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Literature Review

Gender Differentiated Attitude Towards Cesarean Section: A Case of Somali Refugees in Dadaab, Kenya

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Abstract

Caesarean section (CS) is the most commonly performed obstetrical surgery for life-saving and prevention of delivery complications. The World Health Organization (WHO) recommends a Caesarean section rate of between 10 and 15% as an acceptable level. However, studies have suggested that African women have an aversion for CS preferring vaginal delivery to caesarean section even when there is need to address basic obstetric complications; they perceive CS as being dangerous to the mother and baby. The inadequate use of CS in African countries has been identified as a key factor in the continuing high rates of maternal and perinatal morbidity in the region. In light of non-acceptance of CS among women in many developing countries, this study sought to explore gendered differentiated attitude towards CS among Somali Refugees who seek the services of Traditional birth attendants (TBA) in Dadaab. A qualitative case research design was employed with Ten Traditional Birth Attendants (TBAs), 3 pregnant women, 2 men and 2 refugee safe mothers who were Purposively selected from IFO refugee camp in Dadaab, Kenya. Additional responses were sought from 10 Nurses and 15 mothers in Red Cross hospital in IFO camp. Data was collected through in-depth interviews and personal observations. The study found that both men and women were reserved about CS expressing fear of death. Women also avoided CS due to fear of facing rejection from their husbands, psychological and emotional trauma of being stigmatized by the community; men felt that their conjugal rights were restricted if their women went through CS. They also indicated that TBAS are fellow women who help mothers to deliver at home, while in hospitals CS is done by men which is against the Somali culture. These findings indicate that there are many perceptions about CS among refugee community and thus need for programs to increase community understanding of CS as a method of delivery. The findings may also be a valuable process indicator for identifying the gaps in obstetric care that can be used for advocating improvements for healthcare.

Keywords: Traditional Birth Attendants; Caesarean Section; Attitude

Background

Cesarean section (CS) is the most commonly performed surgery in obstetrical care. It can be life-saving and is also a highly effective procedure for preventing delivery complications. The World Health Organization (WHO) has recommended a Caesarean section rate of between 10 and 15% (average 12.5%) as an acceptable level. This recommendation has formed the basis on which Caesarean rates have been considered normal, low or high [1]. WHO in 2015 further stated that every effort should be made to provide CS to women in need, rather than striving to achieve a specific rate. Despite recommendation by WHO studies have revealed that Caesarian section have continued to increase in an unprecedented manner.

Studies shows that in many cases cesarean section is not always necessitated by medical reasons but lack of awareness, false beliefs and behaviors determine the method of delivery, i.e. giving priority to cesarean delivery roots in psychological, social, and cultural factors [2]. In addition [3] in many societies, cesarean has converted to a cultural issue and more than half of the women choose cesarean delivery voluntarily.

Each year 1.5 million childbearing women have cesarean deliveries, and this population continues to increase [4]. A global survey conducted in 2012 showed that there was a CS rates of 19.8 % in Japan and 32.8 % in USA while in a report of 2011 the average CS rate of 18 European Union member states was 26.8% [5]. The rise in CS rates in middle-income countries, such as Argentina and Paraguay, has been found to be faster in recent decades than that in high-income countries. The CS rates in large Chinese cities with populations over 100 million rose from 10.12% to 63.0% between 1993 and 2008 [5].

In south Africa there has been a trend of increasing frequency, acceptance, and popularity of Cesarean sections. Noting that Eighty

six percent of the Caesarean sections were emergency Cesarean sections and 65% were primary Caesarean sections. This finding is in keeping with other studies which showed that in developing countries, majority of the C-sections are emergencies rather than elective procedures [6].

Despite high acceptance of CS as lifesaving intervention in the world, Caesarean section rates in developing countries have been found to be low. An analysis of data from 42 countries in sub- sub-Saharan Africa, Asia, Latin America and the Caribbean carried out in 2006, Caesarean section rates were found to be extremely low among the very poor. The data further showed that the poorest 20% of the population in 20 countries had Cesarean section rates below one percent implying very limited access to lifesaving Caesarean sections [7].

Data, collected through the routine health information system of the Ministry of Health, Kenya, indicates that the rate of hospital-based caesarean section was 6.3% of all births (range 0.3-37%), whereas the rate of population-based caesarean section was 0.95% (range 0.1%-4%). This indicates that rates of population-based caesarean section are low in Kenya, especially in the rural areas. The rate of caesarean section may be a valuable process indicator for identifying the gaps in obstetric care and may be used for advocating improvements for healthcare to the relevant authorities [8].

Objectives of the Study

According to MDG Goal 5, improving maternal health globally is vital. So too, SDG Goal 3 emphasizes the need to reduce maternal morbidity. The aim of this study was to

- To provide information that would promote local responses among midwives who are providing some of the most invaluable support to refugees in emergency contexts.
- To generate knowledge that can be included in antenatal/prenatal health education topics to demystify the view of CS among refugee Somali
- To assess the influence of men on CS decisions and endeavor to include them in antenatal/prenatal education.

Literature Review

Caesarean section (CS) rates have been increasing steadily globally. The safety of the procedure has resulted in some women requesting it in the absence of any medical indication, particularly in the developed countries [9]. However Caesarean section yet to be embraced in some regions especially in the developing countries.

In developed countries, studies have been done to show reasons for the high and increasing Caesarean section rates. Some of the identified factors are, demographic such as maternal age and parity, others are obstetric such as failure to progress in lab our and yet other factors are non-obstetric such as maternal request for Caesarean delivery [10]. A study trends on Caesarean section rates in United States, Australia, and Canada and reported that the Caesarian sections in those countries have increased rapidly up to a rate of 38%. Some of the reasons that have been cited for the high and increasing Caesarean section rates includes demographic such as maternal age and parity, others are obstetric such as failure to progress in lab our and yet other factors are non-obstetric such as maternal request for Caesarean delivery [11].

In south Africa there has been a trend of increasing frequency, acceptance, and popularity of Caesarean sections where 86% percent of the Caesarean sections were emergency Caesarean sections and 65% were primary Caesarean sections [12]. Caesarean delivery has its risks; there are risks related to the surgical procedure as well as risks related to the anaesthetic procedure. Compared with other modes of delivery, Caesarean delivery involves more resources and increased length of stay in hospital. Efforts at reducing high Caesarean section rates aim to improve maternal and child health outcomes but also have as a secondary aim, reduction of expenditure [6].

In a study conducted among women and caregivers in a public university hospital in Dar es Salaam, Tanzania both women and caregivers preferred vaginal birth, but caregivers also had a favorable attitude towards caesarean section. While caregivers provided women counselling on CS, the women often reacted with fear and shock to the caesarean section decision and perceived that there was a lack of indications. Although caesarean section was perceived as involving higher maternal risks than vaginal birth, both women and caregivers justified these risks by the need to 'secure' a healthy baby. Religious beliefs and community members seemed to influence women's caesarean section attitudes, which often made caregivers frustrated as it diminished their role as decision-makers. Undergoing caesarean section had negative socio-economic consequences for women and their families; however, caregivers seldom took these factors into account when making decisions [13].

A study conducted in Ghana of the 317 women interviewed an overwhelming majority of the women interviewed (93.3%) preferred vaginal delivery to caesarean section. 164 (51.7%) perceived caesarean section as being dangerous to the mother and baby; 94 (30.6%) felt CS was not dangerous, whilst 56 (17.7%) could not tell whether or not the operation was dangerous to the mother or baby. The reasons cited for caesarean section being considered dangerous and the number of women giving such responses was: death of the mother (10), harm to the baby (30), post-operative complications such as pain (120), loss of 'vitality' and strength (100) [9].

In a similar study involving 180 pregnant women in Chile where the caesarean section rate is reported to be as high as 60% in private clinics, 77.8% of the women preferred vaginal delivery, 9.4% preferred caesarean section and 12.8% had no preference [14]. Another study in Australia involving 290 pregnant women also showed a high preference for vaginal delivery (93.5%), with only

6.4% of them preferring caesarean section [15]. Caesarean section rate of at least 3.6%-6.5% is needed to address basic obstetric complications in West Africa.

A study carried out in Iran indicated that Society members' and others' viewpoints, beliefs, and attitudes affect women's viewpoints about cesarean and its preference. Hearing positive or negative stories of others lead their tendency to do cesarean delivery. Another factor which caused women to be afraid of normal delivery in hospitals was fear of the lack of midwives' support during labor and delivery and fear of emanating from observing severe labor pain in other pregnant women; husbands also played a main role in selecting cesarean. They believed the most important advantage of cesarean was lack of vaginal relaxation and so, lack of intercourse dysfunctions. The advantages of CS were cited as lack of labor pain, ensuring fetal health, preservation of genital system's beauty, fast delivery, lack of numerous examinations, lack of great pressure to abdomen, lack of uterine and ovarian dysfunction and so on. The most important advantage of cesarean was noted to be preservation of genital system's beauty and lack of vaginal relaxation, which they regarded as a main factor for maintaining intercourse; this was drawn from a general believe that vaginal delivery *causes urinary and intercourse dysfunctions in future [16]*.

In Somalia health services remains a challenge and Caesarean section rates are low as more and more women resist Caesarean sections [17]. This is attributed to cultural and sometimes economic reasons for their refusal to consent to Caesarean sections. Similarly, in Ethiopia C-section rates are low and many deliveries are not attended by skilled health care personnel, the Government has attempted to improve access to care by training Non-Physician Clinicians to perform Caesarean sections [18].

Methodology

A qualitative Case research design was employed to examine the attitudes towards CS amongst Somali refugees who seek the services of Traditional birth attendants. Purposive sampling was used to choose10 TBAS, 3 pregnant women, 2 men and 2 refugee safe mothers. Safe mothers are volunteers under Red Cross who helps women with prenatal and neonatal care. Purposive sampling allows the researcher to use all cases that have the required information with respect to the objective of the study. The reasons for choosing purposive method was because the topic under investigation is sensitive and private since the refugees who seek the services of TBS do it against the government directive. Data was collected through a combination of interviews and personal observations. The researcher also sought the views of 10 midwives and 15 mothers who were in hospital by the time the study was underway. These mothers had either given birth in the hospitals or had been rushed there after complications related to childbirth.

Research findings

Somali women attitudes towards cesarean section

The study found out that pregnant women of Somali refugee origin in Kenya were aware of the hospital deliveries and possible caesarean section as alternative to vaginal delivery. However according to the results of the study, the refugee Somalis seek the services of Traditional birth attendants (TBAs) for delivery of their babies because they perceive TBAS to have expertise in the area of delivery. This expertise, they said, has been passed on to the TBAS through training by senior TBAs at the camp blocks who have accumulated experience in the practice. This finding indicates that there is a deeply-rooted culture among Somali women when it comes to childbearing. The only people whom they trust to handle them adequately are the TBAs whose skills cut across generations. The ability for the TBAs to handle the women during childbirth does not however negate the fact that Somali women need modern medical help or health services when handling their pregnancies and also at childbirth. It is the reason the study delved further into the issue by asking the midwives at Red cross hospital in Dadaab whether the women attended antenatal clinics. It was noted that approximate 90% of the Somali women were aware of and attended the ANCs. The implication, therefore, is that the women simply preferred the TBAs when it came to delivery because they trusted them. The responses from the midwives, who were registered nurses with varied numbers of years of experience in their work, indicated that the women did attend the ANCs by a majority of 90%. Figure 1shows the responses of the midwives to this question.

A closer look at figure 1 shows that all the Somali women in the blocks are aware that they are supposed to attend the ANCs, and ultimately deliver from the hospitals. Therefore, their choice of TBAs over hospitals must have had a reason.

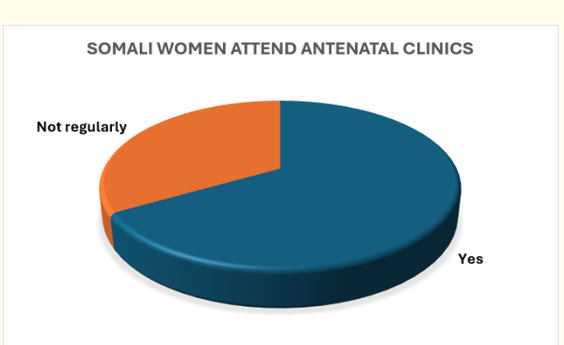

Figure 1: Attendance of Antenatal Clinics by Somali Women.

However, another aspect that came up while on the issue of TBAs vis-à-vis attendance of ANCs by the Somali women is that most of these women did not commit to delivering in hospitals especially because their culture was against it. However, beyond culture, there was a natural belief that only TBAs could handle them at childbirth and this means that their attendance of the ANCs was a matter of regulation rather than a matter of importance. The study conducted by [19] indicates that the safety and care of women during childbirth needs to be part of the reasons ANCs should be of priority to women. Besides, the government has a regulation that women should attend ANCs at health facilities to safeguard their lives and the lives of their unborn children. Therefore, as a way of understanding why TBAs were most preferred by most of the Somali women, the researcher asked the informants about this trend.

The women reported that the TBA have the expertise of massaging mothers whose delivery is delayed which according to them the safe mothers (refugee midwives) do not have since they are not trained to do so. This sentiment was also echoed by men. The finding supports a study by [18] which reported that in Ethiopia C-section rates are low and many deliveries are not attended by skilled health care personnel and the Government has attempted to improve access to care by training Non-Physician Clinicians to perform Caesarean sections. The women also felt that the midwives in hospitals are not respective and do not provide the care that they receive from the TBAS. This also concurs with what was reported in a study conducted in Iran where women were reported to fear normal deliveries in hospitals due to lack of midwives' support during labor and delivery [16].

When women were asked to give other reasons for preferring TBAS than the hospitals they provided varied reasons that included; 1) TBAS are women who help fellow mothers to deliver, while in hospitals delivery including CS is done by men and according to the Somali culture men are not supposed to help women deliver. 2) The women also fear the actual death that may come with delivery through CS and this fear was also expressed by men. 3) Possibility of getting blood transfusion from a sick person in the hospital. 4) The ovaries may be damaged or removed from her. 5) It disables a woman, one cannot do house chores such as fetch water, firewood clean clothes, etc 6) woman may be rejected by the husband etc Both men and women expressed fear of death at the hospitals while undergoing CS stating that they have faith and trust in TBAs because according to them they never lose their clients to death and yet they hear of many cases of deaths of women while giving birth in hospitals. This view is consistent with a study done in an urban setting in Nigeria where over half of the women in the study considered caesarean section as being dangerous. The reasons given for this perception were death of mother, harm to the baby and pain [20].

The findings of the study about the attitudes of the Somali women on CS show that there is a totally negative attitude towards it. However, there is a difference between the attitudes of the women and the realities that some of them had experienced both at the hands of the TBAs and at the hospitals. The researcher asked mothers who had delivered in hospitals whether they would recommend CS to other mothers. Figure 2 shows how the 15 respondents who were sampled for this study responded to this question. However, it is noted that these responses are a result of the near-fatal experiences that the mothers had had at the hands of the TBAs or while carrying their pregnancies. Some of the women in the blocks (the living areas that are subdivided into blocks by UNHCR) had the CS as a last resort and not because they considered it the best way to deliver their children.

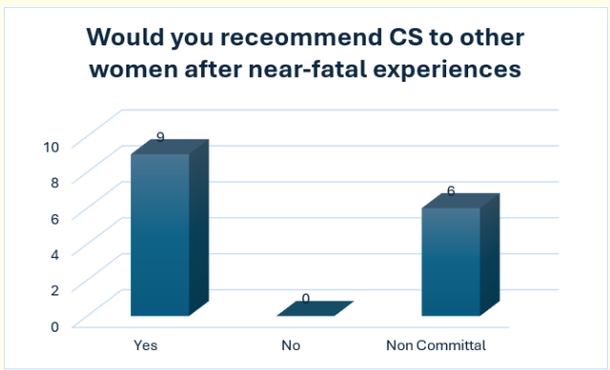

Figure 2: Recommendation of CS to other women by women who had delivered in hospitals.

It is clear that the women who have given birth in hospitals, whether through normal delivery or CS, understand how important the CS is. The responses of the 9 women who committed that they would recommend CS to their friends show that they had trust in the section. This was against the backdrop of the knowledge that their husbands or even the culture would not support them on this. However, as [21] noted, the experiences of women during childbirth can make them change their minds about some societal or cultural standpoints as the women showed through their responses. The trust is in the understanding that the caesarian section was life-saving in the face of imminent death, despite challenges associated with it. In trying to understand why some women would still hesitate to recommend the CS to others even after their lives had been saved by the CS, the researcher sought the views of the women about their reluctance. It was noted that the women have a lot of fear of their husbands and that alone is reason enough to think twice about CS even when the life of another woman was in danger. Due to the deeply rooted beliefs about CS and their TBA approach to childbirth, Somali women still held the belief that going under the knife was similar to death.

According to the women's word for death, it was observed that it had more meaning than actual physical death. It denoted a curse that comes along with CS in the sense that it may result into psychological and emotional trauma of being stigmatized by the family and community, the rejection by their husbands to an extent of a

man marrying another wife. The women also reported that going through CS makes them physically incapacitated this leading to inability to perform their daily chores and errands for an extended period of time. They bitterly observe that, 'indeed CS is a curse, it is death'. The claim of stigmatization by the community was also reported in the Iran study which indicated that Society members' and others' viewpoints, beliefs, and attitudes affect women's viewpoints about cesarean and its preference. The sentiment about women facing rejection from their husbands after being subjected to CS contradicts the study by [16] which indicated that women preferred CS because they believed that it lacked vaginal relaxation, intercourse dysfunctions and preserved genital system's beauty which were important factors in sexual satisfaction of the husband.

Influence of the somali women experiences with cesarean section on their attitudes

As noted in the foregoing section of this study, the experiences of the Somali women with CS influenced their attitudes. While a section of the women indicated that they would recommend the CS to other women because of how their lives had been saved, it was also noted that, the first time some of these women had CS impacted greatly on the attitudes that they ended up with. These are the real situations that the women faced and which forced them to undergo caesarian section. Thus, their perceptions were changed about the operation and also they gained a deeper understanding of the CS. Holding reservations seem to be part of other women who may not have found themselves in a situation that is very needy. Approximately 70% of the informants indicated that their first experience with CS was not good but it was worth. In particular, the researcher asked them to describe their first experience with CS and if they freely consented. One of the informants, Respondent 14, indicated that she lost her child and that broke her. She had expected to give birth normally but she ended up without her child and fear gripped her because of the labelling that was done to such women by the community. This means that the experience shaped her perception of CS and it could not be viewed in any other way. However, another informant, Respondent 15, indicated that the CS was quite helpful to her. She had experienced prolonged labour and therefore was to undergo the CS. Her perception indicates that the caesarian section was life-saving and that both her life and the life of her child dependent on it. Therefore, going by these experiences, it is argued in this paper that the perceptions of the women about CS were informed by their experiences and the experiences of other people who had undergone it. The study notes that experiences play an important part of formation of perspectives. The experiences of the women while undergoing the CS process play an important role in indicating what kinds of attitudes they would pick towards the procedure. According to experientialists, a phenomenon is defined according to the experiences it gives an individual. For instance, there are people who consider education to be a torturous venture that eventually leads to frustrations. The perception is informed by the struggles the individuals have had to go through and even after the struggles, nothing good seems to have come out of it. A current situation that depicts this definition or perception is the problem of the educated unemployed. The fact that millions of young educated people are struggling to sustain their lives has affected the attitudes or perceptions they have towards education. However, among the same young people, there are those whose definition of education is the bridge to a life of their dreams.

The perceptions of the Somali women about CS has largely been informed by their experiences or those of others. However, it is also noted that traditions and culture have an important role in the shaping of perceptions. The women who took part in this study indicated that there were specific traditions associated with childbirth that particularly make TBAs more preferred to hospitals and CS. The most recurrent aspect was the burying of the placenta. The placenta holds a very important part of the traditions associated with childbirth since it is considered as a part of the woman's body. Therefore it cannot be disposed anyhow. When the researcher asked the women to indicate the birth traditions that were important to them, only one out of the 15 women did not have any attachment to these traditions. The rest of the women indicated that they found the traditions very important, including burying the placenta. Other traditions included staying indoors for 20 days to keep off bad eyes and also because they considered themselves unclean for their husbands. The traditions of the Somali people therefore are also at the centre of the attitudes towards CS. According to studies that have been carried out on the impact of culture and tradition on modern healthcare, especially in Africa, it is noted that cultures and traditions are important to the individuals and communities that practice them. The traditions associated with childbirth among the Somali hold an important place, which means that anything that comes between them and the traditions will become a bad thing in their eyes and minds. These traditions form an important part of the experiences that the Somali women have.

The study established that the role which TBAs play in the lives of pregnant women cannot be easily wished away. They are the ones that form the basic decision-making moments for the women. According to the responses that the Somali women on the block gave, TBAs are among the first people they visit during their pregnancies. They only visit hospitals whenever the situation seems to have gone out of control and the TBAs are unable to handle it. A keen analysis indicates that the women do not view hospitals as the priority places where they should have their babies from but the final places they can go when their TBAs have failed. The danger here is that TBAs are not always successful and there have been cases of excessive loss of blood and even death during childbirth in the hands of TBAs. For some women, these cases are what make them feel that hospitals are better places and safer for them to have their babies from. Thus, the experiences of the women, first hand or otherwise, impact either positively or negatively on the attitudes of women towards CS.

The question of perception towards modern ways of receiving healthcare services, especially during pregnancy and at childbirth also brought out other aspects about childbirth in the Somali culture. The researcher asked the women to draw where they sought help whenever they needed it during childbirth. The results of this activity indicate that Somali women do not perceive the modern-day ways of childbearing as being a priority. Instead, their immediate family members and friends are the first to seek before thinking of anyone else.

Somali men's attitudes towards cesarean section

The Somali refugee men were also reserved about having their women going through CS. One of the men respondent had this to say "The only thing doctors know is caesarian, yet it is crippling and make our wives, daughters and sisters invalid and condemned, it is like a curse". They emphasized that caesarian section is actually like death as it affects them and their families too. These claims were substantiated with various reasons.1) the woman becomes disabled requiring that the man help her and the children and this obviously affects the man's other schedules. 2) The doctors advise their women not to become pregnant until after two years of going through CS and such advice put men off. As one man explained, 'This is terrible because we need her to get another child as soon as possible. Worse, still I cannot have sex with her until after two years for fear of making her pregnant, which means I am forced to take another wife'. These responses point to a cultural issue among Somalis where women are for childbearing and need to be there for their men. While there is totally no issue with women being available whenever their men need them, it is also not lost on the researcher that the lives and welfare of the Somali women do not matter to their husbands for as long as they fulfill what the culture dictates them to. This view is even firmed by the responses of the men when the researcher probed further why they could not have sex as a result of the CS. Accordingly, the men indicated that sharia law forbids their women to do any family planning. Thus, one of the men who responded indicated that he cannot have sex with his wife lest she conceives and ends up experiencing problems when her wound has not healed as a result of the CS.

The involvement of men in decisions about CS is supported by past studies. A study by [22] reported that husband and others play prominent roles in selecting the kind of delivery. The pregnant woman selects her kind of delivery based on her husband's, families' and friends' opinions regarding the kind of delivery because their ideas are important to her. The roles that husbands play in the decision-making process is central because they are the ones whose authority is sought before an operation is done. The hospital must get the clearance and consent of a close family member when the woman needs to undergo CS and in the Somali culture, a married woman is under the obligation of her husband. In any case, this is also the case anywhere else where the spouse will be the first priority when consent and opinion is sought on a health issue that concerns their spouse. Therefore, the attitudes of Somali women towards CS are even an extension of their husbands' attitudes. The decision that their husbands make largely remains the sole decision, despite the fact that it is not the life of the husband which is at risk. What is even intriguing is that any woman who experiences difficulty during childbirth, and therefore may need to undergo CS, is quarreled by her husband and relatives. This response was shared by one of the midwives while noting her experiences working with families.

Culture and traditions of the Somali form part of the most important factors in the creation of perceptions and attitudes among Somali men. Child bearing is the work of women among Somalis as the data indicated. Women who took part in this study indicated to have at least 4 births. Compared to their ages, it is noted that Somali women begin to give birth either at an early age or do not space their children. Drawing from the attitudes of the men in this community, women are meant to give birth to as many children as possible. As a result, anything that would hinder them from achieving this would naturally be met with utmost opposition. CS is one of those practices which is not supported by men because it stands between them and their women's ability to give birth to as many children as possible. The culture of bearing many children is therefore an impediment to the realization by the Somali men that CS can be life-saving. They therefore would prefer their women vising TBAs as opposed to going to hospitals for childbirth, knowing that TBAs would help their women bear the children naturally as opposed to the possibilities of CS when they visit hospitals. However, the danger is that such perceptions disregard the fact that the lives of these women could be endangered in case there are problems delivering naturally and an urgent operation is needed. Therefore, while the men have the power to decide where their women will deliver from and whether or not they can undergo CS, the women do not have that power to decide. As such, the attitudes of men are also out of fear that they will lose their power over their women or may have to marry another wife when they did not have the plan to do so. The responses of both the midwives and the women concerning the support the men offer show that there are those who help them when they need that help while others do not. Men therefore remain indifferent on matters childbearing until that time when the woman needs to undergo CS. In most cases, when they resurface, it is to say no to the operation as the data from the midwives indicated.

Discussion

The study found that the refugee Somalis seek the services of Traditional birth attendants (TBAs) for delivery of their babies because they perceive TBAS to have expertise in the area of delivery. They further state that TBA have the expertise of massaging mothers whose delivery is delayed which according to them the safe mothers (refugee midwives) do not have since they are not trained to do so. Professionals in midwifery should seek to find out what this expertise that is possessed by TBAS is and how it can

be used in formalized situations to help mothers with delayed lab our complications. The TBAS should not be totally ignored as they may have some knowledge though not documented that could be instrumental in midwifery procedures. Hence Strategies should be put in place to debrief them of such knowledge.

The respondent mothers also indicated that a key reason for preferring TBAS was because they are fellow women while in hospitals women may be attended by men which is against their culture This being cultural issue the health providers should seek ways to educate both genders in the refugees' community. Both Somali refugee men and women were reserved about CS expressing fear of death at the hospitals while undergoing CS. This would indicate that that they should both be part of prenatal and antenatal education given to pregnant mothers. Hence, midwives and physicians could help them through improving the quality of prenatal care and giving them positive perception towards CS delivery through presenting useful information about the nature of different modes of delivery, and their advantages and disadvantages.

The fear of CS among women revolves around rejection by their husbands who may opt to take other wives if the women cannot meet their conjugal rights. Similarly, the men felt that their conjugal rights will be restricted if their women went through CS. The study also found that women avoided CS due to fear of facing psychological and emotional trauma of being stigmatized by the family and community. This indicates that there are many perceptions about CS among the refugee communities. As a result, there is need to ensure information on caesarean section is part of antenatal clinic educational topics. Additionally, more education on CS need to be provided to the populations in the refugee community.

Conclusion

The study concluded that Men and women of Somali refugee origin in Kenya are aware of the Antenatal clinics in hospitals and subsequent hospital deliveries. However, they prefer delivery by TBAs due to Perceived fear of going through Cesarean Section in hospitals. The attitudes towards caesarean section was informed by social and cultural factors as well as hospital experiences. In view of the current high caesarean section rates, appropriate information about the operation should be considered routine at the antenatal clinic. The health workers should clearly tell expectant mothers the indications for the procedure and answer any questions they may have before surgery to improve the acceptability of the operation. Finally, the attitudes towards CS by Somali refugees in Dadaab provide important information to relevant authorities for identifying the gaps in obstetric care that can be used for advocating improvements in reproductive healthcare.

Bibliography

1. Betran A., *et al*. "What is the optimal rate of caesarean section at population level? A systematic review of ecologic studies". *Reproductive Health* 12 (2015): 57.

2. Movahed M., *et al*. "Related Factors to Choose Cesarean Rather than Normal Delivery among Shirazian Pregnant Women". *Journal of Fasa University of Medical Sciences* 2 (2012): 78-83.

3. Ghanbari Z., *et al*. "Assessing the relative contribution of causes leading to cesarean section among women who had referred to Shahid Madani Clinic in Marand city". *International Journal of Women's Health and Reproduction Sciences* 2 (2014): 26-29.

4. Guise J., *et al*. "Vaginal Birth after Caeserian". PubMed Central Budin, Wendy C (2016).

5. Honglei J., *et al*. "Factors contributing to the rapid rise of caesarean section: a prospective study of primiparous". Chinese women in Shanghai (2012).

6. Inyang-Out S. "Factors associated with high caesarean section rates in Berther Gxowa hospital" (2014).

7. Ronsman C., *et al*. "Socioeconomic differentials in Caesarean section rates in developing countries: a retrospective analysis". *Lancet* 368.9546 (2001): 1516-1523.

8. Gichangi P., *et al*. "Rate of caesarean section as a process indicator of safe-motherhood programmes: the case of Kenya". *Journal of Health, Population and Nutrition* 19.2 (2001): 52-58.

9. Adageba R., *et al*. "Awareness and Perceptions of and Attitudes towards Caesarean Delivery among Antenatal". *Ghana Medical Journal* 42.4 (2004): 137-140.

10. Barber EL., *et al*. "Indications contributing to increasing caesarean delivery rate". *Obstetrics and Gynecology* 118 (2011): 29-38.

11. Menacker F and Hamilton BE. "Recent trends in Cesarean delivery in United States". NCHS Data Brief, No 35. Hyattsville, MD: National Centre for Health Statistics (2010).

12. Van Dongen PWJ. "Caesarean section etymology and early history". *SAJOG* 15.2 (2009): 1162-1165.

13. Liptorp H., *et al*. "'What about the mother?' Women's and caregivers' perspectives on caesarean birth in a low-resource setting with rising caesarean section rates". *Midwifery* 31 (2015): 713.

14. Angeja AC., *et al*. "Chilean women's preferences regarding mode of delivery: which do they prefer and why?" *British Journal of Gynaecology* 113.11 (2006): 1253-1258.

15. Gamble JA and Creedy DK. "Women's preference for a caesarean section. Incidence and associated factors". *Birth* 28.2 (2001): 101-110.

16. Latifnejad R., *et al*. "Cultural perceptions and preferences of Iranian women regarding cesarean delivery" (2014).

17. Borkan A. "Rejecting vulnerability. Somali women's resistance to cesarean section in Columbus Ohio". Honours thesis in cultural anthropology (2010).

18. Fesseha N., *et al*. "A national review of caesarean delivery in Ethiopia". *International Journal of Gynecology and Obstetrics* 115.1 (2011): 106-111.

19. Wynne SJ., *et al*. "The timing and quality of antenatal care received by women attending a primary care centre in Iquitos, Peru: A facility exit survey". *PLoS ONE* 15.3 (2020): e0229852.

20. Aziken M., *et al*. "Perceptions and attitudes of pregnant women towards caesarean section in urban Nigeria". *Acta Obstetricia et Gynecologica Scandinavica* 86.1 (2007): 42-47.

21. Namujju J., *et al*. "Childbirth Experiences and Their Derived Meaning: A Qualitative Study Among Postnatal Mothers in Mbale Regional Referral Hospital, Uganda" (2018).

22. McGrath P., *et al*. "Vaginal birth after Caesarean risk decision-making: Australian findings on the mothers' perspective". *International Journal of Nursing Practice* 16 (2010): 274-281.