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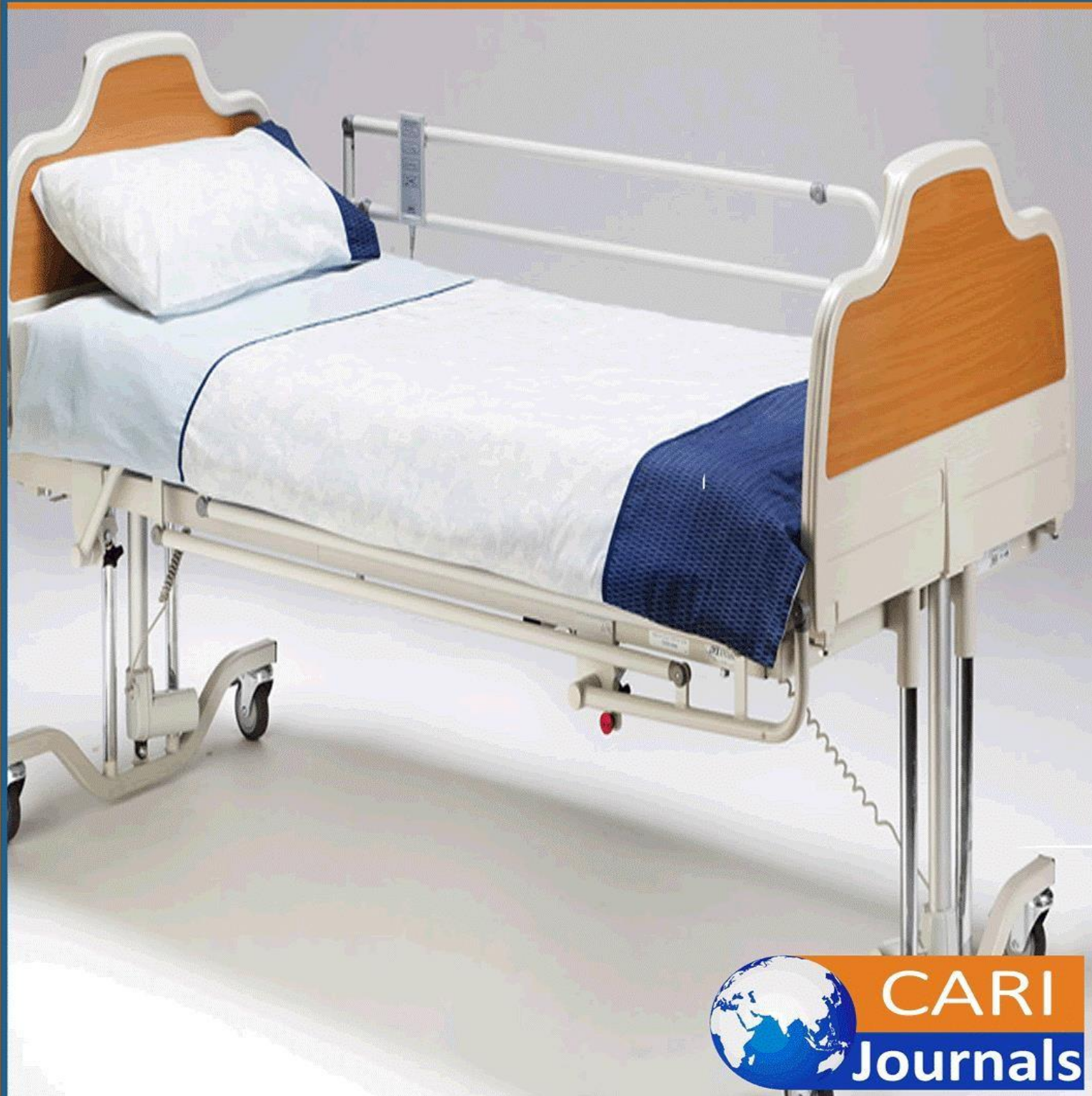

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Perceptions and Experiences of Women Undergoing Emergency Caesarean Section in Mbandaka, Democratic Republic of the Congo

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Abstract

Purpose: This study aimed to explore how women in Mbandaka perceive and experience emergency caesarean sections in a context marked by an increasing frequency of such procedures and growing mistrust toward maternity care services.

Methodology: A qualitative phenomenological study was conducted to understand the personal meanings attributed to experiences of emergency caesarean sections. Data were collected through semi-structured interviews with women who had undergone an emergency caesarean section in Mbandaka. The transcripts were analyzed using a thematic approach in order to identify major themes and recurring perceptions.

Findings: The majority of participants expressed negative perceptions of emergency caesarean sections. Several associated the procedure with bad luck and believed it was sometimes performed for financial gain by healthcare providers. These perceptions generated mistrust, fear, emotional distress, and a sense of inadequacy among the women concerned. The findings also highlight a breakdown of trust between patients and healthcare professionals within maternity services.

Unique Contribution to Theory, Policy and Practice: This study highlights the socio-cultural and emotional dimensions associated with emergency caesarean sections in the context of Mbandaka. It contributes to a better understanding of women's perceptions of emergency obstetric interventions. From a policy and practice perspective, the findings emphasize the need to strengthen communication between healthcare providers and patients, promote transparency in medical decision-making, and develop community-based awareness strategies to improve trust in maternal healthcare services.

Keywords: *Women's Perceptions, Emergency Caesarean Section, Qualitative Study, Phenomenological Approach, Mbandaka, Democratic Republic of the Congo*

JEL Codes: *I12*

1. Introduction

An emergency caesarean section is a sudden and unpredictable surgical intervention performed when complications arise during labour that threaten the life or health of the mother or the newborn. Such complications may include foetal distress, obstructed labour, instrumental failure, or prenatal haemorrhage [1]. Many maternity wards now use a colour-coded urgency system to classify caesarean sections: green for procedures that must be performed within 30 minutes, and red for those requiring immediate action within 15 minutes [1]. Although emergency caesarean sections are often medically necessary and lifesaving, their increasing frequency has become a global concern. According to the World Health Organization, caesarean deliveries are expected to account for 29% of all births worldwide by 2030—representing approximately 38 million procedures, the majority in low- and middle-income countries. The highest proportions are projected in North Africa, particularly Egypt, where rates could reach 48% by 2030 [2]. Beyond clinical necessity, several factors appear to be driving this trend. Economic incentives, professional convenience, and institutional pressures have been identified as major contributors to the rising number of caesarean sections [2, 3].

Evidence suggests that financial gain may play a role in encouraging unnecessary surgical deliveries in some settings [2]. Yet, despite their widespread use, the benefits of frequent caesarean sections for maternal and neonatal health remain uncertain. Studies have shown no consistent correlation between high caesarean section rates and improved reproductive health outcomes, while the procedure can expose women to both somatic and psychological complications [3]. In Mbandaka, between 2022 and 2023, the emergency caesarean section rate reached an alarming 62.5%. This situation raises critical questions about women's perceptions and experiences of such procedures in this context. Specifically, it is important to understand how women interpret the necessity, meaning, and implications of emergency caesarean sections in their lives. This study therefore seeks to explore how women in Mbandaka perceive and experience emergency caesarean sections. Its specific objectives are to:

- Identify women's perceptions regarding the indications and justification for emergency caesarean sections;
- Analyse the meanings they attribute to their lived experiences;
- Describe the emotional, psychological, and social dimensions associated with undergoing an emergency caesarean section;
- Examine the respondents' views on mechanisms to reduce the recurrence of emergency caesarean sections in Mbandaka.

Justification and relevance of the study

The choice of this study in the field of reproductive health is justified by its potential to highlight the magnitude of the phenomenon through the voices and experiences of affected women. Understanding these perceptions can shed light on the attitudes and behaviours observed among women who have undergone emergency caesarean sections in Mbandaka. Moreover, documenting these experiences contributes to improving patient–provider relationships, promoting ethical obstetric care, and guiding interventions to restore trust within the maternity healthcare system.

2. Materials and Methods

2.1. Study Design and Approach

This research adopted a qualitative design grounded in a phenomenological framework to explore how women in Mbandaka perceive and experience emergency caesarean sections. Phenomenology was selected because it seeks to reveal the meaning and depth of human experiences rather than merely describe them [4, 5]. The goal was to capture women's subjective interpretations, emotions, and beliefs surrounding this often unexpected surgical event.

2.2. Study Setting

The study took place in Mbandaka, the capital of Équateur Province in northwestern Democratic Republic of the Congo. The city encompasses a network of both public and private maternity units offering obstetric and emergency surgical services. Despite these resources, many women still face financial, logistical, and cultural barriers to timely maternal care. Ten health facilities were purposively selected for inclusion based on patient volume and accessibility: Basoko, Bolenge, Bongonde, Camp Ngashi, Kisolokele, Mama Balako, Mama wa Elikya, Mbandaka, Secli Wenji, and Wangata.

2.3. Study Population and Sampling

Participants were women aged 18 years or older who had undergone an emergency caesarean section in 2024 at one of the selected facilities. Sampling followed a purposive, criterion-based strategy to capture a range of sociodemographic backgrounds and diverse personal experiences [6].

A total of 26 women were interviewed, a number determined by data saturation, reached when no new insights emerged from additional interviews [7]. This small yet information-rich sample aligns with the depth-oriented nature of phenomenological research.

2.4. Inclusion and Exclusion Criteria

Women were eligible if they:

- Had an emergency caesarean section between January and December 2024;
- Were 18 years of age or older;

- Could communicate effectively in either Lingala or French; and
- Provided written informed consent.

Exclusion criteria included:

- Women who had elective (planned) caesarean sections;
- Those unable to participate due to medical or psychological conditions; or
- Those who refused participation after being informed of the study's purpose.

2.5. Data Collection Procedure

Data collection occurred from September to November 2024 through semi-structured, in-depth interviews conducted in participants' preferred language (Lingala or French). Interviews were held in maternity wards or child and maternal health (CPS) units within the selected facilities.
Each session began with a broad, open-ended question such as: *"Can you describe what it was like for you to go through an emergency caesarean section?"* Follow-up questions were used to deepen participants' reflections on their physical, emotional, and social experiences. Each interview lasted 18–22 minutes (average: 20 minutes). Sessions were audio-recorded with prior consent and transcribed verbatim. Professional linguists translated the transcripts from Lingala into French to maintain accuracy and nuance. Field notes captured nonverbal cues and contextual observations.

The interviewer adopted an empathetic and non-judgmental stance, creating a safe and confidential environment that encouraged participants to speak freely. All participants were informed that their data would remain anonymous; they were assigned codes (A–Z) instead of names. Data saturation was reached relatively quickly as themes began to recur across interviews despite personal variations in experience.

2.6. Data Management and Analysis

A thematic analysis was performed following the six-phase framework of Braun and Clarke [8]:

- Familiarization with the data,
- Generating initial codes,
- Searching for potential themes,
- Reviewing themes,
- Defining and naming themes, and
- Producing the report.

All transcripts were read several times to identify recurring patterns and relationships. Coding was performed manually by two researchers, and results were compared to enhance reliability and minimize interpretation bias. The analysis was iterative and reflexive, with researchers

continuously revisiting earlier data to refine emerging categories and ensure conceptual saturation. Interpretations were grounded in participants' original words, consistent with the phenomenological tradition [9].

2.7. Ensuring Trustworthiness

The study's rigor was maintained through Lincoln and Guba's [10] four criteria:

- Credibility: Achieved through triangulation, prolonged engagement, and participant feedback (member checking).
- Dependability: Strengthened by detailed documentation of all methodological steps.
- Confirmability: Ensured via reflexive journaling and independent review of analytic decisions.
- Transferability: Supported by rich, contextual descriptions of Mbandaka's healthcare environment and participants' lived contexts.

3. Results

Thematic analysis revealed seven overarching sub-themes that encapsulated women's perceptions and lived experiences related to emergency caesarean sections in Mbandaka: (1) perceptions of the emergency caesarean itself; (2) experiences during and after the intervention; (3) expectations of healthcare providers; (4) perceptions of maternal mortality associated with caesarean delivery; (5) views on the indications leading to caesareans; (6) coping experiences; and (7) challenges in reducing recurrent emergency caesareans.

3.1. Women's Perceptions of Emergency Caesarean Section

Participants expressed three dominant views regarding emergency caesareans. Some perceived the procedure as a misfortune or divine punishment, reflecting deep-rooted sociocultural beliefs about childbirth and fate. Others viewed it cynically, suggesting that healthcare providers performed caesareans as a means of generating income rather than medical necessity. However, a third group recognized the procedure as a lifesaving intervention, emphasizing that it was essential for protecting both the mother and child when complications arose. These contrasting perceptions highlight the coexistence of mistrust and gratitude among women toward modern obstetric practices in Mbandaka.

3.2. Experiences of Women Who Underwent an Emergency Caesarean

Women's narratives revealed a complex emotional and psychological journey surrounding emergency caesarean delivery. Many reported distrust and apprehension immediately after the surgical decision was announced, fearing the unknown outcome for themselves and their babies. Feelings of panic, anxiety, and confusion dominated the pre-operative phase, while others described surrendering to divine will as a coping mechanism amid uncertainty. Postoperatively,

several participants struggled to adapt physically and emotionally, reflecting the long-term psychological toll associated with emergency obstetric interventions.

3.3. Expectations Toward Healthcare Providers

Women's expectations of healthcare professionals centered around two main themes: survival and prevention. Most participants expected clinicians to act swiftly and competently to save their lives and those of their infants. Beyond survival, some women also hoped that medical staff would provide guidance to prevent similar complications in future pregnancies, particularly by offering better antenatal follow-up, education, and emotional support. This demonstrates the dual expectation of technical proficiency and compassionate care within emergency obstetric settings.

3.4. Perceptions of Maternal Mortality Linked to Caesarean Delivery

Maternal mortality following caesarean section was interpreted through a socio-religious lens. Some women attributed deaths to witchcraft or familial curses, reinforcing traditional explanations for adverse outcomes. Others described these deaths as profoundly painful experiences rooted in delays in reaching health facilities or as inevitable acts of God. This combination of spiritual, cultural, and biomedical interpretations reveals how local belief systems shape women's understanding of maternal risk and mortality.

3.5. Perceptions of Indications for Emergency Caesareans in Mbandaka

Participants held diverse views about the reasons leading to emergency caesareans. A significant number perceived incompetence among healthcare workers or suspected that indications were fabricated for financial benefit. Some women linked these procedures to complications from contraceptive use, while others attributed them to divine or cultural causes rooted in religious and traditional norms. These findings expose the tension between medical rationality and socio-cultural interpretation in local maternity contexts.

3.6. Challenges in Reducing Recurrent Emergency Caesareans in Mbandaka

Several systemic and behavioral barriers were identified as obstacles to reducing emergency caesareans. Participants emphasized the need to involve religious leaders in sensitization campaigns, discourage long-term contraceptive use perceived as harmful, and promote adherence to antenatal care standards. They also stressed the importance of ensuring fair remuneration for healthcare providers to minimize unethical practices and assigning competent, well-trained staff to maternity wards. Collectively, these perspectives point to the intersection of socio-economic, institutional, and cultural factors in obstetric outcomes.

3.7. Coping Strategies after the Event

Women described multiple strategies for coping with the physical and emotional aftermath of the caesarean experience. Emotional support from spouses and family members was considered essential, while prayer and faith provided psychological resilience and acceptance. The survival of a living child served as a profound source of comfort, giving meaning to their suffering.

Additionally, advice and reassurance from healthcare providers facilitated recovery and adaptation, underscoring the importance of post-operative communication and psychosocial support in obstetric care.

Following the identification of these categories, verbatim analyses were conducted to explore the underlying meanings of each theme, providing an in-depth understanding of women's perceptions, experiences, and expectations related to emergency caesarean sections in Mbandaka.

Table 1 Sociodemographic Characteristics of Interviewed Caesarean Recipients

Sociodemographic Characteristics	Frequency (%)
Age group	
○ 16-20 years	19
○ 21-25 years	23
○ 26-30 years	30.7
○ 31-35 years	19
○ 41-45: years	7.6
Marital status	
○ Married	76.5
○ Single	15.3
○ Divorced	7.6
○ Higher education and university	19.2
Level of education	
○ No level	3.8
○ Primary	23
○ Secondary	53.8
Parity	
○ 1-4	73
○ 5-8	27

The study sample was predominantly made up of young adult women, with those aged 26–30 years being the largest group (30.7%), followed by 21–25 years (23%) and 16–20 years (19%), while women aged 31–35 and 41–45 represented 19% and 7.6%, respectively. Most participants were married (76.5%), with 15.3% single and 7.6% divorced. In terms of education, 53.8% had completed secondary school, 23% primary school, 19.2% higher education or university, and 3.8% had no formal education. Regarding parity, 73% had between 1 and 4 children, while 27% had 5 to 8. These findings suggest that the sample primarily included young, married women with sufficient education to understand and consent to the caesarean procedure and with prior maternal experience, factors likely shaping their perceptions and experiences of caesarean delivery as well as their coping strategies and expectations of healthcare providers.

Table 2 outlines the main characteristics of the study participants.

Table 2 Perceptions of Women Who Underwent Emergency Caesarean Sections in Mbandaka

Sub-theme	Categories	Verbatim
Perception of caesareans	○ Bad luck	**P1:** "*Motema mabe ya bato*" (people's evil hearts). I am a multiparous woman, and I never imagined I could undergo an emergency caesarean section. **P2 and P13:** "*Komipesa na losambo*" (to devote oneself to prayer). If it were not for my life of prayer, I would not be alive today, as there had been prophecies concerning my difficult childbirth. **P9:** "*Butu moi kaka ba ndoto ya mabe*" (recurrent bad dreams during pregnancy). When I was told I needed an emergency caesarean section, I lost all hope of survival.
	○ A practice established by healthcare providers to make money.	**P1:** *"We have become their field of cultivation."* According to this respondent, caesarean sections have become a means for healthcare providers to generate income. **P4:** *"It is also a survival mechanism."* Many healthcare providers are not yet integrated into the civil service, and those who are receive only a very modest salary. **P7:** *"The government should address this issue."* This statement attributes the problem to inadequate remuneration and the lack of appropriate support from the government for healthcare personnel.
	○ Saving Human Lives in Danger	**P2, P8:** *"Namonaki liwa na miso"* (*I saw death with my own eyes*). This statement reflects the respondents' acknowledgment of the practitioners' expertise, through which they affirm that both their own lives and those of their babies were saved.

From Table 2, it is evident that the participants' opinions were divided. On one hand, the majority of women perceived emergency caesarean deliveries in Mbandaka as a phenomenon associated with witchcraft; on the other hand, some regarded them as a means of saving lives at risk.

Table 3 presents women's personal accounts and perceptions of how they experienced the emergency caesarean section.

Table 3. Women's Experiences of Undergoing an Emergency Caesarean Section

Sub-theme	Categories	Verbatim
Experience of Emergency Caesarean Section	○ Mistrust	P2: "Ya ngai ekomaki nde makila mabe" (bad luck to fall into the hands of unethical caregivers) P5: These people didn't tell the truth about my case; I've always given birth without any problems.
«	○ Emotion, frustration and fear ○ ○ ○	P17, P11, P7: "Motema kobeta butu moi" (My blood pressure had become unstable due to the emotion since the announcement of the cesarean section decided for me) P22, P15: I still had the urgent need to urinate at any time due to the fear related to the cesarean section; It reminded me of the cases of some women I knew who died following cesarean sections; and I told myself that it would be my turn
	○ All in God's hands	P19: I had asked the pastor to come and pray for me because I had no other choice but to wait for God's intervention.
	○ Inadaptation ○	P 18: I had difficulty adapting to the advice of the caregivers, I told myself that they were distracting me to minimize the situation.

From Table 3, it appears that women who underwent emergency caesareans predominantly developed a sense of distrust towards healthcare providers. Some participants acknowledged experiencing intense emotions, primarily driven by fear of the procedure, and felt that their only recourse was to entrust everything to God. Others, however, struggled to adapt to the experience they had undergone.

Table 4 summarizes the expectations expressed by women concerning the role, attitude, and support they anticipated from healthcare providers.

Table 4. Women's Expectations Regarding Healthcare Providers

Sub-theme	Categories	Verbatim
Expectations of caesarean patients with regard to providers	○ Save my life and my child's life;	P10, P21, P3, P17: "Nyonso na maboko ya bino" (I only count on you, on your knowledge and your love so that I can be cured, as well as the child who made me risk my life).
	○ Break the mechanism of designing to avoid these kinds of risks.	P5, P3, P16: "Elengi ya kobota ekomemela ngai liwa" (Convince my partner to agree to use contraceptive methods in order to stop conceiving, otherwise I want to lose my life soon following this type of childbirth).

From Table 4, it can be observed that the expectations of women who underwent caesareans varied. Some were primarily concerned with restoring their own health and ensuring the survival of their babies, while others expressed a desire to avoid further pregnancies due to fear of risking their lives again.

Table 5 presents women's reflections and experiences related to maternal mortality associated with caesarean delivery.

Table 5. Women's Experiences Concerning Maternal Mortality Linked to Caesarean Delivery

Sub-theme	Categories	Verbatim
Experience on maternal mortality linked to caesarean section	○ Witchcraft in the family	P4: "Oyo bondoki ya famille te?" (It is said that many women who die here are due to evil spells cast by sorcerers, especially those on their respective families).
	○ Painful event	**P19:** *"Soki ozali na motema te, okoki kondima yango te"* ("If you do not have the courage, you cannot accept it").
		P14: "I cannot bear it; I cry a lot and suffer from insomnia."
	○ Late arrival at the health center by the parturient	P 5, P13:
		- "kilo esengaka pe ofuta mbongo"
		- "kilo ya molimo"
		(Women in labor prefer to give birth at home due to lack of money. It's only when the situation becomes complicated that they go to the center, and often it's too late. Others devote themselves more to prayer.)
	○ Will of God;	P8, P24: "Ezali mokano ya nzambe"
		(If God had not willed, nothing bad would happen to women giving birth).

Opinions in Table 5 were divided. On one hand, some women attributed maternal mortality associated with pregnancy and delivery to witchcraft; on the other hand, there was a tendency to place responsibility on women who arrived late at health centres. Nevertheless, to console families, participants also stated that such outcomes were the will of God.

Table 6 summarizes women's perceptions of the clinical and contextual indications leading to recurrent emergency caesarean deliveries in Mbandaka.

Table 6. Perceptions of the Indications for Recurrent Emergency Caesarean Deliveries in Mbandaka

Sub –theme	Categories	Verbatim
Perception of cesareans on the indications for emergency cesareans undergone	○ Incompetence of healthcare providers;	P 26, P 23: "Mosala oyo eponi bilongi" (Current providers don't know their job, too much trial and error; midwives back then worked well; we didn't see many cesareans like today).
	○ Indications produced by providers	P23: We're being forced to have C-sections for purely lucrative purposes, not for real reasons. P24: If you refuse the forced C-section, and sometime later you give birth without any problems, why is that?
	○ Customs and traditions	P8, P13: "Okobela sanga ya kimokolo" (A husband's infidelity can have repercussions on his wife's pregnancy and even during childbirth)

For Table 6, diverse opinions were recorded. Some participants accused healthcare providers of incompetence or holding qualifications of little value. Another group argued that the indications for caesareans were fabricated and unjustified, primarily as a means of generating income, particularly since surgical procedures are more lucrative. Others, drawing on cultural beliefs, stated that women with unfaithful husbands risked their lives during childbirth.

Table 7 presents the strategies women adopted to cope with the emergency caesarean event and its emotional, physical, and social consequences.

Table 7. Strategies Adopted by Women to Cope with the Experienced Event

Sub –theme	Catégories	Verbatim
The experience of overcoming the event suffered	○ Presence of my partner at my side	P 1, P5: "komona mokolo zemi pe asala bien" (The presence of the spouse is greatly appreciated because it provides moral comfort to the cesarean patient).
	○ Prayer sessions	P13, P6: "mabondeli ya basali ya Nzambe, kisi monene" (Prayer offered by a servant of God protects you from evil forces)
	○ Presence of the living child	P 17: "komona mwana abotami, okobosana ata pasi ya pota" (The sight of the newborn baby still eases the pain caused by the cesarean section) P 10: "Pota ya pamba?" (Was it for nothing that I had this operation?)
	○ Advice given by caregivers	P 4, P 9: "Mateya ya minganga pe esalisaka" (The advice given by the healthcare staff also helps minimize the problem).

From Table 7, many participants reported that they were able to cope with the event when their spouses were by their side to provide support and encouragement. Another group found solace through prayers offered by pastors accompanying them. For others, seeing their children alive served as a source of lasting reassurance. Finally, advice provided by healthcare providers played an important psychological role.

Table 8 outlines the challenges identified by women regarding the reduction of recurrent emergency caesarean deliveries in Mbandaka.

Table 8. Challenges in Reducing Recurrent Emergency Caesarean Deliveries in Mbandaka

Sous –thème	Catégories	Verbatim
Reduction in recurrent emergency caesareans in Mbandaka	○ Involve God's servants in the phenomena of caesareans;	P16, P13: "Basali ya Nzambe batalela biso likambo oyo" (Fervent prayers in hospital settings could stop recurrent emergency cesareans)
	○ Avoid the use of long-term contraceptives;	P2, 20, P26: "Bipesa pesa, bimela mela: ndeko ya ba cesarean na ba diseases ndenge na ndenge" (The products we are given to limit pregnancies are the cause of multiple complications).
	○ Customs and traditions	P25: Apply traditional medical products that can help women with problems during pregnancy and childbirth. P17: Pregnant women must respect traditional prohibitions to avoid complications that lead to cesarean sections.
	○ Compliance with CPN standards;	P 9: "Matoi mangongi pe ya biso" (Sometimes it's our own fault; when we're asked to attend ANC regularly to avoid problems during childbirth, we don't comply, especially for multiparous women). P24: Individualized and regular follow-up at ANC can significantly reduce recurrent cesareans.
/	○ Pay healthcare providers well;	P 7, P12: "Mosala nde papa, mosala nde mama" (Good pay leads to good work).

The analysis of Table 8 indicates that fervent prayers within hospital settings could help reduce mortality associated with childbirth and prevent recurrent emergency caesareans in Mbandaka. Secondly, the women interviewed expressed reluctance to use contraceptives, believing that they are a primary cause of severe and potentially fatal complications. Some participants emphasised the importance of adhering to cultural practices and advocated for the use of traditional medicinal products to address conditions that might otherwise lead to caesarean deliveries. Conversely, a few respondents highlighted non-compliance with antenatal care standards as a contributing factor. Finally, adequate remuneration for healthcare providers was suggested as a measure to prevent

such practices.

4.Discussion

4.1 Sociodemographic Characteristics of the Participants

Among the women who underwent caesarean sections and agreed to participate in our interviews, 30% were aged between 26 and 30 years, representing the age group most exposed to caesarean delivery according to our study. A similar age distribution was observed in [11, 12] study on women's experiences of caesarean delivery in a district hospital in Bamako, where 53% of participants were aged between 20 and 34 years. These findings also align with those of [13] who reported that the mean age of patients in African settings was 29 years, with extremes ranging from 15 to 45 years. In addition, [14] identified patients with a mean age of 26.7 years, 64% of whom were aged 20 to 34 years. In our study, 76.5% of the interviewed women were married, whereas [13] reported that 95.4% of their participants were married. Regarding parity, [13] found a median parity of 2, with extremes ranging from 1 to 12, and a predominance of primiparous women (41.7%). In contrast, our study found that 73% of participants had a parity between 1 and 4, with a predominance of multiparous women (95.2%), and only 27% were grand multiparous.

4.2 Results on Thematic and Categorical Analysis

The analysis focused on two main themes, perceptions and experiences, with seven sub-themes identified: perceptions of women regarding the emergency caesarean they underwent; experiences of women who underwent an emergency caesarean; expectations of women regarding healthcare providers; perceptions of maternal mortality associated with caesarean delivery; perceptions of the indications for emergency caesareans; coping strategies employed by women following the event; and challenges in reducing recurrent emergency caesareans in Mbandaka. Regarding perceptions of the emergency caesarean, participants described it variously as misfortune, a procedure implemented by healthcare providers for financial gain, or a necessary life-saving intervention. Some attributed emergency caesareans to malevolent forces, particularly multiparous women accustomed to vaginal delivery, while others questioned the motivations of healthcare providers and the government's role in supporting the health sector. Conversely, several participants recognized the life-saving importance of the procedure for both mother and child [15]. Experiences reported included distrust toward healthcare providers, emotional distress, fear, frustration, and difficulty following medical guidance, consistent with previous findings that women's responses to caesarean announcements include fear (53.8%), sadness (25.2%), and relief (21%), with 85.5% perceiving the procedure as beneficial and 14.5% as traumatic [12, 13, 16, 17, 18]. Expectations of healthcare providers included reliance on their competence to ensure maternal and neonatal survival, as well as, in some cases, the wish to prevent further pregnancies, highlighting the importance of family-centred support and culturally sensitive care [19]; MSF [20]).

Experiences of maternal mortality associated with caesarean delivery were interpreted in various

ways, including witchcraft, delayed healthcare access, painful experiences, or the will of God, with maternal death recognized as catastrophic for families and communities [21]. Concerning the indications for emergency caesareans, perceptions encompassed provider incompetence, fabricated indications for financial gain, and cultural norms influencing childbirth outcomes [22, 23, 24]. Coping strategies included the presence of spouses, prayer sessions, guidance from healthcare providers, and psychoeducational support to mitigate postpartum depression [25]. Challenges to reducing recurrent emergency caesareans involved engaging religious leaders, hospital-based prayer practices, concerns about long-acting contraceptives, adherence to cultural practices, compliance with prenatal care standards, and proper remuneration for healthcare providers, underscoring the need for systemic and context-specific measures to improve maternal health outcomes [26, 27, 28].

Study Limitations

This study presents several limitations. Due to its qualitative and phenomenological design, the findings reflect participants' personal perceptions and experiences and cannot be generalized to all women in Mbandaka or other settings. The sample, restricted to women who had experienced an emergency caesarean, may not fully represent all age groups or socio-economic backgrounds, and the participant selection process could have introduced recruitment bias. Responses might have been shaped by participants' desire to please the interviewer or influenced by cultural and religious factors, while reliance on memory introduces potential recall bias. Moreover, the unique local context limits the broader applicability of the results, and the absence of objective quantitative data prevents verification of the reported perceptions. Finally, interactions with the interviewer may have affected responses on sensitive issues, including distrust toward healthcare providers and religious beliefs.

5.Conclusion

The study revealed that women aged 26–30 years are the most frequently affected by emergency caesarean sections in Mbandaka. Participants' perceptions varied, with some viewing the procedure as life-saving, others as misfortune, and some as motivated by financial gain or healthcare provider incompetence, while late arrival at health centres was also cited. These perceptions fostered mistrust, emotional distress, and challenges in following medical guidance, prompting many women to turn to traditional practices and spiritual support. The findings point to a weakened patient–provider relationship and highlight the need for interventions to rebuild trust through transparent communication, community education, consistent psychosocial support, adherence to prenatal care standards, and improvements in healthcare staff training and working conditions. Future research should investigate ways to harmonize traditional and biomedical practices, reduce unnecessary caesareans, and assess long-term maternal and neonatal outcomes. The study's qualitative design and sample size may limit the generalizability of the results.

Declarations

Ethical Approval: The study protocol was approved by the Ethics Committee of the Institut Supérieur des Techniques Médicales (ISTM)–Kinshasa (Approval No. ISTM/EC/2024/042), with additional authorization from the Provincial Health Division of Équateur. All participants received detailed information regarding the study's purpose, voluntary participation, and confidentiality measures, and written informed consent was obtained prior to their involvement. Participant anonymity and data confidentiality were strictly upheld throughout the study.

Consent to Participate: Before participating in the study, all individuals received a comprehensive information sheet explaining the study's objectives and procedures. Written informed consent was obtained from each participant. Throughout data collection and analysis, strict measures were followed to ensure confidentiality, protect personal information, and maintain participant anonymity.

Consent to publish: Not applicable

Conflicts of interest: The authors indicate that they do not have any competing interests

Data availability: These are available from the corresponding author on reasonable request

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