



## **Sterilisation during unplanned caesarean sections**

Reference: Verkuyl, D.A.A. "Sterilisation during unplanned caesarean sections for women likely to have a completed family – should they be offered? Experience in a country with limited health resources" *British Journal of Obstetrics and Gynaecology*, August 2002; 109:900-904

### **1 Introduction**

During an unplanned caesarean section (CS), offering a sterilisation by tubal ligation (TL) is generally considered to be unethical. This is mostly because a decision of such permanence should not be taken at short notice and under stress. Also, the baby's life is more likely to be at risk after a CS.

However one hospital in Zimbabwe has a policy of offering TL to women during an unplanned CS, if the woman is over 30 and has three or more children. This researcher has contacted hundreds of women who were offered a TL and accepted or declined, as well as some women who delivered normally. They were asked about their satisfaction with the decision they made.

### **2 What the researcher said**

Of women who had an emergency CS, 2.5% who had a TL regretted their decision, while 56.4% of women who declined a TL expressed regret.

The article states that, nationwide, for each 100,000 live births 695 women die. It is also mentioned that in Tanzania, women on a waiting list for sterilisation had many abortions while waiting. Research suggests that Zimbabwean women have an ideal reproductive goal: "first child at age 19-22: two to four well spaced children" and that, on average, women reach their desired family size by age 32, leaving them with potential fertility for 18 more years.

According to the author, Zimbabwean women only have access to modern hormonal contraceptive methods "and are often subjected to anticontraceptive propaganda (cancer, thrombosis, poisonous blood retention, abnormal children, hell). The result is often unwanted children or unsafe abortion".

Unlike Western nations, Zimbabwean women do not have easy access to TL at any time, so that author sees the time of CS as a good opportunity for this procedure.

The assertion is therefore made that "women were far more likely to regret declining a tubal ligation than regret accepting one. In this setting, some women are more likely to die of the next pregnancy than to regret an emergency tubal ligation".

The author's conclusion is that it is unethical *not* to offer TL in women with high parity at the time of an emergency CS in countries such as Zimbabwe, which have limited health resources.



### **3 Ethical analysis**

In western countries it is considered unethical to offer women TL at the time of an emergency CS. Sterilisation is an unrelated procedure, and the stress, pain and emotion involved during childbirth are likely to cloud judgment.

Why should developing countries accept different ethical standards? In this case, the justification is a utilitarian analysis which (a) makes judgments about how many children women should have, (b) compares a national mortality rate with the details of one maternity hospital, and (c) employs a slippery notion of “regret”. It also fails to justify sterilisation as an ethically acceptable procedure, particularly in a largely Christian nation.

The women in the study were those who had attended the hospital for their birth. This group is not representative of all Zimbabwean women. Many women will have no access to health care, and these are the women most likely to die as a result of pregnancy or childbirth. It is misleading to compare the national maternal mortality rate with a group of women attending one hospital.

The concept of ‘regret’ was assumed to mean the same thing for each woman. However the survey had no method of discerning types or levels of regret. Did a woman regret declining a TL because she was financially stretched and had little support from her husband, so that more children would be difficult to cope with? Did she regret declining a TL simply because she had to continue purchasing contraceptives? If a woman regretted accepting a TL, her regret is likely to be related to her now-permanent infertility. Unwanted infertility can be devastating. Sterilised women *cannot* have children; women who maintain their fertility can still try to prevent pregnancy.

There also remains the underlying possibility of coercion in the hospital context, even though the TL would seem, on the face of it, to be the woman’s decision. The author recommends that doctors initiate discussion about sterilisation during other operations on multiparous women, not only during CS. The mere fact of a doctor mentioning a particular option sways the patient towards thinking that it would be beneficial. It also suggests to the woman that perhaps she should not have any more children. The author’s justification for such a policy – the danger of childbirth, the difficulties in obtaining TL afterwards, the failure rate of contraceptives – if mentioned to the woman, might alarm her and again sway her decision.

Zimbabwe’s high maternal mortality ratio is not a fixed constant. It is a result of a lack of health resources for women. The ethically responsible reaction is to improve health services, not to manipulate women into accepting sterilisation.