

Original Research Article

Perception regarding mode of delivery among affluent women of the society: a qualitative study conducted in the urban areas of Ganjam, Odisha

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ABSTRACT

Background: Increasing rates of cesarean sections worldwide are of global concern, especially among affluent women of the society. In recent years, every woman has their own birthing plan which has become a heated debate issue. Hence this study aims to find the maternal reason for their preference for a particular mode of delivery.

Methods: A descriptive qualitative study was done among the women of reproductive age group (15-49 years) in the district of Ganjam, Odisha from March 2024 to September 2024 by conducting in-depth interviews. Inductive coding was done and data was analyzed using content analysis.

Results: The majority of the study subjects preferred cesarean section over normal vaginal delivery. Maternal reasons for normal delivery preference included safety concerns for the child and superstitious beliefs. Reasons for cesarean preference included fear of labor pain and vaginal birth, safety concerns related to health risk perceptions, negative birth experiences in some, and positive attitudes towards cesarean birth, especially among private healthcare setups. Most women had more than one reason for opting for their preferred mode of delivery.

Conclusions: This results suggest an increasing trend of private hospital preference and C-sections, especially amongst women of higher SES. The behavior of providers needs to be closely monitored to ensure that C-sections are performed only when medically indicated.

Keywords: Affluent, Cesarean section, Hospital, Maternal, Negative experience

INTRODUCTION

Cesarean section is a lifesaving procedure for mothers and newborns in certain circumstances. It can, however, lead to adverse maternal and fetal outcomes.^{1,2} Socioeconomic changes and scientific advancement have led to multidimensional changes in the birth delivery system and consequently a gradual increase in the prevalence of cesarean sections (CSs).³ The prevalence of C-sections has increased in all regions of the world, except Sub-Saharan Africa, with the global average increasing from 6.7% in 1990 to 19.1% in 2014.⁴ However, in some of the poorer countries, or among certain subgroups within countries, it remains extremely low, indicating the possibility of a lack of access to

adequate obstetric care. Although the international healthcare community has proposed an ideal rate for C-sections to be between 10% and 15%, the optimal rate of C-sections in each context is difficult to identify because of challenges in ascertaining the rate of true indications of medical needs at the population level.⁵ India has also experienced a fast-growing C-section rate with substantial which vary among the states. The national prevalence of C-sections was 17.2% in 2016, while the state prevalence range differed widely from 6.2% in Bihar to 57.7% in Telangana.

Factors contributing to this increase included delay in childbearing among women, policies promoting repeat cesarean section, refusal to offer vaginal birth after

cesarean section, wide use of continuous electronic fetal monitoring, use of epidural analgesia, fear of malpractice liability, professional practice style, professional expectations for work-life balance, reimbursement systems, financial incentives, maternal request and lack of regulations.^{4,7-9} On the other hand, medically unnecessary C-section does not benefit women and their newborns, and may even increase short-term and long-term health risks.¹⁰ There are multifaceted impacts of increased C-sections ranging from maternal and child health to the influence on the overall health system to the cost of healthcare. Studies reported that C-Section is associated with child and adolescent obesity, which translates to the risk of early life.¹¹

Previous studies have identified various factors associated with the utilization of C-section, among which the patient's socioeconomic status (SES) and type of provider were found to be key contributors.¹² It was demonstrated that women's higher SES and private hospital are more strongly associated with C-section delivery compared to their counterparts in Low and Middle-Income Countries (LMICs).¹²⁻¹⁶

Cesarean section upon maternal request is a rising concern as one of the contributing factors to increased cesarean section rates.^{17,18} These rates have been estimated to be 4-18%.^{2,19} The Royal Thai College of Obstetricians and Gynecologists just announced a position statement against cesarean sections without medical indication, in order to control cesarean section rates. The choice of C-section is a complex social process, influenced by a combination of various factors including clinical status, family and social factors, availability of technology, and women's perception toward the C-section, etc.²⁰

Hence, this study aims to explore the maternal reason for their preference for a particular mode of delivery amongst affluent women in the Urban areas of Ganjam, Odisha.

METHODS

This qualitative study was conducted amongst women in the reproductive age group (15-49 years) who are women with at least one living issue in the district of Ganjam, Odisha from March 2024 to September 2024. The Institutional Ethical Committee provided ethical approval IEC No. 1339. Written informed consent was obtained from all participants before recruitment into the study. Participants visiting the Immunization Clinic at MKCG Medical College, Berhampur who fulfilled the eligibility criteria were invited to participate and assured of confidentiality and anonymity. Inclusion criteria were: Women of reproductive age group with 1) singleton pregnancy and 2) Child <12 months of age. 3) Belonging to the upper or upper middle class of Socioeconomic status with minimum up to class 12 education. (Affluent women include women belonging to the upper or upper

middle class of socioeconomic status with minimum up to class 12 education).

Exclusion criteria

Exclusion criteria were women who could not read or write or understand English, Hindi, or Odia language or whose fetuses had obvious anomalies.

In-depth interviews were performed to explore the reasons why pregnant women preferred having a cesarean birth. Women were individually interviewed by the first author in the immunization clinic in a private room using a narrative style.

Participants were prompted to elaborate on any unclear concepts until the reasons were made obvious. The interview guide is available in the supplementary file. Each interview lasted 20-30 min. All conversations were audio recorded and transcribed verbatim by the interviewer. The material was evaluated by the first author as being saturated after interviewing 24 women with sufficient confidence to answer the research questions. Analysis was done using appropriate software in the Department of Community Medicine, MKCG Medical College and Hospital.

RESULTS

A total of 24 participants were interviewed in this study. Table 1 provides a summary of the demographic characteristics of the respondents. The majority of mothers aged between 26-30 years of age, at least graduated, were married for 7-9 years, and had planned pregnancies. Based on these demographic profiles, we consider the sample to have an adequate representation of different disciplines (Table 1).

46 codes emerged from the manual analysis of the 24 transcripts. These were grouped into 9 subthemes which led to the emergence of 3 themes, namely birthing place preference, preference of a mode of delivery, and reasons for such preference (Table 2).

The figure shows the various code clouds based on frequencies. 'Private hospital preferred' is the most frequently generated code. Other frequently generated codes are 'Cesarean section', 'labor pain', 'injury to the fetus', and 'late recovery'. Codes like 'auspicious occasions', 'anesthesia', 'pain', and 'risk' are among the least generated codes (Figure 1).

Birthing place preference

Most of the mothers preferred to be delivered in a private medical institute due to its cleanliness, good behavior, and support from staff.

“I want to give birth at a private medical facility because of the sanitary and clean surroundings”, said Respondent 1.

“I would prefer to have my baby in a private setup (short pause) because the government is not clean. in private setup, it is very neat and clean and the service is good” [Respondent 7]

Table 1: Socio-demographic characteristics of study participants (n=24).

Characteristics	Percentage
Age (years)	
15-20	7
21-25	33
26-30	40
31-35	20
Socio-economic status	
Upper middle	86.67
Upper	13.33
Educational qualification	
10 th passed	-
12 th passed	13.33
Graduate	53.33
Post graduate	33.33
Years after marriage	
0-3	7
4-6	26
7-9	60
10-12	7
Type of pregnancy	
Planned	93
Unplanned	7

Table 2: Emergent themes, subthemes, and codes.

Themes	Subthemes	Codes
Birth place preference	Government Hospital not preferred	Not clean
		Overcrowded
		Less staff
		Rude behaviour
	Private Hospital preferred	Very clean
		Not overcrowded
		Friendly behaviour
		Supportive staff
Preference of mode of delivery	Normal vaginal delivery advantages	Quick recovery
		No scar
		Natural process
		Less hospital stays
	Normal vaginal delivery disadvantages	Labour pain
		Prolonged duration in labour
		Chances of injury to mother
		Chances of injury to foetus
		Date not confirmed
	Caesarean section advantages	Less labour pain
		Less duration of labour
		Anaesthesia makes procedure easy
		Less injury to mother
		Less injury to foetus
		Safer for high-risk pregnancies

Continued.

gynecologists, previous birthing experiences, some superstitious beliefs and social media influences.

“Planned caesarean sections are convenient, date and time can be selected, and there is no need to wait for spontaneous labor. I can prepare for the coming of the baby” [Respondent 3]

“According to my acquaintance, her spinal block-assisted cesarean section was painless.” [Respondent 11]

“I prefer cesarean birth because I can set an auspicious time for the birth of my baby.” said Respondent 14, looking hopeful.

DISCUSSION

Women who favoured caesarean delivery gave several explanations. This study revealed the following: superstitious beliefs about auspicious birth dates, fear of labour, safety concerns connected to health risk perceptions, unpleasant birth experiences in the past, good attitudes regarding caesarean birth, and access to biased information.

Except the individual superstitious belief in lucky birth dates, which is only present in a few Asian nations (such as China, India, Taiwan, and Thailand), almost every feature matched earlier research.²¹⁻²⁵ Fear of childbirth was the most common reason for cesarean birth preference, which was similar to previous studies.²⁶ Negative birth experiences have been identified as a significant predictor of preference for caesarean delivery, according to earlier research. History of traumatic births made women fear birth, hence the request for planned cesarean section to avoid such bad events. In our study, women expressed their feelings on how they suffered from birth experiences in three aspects, including inadequate pain control, dystocia, and injury to the baby both in government and private setups, but more so in government setups. This reflects the quality of care during labor, as pain control should be offered in addition to mental support.

Cavallaro et al reported an increasing (unadjusted) gap in the prevalence of C-section among wealth quintiles over the years in 26 Southern Asian or Sub-Saharan African countries.¹³

Positive views on cesarean delivery are a significant influence, and this may be connected to a lack of healthcare literacy. Women were grateful for the ease, less time for delivery, and lack of agony associated with cesarean delivery. Some women believed that the procedure was safe and lacked knowledge concerning serious complications in subsequent pregnancies. Knowledge has an influence on attitudes and with the correct knowledge, attitudes might change.²⁷

Most women who had positive attitudes toward uncomplicated vaginal birth would prefer that in their present pregnancies.²⁸ Perceptions and interpretations were different among people based on their experiences, beliefs, critical thinking, and reasoning. One-way communication can lead to the spread of false information.

Therefore, obstetricians should enlighten expectant mothers about misconceptions or false notions. Women may modify their views regarding the manner of delivery if they were given accurate, professional, and educational information. This might result in a decline in the number of on-demand caesarean births.

In addition to educating people about the negative effects of elective cesarean delivery on mothers and their unborn children, addressing personal beliefs and ideologies can be difficult. Obstetricians could simply decline to perform a cesarean section on maternal request, but this obviously may lead to conflict. It would possibly make the woman and her family choose another obstetrician who would be willing to perform surgery, especially in the private sector. Our qualitative study contributed data from affluent women from a part of India, reflecting cultural preferences in India with a different culture from that of Western countries.

Obstetricians find it tough to tackle this because these kinds of concepts and belief systems are hard to alter. While familial origins appear to have a greater influence, these attitudes might not be tied to education level. The strength of this study was that two investigators performed the content analysis independently and then discussed the results to obtain consensus. Because various researchers may get different findings from the same data, this raises the validity of the study. The two investigators have different personal backgrounds so our findings were approached and discussed from different angles to ensure consistency in the analysis.

CONCLUSION

The disparity in C-section preference and in between private and public providers has increased over the last 15 years and was higher. While further analyses are needed, our study suggests that the government needs to closely monitor the activities of service providers to ensure that C-section is performed only when medically necessary. Also, lower-level public health institutions need to be properly equipped for essential and emergency care adhering to the hygiene and quality standards so that even affluent women can avail the benefits of Government setup without hesitation.

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