

# Experience of caesarean patients facing their pregnancies and labour in the town of Isiro, Democratic Republic of the Congo

Bwembola, V. B.<sup>1,2</sup>, Mwimba, R. M.<sup>3</sup>, Omanyondo, M. O.<sup>2,4</sup>, Bonangaleki, C. B.<sup>1</sup>, Malonga, D. B.<sup>1</sup>, & Bukasa, A. K.<sup>5</sup>

<sup>1</sup>Higher Institute of Medical Techniques of Isiro, City of Isiro, Democratic Republic of the Congo

<sup>2</sup>Doctoral School of the Higher Institute of Medical Techniques of Kinshasa, City of Kinshasa, Democratic Republic of the Congo

<sup>3</sup>Faculty of Medicine, University of Kinshasa, City of Kinshasa, Democratic Republic of the Congo

<sup>4</sup>Midwife Section, Higher Institute of Medical Techniques of Kinshasa, City of Kinshasa, Democratic Republic of the Congo

<sup>5</sup>Nursing Sciences Section, Higher Institute of Medical Techniques of Kinshasa, City of Kinshasa, Democratic Republic of the Congo

## ARTICLE INFO

**Received:** 29 July 2024

**Accepted:** 19 September 2024

**Published:** 22 October 2024

### Keywords:

Caesarean section, pregnancy, labour, woman, patient

**Peer-Review:** Externally peer-reviewed

© 2024 The Authors.

Re-use permitted under CC BY-NC 4.0  
No commercial re-use or duplication.

### Correspondence to:

Augustin Kadiata Bukasa  
[augustinkadiata@gmail.com](mailto:augustinkadiata@gmail.com)

### To cite:

Bwembola, V. B., Mwimba, R. M., Omanyondo, M. O., Bonangaleki, C. B., Malonga, D. B., & Bukasa, A. K. (2024). Experience of caesarean patients facing their pregnancies and labour in the town of Isiro, Democratic Republic of the Congo. *Orapuh Journal*, 5(5), e1148  
<https://dx.doi.org/10.4314/orapi.v5i5.48>

**ISSN:** 2644-3740

Published by Orapuh, Inc. ([info@orapuh.org](mailto:info@orapuh.org))

Editor-in-Chief: Prof. V. E. Adamu  
Orapuh, Inc., UMTG PMB 405, Serrekunda, The Gambia, [editor@orapuh.org](mailto:editor@orapuh.org).

## ABSTRACT

### Introduction

Pregnancy and childbirth have historically been considered, both in collective imagination and cultural transmission, as situations that threaten maternal and fetal survival.

### Purpose

This study aims to understand the experiences of women who underwent Caesarean sections at Isiro General Reference Hospital, in relation to their pregnancies and labour, in order to inform precautions for future cases.

### Methods

This is a qualitative study with a phenomenological approach. The population consists of women who underwent Caesarean sections in the gynecology-obstetrics department of Isiro General Reference Hospital. Data were collected through individual, semi-structured face-to-face interviews.

### Results

For most women in the town of Isiro, pregnancy and childbirth are perceived as difficult and painful experiences. They reported discomfort and embarrassment, describing a variety of symptoms that were often mild: various pains, eating and digestion disorders, headaches, shortness of breath, dizziness, etc. In addition, the expectant mothers often felt vulnerable.

### Conclusion

The conception of a child triggers a significant emotional upheaval in women, with psychological and physiological changes, particularly hormonal. These should not obscure the psychological challenges involved. Pregnancy and childbirth represent a period of identity crisis and psychological maturation for the woman transitioning into motherhood.

## INTRODUCTION

Globally, childbirth is often seen as a promise of life and happiness. After nine months of anticipation, expectant

mothers face the significant risk of losing their lives during pregnancy or childbirth. If they survive, they may still lose the child. In severe cases, both mother and child may be

lost simultaneously (World Health Organization [WHO], 2015). Pregnancy and childbirth have historically placed women at mortal risk (Coulibaly, 2007). This period almost always represents an intense experience on emotional, physical, and psychological levels. It is a phase of hormonal upheaval, but also a period of psychological vulnerability, during which past traumas may resurface (Bayle, 2017).

At the beginning of pregnancy, the child is just an idea. As the pregnancy progresses, particularly when fetal movements are felt, this concept becomes more tangible. The child becomes increasingly imagined by the mother, only becoming fully real after birth, which cannot occur without going through childbirth (Bayle, 2017). Childbirth is the climax of the prenatal period, linking pregnancy and the birth of the child. Although it is often a joyous moment, it also signifies a physical separation from the child. This can be a source of stress, anxiety, or even rejection, especially when complications arise or the birth does not proceed as the mother had envisioned (Jacques, 2017).

For many women, childbirth is imagined as a vaginal delivery, more or less medicalized. However, many unforeseen events can complicate the birth process. In France, until the late 19th century, the prospect of childbirth was fraught with anxiety. The popular saying "A fat woman has one foot in the ditch" illustrates the persistent perception of pregnancy as a dangerous state. Childbirth was often referred to as the "great ordeal," "critical moment," or "fatal moment." The fears of expectant mothers can be summed up in terms such as "tearing, hooks, irons, blood, infection," which evoke pain, permanent disability, and especially death in childbirth for both mother and child (Berthiaud, 2012).

In many African countries, particularly Mali, Ethiopia, and Angola, weak obstetric prophylaxis, inadequate medical staff, poor pregnancy monitoring, and the frequency of severe complications, as well as nutritional or pathological causes of pelvic abnormalities, have made Caesarean sections a common procedure. These surgeries are often performed under suboptimal conditions, constituting a risky operation (WHO, 2023). In the Democratic Republic of Congo, the perception of Caesarean sections varies between cities and provinces. In Mbuji-Mayi, a study

shows that for women and their families, undergoing a Caesarean section raises multiple issues. Cultural perceptions often link femininity with vaginal delivery, and thus, Caesarean sections are viewed negatively by both women and their families. Caesarean sections are seen as a failure in expressing womanhood and motherhood. Since this status is often socially validated, the feeling of failure is exacerbated by communal discourse. Economic implications are also significant, as Caesarean sections entail high financial costs for rural households. Even where financial support systems exist, these costs remain considerable for families, particularly for men who are socially responsible for covering healthcare expenses (Kabongo et al., 2018).

In Kinshasa, the capital of the DRC, a study on the knowledge, attitudes, and perceptions of Caesarean sections among pregnant women attending antenatal consultations (ANC) in six health facilities found that the majority of women had sufficient knowledge of Caesarean sections and a positive perception, though they maintained a negative attitude towards the procedure (Lukunda et al., 2024). These varying perceptions of Caesarean sections deserve further exploration in other provinces or cities to improve the image of this intervention. To date, no study has been conducted in the province or city of Isiro to explore the experiences of women who undergo Caesarean sections regarding their pregnancies and labour. This lack of data prompted the present study, which aims to understand the experiences of women undergoing Caesarean sections at the Isiro General Reference Hospital in relation to their pregnancies and labour, in order to inform precautions for future cases.

## METHODS

### *Research Design and Study Setting*

A qualitative study with phenomenological inspiration was chosen for this work, titled "*Experiences of caesarean patients facing their pregnancies and labor ...*" Specifically, this is a descriptive study where women who have given birth via caesarean section were asked to describe their experiences by responding to an interview guide questionnaire. The study was conducted in the gynec-obstetrics department of the Isiro General Reference Hospital (HGR/Isiro), located in the town of Isiro, Democratic Republic of the Congo.

### *Population and Sample*

The population for this research consists of women who underwent caesarean section in the gynecology-obstetrics department of HGR/Isiro. To obtain a homogeneous sample, specific inclusion criteria were used. The inclusion criteria were: women who had undergone caesarean section during the data collection period, who voluntarily agreed to participate, and who were present during the investigation. The exclusion criteria included women who had vaginal deliveries, caesarean patients who had been discharged, and those who refused to participate in the study.

### *Sampling and Sample Size*

In qualitative studies, the focus is on the characteristics of a phenomenon rather than the number of participants. By targeting the content of the interviews, high-quality data can be obtained, and a solid theorization can be developed with 10 to 15 interviews. According to Corbière and La Rivière (2014), sampling is "theoretical," meaning the researcher evaluates the phenomenon by selecting participants with typical characteristics. Amuli (2017) also noted that this type of sampling is reasoned, indicating that participants are selected based on relevance to the study. The sample size was built gradually in the field until saturation was reached with 17 participants, who provided the necessary information related to the research themes.

### *Data Collection Method, Technique, and Instrument*

This study employed a phenomenological qualitative method. The choice of this method is justified by its focus on subjective knowledge, specifically the meaning of certain human experiences as described by those who have lived through them. Data collection was done through individual, face-to-face, unstructured interviews, which allowed the collection of data on the daily experiences of women undergoing caesarean sections regarding their pregnancy and childbirth.

The unstructured interview is a preferred technique in qualitative research. The questions were not predetermined but were left to the discretion of the interviewees, allowing them to respond freely. A semi-structured interview guide was used, with interviews lasting 30 to 45 minutes and recorded using a smartphone.

This tool allowed for the collection of sociodemographic data in the first part and the women's experiences regarding pregnancy and labor in the second part (Gaspard, 2019). The interview guide was validated by two experts, ensuring that the content aligned with the study's objectives and research questions. The guide was translated into Lingala to facilitate data collection from non-French speakers, with both versions evaluated for translation accuracy by bilingual experts.

Data collection occurred between December 15 and February 15, 2024, at the Isiro General Reference Hospital. Interviews took place at the patients' bedside, starting with an introduction of the researcher, an explanation of the project, the signing of informed consent, and permission for audio recording. The interview concluded with thanks to the participants. The average duration of each interview was 38 minutes. According to Girard and Bréart (2015), the researcher's subjectivist paradigm influences the process. In this study, the researcher remained humble, kind, and respectful. Saturation was reached after interviewing 17 caesarean patients during their hospitalization. Sample saturation occurs when no new data is obtained (Omanyondo, n.d.).

### *Data Processing and Analysis Plan*

For this study, the five steps of phenomenological research methodology outlined by Giorgi (1977) were followed.

#### *Collection of Verbal Data*

The first step involved collecting detailed descriptions of the participants' experiences. The interviews were recorded and transcribed verbatim using a smartphone. A thematic analysis grid was created to study the interviews based on the central theme.

#### *Reading Data*

Participants' speeches were read and re-read to identify the overall meaning of each interview. This stage, according to Deslauriers (1991), is crucial for developing a "feel" for the data.

#### *Dividing Data into Meaningful Units*

Data were divided into meaningful units. As the verbatim transcripts were reread, units of meaning emerged when a shift in meaning was perceived. Neutrality was maintained to allow unforeseen meanings to surface.

*Organizing Raw Data in the Language of the Discipline*

The meaning units were examined and analyzed according to their relevance to nursing science. Giorgi's fourth step involves analyzing each statement in the context of nursing science.

*Data Synthesis*

The final step was synthesizing the data under different sub-themes, revealing the structure of the phenomenon. Seven sub-themes emerged: (1) manner of pregnancy occurrence (wanted or unwanted), (2) concerns during pregnancy, (3) participation in prenatal consultations, (4) course of pregnancy, (5) imagining childbirth (vaginal or caesarean), (6) progress of labor (triggering, pain), and (7) feelings about pregnancy and childbirth.

*Ethical Considerations*

This study adhered to ethical guidelines for research involving human subjects, as set out by the Social Sciences and Humanities Research Council of Canada, the Natural Sciences and Engineering Research Council of Canada, and the [Canadian Institutes of Health Research \(2010\)](#). Ethical approval was obtained from the Ethics Committee of the Doctoral School of the Higher Institute of Medical Techniques of Kinshasa, Democratic Republic of Congo. Participants were informed about the study's purpose and methods. Data were kept confidential, with names changed to protect anonymity, and were stored securely. Participation was voluntary, and respondents could withdraw from the study at any time without prejudice.

**RESULTS**

This section presents the results of the analysis, which consists of finding meaning in the collected data and demonstrating how they answer the research questions of this study: *How did the Caesarean patients experience the progression of their pregnancies and labour in the town of Isiro?*

*Sociodemographic and Clinical Data of Participants*

**Box 1:**  
Sociodemographic Data of Participants

Identification code	Age/Years	Marital status	Studies	Common origins	Gender/ baby
E1	30	Bride	Less than a state diploma	Municipality MENDAMBO	Male DCD
E2	19	Bride	state graduate	C/ KUPA	Feminine
E3	24	Bachelor	Less than a state diploma	C/ M ambaya	Feminine
E4	30	Bride	Illiterate	C/ mambaya	Male
E5	32	Bride	Illiterate	Outside the town of Isiro	Male dcd
E6	17	Bride	Less than a state diploma	C/ mendambo	Male
E7	19	Bride	Less than a state diploma	C/ Mambaya	Feminine
E8	33	Bride	Less than a state diploma	Outside the city of Isiro	Feminine
E9	26	Bride	Less than a state diploma	Commune Mambaya	Male
E10	42	Bride	State graduate	C/ MENDAMBO	Male
E11	19	Bachelor	State graduate	C/ MENDAMBO	Male
E12	28	Bride	Less than a state diploma	C/ KUPA	Feminine
E13	17	Bride	Less than a state diploma	C/ KUPA	Feminine
E14	18	Bride	State diploma	C / Mambaya	Male
E15	24	Bride	Less than a state diploma	Outside the town of Isiro	Male
E16	26	Bride	Less than a state diploma	C / Mendambo	Male
E17	27	Bride	Less than a state diploma	C / Mendambo	Feminine

Seventeen women participated in this survey. The ages of the participants range from 17 to 42 years. The majority of participants are married, have an education level below the state diploma, and live in the town of Isiro.

**Box 2:**  
Clinical Data of Participants

ID code	Size/ cm	Weight Mother /KG	Weight of NN/ Gr	Gesture	Parity	No. cesarean section	Term of pregnancy	Wound condition	Condition
E1	158	57	2900	6	4	2	+	Good	Good
E2	152	54	2500	2	2	2	+	Good	Good
E3	168	62	1900	2(1AV)	1	1	+	Infection	Good
E4	153	48	4900	5	5	5	+	Good	Good
E5	-	-	-	7	7	2	(-)	Good	Good
E6	152	58	2800	1	1	1	+	Good	Good
E7	149	50	3800	2	2	1	+	Good	Good
E8	166	55	2600	7	7	1	+	Good	Good
E9	148	53	3900	3	3	1	+	Good	Good
E10	154	60	3500	7	7	2	+	Good	Good
E11	157	54	2400	1	1	1	-	Good	Good
E12	148	53	3900	3	3	1	+	Good	Good
E13	152	53	2600	2	2	2	+	Good	Good
E14	159	55	2700	1	1	1	+	Good	Good
E15	145	48	2500	2	2	2	+	Good	Good
E16	154	55	2700	2	2	1	+	Good	Good
E17	161	61	2950	1	1	1	+	Good	Good

The clinical data shows that, despite the disparities in height, weight, parity, gestational age, and number of Caesarean sections, the progress in all cases remains positive.

*Results of Qualitative Analysis*

Using Giorgi's five-step method (1997a), the thematic analysis revealed seven main sub-themes:

1. Manner of Pregnancy Occurrence (**wanted or unwanted**)
2. Concerns During Pregnancy
3. Attendance at Prenatal Consultations
4. Course of Pregnancy
5. Imagination of Childbirth (vaginal or Caesarean section)
6. Progress of Labour (**triggering, pain, etc.**)
7. Depiction of Pregnancy and Labour

**Sub-Theme 1: Manner of Pregnancy Occurrence**

Categorical analysis revealed three categories within this sub-theme:

- Desired pregnancy
- Undesired pregnancy
- Undecided

**Sub-Theme 2: Concerns During Pregnancy**

This sub-theme covers issues such as abandonment by family and the perpetrator of the pregnancy, disputes and quarrels, fear of humiliation in motherhood, and fear of death. These concerns are categorised into four main areas.

**Sub-Theme 3: Participation in Prenatal Consultations**

Three categories emerged within this sub-theme:

- Full participation
- No participation
- Incomplete participation

**Sub-Theme 4: Course of Pregnancy**

This sub-theme revealed three categories:

- No problems
- Severe suffering
- Threat of abortion or premature birth

**Sub-Theme 5: Imagination of Childbirth**

Two categories emerged in this sub-theme:

- Vaginal delivery
- Caesarean section
- Undecided

**Sub-Theme 6: Progress of Labour**

Three categories emerged here:

- Long duration
- Poor progress
- Exaggerated pain and sudden onset of labour

**Sub-Theme 7: Depiction of Pregnancy and Labour**

This sub-theme had three categories:

- Psychosomatic disorder
- Door to death
- Socio-economic problem
- Physiological phenomenon

**Box 3:**  
Manner of Pregnancy Occurrence

**Question: Was your pregnancy wanted?**

Subtopics	Categories	Verbatim
Manner of occurrence of pregnancy	Desired pregnancy	E1 "...Yes, Dad, I really needed this pregnancy because I only have one daughter..."
		E12 "...Of course yes, the first pregnancy ended in a stillbirth [...]  Having a child was a necessity for me..."
		E7 "...humm..., as I am here, the desire for pregnancy was priority,  Yes, me and my husband liked it..."
Unwanted pregnancy	Unwanted pregnancy	E6 "... papa munganga, being married without children you know what happens to us Africans, I had wanted the pregnancy..."
		E13 "... I didn't like the occurrence of this pregnancy, I'm still at home and at the bottom of school, really it wasn't the time yet ..."
		E4 "no no, dad, it wasn't even in my dreams yet, pregnancy?, but it happened  E5 "...this pregnancy was not wanted for me"
Undecided	Undecided	E10 "...My mind wasn't calm, at first I didn't like it but today it's okay, ..."  E9 "...really, I was very stressed when I saw the pregnancy test result came back positive, whether I want it or not I am already pregnant, no more choice ...".  E16 "...dad, humm wanted or not the pregnancy was there..."

The data shows that most of the Caesarean patients reported that their pregnancies were wanted. A minority mentioned their pregnancies as unwanted or expressed uncertainty about their response.

**Box 4:**  
Concerns During Pregnancy

Subtopics	Categories	Verbatim
Concern during pregnancy	abandonment by the family and the author of the pregnancy,	E17 "...eh hummm the parents did not accept this pregnancy and they kicked me out of the house, my life had become an ordeal as the author of the pregnancy was also on the move, the nine months were not easy for Me ... "
		E14 "... HUUU... my husband left me alone at home, he went to the mining quarries, there... life had become difficult for me and the children at home..."
		E11 "... it was serious dad humm, when the pregnancy was announced, the perpetrator fled until today, I was abandoned..."
dispute and quarrel,	and	E16 "...I had big problems with my sister-in-law, quarrels and fights at all times, even in the presence of my husband who was always for his sister..."
		E8 "...I loved my pregnancy but my parents didn't like the owner of the pregnancy while I loved him very much, so the situation worried me throughout the entire period of the pregnancy..."
		E4 "... First of all for myself, the pregnancy was not wanted in addition the family also did not want the pregnancy either [...] I believe that it is this anxiety which led me to the fifth cesarean..."
		E1 "... , quarrel, tears, worry, incomprehension, fighting all the time with my husband, I didn't eat
fear of death		E6 "...I was afraid of death, so much so that I am still a minor and especially the first experience of life of becoming a mother the pelvis is not used to it, good God has given me grace I am alive..."
		E4 "...hummm I was really afraid of death, dad knowing that I have already given birth 4 times by cesarean section, the fate of this pregnancy did not leave me alone until today I realized the fifth

This box highlights concerns such as abandonment by family and the perpetrator of the pregnancy, fear of humiliation in motherhood, fear of death, and disputes and quarrels.

**Box 5:**  
Participation in Prenatal Consultations (CPN)

*Question: Did you participate in CPN?*

Subtopics	Categories	Verbatim
Participation in the CPN	Normal participation from start to finish (4)	E1 "... Well, I carried out the 4 planned CPNs until the birth, I really respected that..."
		E4 "...I followed the advice of the midwives to the letter and I completed 4 CPNs before going to the maternity ward for the birth"
		E 3 "..., I normally finished my CPN before giving birth... it was in the third month that I started gaining weight..."
Partial participation		E6 "... I started my CPN at the sixth month and I completed it 3 out of 4, but soon I have to improve Dad..."
		E 11 "... given the difficulties I encountered during my pregnancy, I did not want to appear to the public, hence my absence from the CPN..."
No participation		E14 "...No no dad, never once did I have anything to wear to go with me to the CPN, even my delivery was not well prepared..."

The responses show that opinions vary regarding CPN participation. The majority said they participated fully, some partially, while a few stated that they did not attend any prenatal consultations.

**Box 6:**  
Course of Pregnancy

**Question:** How did you find the course of your pregnancy?

Subtopics	Categories	Verbatim
Course of pregnancy	No problem	E15 "...my pregnancy had gone well, I only arrived at the hospital for the prenatal consultation, apart from that nothing else..." E 6 "...no I was fine except for malaria..." E2 "...no, I progressed without any problem from the beginning to the end of my pregnancy..."
	Huge suffering	E1 "...Too many problems with my husband, I wasn't comfortable, my pregnancy was characterized by crying every day..."  E3 "...not good, first the vomiting at the beginning of the pregnancy until the third month and then the anemia throughout the pregnancy, I had a horrible time with this pregnancy..."  E7 "...dad I endured a terrible ordeal, six months without eating normally, I had no appetite..."  E5 "... at the beginning I was fine, when I reached the sixth month, everything changed, intense discomfort, dizziness, difficulty making movements and I was in bed all the time, which even caused my cesarean section..."
	Threat of abortion and premature birth	E4 "... From the beginning to the end of this pregnancy it was only the taking of medicine, the hospital had become my home all the time, the pregnancy threatened to end from the fourth month..."  E12 "... Dad, I almost died because of the hemorrhage six months into the pregnancy, I stayed in hospital for three months before the cesarean..."

For some participants, the pregnancy progressed without issues. However, others experienced severe suffering or threats of abortion or premature birth.

**Box 7:**  
Imagination of Childbirth

**Question:** How did you imagine your childbirth?

Subtopics	Categories	Verbatim
imagination of kind of childbirth	Vaginal birth	E1 "...Dad, who can enjoy giving birth by cesarean section on their own, I preferred the low route but man suggests, God disposes, they say..."  E2 "... my concern was to give birth vaginally to feel that I am a woman, that is not childbirth but an operation..."
	Upper birth	E6 "...dad, cesarean section cannot be someone's preference, I imagined a normal birth but alas..." E4 "... humm, it's hard, I already imagined my fate, even, the birth had already told me so; four times cesarean section, I knew that my outcome would be a cesarean section, that's it..."
	undecided	E7 "...Me personally I had no imagination in my head because I entrusted everything in the hands of the Lord for the future, I really didn't have the idea..." E11 "...despite my difficulties, I had not imagined one or the other way of giving birth..." E13 "...no idea, I knew that only God knows the rest..."

The majority of women expressed a preference for vaginal delivery over a Caesarean section.

**Box 8:**  
Progress of Labour

*Question:* What was your labour experience like?

Subtopics	Categories	Verbatim
delivery process	Long duration	<p>E5 "...the beginning I felt lower back pain following the flow of clear liquid, I spent two days with the same situation in a health center, which brought me back to the general hospital where we proceeded directly to the intervention because I lingered a lot..."</p> <p>E8 "... arrived at the hospital in the morning, with epigastric heat which triggered labor, we dragged on for three days without this delivery taking effect and the doctor decided to have a cesarean section..."</p>
	poor development	<p>E4 "...Dad, the contraction was there but the cervix does not always open completely, which led the doctor to make the decision to have a cesarean..."</p> <p>E9 "...I have no idea what happened, but I heard the midwife saying all the time that the progress is not good..."</p> <p>E1 "...I had strong contractions, the cervix was also dilated but I did not have the strength to push, the child dragged a lot in my pelvis, which meant that despite the cesarean section we were not able to get the baby back..."</p>
	exaggerated pain and sudden onset	<p>E13 "... dad, I myself asked for a cesarean section in order to be free from the pain, at first the induction was very brutal, which did not allow me to carry out the essentials to return home hospital..."</p> <p>E16 "... at the beginning it was the first day I felt a slight pain in the lower abdomen, arriving at night around 1 a.m., I felt a strong abdominal pain in the form of a cramp, I was rushed to the hospital where the cesarean section was decided..."</p>

The responses indicate that labour was characterised by a long duration, poor progress, and exaggerated pain, often accompanied by a sudden onset of labour.

**Box 9:**  
Depiction of Pregnancy and Labour

*Question:* How did you experience your pregnancy and labour?

Subtopics	Categories	Verbatim
depiction of pregnancy and labor	Psychosomatic load	<p>E11 "... humm, pregnancy on the one hand and labor on the other, are stressful situations in a woman's life, no good sleep, pain everywhere, eh, it's serious..."</p> <p>E14 "... It's an additional burden in a woman's life, stress, anxiety, occurrence of illnesses linked to pregnancy, nutritional disorder which causes anemia, anorexia..., ..."</p>
	The door to death	<p>E13 "... dad, I myself asked for a cesarean section in order to be free from the pain, at first the induction was very brutal, which did not allow me to carry out the essentials to return home hospital...really I already saw death approaching me..."</p> <p>E16 "... at the beginning it was the first day I felt a slight pain in the lower abdomen, arriving at night around 1 a.m., I felt a strong abdominal pain in the form of a cramp, I was rushed to the hospital where a cesarean section was decided, labor means death..."</p>
	socio-economic problem	<p>E11 "... Pregnancy separated me from the dear people in my life, I was abandoned by my people (my family) because of the pregnancy</p> <p>E17 "...My parents kicked me out of the house because of the pregnancy, don't you think that's a problem in society? If a father or mother throws his own daughter out of the house... Life had become difficult, to give birth so the preparation was not easy due to lack of money..."</p> <p>E16 "...Conflict, quarrels and fights at all times do not leave a good social climate at home..."</p> <p>E14 "...as my husband went into career, I led a very difficult life due to lack of financial means..."</p>

Participants depicted pregnancy and labour as a psychosomatic disorder, a "door to death," and a socio-economic problem.

**DISCUSSION**

*Sociodemographic and Clinical Results*

Seventeen women participated in this survey. The ages of the participants ranged from 17 to 42 years. Of the participants, 58.3% were married, and 41.7% were single. Furthermore, 75% had an education level below the state diploma, while 25% had a state diploma. Additionally, 16.6% of the participants lived outside the town of Isiro.

According to Marlama (2010), age has a transversal influence on negative experiences regarding pregnancy

and childbirth. Adolescents and young adults often lack the cognitive, emotional, and social skills that older adults possess to adapt to such situations. Consequently, younger individuals, especially those with limited experience in childbirth and infection management, may struggle to care for themselves to prevent infections. Bougoudogo (1998) also highlighted that a lack of education among women giving birth is associated with pregnancy and postpartum complications, as they may lack awareness of obstetric care, which encompasses prenatal, delivery, and postpartum care. This care is crucial in preventing health problems during pregnancy, detecting abnormal conditions, and ensuring proper medical intervention when necessary.

Mahalik et al. (2017) further noted that less educated mothers often fail to understand the importance of prenatal consultations. Even when they attend such consultations, they may struggle to remember the principles and apply them. The lower education level could explain the disparity in preventive behaviors. Regarding residential origin, the study suggests that this may be coincidental, as the experience of pregnancy does not necessarily depend on the environment for all women, regardless of their background.

#### *Thematic and Categorical Results*

After analyzing the collected data, a single central theme was identified for the study: "Women's experiences facing pregnancy and labor." From this central theme, eight sub-themes emerged. The respondents' experiences varied, with some describing them as negative and others as positive, as detailed in the results section.

#### *Manner of Occurrence of Pregnancy (Wanted or Unwanted)*

The first research question explored whether the pregnancies were wanted or unwanted. The study revealed three main categories: wanted pregnancies, unwanted pregnancies, and respondents who were unsure. The majority of participants desired pregnancy to confirm their status as mothers. Emmanuel (2014) explained that pregnancy is often desired as it grants women the status of motherhood. Historically, in the 18th and 19th centuries, the desire for children was almost unquestioned, especially since motherhood was considered a "natural" vocation for women. Procreation was also emphasized in

Christian teachings as the primary purpose of marriage. Fertility was highly valued in traditional rural societies, as births ensured the continuation of life. Women, especially after marriage, expressed a strong desire to conceive, viewing motherhood as a duty.

The following responses from participants illustrate these sentiments:

*E7: "As I am here, pregnancy was a priority. Yes, my husband and I wanted it."*

*E6: "Being married without children, you know how it is for us Africans, I wanted the pregnancy."*

#### *Various Concerns During Pregnancy*

The second research question examined women's concerns during pregnancy, revealing four categories: family abandonment, disputes and quarrels, fear of humiliation at maternity, and fear of death. While women often desire children, pregnancy itself is not always pleasant. Historically, pregnancy was rarely associated with well-being, and for many women, illness and pain were common companions during the reproductive process. This aligns with historical views from doctors who treated pregnancy as one of many women's illnesses (Emmanuelle, 2014). Even George Sand (2009), who celebrated motherhood, acknowledged the discomfort associated with pregnancy.

Some participants shared their concerns:

*E8: "I loved my pregnancy, but my parents didn't like the father of the child, which worried me throughout."*

*E4: "The pregnancy wasn't wanted by me or my family. I believe the stress led to my fifth cesarean."*

#### *Participation in Prenatal Consultation*

Responses to the third research question revealed three categories: normal prenatal consultations (PNCs), partial PNCs, and no participation in PNCs. Prenatal consultations are essential for detecting and treating complications during pregnancy (Kamdem, 2012). In many African cultures, a woman's development is often linked to pregnancy, which is not viewed as an illness but requires regular monitoring.

Some participants noted their experiences:

*E1: "I attended all four planned PNCs before the birth."*

*E4: "I followed the midwives' advice and completed all four PNCs before delivery."*

In our study, a small number of participants did not fully complete the PNCs, which could be attributed to ignorance or lack of awareness.

#### *Imagination of the Birth Canal*

The fourth research question identified three categories: vaginal delivery, cesarean section, and the undecided. In Haut Uélé Province, cesarean sections are generally undesirable due to the perceived risks, including death. Women preferred vaginal deliveries over cesarean sections.

Some testimonies include:

*E1: "Who would willingly choose a cesarean? I preferred a natural birth, but ultimately, God decides."*

*E2: "I wanted to give birth naturally to feel like a woman."*

This societal pressure for natural childbirth contrasts with the growing trend of medicalization during delivery, especially in countries like France, where cesarean sections are common (Fabregoul, 2016).

#### *The Course of Labor*

The participants' responses to this question revealed three categories: long labor, poor progress with excessive pain, and sudden onset. Normal labor usually lasts 12 to 18 hours for a first pregnancy, and shorter for subsequent pregnancies (World Health Organization, 2018).

Participant testimonies included:

*E5: "I had back pain for two days before I was transferred to the general hospital for a cesarean."*

*E8: "I spent three days in labor before the doctor decided on a cesarean."*

Factors such as drugs, alcohol, or debilitating diseases can negatively influence labor progress.

#### *Representation of Pregnancy and Labor in a Woman Who Had a Cesarean*

Participants who had cesareans viewed pregnancy and labor as sources of psychosomatic disorders, gateways to death, and socioeconomic problems. A similar study in

Haiti revealed that women who had cesarean sections experienced feelings of fear, failure, and guilt, as they did not give birth "normally" (Joseph et al., 2023). Coulibaly (2015) found that pregnancy and childbirth symbolized emotional, physical, and psychological challenges. Many women also faced financial difficulties during this critical period.

Some women shared their experiences:

*E11: "Pregnancy and labor are stressful periods in a woman's life. No good sleep, pain everywhere."*

*E17: "My parents kicked me out of the house because of the pregnancy. Don't you think that's a societal problem?"*

#### *The Limitation of the Study*

One major limitation of qualitative research is the small sample size, which does not allow for generalization of the results (Gillis & Jackson, 2012). Additionally, there was uncertainty regarding the accuracy of the respondents' accounts, as researchers cannot fully step into their shoes. Furthermore, the researcher's position as a police officer may have influenced participants' willingness to share, as they feared the study could lead to punishment for healthcare providers.

To mitigate these limitations, we triangulated the research by having another researcher analyze the raw data. This expert review confirmed that the same conclusions were reached. To ensure validity, participants were allowed to review the data collected to verify our interpretations (Lincoln & Guba, 1985).

## CONCLUSION

Pregnancy and labor were perceived as psychosomatic disorders and gateways to death by the study participants. These experiences, marked by anxiety, pain, and danger, emphasize the need for special attention during pregnancy to reduce maternal and fetal morbidity and mortality.

**Ethics Approval:** Ethical approval was obtained from the Bioethics Committee, Higher Institute of Medical Techniques of Kinshasa, Kinshasa, Democratic Republic of the Congo (n°055/ESU/ISTM/DG/2022 du 06/10/2022).

**Conflicts of Interest:** None declared.

#### ORCID iDs:

Bwembola, V. B.<sup>1,2</sup>: Nil identified  
Mwimba, R. M.<sup>3</sup>: Nil identified

Omanyondo, M. O.<sup>2,4</sup>: Nil identified  
 Bonangaleki, C. B.<sup>1</sup>: Nil identified  
 Malonga, D. B.<sup>1</sup>: Nil identified  
 Bukasa, A. K.<sup>5</sup>: <https://orcid.org/0009-0004-3811-8650>

**Open Access:** This original article is distributed under the Creative Commons Attribution Non-Commercial (CC BY-NC 4.0) license. This license permits people to distribute, remix, adapt, and build upon this work non-commercially and license their derivative works on different terms, provided the original work is properly cited, appropriate credit is given, any changes made are indicated, and the use is non-commercial. See: <https://creativecommons.org/licenses/by-nc/4.0/>.

## REFERENCES

- Abdoul, K. C.** (2015). *La césarienne au Centre de santé de référence de Koutiala: Indications et pronostics fœto-maternels* (Doctoral thesis). Université de Bamako, Mali.
- Amuli, J. P., & Ngoma, O.** (2017). *Méthodologie de la recherche scientifique en soins et santé, Tome 1, de la conception à la diffusion des résultats*. Édition Médiaspaul.
- Belliot, E.** (2015). Impact des césariennes en cours de travail sur les interactions précoces. *Vocation sage-femme*, 115, 22–26.
- Benoît Bayle.** (2017). *Traumatismes psychiques à l'aube de la vie*. Collection La vie de l'enfant.
- Berthiaud, E.** (2012). Le vécu de la grossesse aux XVIIIe et XIXe siècles en France (pp. 93–108). <https://doi.org/10.4000/hms.282>
- Berthiaud, E.** (2014). Vécu de la grossesse aux XVIIIe et XIXe siècles en France: Histoire, médecine et santé.
- Bosselier, P.** (2012). Indication de la césarienne itérative sur utérus cicatriciel à la clinique Sainte Anne Chatelleaut. Deuxième journée obstétricale du colloque de gynécologie de Bordeaux.
- Clement, M.** (2014). Indication de césarienne dans les grossesses uniques dans deux pays danois avec un taux de césarienne différent. *Acta Obstetrica et Gynecologica Scandinavica*, 73(2), 129–135.
- Corbière, M., & Larivière, N.** (2014). *Méthodes qualitatives, quantitatives et mixtes: Dans la recherche en sciences humaines, sociales et de la santé*. Presses de l'Université du Québec.
- Dageville, C.** (2011). Protéger la rencontre entre la mère et son nouveau-né. *Spirale*, 59, 99–115. <http://www.cairn.info/revue-spirale-2011-3-page-99.htm>
- Giorgi, A.** (2010). Phenomenology and the practice of science. *Existential Analysis*, 21(1), 3–22.
- Grimes, H. A., Forster, D. A., & Newton, M. S.** (2014). Sources of information used by women during pregnancy to meet their information needs. *Midwifery*, 30(1), 1–5.
- Herbinet, E.** (2011). L'aube des sens... Raisons et violence. *Spirale*, 57, 21–28.
- Jacques, B.** (2017). L'expérience de la maternité sous influence médicale. *Face à face*. <https://journals.openedition.org/faceface/551?ang=en>
- Joseph, J., Simon, T., & Carmil, S.** (2023). Perception et expérience de la césarienne d'urgence par les femmes haïtiennes. *Périnatalité*, 15(2), 101–109. <https://doi.org/10.3166/rmp-2022-0191>
- Julie, F.** (2016). Vécu chronologique de la césarienne en urgence et de l'accompagnement par les professionnels. Lyon Sud, Charles Merieux.
- Kabongo, M. A. G., et al.** (2018). Césarienne en milieu rural du Kasai Oriental (RD Congo): Perceptions et vécu à Kasansa et à Tshilenge. *International Journal of Medical and Health Research*, 4(3), 52–60.
- Kandem, I.** (2012). Évaluation des connaissances des conjoints relatives aux consultations prénatales (Unpublished master's thesis). International School for Nurses and Technical Sanitary Personnel, Cameroon.
- Koné, A.** (2004). Facteurs de risque des complications maternelles post-césariennes à l'hôpital Gabriel Touré et au Point G (Doctoral thesis). Université de Bamako, Mali.
- Le Guedec, B.** (2015). La césarienne, un mode de naissance peu abordé en PNP. *Dossier Obstétrique*, 446, 18–19.
- Leboyer, F.** (2013). *Pour une naissance sans violence*. Éditions du Seuil.
- Léroy, F.** (2002). *Histoire de naître de l'enfantement primitif à l'accouchement médicalisé*. De Boeck et Larcier.
- Lukunda, D. P., Mbungu, M. R., Mbangama, M. A., Kahindo, M. P., Tandu, U. A., Mwimba, M. N., Lumaya, A. J., Sengeyi, M. A., & Lokomba, B. V.** (2024). Connaissances, attitudes et perceptions de la césarienne chez les gestantes suivies en CPN dans 6 maternités de Kinshasa. *Revue Africaine De Médecine Et De Santé Publique*, 7(1), 106–120.

- <https://www.rams-journal.com/index.php/RAMS/article/view/346>
- Lukunda, D. P., Mbungu, M. R., Mbangama, M. A., Kahindo, M. P., Tandu, U. A., Mwimba, M. N., Lumaya, A. J., Sengeyi, M. A., & Lokomba, B. V.** (2024). Connaissances, attitudes et perceptions de la césarienne chez les gestantes suivies en CPN dans 6 maternités de Kinshasa. *Revue Africaine De Médecine Et De Santé Publique*, 7(1), 106-120. <https://www.rams-journal.com/index.php/RAMS/article/view/346>
- Mahalik, J. R., Burns, S. M., & Syzdek, M.** (2017). How do men construct and explain men's violence? *Journal of Interpersonal Violence*, 32(15), 2417-2439. <https://doi.org/10.1177/0886260515625511>
- Marlma.** (2010). Grossesse et accouchement: Les logiques sociales des responsables, du personnel de santé et des femmes (Algérie). *Face à face*, 14. <http://journals.openedition.org/faceface/1149>
- Melchior, J., Bernard, N., & Raoul, A. I.** (2008). Évolution des indications de césariennes mises à jour en gynécologie et obstétrique. Vigot.
- Merger, R., Levy, J., & Melchior, J.** (2004). *Précis d'obstétrique* (6th ed.). Masson.
- Mignot, S.** (2012). Césarienne: Des cicatrices difficiles. *Profession sage-femme*, 116, 44-45.
- Nadi, J.** (2019). Césarienne: Pronostic maternel et périnatal (Unpublished specialization thesis). Université de Kisangani, Democratic Republic of Congo.
- Odent, M.** (2015). *Césarienne: Questions, effets, enjeux, alerte face à la banalisation*. Le Souffle d'Or.
- Omanyondo, M. C.** (2018). Séminaire de méthodologie de la recherche scientifique (approche qualitative), Master 1 en santé maternelle et infantile, ISTM-Kinshasa.
- Organisation Mondiale de la Santé.** (2010). *Déclaration de l'OMS sur les taux de césarienne*. [http://www.who.int/reproductivehealth/publications/maternal\\_perinatal\\_health/cs-statement/fr/](http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/cs-statement/fr/)
- Sand, G.** (2009). *Correspondance* (Vol. 1, 1812-1831, G. Lubin, Ed.). Garnier Frères.
- Sigurdardottir, V. L., Gamble, J., Gudmundsdottir, B., Kristjansdottir, H., Sveinsdottir, H., & Gottfredsdottir, H.** (2017). The predictive role of support in the birth experience: A longitudinal cohort study. *Women and Birth*, 30(1), 153-159.
- Soumare, H.** (2010). Complications maternelles infectieuses bactériennes post-césariennes (Doctoral thesis). Université de Bamako, Mali.
- Stark, M.** (2010). Technique de césarienne: La méthode Misgav Ladach. In: Pop King.
- Technical Working Group, World Health Organization.** (2018). Care in normal birth: A practical guide. *Birth Issues in Perinatal Care*, 24(2). <https://doi.org/10.1111/j.1523-536X.2018.241.2>
- Thoulon, J. M.** (2010). *Les césariennes*. Encyclopédie Médicale Chirurgicale, Paris, France.
- Titran, M.** (2010). L'accompagnement à la naissance. *Spirale*, 55, 67-73. <http://www.cairn.info/revue-spirale-2010-3-page-67.htm>
- Tucker Edmonds, B., Mogul, M., & Shea, J. A.** (2015). Understanding low-income African American women's expectations, preferences, and priorities in prenatal care. *Family & Community Health*, 38(2), 149-157.
- Vozari, A. S.** (2015). Si maman va bien, bébé va bien: La gestion des risques psychiques autour de la naissance. *Recherches Familiales*, 12, 153-163. <http://www.cairn.info/revue-recherches-familiales-2022-1-page-153.htm>
- WHO.** (2015). *Mortalité maternelle*. <https://www.who.int/fr/news-room/fact-sheets/detail/maternal-mortality>