

Post-cesarean rehabilitation practices without an ERAS protocol in two hospitals in Kinshasa: A prospective descriptive study

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ABSTRACT

Introduction

Post-cesarean rehabilitation aims to promote functional recovery after surgery. In low-resource settings, these practices often remain conservative, particularly in the absence of formal Enhanced Recovery After Surgery (ERAS) protocols.

Purpose

To describe post-cesarean rehabilitation practices in two hospitals in Kinshasa without an ERAS protocol, in order to provide baseline data for future strategies aimed at improving postoperative care.

Methods

This prospective descriptive study was conducted from December 2024 to February 2025 at the Kinshasa University Clinics and Ngaliema Clinic. Women aged ≥ 18 years, classified as American Society of Anesthesiologists (ASA) physical status II, and who underwent cesarean delivery were included. Patients with perioperative or postoperative complications likely to prolong hospitalization were excluded. A consecutive exhaustive sampling strategy was used throughout the study period. Data were collected through direct observation and structured interviews using a standardized data collection form. Statistical analysis was descriptive.

Results

A total of 204 patients were included in the analysis. The mean age was 29.9 ± 5.8 years, and 62.3% of cesarean deliveries were performed as emergencies. Spinal anesthesia was used in 98.5% of patients, with limited use of intrathecal morphine. Prevention of postoperative nausea and vomiting using dexamethasone was performed in 5.4% of cases. Mean times to postoperative recovery milestones were 11.7 ± 5.3 hours for first oral fluid intake, 40.5 ± 12.8 hours for the first meal, 25.1 ± 10.6 hours for urinary catheter removal, 62.9 ± 28.5 hours for intravenous catheter removal, and 21.4 ± 9.0 hours for first mobilization. At 24 hours postoperatively, 78.9% of patients reported moderate to severe pain (numerical rating scale [NRS] > 3). Indicators of mother-infant bonding, such as infant carrying, were infrequent. The mean length of hospital stay was 5.1 ± 0.7 days.

Conclusion

These findings indicate underutilization of several ERAS components, particularly early feeding, early mobilization, and optimized multimodal analgesia. This highlights opportunities for the progressive implementation of ERAS strategies adapted to the local context.

INTRODUCTION

Cesarean section is a surgical procedure involving fetal extraction through hysterotomy following laparotomy. It is one of the most commonly performed surgical interventions worldwide. The global cesarean section rate has been estimated at 21.1%, with projections reaching 28.5% by 2030 (Betran et al., 2021).

In the Democratic Republic of Congo, cesarean section rates vary across settings, reaching 31.2% in Kinshasa (Mbungu et al., 2017) and 10.65% in Lubumbashi (Kinenkinda et al., 2017). This increase is associated with a higher risk of complications compared with vaginal delivery (Souza et al., 2010; Pinho & Costa, 2024), as well as longer hospital stays (Roy & Montgomery, 2018; Pinho & Costa, 2024).

Post-cesarean rehabilitation encompasses all practices aimed at promoting rapid and functional recovery after surgery. In low-resource settings, these practices often remain conservative, which may result in prolonged recovery times.

Enhanced Recovery After Surgery (ERAS) has emerged as a modern model of perioperative care. Initially developed in digestive surgery in the 1990s by Kehlet (1997), ERAS is based on a systematic, multidisciplinary, and evidence-based approach. Its principles include multimodal analgesia, early oral feeding, early mobilization, and early removal of intravenous and urinary catheters (Deniou et al., 2014; Macones et al., 2019). These principles have progressively been adapted to obstetrics, with encouraging results.

In cesarean delivery, ERAS has also been shown to improve maternal-infant bonding (Laronche et al., 2017) and maternal satisfaction (Walker et al., 2025), and to reduce maternal mortality and morbidity (Talhaoglu & Ceyhan, 2024).

In high-income countries such as France, post-cesarean ERAS is increasingly becoming a standard of care (Blondel et al., 2017). In Africa, available data remain limited and suggest low implementation of these principles (Jarraya et al., 2016; Guibla et al., 2021).

Despite the increasing global adoption of ERAS protocols in obstetrics, evidence from sub-Saharan African settings

remains scarce, particularly regarding baseline postoperative practices. In the Democratic Republic of Congo, no study has, to our knowledge, described post-cesarean rehabilitation practices.

Therefore, the objective of this study was to describe post-cesarean rehabilitation practices in two hospitals in Kinshasa where no ERAS protocol was implemented, in order to provide baseline data for future strategies aimed at improving postoperative care.

METHODS

Study Design and Setting

This was a prospective descriptive study conducted from December 2024 to February 2025 at the Kinshasa University Clinics and Ngaliema Clinic in the Democratic Republic of the Congo.

The Kinshasa University Clinics is a tertiary referral teaching hospital affiliated with the University of Kinshasa and provides specialized care. Ngaliema Clinic is a secondary-level referral hospital serving a large urban population. Both institutions perform a substantial number of cesarean deliveries annually.

Study Population

Inclusion Criteria

All women aged 18 years or older, classified as American Society of Anesthesiologists (ASA) physical status II, who underwent cesarean delivery and provided informed consent were included.

Restricting inclusion to ASA II patients allowed the study to focus on women with uncomplicated clinical profiles, in order to describe routine postoperative recovery practices without the confounding influence of severe comorbidities.

Exclusion Criteria

Patients with intraoperative injuries to adjacent organs (bladder, ureters, or intestines), postoperative complications (infection, hemorrhage, venous thromboembolism, urinary dysfunction, postpartum depression, or intestinal obstruction), those admitted to intensive care, or those who died were excluded.

The exclusion of complicated cases may introduce selection bias. However, this methodological choice was

made to specifically describe routine postoperative management in uncomplicated cesarean deliveries.

Sampling Method

A consecutive exhaustive sampling strategy was used throughout the study period.

Study Variables

The variables studied included patient characteristics, intraoperative practices, and postoperative practices (pain, postoperative nausea and vomiting, venous thromboembolism prevention, and antibiotic therapy). Time to recovery of postoperative functions (first oral fluids, first meal, urinary catheter removal, intravenous catheter removal, and first mobilization), mother–infant bonding (breastfeeding, infant carrying, and newborn care), complications, and length of stay were also recorded.

Data Collection

Data were collected through direct observation and structured interviews using a standardized data collection form.

The form was developed based on the study objectives and the literature on post-cesarean rehabilitation and was pilot-tested before the study to ensure clarity and feasibility. Data collectors were anesthesia and intensive care residents who received prior training on study procedures, operational definitions, and standardized data recording in order to ensure consistency and reliability.

Operational Definitions

Numerical Rating Scale (NRS): Pain assessment scale ranging from 0 (no pain) to 10 (worst pain imaginable). Scores ≤ 3 were classified as mild pain, and scores > 3 as moderate to severe pain.

Time to first oral fluids: Time interval (in hours) between the end of the cesarean section and authorization to drink liquids (e.g., tea, water, or juice).

Time to first meal: Time interval (in hours) between the end of the cesarean section and authorization to consume solid foods (e.g., potatoes, sweet potatoes, bread, or rice).

Time to first mobilization: Time interval (in hours) between the end of the cesarean section and the first episode of walking, assisted or unassisted.

Time to intravenous catheter removal: Time interval (in hours) between the end of the cesarean section and removal of the peripheral intravenous catheter.

Time to urinary catheter removal: Time interval (in hours) between the end of the cesarean section and removal of the urinary catheter.

Mother–infant bonding: Set of interactions between the mother and newborn, including breastfeeding, holding, and newborn care.

Length of stay: Number of days between the end of the cesarean section and discharge from the hospital.

Statistical Analysis

Statistical analysis was performed using SPSS version 26.0. Quantitative variables were expressed as mean \pm standard deviation, and qualitative variables as frequencies and percentages. No comparative analysis was performed, as the aim of the study was to describe practices rather than evaluate effectiveness.

No missing data requiring statistical imputation were identified during analysis. Given the descriptive nature of the study, all eligible patients during the study period were included.

Ethical Considerations

Institutional authorization from both hospitals was obtained before data collection. The study received approval from the Ethics Committee of the Faculty of Medicine of the University of Kinshasa (ESP/CE/076/2025) and was conducted in accordance with the Declaration of Helsinki.

RESULTS

A total of 228 patients were enrolled, of whom 204 were included in the final analysis after exclusion of 24 patients who developed postoperative complications.

Patient Characteristics

The mean age was 29.9 ± 5.8 years. Emergency cesarean sections accounted for 62.3% of cases.

Intraoperative Practices

Spinal anesthesia was used in 98.5% of patients. Bupivacaine was systematically administered, combined with fentanyl in 78.6% of cases or with fentanyl-morphine in 21.4% of cases.

Only 5.4% of patients received dexamethasone for the prevention of postoperative nausea and vomiting.

All patients received oxytocin as a bolus followed by infusion, which lasted more than 4 hours in the majority of cases.

All patients received antibiotic prophylaxis, mainly amoxicillin-clavulanic acid in 68.6% of cases. In 65.7% of cases, antibiotics were administered after umbilical cord clamping.

Postoperative Management

For postoperative pain management, the tramadol-diclofenac combination was the most frequently used (31.4%).

Venous thromboembolism prevention using low-molecular-weight heparin was implemented in 98.5% of patients, most commonly for 3 days (78.0%).

All patients received postoperative antibiotic therapy, administered intravenously for 1-3 days in 88.2% of cases, followed by an oral switch for a similar duration in 86.8% of cases.

Recovery Milestones

Table 1:
Recovery Milestones and Neonatal Outcomes (N = 204)

Variables	Value
Neonatal outcomes, n (%)	
Neonatal deaths	2 (1.0)
Newborn kept in maternity ward	155 (76.0)
Neonatal hospitalization	47 (23.0)
Time to recovery of postoperative functions (hours), mean ± SD	
First oral fluids	11.7 ± 5.3
First meal	40.5 ± 12.8
Urinary catheter removal	25.1 ± 10.6
Intravenous catheter removal	62.9 ± 28.5
First mobilization	21.4 ± 9.0

Note: SD = standard deviation. Neonatal outcomes were reported because neonatal hospitalization may influence maternal recovery and early mother-infant bonding.

Pain Outcomes

Table 2:
Pain Outcomes (N = 204)

Variables	Value
NRS at 24 hours, n (%)	
≤ 3	43 (21.1)
> 3	161 (78.9)
NRS at 48 hours, n (%)	
≤ 3	115 (56.4)
> 3	89 (43.6)

Note: NRS = numerical rating scale.

Mother-Infant Bonding

Table 3:
Mother-Infant Bonding Indicators (n = 155)

Variables	Value
Baby carrying, n (%)	
Rarely	137 (88.4)
Frequently	18 (11.6)
Newborn care, n (%)	
With some difficulties	116 (74.8)
Without difficulty	39 (25.2)
Feeding method, n (%)	
Bottle feeding	6 (3.9)
Mixed feeding (breast + bottle)	105 (67.7)
Exclusive breastfeeding	44 (28.4)

Note: Mother-infant bonding indicators were analyzed among 155 patients whose newborns were neither deceased nor hospitalized in neonatology.

Length of Stay

The mean length of hospital stay was 5.1 ± 0.7 days.

DISCUSSION

The mean age of patients and the high proportion of emergency cesarean sections observed in this study are comparable to findings reported in several African studies (Essola et al., 2019; Mbongo et al., 2016; Mbungu et al., 2017; Sima et al., 2017). This high rate of emergency cesarean deliveries may be influenced by organizational factors such as irregular antenatal care attendance, delayed decision-making, or late referrals to tertiary care facilities.

Spinal anesthesia was the nearly exclusive anesthetic technique, consistent with widely reported obstetric practices. The limited use of intrathecal morphine, despite its well-documented prolonged analgesic effect (Deniou et al., 2014; Roofthoof et al., 2021), illustrates variability in

clinical practice and may be related to medication availability, local prescribing habits, or the absence of formal institutional protocols.

Measures to prevent postoperative nausea and vomiting were rarely implemented. This may reflect limited awareness of their role in postoperative recovery or economic constraints.

The near-systematic use of postoperative antibiotic therapy and prolonged oxytocin infusion reflects a maternal safety-oriented approach aimed at reducing infectious and hemorrhagic complications in settings where postoperative monitoring conditions may be inconsistent.

Postoperative pain management relied mainly on multimodal analgesic combinations. However, a large proportion of patients reported moderate to severe pain at 24 hours. This may be related, among other factors, to the limited use of intrathecal morphine and the absence of standardized pain management protocols.

The time to first mobilization observed in this study was comparable to that reported in a study from Madagascar (Rafanomezantsoa et al., 2016). Persistent postoperative pain and prolonged maintenance of medical devices may delay mobilization. Similarly, resumption of oral fluids and meals followed a conservative approach, as described in other studies conducted in comparable contexts (Guibla et al., 2021).

Urinary and intravenous catheter removal also occurred relatively late, which may be related to reliance on injectable treatments and a cautious approach to postoperative monitoring.

Almost all patients received pharmacological venous thromboembolism prophylaxis, often without a formal individualized risk assessment (American College of Obstetricians and Gynecologists [ACOG], 2018). This practice may be explained by delayed mobilization and the limited availability of mechanical prevention methods in the study settings.

Mother-infant bonding appeared limited, with restricted participation in newborn care and modest exclusive breastfeeding rates. Postoperative pain, delayed

mobilization, and prolonged maintenance of medical devices may contribute to these findings.

The mean length of hospital stay was longer than that reported in settings where structured ERAS strategies have been implemented (Aka et al., 2023; Pinho & Costa, 2024).

The persistence of conservative postoperative practices observed in this study may reflect several contextual factors, including limited institutional protocols, variability in staff training, resource constraints, and cautious clinical approaches in environments where postoperative monitoring conditions may be inconsistent (Kitil et al., 2024).

According to ERAS recommendations, oral feeding is generally initiated within 6 hours after cesarean delivery, mobilization within 12 hours, and urinary catheter removal within 24 hours. The longer delays observed in this study highlight the gap between current practices and ERAS benchmarks.

These findings suggest that gradual implementation of ERAS components, such as standardized multimodal analgesia, earlier oral feeding, and staff training, could represent feasible and cost-effective strategies to improve postoperative recovery in low-resource settings (Pinho & Costa, 2024).

Strengths and Limitations

This study provides one of the first descriptions of post-cesarean rehabilitation practices in the Democratic Republic of Congo. Its prospective design and exhaustive sampling represent major strengths. However, the descriptive design, inclusion of only two hospitals, exclusion of complicated cases, and lack of assessment of organizational and material resources limit the generalizability of the findings.

CONCLUSION

This study highlights several characteristics of postoperative care after cesarean delivery in two hospitals in Kinshasa, including delayed mobilization, a high prevalence of postoperative pain, and prolonged hospital stay. Although limited by its descriptive design, the study provides important baseline data. These findings support the need for pilot ERAS programs, staff training, and

prospective comparative studies to improve post-cesarean recovery in low-resource settings.

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