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Dominican Republic, Research Grant

Summer 2015

Agency in Dominican Birth: Can Women in Region III Influence

Exposure to Unnecessary Cesareans?

For two months I conducted research on women's sense of agency during childbirth in the Dominican Republic's Region III. This project was designed in response to the Dominican Republic's inflated cesarean rate, which in Region III is around 490% of the suggested rate by the World Health Organization.^{1,2} The problem of cesarean overuse is a major issue in global health, yet its causes are multi-faceted. Possible causes of cesarean overuse can be related to the medical team, the healthcare infrastructure, and maternal preferences. My project focused on maternal preferences. Thus, my findings shed light on the causes of elective cesareans and on maternal vulnerability to manipulation by medical professionals with cesarean preferences.

My data collection occurred in a regional public hospital in Region III of the Dominican Republic. This hospital receives references from the surrounding areas and has the ability to treat a wide range of illnesses. The hospital was under construction, therefore creating a chaotic, dusty, loud environment. Oftentimes, informants could not be heard over the screeching of power drills and crying babies. The dust led people to cover their faces and move to different areas of the hospital. Indoor temperatures were often in the 90s. Needless to say, this was not a peaceful birthing environment.

¹ Oficina Nacional De Estadística. "Samaná En Cifras." *Samaná En Cifras* (n.d.): n. pag. *ONE.gob.do*. Web. 13 Nov. 2014. <http://www.one.gob.do/themes/one/dmdocuments/perfiles/Perfil_Samana.pdf>.

² Gibbons, Luz, José M. Belizán, Jeremy A. Lauer, Ana P. Betrán, Mario Meriardi, and Fernando Althabe. "The Global Numbers and Costs of Additionally Needed and Unnecessary Caesarean Sections Performed per Year: Overuse as a Barrier to Universal Coverage." *WHO.int*. World Health Organization, 2010. Web. 13 Nov. 2014.

My project entailed two phases. The first phase consisted of roughly 100 interviews with pregnant women and mothers who had given birth in the past ten years. These women were recruited in the hallways and waiting rooms of the hospital. The second phase of my project consisted of individual case studies and medical team observations. During this phase, I worked in the labor ward, interviewing 13 medical professionals, holding a conference with the physicians, and investigating the cases of all consenting, qualifying patients. All in all, I interviewed and accompanied around 30 patients during this phase. They were either women in labor or women who had recently given birth.

Although my data is still being organized and reviewed, I have interesting preliminary findings. The women of Region III have a low sense of agency during birth. This is partially due to an exaggerated understanding of the risks involved with natural birth. For instance, 82% of patients estimated that at least half of the women who attempt a home birth would die. The vast majority of this 82%, believing that at least 90% of home-birthing women would die. Women do not trust labor—it is perceived as extremely dangerous, unpredictable, and impossible without a physician present.

Interestingly, the vast majority of women still prefer natural birth to cesarean. This preference is largely based off of perceived time of recovery and total pain. If a woman perceives natural birth to be quicker and less painful, then her preference is natural birth. If a woman perceives a cesarean to be quicker and less painful, then her preference is cesarean birth. Preference is not significantly based on differences in safety, neonatal health outcomes, cost, or bodily and/or cosmetic changes.

In many women's perceptions, cesareans are most associated with long, painful recoveries. Interestingly, many mentioned a fear of back pain, associated with the use of

an epidural during the cesarean operation. Epidurals are associated with cesareans; they are not utilized for natural birth in the Dominican Republic's public hospitals.

When inquiring about the perceived safety of natural vs. cesarean birth, most women correctly identified cesareans as a (generally) more dangerous process. When citing the dangers of a cesarean, an exceptional number of women mentioned the risk of surgical objects left in the body during a cesarean—gauze, scissors, etc. In contrast, many women noted that the benefit of a natural birth is that the body's system is cleared out—everything is shed and the woman is left properly cleaned and emptied.

Many women mentioned a fear of the episiotomy (vaginal cut during natural birth). The intimacy and sensitivity of this cut led many women to (mistakenly) believe it to be a more dangerous cut than that of a cesarean. The fear of episiotomies could partially lead women to prefer cesarean deliveries.

Prenatal check-ups are monthly and well-attended. They are focused on monitoring diets, weight, supplements, and analyzing risk factors (like diabetes, hypertension, anemia, etc.). During monthly check-ups, women take numbers and file through a quick, systematic process. Although the meetings are effective for monitoring pregnancy progress, women are not educated about childbirth. They do not learn how to push, breathe, nor what to expect. The lack of realistic expectations and training may contribute to the hospital's poor preparation of its especially young pregnant population.

Dominican protocol does not allow vaginal birth after cesarean (VBAC). Therefore, any time that a woman undergoes a cesarean, all subsequent births must also be cesarean. History of a previous cesarean is therefore a major factor in the (possibly unnecessary) use of cesareans for patients with non-recent previous cesareans.

When describing an ideal birth, the most common response was “a natural birth in the clinic”. The clinics throughout the Dominican Republic are the private practices that facilitate healthcare for high-income patients. According to one doctor, “they don’t even practice natural birth in clinics anymore.” The financial incentives of cesareans have led them to become standard practice in private clinics. However, clinics are known as giving superior attention to the patient—making the patient feel more cared for, more important.

The patient birth experience was largely shaped by the care of her family and friends. Women labored in the pre-birth room with one to three supporters—normally a mother, an aunt, and/or a friend. These supporters were there to speak with her, comfort her, bring food (if the hospital food was not sufficient), and prepare the hospital beds for her and the baby. Although these rooms normally held one to three patients, the environment was personal. Doctors and nurses would enter and leave intermittently, but were not a constant, overbearing presence (as I had noted in Mexican hospitals). The presence of supporters has been a major benefit to maternal safety, according to the hospital’s director. The high rate of maternal mortality in the Dominican Republic has been partially attributed to a lack of proper post-partum examination³. Since this hospital allows familiar supporters in the recovery rooms, they ensure that patients are constantly observed and inspected, lowering the instance of maternal death due to postpartum hemorrhaging.

Aside from maternal perceptions, a major factor in the overuse of cesareans may be physician impatience. When asked about the major causes of cesareans in the hospital, a gynecologist asked me, “Do you want the real reason or the lie?” “Both”, I responded.

³ Foster, J., Regueira, Y., & Heath, A. (2006). Decision making by auxiliary nurses to assess postpartum bleeding in a Dominican Republic maternity ward. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 35(6), 728-734.

“The true reason for most cesareans is fear on behalf of the hospital’s administration—that something would happen during a normal birth [in patients with] previous cesareans.” “And the lie?” I asked. “The lie is fetal distress. 5% are real risks—tachycardia, and bradycardia, which is more dangerous.” In concordance with this physician’s insight, I had followed several patients’ labors and noted that many ended in cesarean due to “fetal distress”. Supposedly, risk to the fetus’ safety had been linked to a “prolonged labor” of a mere 6, 7, or 8 hours. Further research may be necessary to identify whether or not the physicians’ impatience is cause for excessive cesarean use.

Entering the Dominican Republic, I had expected to find that the physicians were inflicting their corrupted preferences upon powerless patients. Certainly, physicians are seen as ‘all-knowing’, and patients rarely challenge a physician’s wishes; yet, the public system’s physicians have no real incentives to over-utilize cesareans. My preliminary data analysis suggests an exaggerated, shared fear of natural birth by physicians and the mothers, which significantly contributes to cesarean overuse.

My project will be finalized by November, when I will be presenting this research at the American Anthropological Association’s Annual Meeting in Denver, Colorado. Additionally, I am using this data to co-author a paper with Professor Vania Smith-Oka, entitled, “Purposeful, Anticipated, Intermittent, and Normal: Grappling with the Familiar/Strange Dichotomy of Childbirth Pain.” This paper will also be presented in Denver. I plan to seek publication of both of these projects and to present in the Human Development Conference at the Kellogg Institute for International Studies at the University of Notre Dame.