My Africa

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Ethical and Practical Consideration of Women Choosing Cesarean Section Deliveries without "Medical Indication" in Developing Countries

Cesarean section rates are increasing globally, partly because many patients acquire the procedure on request without clinical indication (1,2). The global medical and midwifery community is divided as to whether it is in the best interest of the woman and her unborn baby to provide elective cesarean delivery on demand. In the United Kingdom, the term "too posh to push" is sometimes used to describe women who request elective cesarean section without any "medical indication" (3). I see some sense, the increased recognition of respect for patient autonomy and human rights in the health care sector (3) has contributed to perception that to avoid being paternalistic, women who request cesarean delivery should be provided the procedure. In most of the developing world, although the debate is not as intense, the dilemma is still present.

History of cesarean section in Africa

Cesarean section is not a new procedure in the health care system, even in the developing world. For instance, experience with abdominal child deliveries in Africa predates colonialism. On January 9, 1884, a Scottish final year medical student, Robert Felkin gave a lecture to the Edinburgh Obstetrical Society about his experience of observing cesarean section in Africa. The title of the lecture was; "Notes on Labor in Central Africa." He narrated how, while in Uganda in 1879, he had observed the Bagandas performing a successful emergency cesarean section using a large knife and alcohol as anesthetic, analgesic, and antiseptic. This was probably the first record on cesarean section performed in Africa under very meticulous conditions (4-6).

Abdominal delivery by choice

There are reports to suggest that many women in both developed and developing nations are choosing to deliver by elective cesarean section (7,8). In some settings, the cesarean section rate (number of cesarean section as proportion of all deliveries) is around 50%. This is against one school of thought that proposes that birthing is a natural process. To this group, vaginal birth is the "real" birth. The "traditional" or con-

servative view that operative delivery is to be considered only when there are clinical or "justifiable" indications for such a procedure. When cesarean section is done in most of such situations, it is clear that maximizing good and preventing harm may be achieved.

Terms like "medicalization" and "interventionist birthing" have been used to refer to elective cesarean section, while vaginal delivery has been described as "normal birthing" (8). From this perspective, the request for cesarean section by a woman with expected vaginal birth has been considered as something abnormal. It is however important to note that women may choose elective cesarean section for a diversity of reasons. These include the desire to protect the sexual function and performance of the pelvic organs after delivery; fear of possible neonatal adverse outcomes such as death of a baby; a quick delivery with minimal pain; and fear of pain due to lack of adequate and appropriate analgesia during delivery. These concerns are not unfounded, because some studies have reported evidence of adverse outcomes after vaginal delivery (9). In Brazil, perception by women that cesarean delivery is superior to vaginal delivery seems to be a factor in the preference of operative delivery (10).

With the global increase in elective cesarean deliveries, questions are being asked as to whether health practitioners should accept and perform elective cesarean sections for the "mere" reason that a pregnant woman has decided that they want to avoid vaginal delivery. Although cesarean section in without clinical indication is considered ethically justifiable by the American College of Obstetricians and Gynecologists, and Italian law permits it, the advice by the UK National Institute of Clinical Excellence (NICE) is that such a request by a woman necessitates seeking a second opinion (1,2). In some other developing nations, the issue is a matter of great controversy. In some countries such as South Africa, two schools of thought persist (11,12). In this paper, I attempt to discuss the ethics surrounding the issue of elective cesarean section in the developing nations, with regard to principles of autonomy, beneficience, non-maleficence, and distributive justice. The concept of *uMunthu* or *ubuntu as* understood by cultures in Southern Africa will also be presented in order to guide decision making (13).

Access to cesarean sections in the world

The traditional view is that cesarean sections are to be conducted in situations where the lives of women, unborn babies, or both are in danger, and not when the likelihood of such danger is minimal. The procedure has been included in the package of comprehensive emergency obstetric care by the World Health Organization (WHO) (14). It is noteworthy to also remember that the availability of cesarean sections to pregnant women is unevenly spread across the globe. In most of the developed nations, emergency cesarean section is almost a given, while in many developing nations, only a fraction of women who need it to save their lives have access to the procedure. In Malawi for example, access to life-saving cesarean section is not always available, not even at the country's largest teaching hospital of Queen Elizabeth Central Hospital (15). When the procedure is available to save lives (in the country's district and central hospital), the level of care is less than optimal with resultant loss of life for women and neonates in many cases (16). This fact has obvious bearing when the ethics of elective cesarean section are to be debated, ie, cesarean section deliveries are risky in many of the developing nations and the safety of the procedure is much lower than in the developed nations. So, the harm-benefit analysis in the developing nation could weigh more in the direction of harm than good.

Like all surgical procedures, cesarean sections have inher-

ent potential harms. These include anesthetic, cardiac, hemodynamic, and respiratory risks, and post-surgical infections. In the developing world, its incidence is likely to be higher than the rest of the world and its treatment poorer, probably due to poor antisepsis as a result of lack of hospital supplies, quality control, and in some cases, lack of infection prevention guidelines. More women in the developing than in developed nations are also likely to have compromised immune systems due to under-nutrition and HIV infection. In some settings, HIV infection rates in pregnant women are as high as 1 in 3. In such environments, many of the women who may request cesarean section "without clinical indications" are likely to be HIV infected also.

The risk of infection and microbial contamination is not unique to the developing world. In fact, in specific situations, the occurrence of contamination in developing nations may be lower than in developed nations. A study by Archibald et al (17) compared blood culture contamination in three hospitals, Duke Medical Center in Durham, North Carolina (USA), Muhimbili (Tanzania), and Kamuzu Central Hospital in Malawi. The study reported that microbial contamination was much lower in Tanzania and Malawi, compared to Durham, North Carolina.

Cesarean section to prevent HIV transmission

When cesarean section deliveries started to become the preferred mode of delivery for HIV infected pregnant women in the developed nations in order to reduce the rate of mother to infant transmission of HIV, the developing world did not take up the initiative to any great extent. Among the reasons was the fear of post-cesarean infections among HV infected women. Without concomitant use of highly active anti-retroviral therapy, cesarean section may carry substantial risks to infection as compared to the same procedure in HIV noninfected women (18).

It is also important to consider individual performance of health facilities even in the developed world. If the safety record of cesarean section in a health facility is poor, elective cesarean section would have to be considered with extreme caution. The basic tenet is that health practitioners have to maximize good (beneficence) and minimize harm (non-maleficence).

The safety of elective cesarean section has not been studied rigorously. Most of the literature on the maternal and neonatal outcomes following cesarean section addresses the emergency cesarean section, and this may not be comparable to elective cesarean section. However, some of the hazards in individual health facilities would be the same for both elective and emergency procedures. In the ideal world, randomized controlled trials would shed better light in determining which was safer, and by how much was the difference between the safety between elective and emergency cesarean section.

In the developing countries, although health care is usually considered to be of poor quality, there are many exceptions where the quality of care is comparable to the best among the developed nations.

Perceived benefits of elective cesarean section

There are a number of potential benefits of elective cesarean section for the woman, the attending health practitioner, and the institution. For the health workers, increased reimbursement, reduced time taken in caring for the patient, and reduced likelihood of being sued could encourage practitioners to prefer elective cesarean section over vaginal deliveries (19).

Informed consent and patient autonomy

In almost all surgical procedures, it is good practice to obtain informed consent from the relevant persons (the patient or legal guardian). The "consent" part of the informed consent may not be a problem when the women themselves are choos-

ing the cesarean section without "medical indication". If the woman is asking for cesarean section, that means she agrees to have the procedure. It is the "informed aspect" which deserves special attention. For consent to be informed it is necessary that the person making the decision has the knowledge and understanding about the procedure, be mentally and legally competent, alternatives choices should be provided, and the decision should be made voluntary (20). Interestingly though, the "choice" to deliver vaginally or operatively is not a choice as is the case in many other clinical conditions. A woman with breast cancer for instance, can choose a combination of any of the following; chemotherapy, radiotherapy, and surgery. However, a woman who does not prefer vaginal delivery must choose an elective cesarean section early enough, or otherwise, when labor starts, she will have to deliver vaginally even if it is against her will.

In situations where the woman opts for elective cesarean section, it is important for health practitioners to be clear as to the reasons of such a choice. In some cases, women may choose operative delivery for fear of pain perhaps experienced in a previous delivery. Some women perceive cesarean section as superior to vaginal delivery. The health practitioner should then attempt to give as much relevant information to the woman as is practicable. Many women present for assistance in labor late or do not attend antenatal care, which makes the situation even more difficult.

In the event that the health facility is a non-paying, (usually public institution), the health practitioner may also wish to draw the attention of scarcity of resources and the health practitioners' stewardship roles as gate-keepers of ensuring that the national cake is available for all, especially those that need it most. In a health facility free to consumer, the consideration of distributive justice (equity), in as far as resources are shared, ought to be considered seriously. Many public health systems in the developing world are in a state of collapse and availability of the basic health resources (supplies and personnel) is rudimentary. In such situations, providing elective cesarean section on demand, and without good clinical conditions, may be against the principle of distributive justice (21).

The woman vs significant others

Health practitioners ought to determine who is behind the request for cesarean section; is it the woman herself, the spouse, or any other significant other in her life? This is important if collective decision making is to be achieved. If there is discrepancy in the wishes of the woman and her significant others, the wishes of the woman should be respected. There is however asymmetry and an ethical hypocrisy in that when a woman chooses vaginal delivery, health care professionals are more likely to accept that as an expression of autonomy. Yet when the woman chooses elective cesarean section, her autonomy is questioned. It is the woman's body and therefore she has the right to make her own decisions, despite being at liberty also to consider advice and suggestions from others.

Ideally, discussions about the possible modes of delivery ought to be discussed much earlier in the pregnancy, when the women (and her family) can be given information about what is the likely safer way of delivery (19). It has also to be emphasized that despite whatever choice that is made, the woman should also understand that the mode of delivery may not be fixed, as it may change depending on the prevailing circumstances.

The spirit of *uMunthu*

Among the Bantu tribes of southern Africa, the *ubuntu* or *uMunthu* concept is well appreciated (14). The Zulu proverb; *Umuntu ngamuntu ngabantu abanye* (an individual is a person through other persons) is well recognized. In Malawi, the communal life extends very deep. It is interesting when one consid-

ers that the traditional way of salutation in personal letters is: *Ngati muli bwino, inenso ndili bwino*, literary translated, "if you are alright, I am also alright", suggesting that my happiness and problems are yours too just as your happiness and problems are mine too.

Lack of availability and accessibility to emergency obstetric care continues to be a major cause of maternal mortality. Lema et al (15) have documented a hospital mortality rate of 1027 deaths per 100 000 live births at the university teaching hospital of Queen Elizabeth Hospital in Blantyre, Malawi. Sepsis, hemorrhage, and eclampsia were the common causes of deaths. Fenton reported the challenges on availability of blood for transfusion during and after cesarean section in a developing country (22). While hemorrhage is responsible for maternal deaths even in the developed nations, what needs to be recognized is that in the developing nations, the skills and resources to ensure fluid replacement, availability of safe and timely blood transfusions may not be adequate, which means that the risks associated with cesarean section are much higher in the developing world.

The spirit of *uMunthu* has bearing on distributive justice and in this paper, elective cesarean section. When an individual's access to scarce resources results in endangering other people's health, such practice may be considered ethically questionable. Elective cesarean section in many locations on the African continent could fall under such category. Although the nonavailability of qualified physicians to perform cesarean section and deliver anesthesia has been partly solved by training appropriate paramedical cadres, the availability of cesarean section is still scarce even for emergency reason. In some private maternity units, the availability of skilled health workers may be comparable to the standard of practice in the West and so choosing elective cesarean section may not directly lead to denying other patients this service. A woman who demands cesarean section from a private hospital, pays huge sums of money, may not have that money to help in paying school fees for her relative. In the *uMunthu* concept, a person cannot really say; "Am I my brother's keeper?" as it is given that a person is responsible for other person's happiness and should endeavor to help carry each other's burden.

Even in private health facilities where occupying the operating team may not directly lead to denying others life saving care, the use of medical insurance for the "non-medically indicated" cesarean section could eventually lead to higher health insurance premiums and denying other people lifesaving care if they may then not be able to afford the premiums (23). This will happen because the cost of health care will rise and the health insurance firms' returns will drop and to cover their costs but also make profits to pay dividends to shareholders, premiums are likely to rise. This has implications for distributive justice. It can also be perceived that what happened as a respect for a woman's autonomy, has ended up causing harm to society.

Double standards

It is tempting to suggest that because resources are scare, health care resources should primarily be devoted to essential supplies and services. Elective cesarean section may or may not therefore fall under non-essential services. Defining what is essential is problematic as it is a value judgment. For many years, many countries in Africa did not consider antiretroviral drugs as essential medicines due to the cost of these supplies. But as global resources for the treatment of HIV were made available, antiretrovirals are considered essential medicines, even by the WHO.

In other areas of medical and nursing practice, there are also concerns about "irrational" prescription of drugs such that vitamins and tonics are considered as non-essential as per WHO Essential Drug List (24). If elective cesarean section is to be

equated to prescription of antibiotics when not "medically indicated," then it is likely to be construed as unethical to provide the procedure on demand. But doing so (compared the cesarean section and antibiotics) may not be the most reasonable thing to do. While many African countries have removed cough syrups/tonic and vitamins from the essential drug list, in favor of antibiotics for coughs and proper diet (instead of multivitamin treatment), the non-availability of cough syrups may even be more harmful as health practitioners are "forced" to prescribe antibiotics when cough syrups would have been offered, were they available. Multivitamins fall in another category. While multivitamins are considered non-essential, they are a multi-billion dollar industry in the developed world. These could have been much more useful in the developing world, where in some countries, chronic malnutrition is faced by a sizeable proportion of the population.

If the argument about scarcity of resources or the risk from anesthesia is advanced in case of elective cesarean section, what are we going to say about the removal of ganglions and keloids which are non life-threatening and essentially cosmetic considerations? Is the use of scarce public health facility resources justifiable for keloid removals, some of which developed after what can be described as self-inflicted piercing of earlobes and tatooing? Should acne be treated with antibiotics when some people obviously do not have access to antibiotics (25)? But people who have their acne properly treated would possibly have better psychological or emotional health, and so would people who had their keloids treated. Is not health also a state of psychological well-being? Is the woman who chooses an elective cesarean section for reasons such as fearing to damage her perineum not justified to be provided with a "perineum-saving procedure?"

In many parts of Africa, public health facilities have provided circumcision facilities at no charge to boys who need such a procedure. This has mostly gained ground in the HIV era when it is intended to discourage the practice of sharing circumcision instruments which may expose the boys to HIV transmission through blood. Can this be justified as a reasonable use of public resources while elective cesarean section is denied.

The fetus or the mother?

The legal status of the fetus varies in different jurisdictions. Obstetricians like to describe the pregnant woman as the "mother-fetal dyad". Obviously, it would be ideal if health practitioners would not have situations where circumstances force them to choose between the fetus and the mother. In the case of pregnant women, the woman's interest ought to be weighed in consideration of the fetus and the fetus' interest ought to be weighed in regard to the interest of the woman. Does a woman lose her legal standing or is it modified because of her pregnant situation? Generally, it does not appear to be the case in the United States where the courts have suggested that "neither fetal rights nor state interests on behalf of the fetus supersede women's rights as ultimate medical decision maker" (26). It can however be argued in most cases, women do wish well for their unborn babies and they are prepared to do many things that will enhance the health of their babies.

Documentation of clinical decisions

It is generally stated that medical records are usually incomplete especially in developing countries. Epidemiologists and other medical researchers recognize the difficulty of extracting clinical data in case-control studies due to lack of important and routine clinical information. It is, however, extremely important that decisions pertaining to the mode of delivery are well recorded, especially where the woman or her family prefer an elective cesarean section. This becomes important when an ad-

verse maternal and/or neonatal outcome (eg, death) occurs and could be attributed to the procedure. The health practitioners need to demonstrate how the decision was reached and that informed consent was obtained.

Obtaining written consent in the developing world, just like conducting any health research, is generally problematic because of high levels of illiteracy (25).

The role of litigation

It is reasonable to suggest that at least in the United States, the ethics discourse surrounding the issue of patients demanding elective cesarean section has been shaped by the high levels of successful litigations against obstetricians especially and physicians in general (3). Litigations have occurred in the case of adverse neonatal outcomes when elective cesarean section could have possibility prevented occurrences of such events. In many of the developing nations, although litigations do occur, this is more of an exception that the rule. The debate of the ethics of elective cesarean section therefore has legal marks.

The role of institutions

The health practitioner can be guided, as an individual by his or her own understanding of ethics. But that is unlikely to serve the practitioner very far if the practice cannot be defended by peers in a litigation case. In developing world, there is a need for health practitioners' associations and regulatory bodies to start discussing about the issue of elective cesarean section. The structure, functions and viability of professional associations differ in various jurisdictions and in some settings, the existence of such health professionals associations is cursory. This may tempt health workers to take individual decisions that may not be supported by colleagues as consensus statements may not be available.

While it may probably be easier in public, non-paying health facilities to discourage cesarean section on demand, it may be different in private for profit-health facilities where the financial ramification for losing out patients to competing health facilities may be considerable. It is possible that patients may not be dissuaded easily just because a health facility's policy discourages cesarean section on demand. An illustrative example is when the State of Illinois in the United States required mandatory premarital HIV testing. This decreased the number of marriages officiated among residents in Illinois and increased the number of marriages of Illinois couples in neighboring states (that did not require HIV testing) rose (27).

Is elective cesarean section against the health practitioners' consciences?

Despite the fact that, in the present circumstances, it seems reasonable to generally discourage elective cesarean sections in most of the developing nations, the situation may change. The safety issues could improve and availability of resources enhance. However, if it is against the health practitioners own conscience to provide elective cesarean section, it would be good not to coerce a woman to have a form of delivery against her own wish, which could be interpreted as assault. A health practitioner who opposes elective cesarean section should refer the pregnant woman to another practitioner.

Conclusion

Globally, more women are choosing to deliver by elective cesarean section than ever before. This challenges the notion that delivering a baby is a natural process that should be facilitated but never interfered if it is unnecessary. On one side of the debate are those that suggest that respecting the woman's choice of mode of delivery is in itself a good and desirable clinical practice as it respects the woman right to free choice (autonomy), while the other camp suggests it is a futile, frivolous, and unnecessary practice that

exposes the health of the woman and her baby to unwarranted potential harm and therefore against the principle of non-maleficence. While the preference to elective cesarean section is experienced in both the developing and the developed world, and opposition and support are exhibited in almost all societies, the ethical and social analysis taking into account issues like distributive justice and national health resources, the local safety issues surrounding elective cesarean section and reasons why women choose operative delivery may differ from society to society. While the ethical principles of beneficence, autonomy, justice, and non-maleficence are argued to be universal, the applicability ought to take into consideration the particularities or specifics of a community. It can be argued that the lack of adequate health care resources in the developing world which make even life saving emergency cesarean section not available to the majority of women, the questionable safety issues surrounding the procedures, would favor that elective cesarean section on demand a potentially risky procedure in the developing world. There is however the need to make emergency obstetric care available to most women who need it and improve on the safety of the procedure. Where an elective cesarean section may be deemed to be in the best interest of the woman and her baby, such a procedure may still be considered.

For most of the developing world, access to life-saving emergency cesarean section is not readily available to save the lives of women and those of their babies. Elective cesarean section in non-paying or heavily subsidized (public) health facilities poses special challenges of distributive justice. The potential harms, in many cases, much higher than experienced in developing nations, tip the equation in favor of vaginal delivery where there are no clinical indications for cesarean section. It should be explored what women actually need to understand in order for them to make informed decisions about the mode of delivery that will preserve their own health and that of their babies and the larger community. Health practitioners need to appreciate that a request for an elective cesarean section may mask a cry for help in several areas of a woman's life. It is also important for national associations of physicians and midwives to debate and formulate guidelines on how to handle complex ethical dilemmas as patient-chosen cesarean section.

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