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Women's Attitude Toward C-Section: Evidence from Bay Regional Hospital in Baidoa, Southwest State of Somalia

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Abstract

Background: The general societal belief among Somali women is that anything other than normal vaginal delivery is riskier than could be imagined or anticipated, no matter the delay or prolongation of labor and related complications. This widely circulated perception has become a reason for many expectant mothers to either completely decline to consider c-section or suffer in prolonged labor that could be fatal to either the mother or the baby or both.

Methods: This study follows several aspects of the triangulation method of research. It adheres to the case study approach by mixing qualitative and quantitative methods. It uses purposive sampling by selecting 19 women who delivered by c-section at Bay Regional Hospital, Baidoa, Southwest State of Somalia.

Results: About 58% had believed c-section as 'very risky' or 'risky' prior to undergoing the procedure; after delivery 89.5% thought it was either 'very safe' or 'safe', while none of the respondents considered it to be 'unsafe' or 'very unsafe' anymore.

Conclusion: Women's perception of c-section changed dramatically after undergoing the procedure as compared to their belief before the surgery. It is also remarkable that they would not hesitate in their next delivery by c-section and that they would recommend it to other women in order to avoid fatal complications.

Keywords: childbirth, health research, labor complications, medical health

Introduction:

Cesarian section, also known as cesarian delivery, cesarean birth, or simply as c-section, is a surgical procedure used to save lives of women and/or babies during labor complications. It is a life-saving operation undertaken in situations when normal vaginal delivery of a baby has become difficult. It is an obstetrically practiced procedure which has become very commonly in use, and which is rising in popularity among women all over the world (Dalvi 2018; Chopra 2016). The increase, according to Byamugisha and Adroma (2020, p.1) is attributed to diverse issues relating to: "patient, institutional, care provider and societal factors." Although cesarian section is necessitated by difficulties that can occur due to maternal conditions like active genital infection, history of prior c-section or a variety of problems leading to labor complications like placenta previa, placenta abruption, failure to progress, shoulder dystocia, malposition, and rapid labor, among others. Rafiei et al. (2018, p. 221, quoting Alehagen et al. 2001) write that "it is gradually being assumed as something luxurious by some communities," (p. 221).

Background

While still at a very young age, Somali girls undergo one or the other (*mild* and *severe*) of several types of circumcision under very fatal and traumatic conditions, physically and psychologically. Although the more serious practice of infibulation traditionally known as *Gudniinka Fircooniga* (Pharaonic Circumcision) is believed to have decreased in recent years, mostly in urban areas and among the educated class, the fatalistic practice of the severe category is not completely abandoned. The '*mild*' aspect of the practice, religiously termed as 'sunnah' (prophet Muhammad's way of life or following his recommendations) is used as the ideal method—which within itself exist different levels of '*mildness*' or to some, '*severity*', depending on one's interpretation of the practice or what one makes of the meaning '*mildness*'.

The stigma of circumcision with infibulation, a practice which in itself is more traditional than religious, leaves a serious impact on the Somali woman, physically and psychologically at various stages of her life. This practice, coupled with the Islamic teaching of privacy and decency of the female in her sexual behavior and attitude that forbid her body from exposure to a male except her husband, can create a tremendous problem in emergencies in the absence of a female obstetrician or gynecologist in the time of childbirth. Viewed through a different lens, Somali women are not culturally, or for that matter even medically, easily convinced to undergo cesarean birth, regardless of the presence of male or female obstetrician. This study aims to contextualize the phenomenon by accessing the perspective of women who underwent c-section at Bay Regional Hospital in Baidoa district, Southwest State of Somalia.

Bay Regional Hospital (BRH)

Bay Regional Hospital is the main referral hospital in Baidoa, the capital of Bay Region which also doubles as the provisional seat/capital of the administration of the Southwest State of Somalia. The hospital has a long history in the health system of Somalia. It was constructed by the Italian colonial administration in the year 1933 (Abdinor et al. 2021) although it was extended and renovated recently. The hospital has experienced difficult situations since the eruption of the civil war and the ousting of the military regime of Mohamed Siad Barre in 1991. As a result of the ensuing state collapse, the hospital became dependent on foreign donors and well-wishers like UNICEF, MSF and other organizations that intervened to assist the needy citizens of Baidoa in the health sector (Yarow et al. 2021). Although BRH is currently under the

management of well-trained professionals from the local community through the Ministry of Health of the SWSS, it receives potential fiscal and technical assistance from foreign organization.

In addition to Baidoa city, BRH serves a wider net of communities including internally displaced persons (IDPs), patients from the different districts of Bay region and others from neighboring regions with limited health facilities. Although BRH is a referral hospital, it does not provide specialized treatment to patients with specific ailments that require expert diagnosis and observation beyond a general practitioner's attention. For such treatments, patients seek medical assistance in Mogadishu, neighboring Kenya whose health system is more advanced, the United Arab Emirates, India, Turkey and as far as other European countries.

Literature Review

Caesarean section has been described as "a contentious topic" that attracted multiple forms of scholarly inquiry into the variety of factors covered in the obstetrics discipline (Tartar et al. 2000). Its impact on moms and their newborns has been enormous that it has attracted scholarly attention in both developing as well as developed countries. The "upsurge" of the practice, though believed to be life-saving, does not necessarily always result in successful outcomes for the newborn and/or its mother, according to Tartar et al. (2000). From another aspect, while there is a claim that a number of related research work has been done in the field, a counter-claim can be drawn from Tartar et al. (2018) on the absence of credible data in countries such as Turkey, though supposed to be medically more advanced than many developing countries in the world.

Due to its increase over the years, c-section has become a very common surgical procedure worldwide and an alternative to normal vaginal delivery as a life-saving operation. Despite it being a crucial life-saver, c-section is associated with negative impacts on both mother and baby (Polidano et al. 2017) as it has risks to the mother such as sepsis and infections of reproductive organ like endometriosis and surgical side-effects including abscess, for instance. It can affect the mother mentally and has potential to develop post-surgical depression or post-traumatic stress disorder (PTSD) (Lopez et al. 2017). C-section can cause maternal morbidity and mortality as well as complicate family planning. Among its problems are the effect it can have on the next parity as well as prolongation of recovery from c-section wounds of incision during the surgery (Aujang 2018).

The practice of c-section can affect a child born via the method as it involves a high risk of clinical infection. C-section children are mostly born preterm or post-term which experts believe can lead to respiratory problems and difficulty in feeding which can have an impact on child growth and development (Magnus et al, 2011). C-section has been reported as having an effect on the baby's head during birth as it soft and flexible to allow for easier passage at birth after vaginal birth it is common the baby to have (cone head) Appearance of baby head depending on how long the child stay the birth canal. Chronicling some difficult cesarean situations is Dalvi (2018, p.345) who imparts how:

Fetopelvic relationships like floating head, deeply engaged head, mal positions like deflexed head, mal presentations like breech and transverse lie, prematurity, multifetal pregnancy, fetal malformations and conjoined twins can create difficult deliveries during C sections.

Other scholars have put their research focus on the child, particularly its access to the mother's milk at the initial stages after birth and the attachment developed as a result of lactation. Therefore, as several studies have suggested, breastfeeding can be difficult for children born via c-section while it can also have numerous

types of challenges to both mother and child. Hobbs et al. (2016, p. 1) acknowledge:

Women who delivered by emergency c-section were found to have a higher proportion of breastfeeding difficulties (41 %), and used more resources before (67 %) and after (58 %) leaving the hospital, when compared to vaginal delivery (29 %, 40 %, and 52 %, respectively) or planned c-sections (33 %, 49 %, and 41 %, respectively).

Comparatively, Hobbs and colleagues maintain:

More women who delivered by planned c-section had no intention to breastfeed or did not initiate breastfeeding (7.4 % and 4.3 % respectively), when compared to women with vaginal births (3.4 % and 1.8 %, respectively) and emergency c-section (2.7 % and 2.5 %, respectively), (p. 1).

However, several other studies including McDonald et al. (2012), Watts et al. (2012), and Ahluwalia et al. (2012) support that the impact c-section may have on the immediate initiation and duration of breastfeeding is dependent upon the specific type of cesarian a mother undergoes—whether as a result of an emergency arising from impossibility or difficulty of vaginal delivery or as a planned surgery on demand.

Tschudin et al. (2009) conducted a research on women's attitudes and awareness concerning demand-based cesarian delivery among first-timers and women who had already delivered by cesarean. As a result, 92% of the respondents admitted to have gained their awareness through either friends, the media or television (Tschudin et al. 2009), while the demand of opting for cesarian or declining it depended mostly on matters pertaining to avoidance of pain during delivery or not wanting to undergo birth experience itself. As Tschudin et al. (2009) revealed, women who had undergone a traumatic situation in their previous delivery, understandably, preferred cesarian on demand for the sake of their person health and their newborn's. However, Tschudin et al. (2009) conclude that women's decision on c-section on demand is driven by undesirable birth experience on the one hand, and partially "on misconception," factors that could be tackled during "antenatal counseling."

Somali Women's Resistance to C-section

While many women may voluntarily choose c-section on demand for several reasons unrelated to maternal health or child well-being per se "Somali refugee women in Kenya are rejecting the operation in attempts to protect their future reproductive capacities," (Lowe 2019). In another joint study by Gee and coauthors (2019) among Somali refugees in Dadaab camps in Kenya's Northeastern Province, women's perceptions of their basic socio-cultural role as child bearers affects their decision of rejecting cesarean birth. Moreover, "mistrust of health service providers also played a role" in women's attitude toward c-section.

In order to educate women in the United States of America, the American Congress of Obstetrics and Gynecologists (ACOG 2004) disseminates brochure containing valuable information about harmful consequences related to cesarean delivery. It highlights some of the conditions under which women should consider the procedure as inevitable such as: pregnancy containing multiples, imminent harm to the baby, unprogressive labor or failure of it, problems with the placenta, previous c-sections, large babies, badly positioned baby, breech position, or in cases where the mother is suffering from infections (Borkan 2010). Nevertheless, in the Somali context:

In the case of obstructed or prolonged labor where a life-saving cesarean section is required, these procedures can only be performed with the approval of the woman's father-in-law, and if he is absent, the expectant husband. Many women die from this inability

to obtain permission, instead of surviving what normally would be a routine procedure," (Deyo 2013, p.2)

Several studies support that Somali women have been less convinced by either obstetric science or the fact that considering timely c-section would save their life or that of their baby. In fact, their attitudes toward cesarian delivery "have been well documented" in a number of studies in the USA, Canada, Sweden and elsewhere, according to Borkan (2010) and described as "adverse." Specifically, studies carried out by Vangen et al (2004), Dundek (2006), Chalmers and Hashi (2000), and Essen et al, (2000) explore the attitude of Somali women's resistance to c-section and their unwillingness to consider the procedure even in critical cases of risk to the mother or the fetus.

Raising the problem as a main concern, Deyo cited in Benson (2013) describes how "Somali women have a perception that doctors rush to c-sections." As Benson elaborates, Somali women are frustrated and would like to be convinced about the reason "why they're not given more time to have natural births," rather than "rush" them to cesarian delivery (Benson (2013). Even in the emergency even that surgical delivery is necessary, "Somali women very simply prefer female providers, period… And this is an issue of modesty. Very simply they do not want to show their private parts to a male provider who is not their husband" (Deyo cited in Benson 2013).

Method of Study

This study follows several aspects of the triangulation method of research. It adheres to the case study approach by mixing qualitative and quantitative methods. It is also purposive in the sense that it targets only women who delivered by c-section at Bay General Hospital between in the month/s of December 2021 to February 2022. A small sample size of 19 mothers was selected exclusively from women who were either in-patients at the time of the study or had just been discharged less than a month ago. A structured questionnaire was used that contained both qualitative and quantitative questions. One of the researchers personally asked the questions and filled in the questionnaires after the respondents answered. In the case of the discharged mothers, the questionnaires were filled in the form of a telephone interview.

Ethical clearance

The study followed ethical standards and guidelines approved by Hakaba Institute for Research and Training, the University of Southern Somalia, and Bay Regional Hospital. Participants' consent was received after thorough explanation of the objectives of the study. Confidentiality was considered and anonymity of respondents was maintained.

Analysis and Discussion

In this section, separate tables are used to present analysis and discussion of the results of each question. Direct quotation of respondents was used where necessary such as in the comments of the qualitative section of the questionnaire

Table 1: Respondents by age

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
14-20	5	26.3	26.3	26.3
21-30	8	42.1	42.1	68.4
31-40	5	26.3	26.3	94.7
over40	1	5.3	5.3	100.0
Total	19	100.0	100.0	100.0

Data presented in Table 1 indicates age distribution of the respondents who participated in the study all of whom had a C-section delivery at Bay Regional Hospital in Baidoa district. All 19 participants answered the question to highlight the age difference of women in the study who underwent c-section. The results show that 5 of the respondents which is 26%, are aged between 14-20 years while 8 respondents which is 47% were at the age from 21 to 30 years. Data also reveal that 4 of the respondents which is equivalent to 26% were at the age of 31-40 years compared to only 1 respondent or 6% of the total who fell within the age bracket of those above 40 years. The result shows that majority of the respondents which is 47% came from the age group of 21-30 years, which means there are more mothers giving birth in this age cluster compared to others either in the older or younger age groups. Second place with 26% each was taken by groups of age 14-20 and 31-40 years old. The result suggests that while women who start delivering children at younger age seem to be few, the number increases as the age also goes higher, and then drops further lower as the mother grows older, as indicated by the 5.3% of women over 40.

Table 2: Residence

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Baidoa	9	47.4	47.4	47.4
IDP CAMP	3	15.8	15.8	63.2
Rural area	5	26.3	26.3	89.5
Outside Baidoa	2	10.5	10.5	100.0
Total	19	100.0	100.0	100.0

The data presented in Table 2 demonstrates the residential location of the participants, which returned the responses of all 19 participants. About 9 of the respondent mothers (53%) come from the residents of Baidoa while 18% identified themselves as members of the large communities of non-residents living in the various IDP camps in the District of Baidoa. In comparison with their counterparts; 5 of the mothers who delivered by c-section or 30% of the respondents are neither from Baidoa nor the IDPs, categorizing their residence as in the rural area. The remaining 2 respondent mothers of 10.5% are from areas outside the jurisdiction of Bay District. Data inform that most of the participants of this study who delivered by c-section at BRH are Baidoa residents and therefore urban society. Furthermore, the study confirms that mothers from rural area are more than those from the IDP camps in Baidoa and its environs. Interestingly, there are more expectant rural community mothers seeking delivery by c-section in BRH than mothers in the IDP camps either within Baidoa or its vicinity with contrast to about 11% who come from neighboring regions.

Table 3: Education

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Primary certificate	6	31.6	31.6	31.6
Secondary certificate	2	10.5	10.5	42.1
Post-Secondary Dip.	3	15.8	15.8	57.9
Bachelor Degree	1	5.3	5.3	63.2
Uneducated	7	36.8	36.8	100.0
Total	19	100.0	100.0	100.0

Data presented in Table 3 provides a reflection of the educational background of the mothers studied in this research as classified into 5 different levels. Mothers without formal education and mothers who completed up to primary education take the top ranks in the list by scoring roughly 37% and 32% respectively. Understandably, the other three categories between the two preceding levels take much lower rates 16% for post-secondary school diploma, 5% for holders of a bachelor's degree and 10% of the respondents achieving a secondary school certificate. When analyzed from a perspective of educated or uneducated, the results support that those who attended school score way higher than women who have not experienced formal learning. The difference can be observed from the fact that in Somalia female enrolment in schools and continuity are both problems often cited in the country's education sector (Eno et al. 2014; Eno et al. 2015) although Abdinor et al. (2021) believe the dominant cultural bias against females is decreasing in the decades since the collapse of the dictatorial regime of Mohamed Siad Barre.

Table 4: Employment

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Public sector	2	10.5	10.5	10.5
Business women	4	21.1	21.1	31.6
Housewife	12	63.2	63.2	94.7
Private sector	1	5.3	5.3	100.0
Total	19	100.0	100.0	100.0

Most of the respondents, 63% are housewives attending to their domestic family activities in the house, while 1(5%) is unemployed, 2 (10%) are employees working in one of the departments of the state administration, hence the public sector. Interestingly, 21% of the mothers in this study are businesswomen who own their own businesses. Although the response choices given were 5 in number including public sector, private sector (NGOs, companies etc.), businesswoman and housewife, none of the respondents offered employment type "private sector" as a choice or occupation practiced for a living. Instead, those in the area of business and entrepreneurship, 21%, make the second category among the given choices, which means they prefer to generate their own income independently and on their own rather than be employed in the public or private sectors or rather than being a housewife who depends on the family income from the man as the head of the family.

Observed from another perspective, the fact that 13 women out of the 19 constitute the uneducated and the lowest educated among all the female respondents, as demonstrated above in Table 3 about education, explains the reason why employment in the public sector is low and merely 10% and occupation in the private sector remains unchosen. On the other hand, women seem not to be handicapped by poor or lack of education as about a 3rd of them are either in own businesses or in the public sector. In a way, the low rate of unemployment gives a clear reflection of the lack of empowerment of women in education and in other professional jobs, despite the change expressed by Abdinor and his coauthors (2021).

Table 5: Respondent's total number of children

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
1-3 children	7	36.8	36.8	36.8
4-6 children	9	47.4	47.4	84.2
7-9 children	3	15.8	15.8	100.0
More than 9	0	0	0	
Total	19	100.0	100.0	100.0

The data results presented in Table 5 indicate the overall number of children the respondent mother has given birth to. In response, 7 of the respondents, which is 37%, have given birth to about 1-3 children, while 9 of them, which corresponds to 47% gave birth to between 4-6 children and the remaining 3, which is equal to about 16%, have responded to have given birth to about 7-9 children. No one among the surveyees has indicated to have given to birth more than 9 children as the choice did not reflect any response by the participants. Therefore, as the results envisage, a majority of the respondents have given birth to between 4-6 children followed by the category of those who gave birth to 1-3 children, whereas the category between 7-9 children has returned 3 responses or 16% and therefore in the third place while the choice of "more than 9" has yielded 0 response. The results in Table 5 seem to validate the data seen above in Table 1 that when a woman marries at an early age and starts giving birth at that age, the number of children increase as she grows older. However, as her age increases from 40 onwards, we see decrease in her productivity which justifies why there was only 1 woman above age 40 among the respondents, while no mother had more than 9 children.

Table 6: Number of children delivered by c-section

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
1 Child	10	52.6	52.6	52.6
2 Children	7	36.8	36.8	89.5
3 Children	1	5.3	5.3	94.7
4-5 Children	1	5.3	5.3	100.0
Total	19	100.0	100.0	100.0

Table 6 provides a comparative analysis of the results of the question about the number of children each respondent mother has delivered by c-section. The statistics produce equal results of 1 mother or 5% each for those who underwent delivery by c-section 3 times or 4-5 times of their childbirth. Comparatively, most of the mothers surveyed in this study, 10 or about 53% at the highest and 7 which is equal to about 37% have experienced delivery by c-section only with 1 child or 2 children respectively. The study informs that slightly over a half of the participant mothers have experienced c-section for the first time of childbirth. When combined with those who have had c-section for their second child these two categories of mothers make an overwhelming 90% of the total. For mothers with 3 or more children by c-section the number has decreased possibly due to the fact that many would not like to delivery by c-section for more than 3 or 4 children as most women in this area believe.

Table 7: What was your perception of c-section before the operation?

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Very risky	7	36.8	36.8	36.8
Risky	4	21.1	21.1	57.9
Neutral	3	15.8	15.8	73.7
Safe	5	26.3	26.3	100.0
Very safe	0	0	0	
Total	19	100.0	100.0	100.0

In order to find out respondents' perception regarding the rate of risk or safety of delivering by c-section prior to their operation, a choice of 5 responses were given across 'very risky', 'risky', 'neutral' and 'safe' and 'very safe'. The data in Table 7 indicates that none of the respondents figured out before their experience that cesarean delivery was very safe and therefore returned a zero response. In the other 4 response categories. Instead, about 37%, which is less than half of the survey participants, had a perception of childbirth by cesarean as a very risky operation compared to 26% of their counterparts with a view as safe operation. About 16% reported being neutral about the idea as they neither thought it risky nor safe. Those who thought cesarean was risky were 4 in number amounting to 21% of the total. In general analysis, a combination of those who perceived cesarean delivery as risky and very risky score close to about 60% of the overall number, leaving about 42% for those with an opinion of delivery by operation either neutral or safe.

Table 8: What is your current perception of delivering by c-section?

Valid	**Frequency**	**Percent**	**Valid Percent**	**Cumulative Percent**
Very safe	6	31.6	31.6	31.6
Safe	11	57.9	57.9	89.5
Fair	2	10.5	10.5	100.0
Unsafe	0	0	0	100.0
Very unsafe	0	0	0	100.0
Total	19	100.0	100.0	100.0

Question 8 was making a very crucial query as the intention was to obtain a comparative opinion of the same participants regarding their current perception of c-section, now that they had undergone the operation and have lived the real experience of the operation. In response, the data presented in Table 8 demonstrates that the current perception of the respondents towards c-section is quite different from their previous thinking. To confirm that difference, data show that 6 of the respondents which is 32% now believe that it is very safe to deliver by cesarean. When this response 'very safe' is compare to the response in the extreme high as shown in the above Table 7 which is 'very risky', we notice a considerable change of opinion in this response category measuring extremity of opinion in the 'risky' response and extremity of opinion in the 'safety' response. Replying to the same question, 11 mothers,

58%, now think that it is 'safe' to deliver by cesarean. Interestingly, when compared to the answer of 'risky' with 21% response return in Table 7 and next to the most extreme reply 'very risky', statistics reveal a wide difference of about 36% positive perception change in Table 8 for the answer 'safe' in the corresponding category which is also in the second position and carries a score of 11 responses or 58%. This change of opinion brings a sigh of relief as the mothers' change of perception plays a tremendous psychological role in society in terms the generally negative idea mothers have about child delivery by c-section. More interestingly, the responses in the lower category of Table 8, 'unsafe', and 'very unsafe' have both returned zero (0) response compared to answers in the high range of 'safe' and 'very safe' in Table 7 and yielded only 26% compared to 90% now after c-section with an improvement 60% towards positive perception.

Table 9: What is your perception of delivering by c-section in the future?

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Very good	6	31.6	31.6	31.6
Good	13	68.4	68.4	100.0
Fair	0	0	0	100.0
Bad	0	0	0	100.0
Very bad	0	0	0	100.0
Total	19	100.0	100.0	100.0

The data presented in Table 9 indicate the participants' perception of delivering by c-section in the future. The choices given in this question were in ranks of 5 from 'very good', 'good', 'fair', 'bad' and 'very bad'. The answers provided to the question completely ignore the three measurement choices of 'fair', 'bad' and 'very bad' all of which have a zero (0) in an overwhelming agreement. Ian comparison, the choices on the other upper/better rank of the choices such as 'good' and 'very good' have shared all the 100%. Between the two choices. 'good' has garnered about 32% of the mothers' perception for a c-section delivery in the future while the most extreme response of having 'very good' perception of the same delivery type is appreciated 68% of the participants. The results in Table 9 are very encouraging similar to those demonstrated in Table 8. In fact, the exploration of the participants' opinions from pre-natal to post-natal and the shift of these perceptions across the measurement tools to the better side indicate how expectant mothers' beliefs are changing regarding c-section. This is amazing because Somali women who mostly adhere or prefer the traditional method of normal delivery, and who in many cases would take the risk of having complications by declining delivery by c-section, now seem to realize that there is little risk in childbirth by cesarian mode. The participants' confidence to have cesarian delivery in the future ushers in a big relief to the medical field as these perceptions present credible evidence of the safety of this method of child delivery when normal delivery is either delaying or other problem are noticed that can endanger the lives of both the mother and her baby.

Table 10: Have you had any normal delivery before the c-section?

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	14	73.7	73.7	73.7
No	5	26.3	26.3	100.0
Total	19	100.0	100.0	100.0

To distinguish between women who have experienced normal delivery by c-section from first-timers by cesarian, a dichotomous question of 'yes' or 'no' was asked. In response, Table 10 displays that 4 of the respondents which is 74% had a normal delivery before c-section and that only the remaining 5 of about 26% underwent through delivery by c-section. The results seem to disagree the Somalis' general perception that women who started with normal delivery do not usually undergo c-section since with that normal delivery the tract has been opened and therefore making it less likely for the mother to have c-section delivery in the future.

Table 11: Do you think delivery by c-section can have a negative impact on your child's growth?

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	5	26.3	26.3	26.3
No	14	73.7	73.7	100.0
Total	19	100.0	100.0	100.0

After posing several questions to the participants that sought their variant perceptions concerning cesarian delivery specifically about the mother, question 10 was aimed to find out whether the mothers had similar concerns that c-section might have negative impact on the child's growth. To express their opinion of the matter, the mothers were given a 'yes' or 'no' question to determine which one of the two they agree to. The respondents who perceived that c-section cannot have a negative impact on their child growth were almost three times more than those who thought it could affect the development of the child. In this case, about 74% of the respondents did not anticipate of any negative impact to the child as a result of c-section when compared to their counterparts (26%), who contemplated that c-section might have an undesirable impact on child growth. The remarkably high rate of response might have been encouraged by the safe delivery the mothers have experienced and as reflected in the responses demonstrated in Table 8 and Table 9 above.

Q12. What worried you most about delivery by c-section?

Question number 12 is intended to bring a new focus into the study. Because the previous questions were typical of quantitative approach with close-ended, predetermined choices of answers, Q 12 was designed to consider the qualitative approach. The aim was to access the personal feelings of the respondents; to allow them express in their own words and according to their emotions the reflection of their own experience. Below are nine answers from 15 of the respondents as categorized and coded according to similarity of opinion:

Worries about anesthesia: Three respondents had worries related to anesthesia but from

different perspectives; (a) pain related to anesthesia; (b) not to return from anesthesia and lapse into comma; (c) negative impact from anesthesia. **Worries for the baby:** Three mothers had worries of (a) losing the baby; (b) possible injury to the baby; (c) delivering all future babies by c-section—a concern reported by Naa-Gandau et al. (2019). Two mothers mentioned that they had **Worries about injury & death of the mother:** (a) injury and/or death; (b) injury to my other organs. However, only one mother admitted that she had **No worries:** (a) No worries at all whatsoever; meaning that all trust was put in Allah who determines the fate of His creatures. Strangely though, none of the respondents mentioned male obstetrician as a problem or a worry about exposing the body to him, unlike the studies cited above that raised male medical doctors as an issue for Somali women.

Table 13: What is your advice to women who refuse c-section during complicated labor?

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
To consider c-section	16	84.2	84.2	84.2
Not to consider c-section	3	15.8	15.8	100.0
Total	19	100.0	100.0	100.0

Similar to questions 10 and 11 above and posed in a dichotomous frame of 'yes' and 'no', Question 13 is limited to only 2 answers which are 'to consider' and 'not to consider'. In more detail, the question attempts to seek the perception of mothers who have experienced c-section on whether they would advise women who follow conservative delivery and do not accept c-section to consider or to not consider the procedure when complications arise and normal delivery is not a better option. Not surprisingly, 16 of the respondents who constitute 84% would advise women to consider and not refuse c-section during complicated labor; while only 3 respondents consisting of 16% replied they would advise their female folks not to consider delivery by cesarian mode.

Despite the 3 advising against cesarian, the result demonstrates that a majority of the respondents at 84% would advise their female fellows towards the consideration of c-section. Among others, the possible reason some women may not feel comfortable with c-section could be related to the Islamic culture or even Somali culture which is conservative about the privacy of women. From another perspective, although Islam is not against a male doctor treating a female patient and vice versa, the culture factor makes some women too shy, too intimidated, and therefore too uncomfortable to expose their body to a male figure regardless of his status as a doctor (Salad et al., 2015). "Somali women very simply prefer female providers, period," (Deyo quoted in Benson 2013). As Benson (2013) further details, "[T]his is an issue of modesty. Very simply they [Somali women] do not want to show their private parts to a male provider who is not their husband."

Q14. Have you got any other comments to add?

Because most of questions were close-ended, Question 14, as the last one in the list, offered the participants to discuss any related matter to the subject that they would like to add. This was added due to the consideration that maybe some of the participants might have something to express that would contribute to their point and consequently to the study. However, majority of the respondents did not have much to add although a few respondents gave the comments below:

1. C-section was good for me and I will come for the delivery of my second child

2. Not everything was good

3. C- Section is good but only the fear is the anesthesia that causes loss of sensation

Whatever the previous (mis)perception, the responses provided in Question 14 indicate the change of belief the participants have made as a result of their real-life experience of cesarean section. Because the operation was undertaken successfully and both the mother and the newborn are healthy, participants are no longer scared of the process and procedures related to CS. Self-confession such as "C-section was good for me," is an encouraging statement and empirical evidence that can be used effectively during awareness campaigns on the improvement of maternal as well as child health. To a great extent, the confidence to admit "I will come for the delivery of my second baby," demonstrates the extreme satisfaction with the outcome by a mother who has undergone a life-saving operation that realized the well-being of both the expectant mother and her newborn child.

Results indicate that a very small ratio of the participants admits that "not everything was good." The notion could be related to the worrisome situation of uncertainty about CS. The psychological condition of the fear of the unknown usually grabs the pregnant woman upon realizing the high risks involved in a delay and the possible complications that can arise from a delayed decision than undergo a cesarean section to save lives. It is a kind of situation in which, as Naa-Gandau et al. (2019) report in their study in Ghana, many women would prefer to undergo normal vaginal delivery, similar to what has been reported of Somali women.

Conclusion and Recommendation

Conclusion

In this study we discussed the perception of 19 Somali mothers who had undergone c-section at Bay Regional Hospital, the main one of two referral health facilities in Bay Region, Southwest State of Somalia (SWSS)—the second facility being Bayhaw Hospital. Women's perception of c-section changed dramatically after undergoing the procedure as compared to their belief before the surgery. It is also remarkable that they would not hesitate in their next delivery by c-section and that they would recommend it to other women in order to avoid fatal complications. Although vaginal delivery is a preferred method of child birth, labor complications can occur in many situations whereby a prompt decision and medical steadfastness are required to save the lives of the mother and the child. The very knowledge of not being able to have normal delivery causes enormous psychological tension and worries about the consequence of what many women believe as "abnormal" delivery rather than a life-saving alternative to traditional vaginal birth. It is such hesitations which in many cases develop into fear and hysteria that make the expectant mother resist against CS until such a time when saving her life or her baby's becomes a huge challenge to the obstetrician, if not a nightmare and in some cases a mission next to impossible. Finally, the results in the study are encouraging in the sense that more women appreciate the positive outcome of their delivery. However, medical personnel should not rush to cesarean when vaginal delivery could still be facilitated. More importantly, obstetrics and other related medical personnel need to be given advanced training to enable them deal with any emergent complications and act fast accordingly.

Recommendation

This study pioneered the research on c-section in Baidoa and the Southwest State in general and covered only one health facility among several others that perform cesarean delivery. It is our recommendation that further investigations be carried out in order to contribute to our professional knowledge of the procedure, including its advantages, disadvantages, benefits and failures so as to serve the society better.

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