FGD session looked at it this way:

'....c-sections don't expand women's rights.....the reason I say this is because when a woman requests for an elective c/s, she thinks she is making an informed consent but can we rule out the possibility of complications? These complications could be primary or secondary some of which might cause death. With a c-section, the healing process takes longest not considering the possibility of infections...if I was to approach an expert to terminate a pregnancy because the foetus I was carrying was not of my sex of choice, I will consider this as a right on my part.....if somebody was to compel me to proceed with something against my will, they would be violating my rights....when we are talking about c-sections, the question of safety does not come up.....c-section is a risky procedure which is only used as an alternative of the safe natural process...alternatives are used to save lives but not because they constitute rights!...'

This study is however of the opinion that certain medical procedures can be abused, thereby denying women certain reproductive rights, but this claim should not be used to deny the increasing importance of NRTs (c-sections) in widening the scope of women's reproductive rights and health.

4.5.0 DECISION MAKERS IN C-SECTION BIRTHS

The decision for or against c-section is made in a fluid environment. Many factors and considerations are involved, and many players abound in the decision making process. What is difficult to determine is who among the players have the last word? Is it the mother, the father, the doctor, the peer group, the insurance firm, the village elder, the bank manager, the hospital management or the priest?

The study establishes that some elective c-sections are doctor driven and are completely unnecessary. The doctors in this instance prey upon women's ignorance by positioning c-section as the ultimate preserve of excellence, making many women to waver that perhaps some unforeseen condition may spell doom for the unborn baby in case she does not agree with the doctor. These doctors hardly ever refer women for second or third opinion and will most certainly admit them in their private hospitals even when the meeting took place in a public facility. According to one pregnant respondent who participated in an in-depth interview, the only person who should recommend a c-section is the doctor. This is because:

"...s/he has all the relevant skills and can always back up his/her recommendations. Other doctors usually revisit a c-section case to see if indeed it was necessary. Therefore, a spouse will not recommend a c-section just for a doctor to blindly agree without giving consideration to medical indications''.

The position that the doctor should have the last say seemed to wield a lot of authority with most respondents. Another respondent in a focus group discussion had this to say with regard to decision makers:

"...the doctor should be the only person to influence women on whether to give birth vaginally or via c-sections, being an expert in reproductive health, s/he knows what best suits her/his clients / patients, s/he can detect minor problems which might appear negligible to the mother but are paramount health wise..."

In as much as the pregnant woman might feel that she wants to give birth via c-section because her body looks strong, her doctor might discourage her depending on the risks involved e.g. excessive loss of blood. Also, a woman might think she is in good shape to give birth vaginally but the baby's head might be too big or might be in a breech position. Therefore, her doctor will advise her accordingly. But the doctor must remain honest

and ethical if they have to be trusted fully. A respondent follows this thought further:

'...a *doctor should be the only person who influences women on what birth process to undergo...the only fear is on the side of the doctor. Some are not honest and don't observe their ethics. If a doctor is confronted by a naïve expectant mother, s/he will take advantage, the doctor will give her information scantily and instil fear in her regarding one process of birthing over the other...therefore, due to the trust the woman has with her doctor who is an expert in this field, she will give in to her/ his advice...*"

It emerged that women who regularly attend clinics have a close relationship with their doctors. Some kind of trust develops, and the pregnant woman tends to put all her faith in the doctor. Whether this is naiveté is not very clear. One nurse in an in-depth interview had this to say:

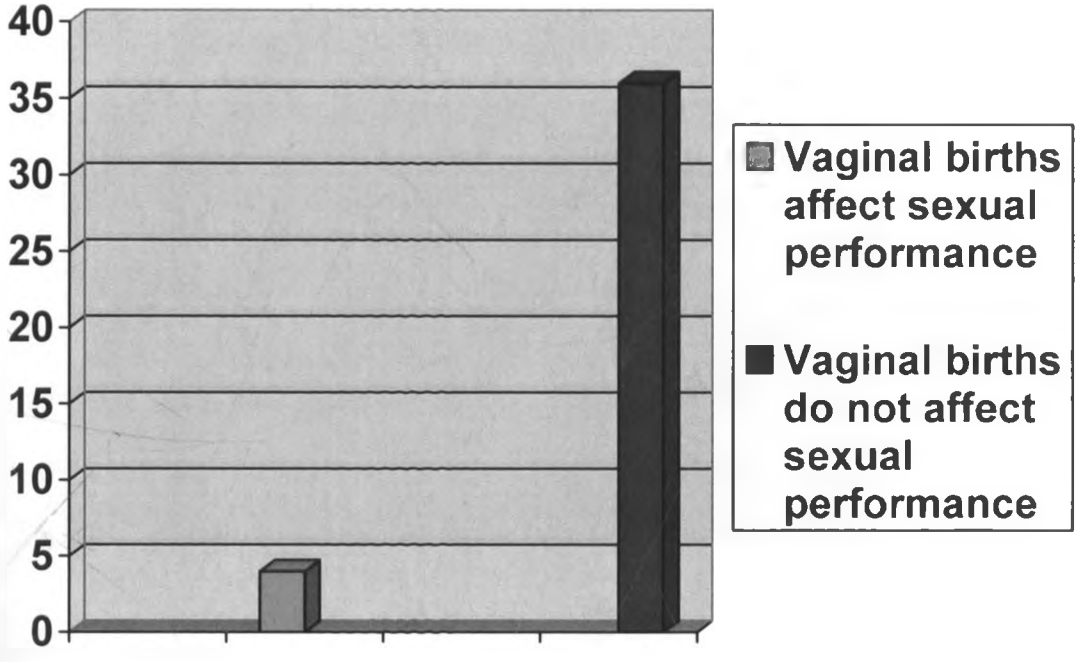
"*.....this is because this is the person who has been attending to her during her ANC and knows of any problems that might be present like a contracted pelvis. Under such a condition, even if the woman did not want to undergo a c-section, she has no alternative. Also, a woman cannot have simultaneous c-section. There must be specific duration between one c-section and the other. This is to avoid having a ruptured uterus which in the end might interfere with the woman's fertility / reproductive life...*"

According to other respondents in the various interviews, the agency of the mother should also be respected, and that the couple should be involved in the decision making. She alone should be allowed to have the final say since this regards her personhood. A social worker in the male focus group discussion gave legitimacy to this perspective. He said:

"*....the decision makers in this process should be the man and his wife. At the end of the day, they bear the cost and repercussions of whatever process they choose.....in doing so, greed and selfishness should be avoided where one person ends up being hurt. The final decision should be in mutual agreement, the doctor should be allowed to give her/ his views from a medical perspective and since health is important, what s/ he says must be taken seriously. But, this is only possible if the expert is not driven by love for money. The individual, who is the subject under discussion, should have a role in deciding what should be done to her body and must always have the last word.....*"

When asked whether vaginal births negatively interferes with sexual performance, ninety five per cent of respondents said no, while only five per cent said yes.

Table 14: Vaginal births and sexual performance

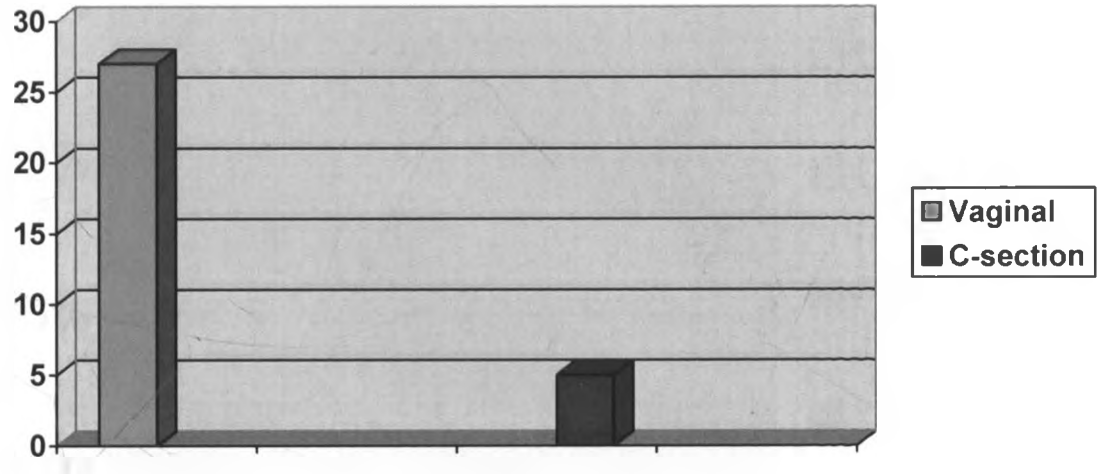


Source: Primary data

Table 14 shows that out of the 40 respondents interviewed, 36 of them were clear that vaginal births do not affect sexual performance. Four respondents were however convinced that vaginal births do interfere with sexual performance.

When asked the mode of birth preferred for their next baby, eighty five per cent said vaginal, while only fifteen per cent preferred c-section.

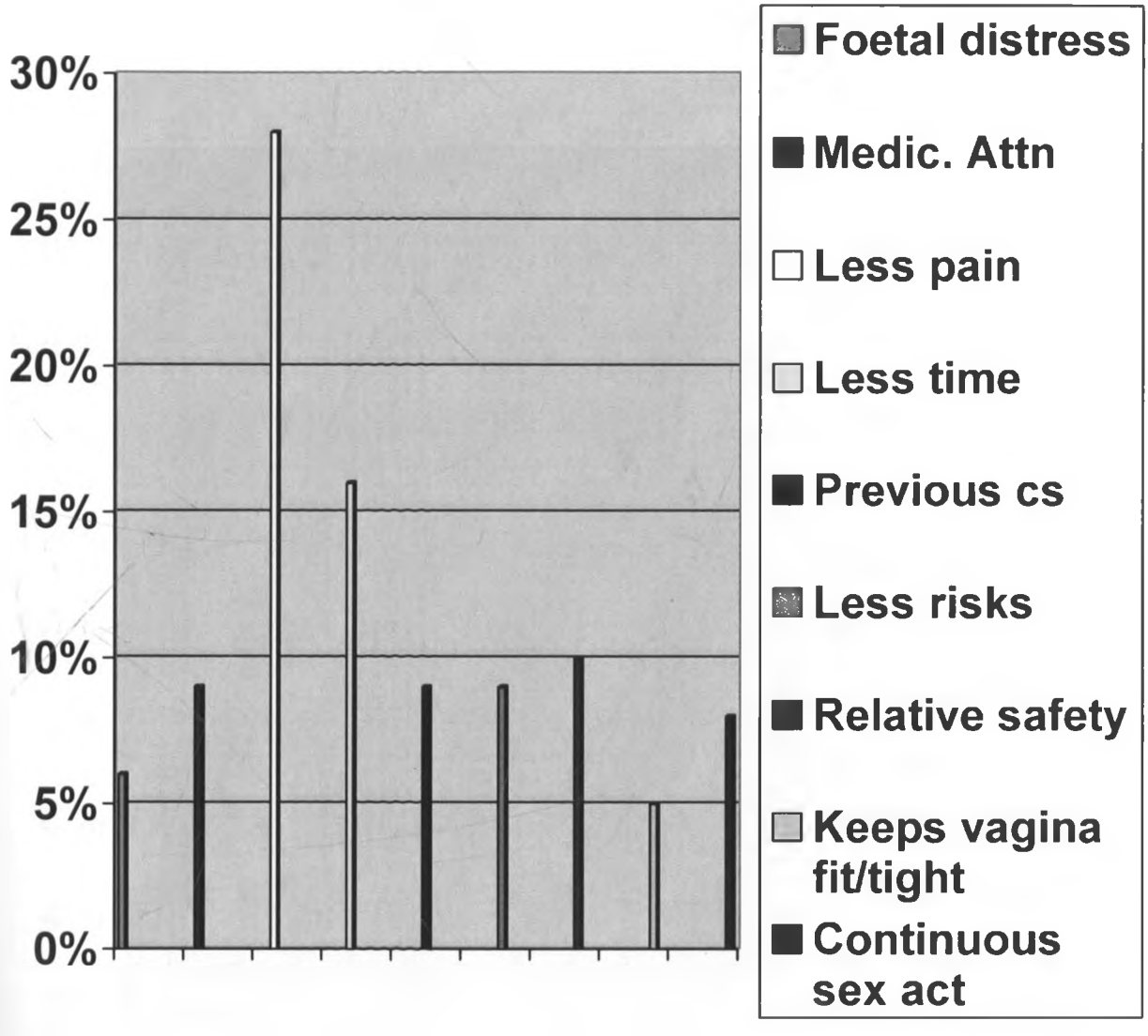
Table 15 Preferred mode of delivery for the next baby



Source: Primary data

Table 15 reveals that 85% of the 32 women interviewed wanted their next pregnancy to be delivered vaginally. Only 15% of them wanted their next pregnancy to be delivered via c-sections. This discovery underscores the feeling that vaginal births remain the most preferred option among the majority of women in Kenya, despite the wonderful gains NRTs have provided in making c-sections safer. It is therefore imperative to give due attention to the few women who show the inclination to give birth via c-sections. At the same time, proper and clear information on NRTs must be devised and disseminated to women to understand the advances made in reproductive techniques.

Table 16: Reasons why some mothers prefer c-sections

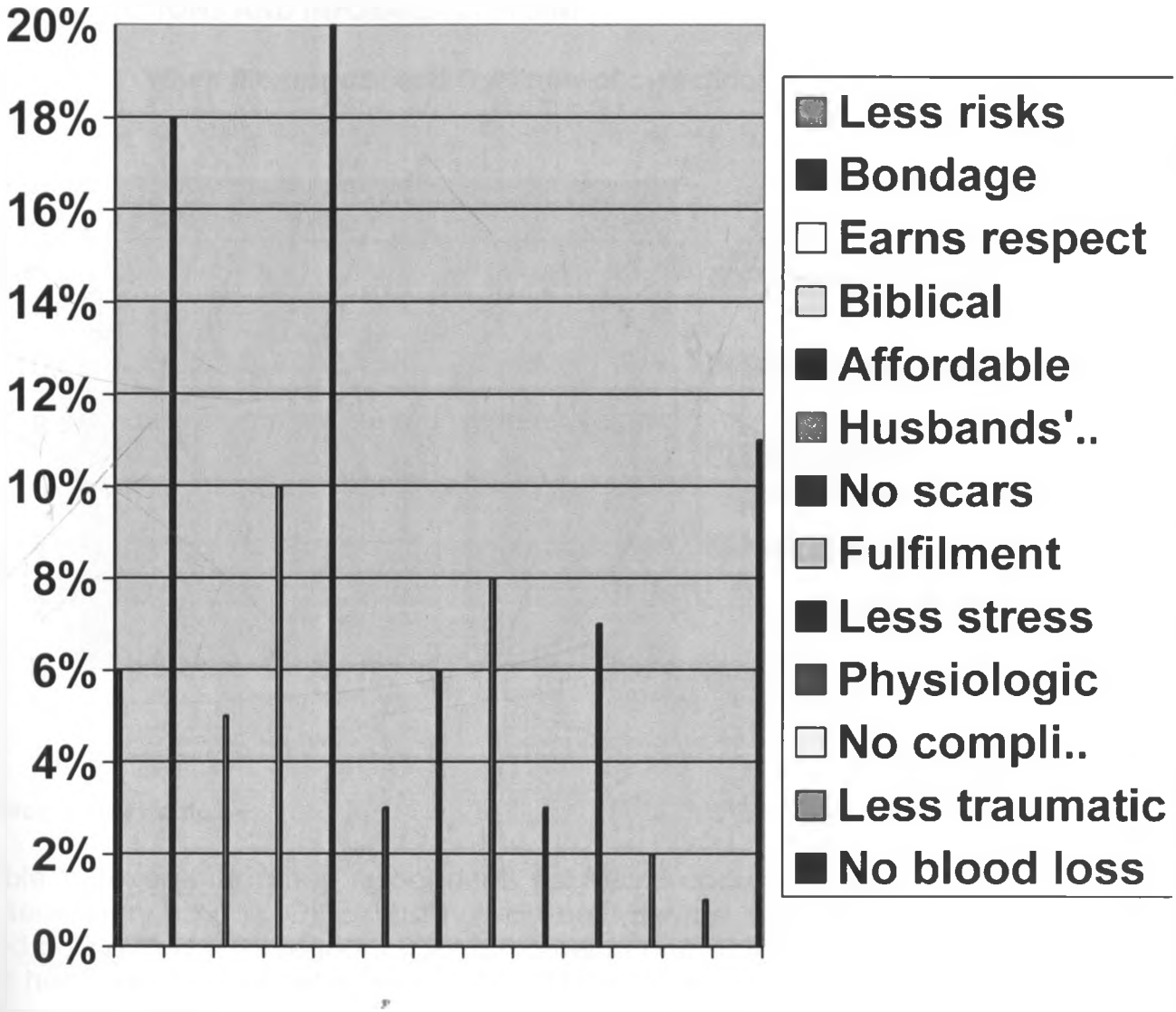


Source: Primary data

According to table 16, the majority of women prefer c-sections because it reduces the pangs of the pain of labour. Secondly, c-sections reduce the amount of time that is spent on labour. Thirdly, it is safe due to improved techniques. Other reasons are that c-sections allow for sex life not to be interrupted for long. It also keeps the vagina fit and tight and does not stress the vagina like vaginal births. Some mothers have been warned by

their doctors to stick to c-sections because their previous births were through c-sections.

Table 17: Reasons why some mothers prefer vaginal deliveries



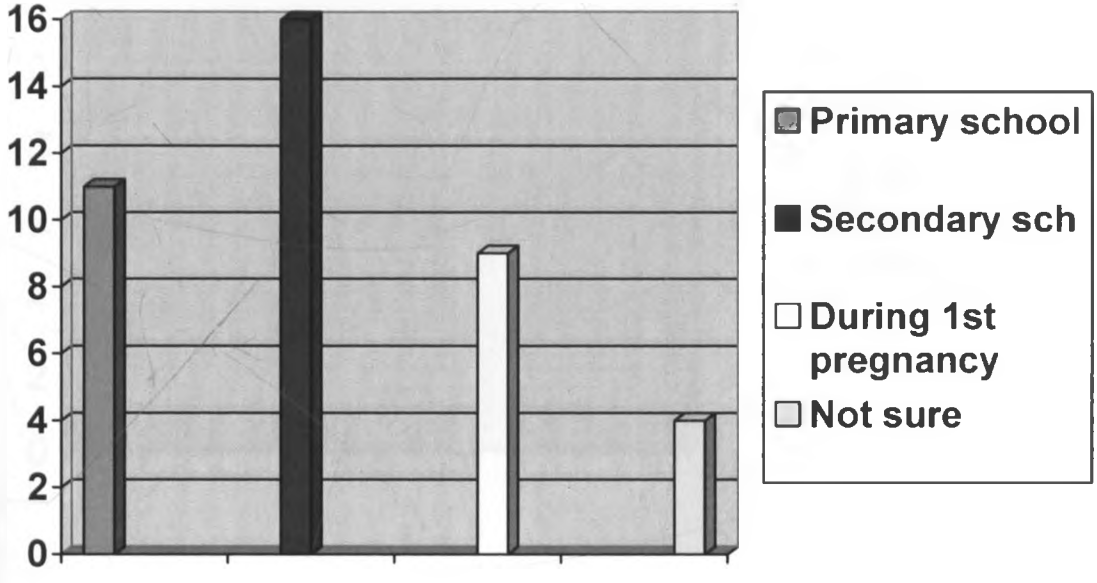
Source: Primary data

The respondents proffered many reasons why they preferred vaginal births. According to table 17, the majority of the 32 women respondents preferred vaginal deliveries because it is cheap and affordable. Secondly, it makes the bonding between mothers and their babies very strong.

Thirdly, vaginal births do not make mothers to loose a lot of blood. One surprising discovery, however, is that vaginal births make some women accomplish the sense of fulfilment as mothers, ensuring that they get the respect they deserve from relatives and friends. Some mothers strictly consider vaginal births since their husbands cannot tolerate any other way.

4.6.0 C-SECTIONS AND INFORMED CONSENT

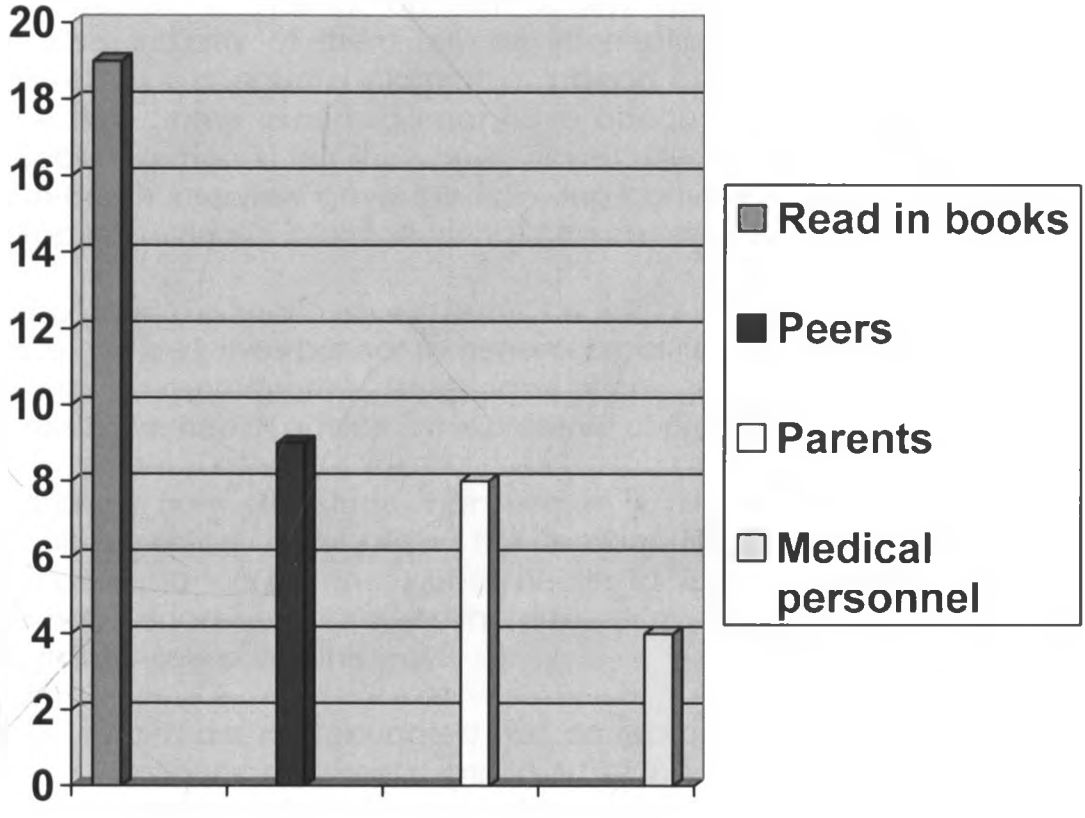
Table 18: When the respondents first knew of c-sections



Source: Primary data

Table 18 reveals that most respondents first heard about c-sections while in secondary schools. Others first heard about it while in primary schools and during their first pregnancy (one mother in one of the FGDs actually first heard of c-section while being rushed to the theatre). The implication here is that important reproductive health information in Kenya does not target women in their younger days, to allow them be able to consume and internalize the consequences. Often times, the mothers are forced to grapple with the reality of NRTs in the very last moments, when their ability to make a decision is highly compromised. This situation is cause of part of the high maternal and infant mortality (especially perinatal deaths).

Table 19: Respondents source of information on c-sections



Source: Primary data

Table 19 shows that majority of respondents learnt about c-sections from books, followed by peers (friends, school mates), then parents, and finally from the medical personnel including doctors, nurses, and patient attendants. A point of concern here is that learning from peers is dangerous because the information may not be factual, and may influence the young minds to develop peculiar ways of coping with reproductive concerns.

The study revealed that many women do not bother to familiarize themselves with reproductive health issues and especially with c-sections until they are faced with it. It emerged that majority of women interviewed only got to know about c-sections in secondary school, and never made any subsequent effort to know more, until they became mothers and faced the options of either vaginal or c-section deliveries.

One of them heard about c-section while in difficult labours and the doctors were demanding consent in order to be taken to the theatre.

Most women in Nairobi do not access quality medical information because majority of them rely on information from friends who they believe have adequate information instead of talking to experts. At the same time, some experts do not have adequate information regarding reproductive health but they pose, nevertheless to give it. One doctor in an in-depth interview gave the following comment on who should offer reproductive health information that can be used to inform consent:

"...*reproductive health issues should be left to obstetrics, gynaecologists, nurses and midwives but not to general practitioners although some have interest in reproductive issues and can give advice.....but strictly, reproductive health advice is the preserve of professionals....*"

It appears from the study that women in Nairobi are not accessing requisite medical information. The reasons for this are poverty, poor education standards, poor public health facilities a lethargic populace and non responsive public health care system. One social worker in an in depth interview puts it this way:

"*..our women are not educated well on reproductive health issues...if a woman had non-problematic previous birthing experiences, she feels she does not need a follow up, any advice given to her is ignored because she wonders why she needs to take precaution now and not in the previous pregnancies...*"

Since most women are ill informed on reproductive health, it becomes very hard to expect them to make informed decisions regarding c-sections. A pregnant woman in one of the FGDs captured this thought in this way:

"*...largely, It is because most mothers are ignorant, they really don't care what happens to their reproductive health.....they're not even aware that healthier living standards are possible among themselves...in clinics, the staffs are too few and the ones who are there are overworked, they thus are too exhausted to offer any advice to the women patients who come to them....the personnel we are having in hospitals are lacking knowledge on reproductive issues so they have no advice to offer...*"

In Nairobi, the idea of informed consent has not really caught up, and it appears that some doctors are taking advantage of the ignorant patients

by not seeking to secure their consent over critical issues that affect their health and life. A doctor interviewed in an in-depth interview said:

'...who really cares about informed consent when a woman with labour complications is brought in unconscious? My duty is to save life and if c-section is the only way, so be it. We do ask questions later...but in developed world, you cannot operate like that....you would be sued immediately...''

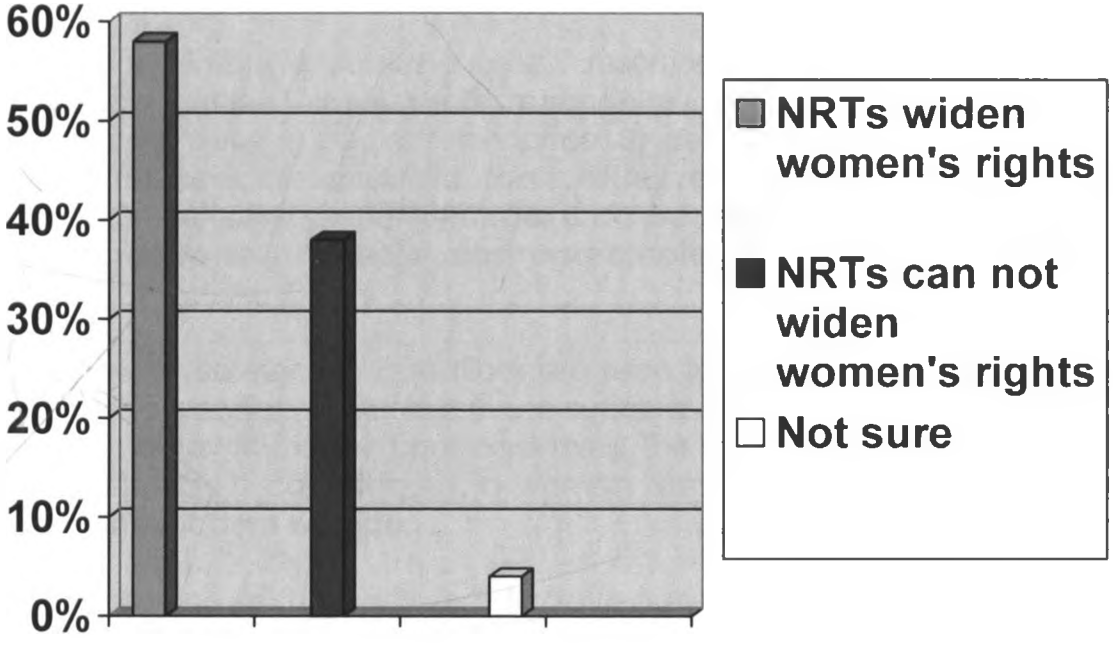
The mothers and mothers to be should be educated on family planning to avoid having simultaneous c-sections, which is emerging to be a big reproductive health concern in Nairobi (KDHS, 2003). The capacity of women should be improved so that they can be held accountable for their own health practices and choices. This is how a social worker in one FGD proposes to do advocacy work and raise awareness and improve the capacity of women to be able to give consent:

"... We should come out of our offices, go for the women in the field, follow them in their houses, and learn from them why they prefer one way of giving birth over the other. We should start by supporting their concerns, encourage them to ask questions... tell them what you feel, allow them to ask questions....do not change their culture...start from far, e.g., if you can get them planting, help them by becoming friends before delivering your message...in my opinion, women in Kenya have a long way to go before they are able to adequately give consent to reproductive issues...."

4.7.0 NRTs AND WOMEN'S REPRODUCTIVE HEALTH

The place of NRTs in promoting women's reproductive health is still unclear in Nairobi. Culture, religion, class, education, race, age and sex still pose challenges that are yet to be conquered. The debate on whether NRTs are beneficial to women's reproductive health or not is the concern of this section.

Table 20: The role of NRTs in women's reproductive health



Source: Primary data

Table 20 above reveals that more than half the respondents (58 %) believe that NRTs do expand women's reproductive rights, 38 % of them however feel that NRTs do restrict women's reproductive rights, while the remaining 4 % are not sure. When asked why they thought NRTs expanded their reproductive rights, part of the 58% were quick to point out that gone are the days when labour pain caused misery, and they are able to schedule birth at their convenience or that of their doctors, and that they fit well in the company of their friends and acquaintances.

The important concern here is not the place of NRTs and their contribution in women's reproductive health per see, but the use to which these NRTs are put into. One nurse in an FGD session looks at it this way:

'.....in my opinion, c-section is very safe, the baby is removed intact so there is no stress to the mother and the baby.....relative safety can be improved by applying infection control method i.e. use sterile equipments and improve reproductive health education..."

One woman respondent, like Gupta, in an FGD session argues that NRTs actually deny women the control over their own pregnancy, making every pregnancy look suspect and forcing women to increasingly rely on foreign interventions over issues that have natural conclusions. This is how she puts it:

"...NRTs don't improve women's rights....resorting to NRTs while the natural method can work is a misuse of technology....whenever technology is abused, users have to pay a heavy price. By denying women the agency to make reproductive decisions, these NRTs create dependency among women. On the other hand, what gains do we realize when one chooses a technique to fit in a social class and creates room for complications later...?"

Women who use elective c-sections are seen to belong to another class. People who cannot afford elective c-sections accuse their counterparts of running away from their traditional roles. The scenario is presented as a class clash. This is captured by a woman respondent disgusted by the pride of the modern woman:

"...if the women of the past went through natural process of giving birth, who does the modern woman think she is not to do the same...tell me what has changed...who then is fooling who?...."

The classic mistrust of new technology also comes into play. This is what Russell refers to as cognitive dissonance. Some respondents go as far as equating the use of NRTs to gambling with human life. One mother in an FGD session pauses this question:

"....NRTs are not safe, any artificial process has some loop holes. These NRTs cause too much trauma to the body. Who gains at the end of a c-section? Is it the woman whose body has been traumatized or the man who thinks by doing so will continue enjoying sex.....reproductive health is too important to be gambled with...."

In reaction to the assertion that NRTs are dangerous, a laboratory assistant gives it a different look. He says:

'...pathologizing normal physiological processes is ok, we need to be updated with modern lifestyles, we cannot always rely on traditional midwives to deliver....If it were possible to deliver a baby using a computer, the better, it would mean less time is used in the whole procedure and we would be assured of sterility almost 100%, therefore, we need to acknowledge technology to avoid high rates of infections..."

Some respondents however are of the opinion that NRTs partially improve women's reproductive rights and partially restrict them. For them, gender and equity concerns are the overarching factors. A male nurse said the following in a key informant session:

"....gender equality has made women want to voice out any issues they have, a woman will feel that its her right not to undergo pain in vaginal delivery, she may end up giving a consent not because she is properly informed on issues of reproductive health but because she wants to have the final say on whatever her body should be put through. Therefore, she is more comfortable having given a consent other than being educated on the dangers of what she has chosen to undergo...that's why I say, it partially improves and partially restricts their rights'

The study registered concern on whether pregnant women should be treated as sick patients during pregnancy or to just regard them as healthy persons until certain indications demand medical attention and therefore, only attend hospital visits as directed by their doctors. NRTs however, want to determine exactly what is happening to the mother and her baby at every developmental stage to enable doctors to be more pro-active in the management of incidental concerns.

For others still, NRTs generally improve women's reproductive rights. This is in terms of convenience, time, and also to avoid protracted labour pains. A nurse in one FGD gives the following perspective:

"....a woman will want to give birth at a particular time and place so that she can schedule birth at her convenience...though human is to error, c-section is more safe.. ..but this depends.....a child is safest when delivered through c-section... this avoids cases of cerebral palsy which occur when the brain of children born through vaginal birth is interfered with...also, if the child is being born to an HIV positive mother, she is born free of the virus...but the health of the mother could be compromised due to heavy blood loss and wounds inflicted on her body may not heal easily....."

The study revealed that the practice and experimentation with NRTs pose specific challenges. It emerged that Kenyan technology is not advanced to handle ideally all cases of c-sections. That mothers' health might be compromised in c-sections where the mother is HIV positive, this limits the procedure for fear of stressing her immunity further. That sterility is a major concern in the case of an emergency c-section; all preparations are done in a hurry, that theatre personnel don't have adequate time to prepare. Some equipment might have needed time to autoclave; surfaces might need enough time to cleanse but in an emergency case the aim is to save life. So sterility is not a paramount priority. This in the end causes infections and takes long to heal. That Kenya has very few surgeons, hence such cases will arise and our surgeons will not be available always to handle them and we end up losing lives in emergency cases. That technology is still developing and being a third world country, we are lagging behind. That whatever we use in terms of technology, its not up-to-date compared to the developed countries.

In conclusion, the gains that available technology has afforded Kenyans must be secured by all means possible. The environment must continuously be made safe so that hygienic standards are not compromised. The use to which NRTs are put must be ethically sound, and every effort must be made to ensure that all women who are desirous of new technology can access it, especially if they can afford it. Public hospitals should also adopt strategies of meeting emergency needs of poor women, so that women do not die for lack of funds in an emergency situation.

4.8.0 THE FUTURE OF C-SECTIONS IN KENYA

The rates of c-sections are set to increase for the following reasons:

- There are many young and underage mothers coming up.
- The elitist modern women and their specific reproductive health concerns that help them to fit in certain social status.
- Genetically inherited conditions (cephalo-pelvic disproportion-CPD) manifested more in present and future generations.
- With improvement on NRTs many more people are getting comfortable with c-sections
- Public sensitization is set to improve knowledge so that women can make choices out of quality education.
- As access to reproductive facilities increase, especially in the rural areas, many more women who used to suffer poor reproductive health in silence will come forward.

CHAPTER 5

5.0.0 CONCLUSION AND RECOMMENDATIONS

5.1.0 Conclusion

The purpose of this study was to obtain reproductive health data on the practice of caesarean section births among the communities living in Nairobi. The factors and indications that lead to the increasing emergency c/s and elective c/se were probed. The objectives were to investigate, document and explain the role of NRTs in the management of pregnancy related complications and indications among other issues. Reproductive health inferences were made from this study for use in interpreting and explaining the fluid environment in which pregnant women, doctors, husbands, religious leaders and other players find themselves while faced with the critical decisions that affect the reproductive choices available for women in general and pregnant women in particular.

With the above in mind, structured questionnaires were administered, key informants were interviewed, and FGDs were conducted in order to collect requisite information. The Cognitive Dissonance theory provided the theoretical framework that guided the gathering and analysis of data. On the basis of the findings on chapter four, this study makes the following conclusions:

1. That the number of emergency c-sections in Nairobi is low. This is an indication that few women have access to this life saving abdominal operation, and that the majority of women suffer poor reproductive health in silence.
2. That the number of elective c-sections is equally low but steadily increasing. The increase may be interpreted to mean that women are eager to take advantage of available technology to lessen pains related to labour and to assert their agency as women more profitably.
3. That reproductive health decisions are complex and made in a fluid and unstable environment involving many players who are themselves products of biased socialization, with limited technological options and working within a framework of strained resource base.
4. That the vast majority of women in Nairobi are ill prepared to give reproductive health consent, because consent stems from an

empowered individual who understands her immediate environment and the range of options available to her.

5. That NRTs can be used to improve women's health and rights when put in good practice. But in Nairobi proper access to basic health infrastructure is still a challenge, thereby denying doctors the time and resources to invest in further research for new technology.

5.2.0 Recommendations

This study has applied its key findings to develop possible set of recommendations which can be adopted by scholars especially medical anthropologists, policy formulators, researchers, medical personnel, social workers and other groups to improve their understanding on the impact of NRTs on women's reproductive health:-

1. That an advocacy strategy be devised to create awareness especially among low income earners in Nairobi, highlighting the options of available NRTs, and to emphasize the importance Anti Natal Clinics (ANC) as a forum for educating expectant women. This will help expectant mothers to make informed decisions when faced with reproductive health concerns.
2. That the government to be lobbied to make ANCs free in public hospitals so that proper diagnosis is done on any suspect pregnancy. This will reduce the number of women seeking emergency related c-sections.
3. That local dispensaries and health centres in Kenya be improved to offer c-section births, especially emergency related c-sections in order to accommodate the large number of women seeking help at the nearest dispensaries. At the moment, only 9% of the total health facilities in the country are able to provide comprehensive essential obstetric care during emergencies (KDHS, 2003). This will help in reducing maternal mortalities that relate to child birth.
4. That NRTs for use in public hospitals be designed to address the basic reproductive health needs of women, and once basic obstetric needs are met among the majority of women, the more advanced NRTs may follow in order to reduce cognitive dissonance among pregnant women in Kenya. At the moment, only 15% of health facilities are able to provide basic obstetric care (The Kenya Women's Manifesto, 2006)[39]

[39] The Kenya Women's Manifesto: Published by Friedrich Ebert Stiftung, 2006.

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6.2.0 Appendix 1

RESEARCH QUESTIONNAIRE (for female subjects)
DEMOGRAPHIC CHARACTERISTICS FORM

No: .....
Name: .....
Estate: .....
House No.: .....
1 Age: ..... yrs
2. Gestational age.....Months
.....Weeks.....
3. Height ..... (In cms) and weight of
mother.....
5. How far is your home from this Hospital? .....kms .....
minutes walk.....minutes drive.....
6. Religion (tick one)
   a. Christian
   b. Muslim
   c. Hindu
   d. Other (please specify).....
7. Do religious doctrines contribute to the type of birth process one undergoes? Yes.....No.....
8. Marital status (tick one)
   a. Married
   b. Divorced
   c. Separated temporarily
   d. Single
   e. Widowed (f) Other.....
9. If married, are you living with your husband? Yes..... No .....
10. Did your husband attend school? Yes ..... No.....
11. If yes, up to what level?
   a. Primary ..... Standard.....
   b. Secondary ..... Form .....
   c. College .....(d) Other.....
12. What is your husband's occupation? .....
13. Have you ever attended school? Yes ..... No .....
14. Can you read and write? Yes ..... No .....
   1. I can read only .....
   2. I can write only .....
15. What is your level of education?
   i. Primary ..... class .....
   ii. Secondary ..... form .....

iii. College .....
iv. Other .....(specify).....

16. What is your occupation? .....
17 What is your total income per month?
1,000 –3,000 ..... 21,000 –50,000 .....
4,000 –10,000 ..... 50,000 -and above .....
11,000 –20,000 .....
18. What is your main source of income?
i. Self .....
ii. Sons .....
iii. Parents in law .....
iv. Husband.....
v. Daughter .....
vi. Others (specify), church donations .....
Relief agencies .....
Neighbours .....
Relatives .....
Community members .....

The main objective for the above questionnaire was to generate demographic data on the characteristics of the respondents. It achieved the desired objectives by clarifying why certain people made certain reproductive decisions.

6.3.0 APPENDIX 2

REPRODUCTIVE HISTORY FORM

1. State the number of pregnancies you have had before.
.....
2. What was your age at first pregnancy?
.....
3. How many children do you have? .....
4. Sate number of births you had that are alive.
.....
5. What was the mode of birth of the children that are living? (Vaginal or c-section)

i. .....
ii. .....
iii. .....
iv. .....
v. .....
vi. .....
vii. .....
viii. .....
ix. .....

6. State number of births you have had that are dead.
.....
7. What was the mode of birth of the children that died? (Vaginal or c-section)

i. ..... age at time of death .....
ii. ..... age at time of death .....
iii. ..... age at time of death .....
iv. ..... age at time of death .....
v. ..... age at time of death .....
vi. ..... age at time of death .....
vii. ..... age at time of death .....
viii. ..... age at time of death .....

8. In your past pregnancies, have there been complications? Yes .....No.....
9. If yes to above, what was the nature of the complication?.....
10. How many complications have you had? .....
11. Do you have children with some form of disability? Yes .....No .....
12. If yes, what was the cause of the disability? .....

13. Do you think women should be left alone to manage pregnancy? Yes .....No.....sometimes .....
14. During this pregnancy, how many times have you visited the doctor?.....
15. At what age did you first hear of c-section? (Tick one)
    a. During my child hood.....
    b. In my teenage .....
    c. In high school .....
    d. During my first pregnancy
16. From whom did you first hear about c-section?
    a. My parents .....
    b. My peers .....
    c. My doctors .....
    d. Read in books .....
    e. Other..... (Specify) .....
17. Do you know any one who has ever had a c-section?
Yes.....No.....
18. If yes above, was it elective or emergency?
Elective.....Emergency.....
19. In your opinion, should elective and emergency c-sections be treated differently? Yes.....No.....Don't know.....
20. In your opinion is elective c-section justifiable? Yes. .....No.....
21. If yes above, which are the reasons? (Tick all options you agree with)
    a. right to choice.....
    b. exercise of personal freedom.....
    c. to keep vagina tight and fit.....
    d. has the money to pay for it.....
    e. to avoid labour pain.....
    f. to schedule birth at personal convenience.....
    g. to schedule birth at the doctor's convenience .....
    h. to fit into my social class in society.....
    i. new reproductive techniques have made it safer.....
    j. other (please specify).....
22. In your opinion, do NRTs expand women's reproductive rights or restrict them?
    a. NRTs expand reproductive rights.....
    b. NRTs restrict reproductive rights.....
23. Give reasons for your stand above.....

.....
24. Have you ever had a c-section? Yes.....No.....
25. If yes to above, who or what convinced you to go for it?
    a. my doctor.....

b. my husband.....
c. my insurance.....
d. my medical complication.....
e. my first birth was through c-section.....
f. my friends.....
g. my parents.....
h. my employer.....
i. other (please specify).....

26. After your vaginal birth how do you feel as a mother?
    a. fulfilled as a mother.....
    b. pained and abused.....
    c. confused and deceived.....
    d. happy.....
    e. bonded well with my baby.....
    f. other (specify).....
27. After your c-section delivery, how do you feel as a mother?
    a. fulfilled as a mother.....
    b. pained and abused.....
    c. confused and deceived.....
    d. happy.....
    e. bonded well with my baby.....
    f. other (specify).....
28. Does vaginal birth interfere with sexual life / performance?
    Yes.....No.....

29. What mode of delivery would you prefer for your next baby?
    a. c-section.....
    b. vaginal.....
30. Give two reasons for your choice above
    1. .....
    2. .....

b. my husband.....
c. my insurance.....
d. my medical complication.....
e. my first birth was through c-section.....
f. my friends.....
g. my parents.....
h. my employer.....
i. other (please specify).....

26. After your vaginal birth how do you feel as a mother?
    a. fulfilled as a mother.....
    b. pained and abused.....
    c. confused and deceived.....
    d. happy.....
    e. bonded well with my baby.....
    f. other (specify).....
27. After your c-section delivery, how do you feel as a mother?
    a. fulfilled as a mother.....
    b. pained and abused.....
    c. confused and deceived.....
    d. happy.....
    e. bonded well with my baby.....
    f. other (specify).....
28. Does vaginal birth interfere with sexual life / performance?
    Yes.....No.....

29. What mode of delivery would you prefer for your next baby?
    a. c-section.....
    b. vaginal.....
30. Give two reasons for your choice above
    1. .....
    2. .....

6.4.0 APPENDIX 3

INDEPTH INTERVIEW

1. In your opinion, do you believe that the New Reproductive Techniques (NRTs) expand women's rights or restrict them? Please elaborate

2. What are the challenges posed by NRTs in Kenya?

3. What is your opinion on the prevalence rates of c-sections in Kenya; does this mean that Kenyan women are enjoying greater reproductive health and rights?

4. In your opinion, are c-sections mostly emergency based or elective based? Is this good health practice?

5. What in your opinion accounts for the elective c-sections?

6. In your opinion, which person is best placed to advise women on whether to go for c-sections or not?

7. Do you think Kenyan women are accessing requisite medical information on reproductive health which can lead her to make strategic reproductive decisions? How can the situation be improved?

8. How safe is c-section in your opinion as compared to vaginal delivery? Is there room to improve on relative safety?

9. Do you think that elective c-section should be treated in the same way as emergency c-sections by planners in reproductive health sector?

10. To what extent should NRTs be used in the management of reproductive concerns in Kenya?
11. What in your opinion is the future of c-sections in Kenya?

NB: All the above questions will be fully probed to allow greatest exchange.

6.5.0 APPENDIX 4

FGDs DISCUSSION GUIDE

1. Does vaginal birth interfere with sexual life / performance?

2. What role do cultures/religion play in influencing men and women with regard to vaginal or C- section births.

3. Do you think that New Reproductive Techniques (NRTs) generally improve women's reproductive rights or do they restrict these rights? How safe are NRTs?

4. In your opinion, who should influence women on whether to give birth vaginally or through c-section?

5. Do you think that elective C-sections should be treated the same way as emergency C-section?

6. Which mode of birth would you prefer for your next child?

6.5.0 APPENDIX 4

FGDs DISCUSSION GUIDE

1. Does vaginal birth interfere with sexual life / performance?

2. What role do cultures/religion play in influencing men and women with regard to vaginal or C- section births.

3. Do you think that New Reproductive Techniques (NRTs) generally improve women's reproductive rights or do they restrict these rights? How safe are NRTs?

4. In your opinion, who should influence women on whether to give birth vaginally or through c-section?

5. Do you think that elective C-sections should be treated the same way as emergency C-section?

6. Which mode of birth would you prefer for your next child?