ABSTRACT The phenomenon of caesarean birth on demand has gained attention, particularly as a first caesarean birth appears to be strongly predictive of subsequent caesareans. Identification of reasons behind caesarean birth on demand is important for planning effective interventions. Therefore, this review reports the factors involved in the tendency of women to undergo caesarean birth, based on studies in the Islamic Republic of Iran. Several keywords including caesarean delivery, childbirth, causes, maternal request/demand, and patient choice were used to search Medline, PubMed, Ovid, Scientific Information Database, Magiran, Google and Google Scholar. The search was conducted on Persian and English language articles, with no time limitation. Using content analysis, the factors influencing caesarean section were
divided into 3 categories: maternal, social and healthcare giver. According to the high prevalence of caesarean section, it is important to design and implement effective programmes and interventions with consideration of the key reasons that lead women to opt for unnecessary caesarean section.

**Analyse des déterminants des naissances par césarienne sur demande de la mère en République islamique d’Iran**

**Introduction**

Caesarean section rates are on the rise worldwide (1). Based on a recent study in the Islamic Republic of Iran, the rate of caesarean section is 49% nationwide (2). Caesarean birth on maternal demand (CBMD) is responsible for some increase in the overall rate. In developed
countries, conservative estimates of CBMD range from 4% to 18% of all caesarean deliveries (3). Although the rate of CBMD in the Islamic Republic of Iran remains unclear because of poor documentation, the total rate of caesarean birth is unfortunately high (4). CBMD is defined as elective caesarean delivery for singleton pregnancy on maternal request at term in the absence of any medical or obstetric indications (5). It is now recognized that performing a caesarean section with no medical indication offers no health advantages for the mother and infant, and has increased health risks, from both physical and emotional perspectives, compared to vaginal birth (6).

The problem is that caesarean birth is associated with an increase in maternal and infant mortality and morbidity, and increased healthcare costs. Theoretically, maternal outcomes of fever, infection, pneumonia and thromboembolism are consistently increased with medically indicated caesarean birth and would also be present in instances of CBMD (7). The issue of cost must also be considered in the broader context of burden to the already stressed healthcare system and the impact on finite resources (6).

CBMD has received increasing attention in the social science literature, with a focus on women’s motivations. The reasons for CBMD are complex and it appears to have interrelated factors that are not easily explained. As the literature review revealed, elective caesarean section is related to personal, psychological and social factors such as autonomy, self-control, perceptions of safety, fear of childbirth, sexuality, and perceived quality of obstetric care (8). Limited information is available about how the decision for elective caesarean section comes about in the clinical environment (9,10). CBMD is clinically relevant because of the increasing numbers of women choosing this mode of delivery, the health risks to the mother and infant, and the increased cost associated with the procedure.

There is a need to gather information about the factors involved in the tendency of women to opt for caesarean section, based on studies that have been conducted in the Islamic Republic of Iran. The ultimate goal is to devise interventions to reduce the number of maternal requests for caesarean sections, thereby reducing their associated mortality, morbidity and healthcare costs. Many studies have investigated the reasons for CBMD in the Islamic Republic of Iran. However, these studies have been in a particular geographical area. Hence, there is a need to identify and summarize the different causes in different regions of the country, and the results could be used to design and implement appropriate national plans and interventions to reduce unnecessary caesarean sections.

**Methods**

This study was a review of the literature regarding elective caesarean birth without specific
medical indications. We searched the following databases: Medline, PubMed, Ovid, Google and Google Scholar. To access Iranian studies published in Persian, we also searched Scientific Information Database, Iran Medex and Magiran. We searched using the terms caesarean delivery, childbirth and birth, maternal request/demand, and patient choice for published articles in Persian and English languages, with no time limit. We reviewed articles from all over the Islamic Republic of Iran because of the ethnic and cultural diversity in the country. Approximately 126 articles were initially obtained including abstracts, quantitative and qualitative research, governmental reports, comprehensive reviews, and opinion/editorial articles. We restricted the search to peer-reviewed full-text articles that explained only CBMD without any medical indications. After excluding irrelevant or repeated articles, experimental and quasi-experimental studies, we analysed 29 articles (24 quantitative and 5 qualitative) related to the objectives of the study. All studies were performed from 2002 to 2014. Selected articles were studied extensively to extract the required information (Figure 1) and we identified the factors influencing the decision for caesarean section.

Results

Several factors influenced women to opt for caesarean birth, which can be divided into 3 groups: maternal, social and healthcare provider. Maternal factors included demographic factors such as age, education, job status and place of living; psychological factors such as fear and anxiety; and other factors such as perception and attitude toward childbirth that was mostly related to individual behaviour and comprehension. The reviewed studies showed that factors influencing women to choose caesarean section included advanced maternal age, high educational level, living in the city, fear of vaginal birth pain, concerns about infant safety, fear of urogenital trauma during vaginal birth, and prior complicated normal childbirth.

The second group were social factors. In some cases CBMD was based on the recommendation of family and friends. Social status was also an influencing factor and women with higher social status were more likely to have an elective caesarean birth.

The third group were healthcare provider factors. Recommendations from obstetricians and midwives were the main reasons behind CBMD in some cases. The results are summarized in Table 1.

Discussion

Historically, the management of pregnancy and labour has been primarily associated with high expectation, and until recently, the concept of requesting a caesarean birth was not recognized
as a possibility for women. To request a caesarean section is a difficult decision for women planning childbirth, and according to previous studies, too many factors are involved in this decision-making process. The aim of this review was to identify the main factors behind this increased tendency of women to request a caesarean section in the Islamic Republic of Iran. We found that CBMD was influenced by maternal, social and healthcare giver factors.

**Maternal factors**

Caesarean section among older women (> 35 years old) is more frequent than in younger women (11–13). Consistent research findings indicate that women who choose elective caesarean tend to be older (14). Maternal age has been reported as an independent risk factor for caesarean delivery. The reasons for this increased risk remain unclear, but other studies have suggested that it may be due to physician and patient concern over pregnancy outcomes in older women (15). Advanced maternal age places women in a risk category in which screening and diagnostic tests for chromosomal abnormalities are routinely offered and is associated with infertility and assisted reproductive technology (16). These factors may contribute to a maternal viewpoint of the pregnancy as being high risk and requiring additional medical intervention, which leads to elective caesarean section (17).

Caesarean section among women with higher education is more frequent than among those with lower education (11,12,18). This is consistent with some studies that have reported an increased tendency for caesarean section among women with higher educational level (19) but inconsistent with other reports that more educated women choose vaginal delivery (20). Although some studies have indicated that women who live in a city and who are in employment are more likely to choose caesarean section (13,21,22), these factors have less effect than other demographic factors on choosing caesarean section.

Psychological factors, especially fear of vaginal birth and its associated pain, are related to the demand for caesarean birth (23–32). Anxiety and fear of childbirth have consistently been associated with maternal request for elective caesarean section (33–36). Severe fear of childbirth can lead to pregnancy complications (37), which is thought to increase the percentage of women who demand elective caesarean birth. Hofberg and Brockington described a condition known as tokophobia, a fear of death in childbirth, preceding pregnancy (38). Women with this condition are afraid that they will die if they give birth vaginally. It is reported that about half of women with tokophobia choose an elective caesarean section (38). The emotional status of women during pregnancy and delivery may be associated with interpretation, expectations and decisions concerning the delivery process. Pregnancy-related depression, stress or anxiety may contribute to lessened confidence, fear and dissatisfaction with the birthing process (39), which can encourage women to opt for caesarean section.
Another important factor is negative past experiences – both with regard to pregnancy and childbirth – and this is currently considered to be one of the main causes of fear of childbirth that might lead to elective caesarean section (12,23,28,40). Women who have had a negative previous birth experience continue to feel fear in subsequent births, especially in relation to labour pain. Labour pain is one of the most stressful episodes in childbirth (41) and a significant association with elective caesarean section has been reported (34,42).

Almost all pregnant women are concerned about the well-being of the fetus and want to provide a safe uterine environment. They desire a type of birth that is safe for the infant. Although there is no evidence to support that caesarean birth with no medical indication offers health advantages for the mother and infant, many women believe that elective caesarean section is safer for the fetus (6). Concerns about fetal safety have been reported in different qualitative studies as a reason for CBMD (43–48).

Many women are concerned about retaining function of their urogenital organs after childbirth. Although there is no consensus that planned caesarean birth preserves the pelvic floor or prevents urinary incontinence or anorectal dysfunction, some women are afraid that having vaginal birth will damage these internal organs (23,24,39).

One study has indicated that some women tend to elective caesarean section because they want their baby to be born on a particular day (27). Studies in Australia and Turkey have suggested that women may opt for caesarean delivery because they can plan for the time of day or week that meets the needs of the obstetricians’ and their own schedules (49,50). This practice is more common in private health care where women have more flexibility and financial strength to schedule delivery.

**Social factors**

The support of family and friends is associated with CBMD (24,26,27). Sharing childbirth experiences within the family may affect a woman’s decision about the method of birth. Women who benefit from the support of family and friends take a more active role in the birth process, and women without such support are more fatalistic about their role in the birth process (51). Some research has shown that women who receive social support in pregnancy and during labour have lower rates of caesarean section (52).

Another social factor that might influence the type of birth decision is social status. Some studies have suggested that caesarean sections are more likely in women of higher social
status (53). In contrast, one retrospective study of a large number of caesarean sections in England stratified by social status found that caesarean sections were not more likely in women of higher social status (54).

**Healthcare provider factors**

Recommendation by physicians and midwives is one of the main reasons for caesarean section (4,55–61). Traditionally, the role of obstetricians has been paternalistic, and women have complied with their recommendations based on the balance of power in the physician–patient relationship. Many complex factors may contribute to obstetricians’ viewpoint about maternal choice and elective caesarean birth, and attitudes among obstetrician appear to be changing.

Several studies have examined maternal choice of caesarean section from the obstetricians’ point of view and found that physicians may play an important role in promoting elective caesarean delivery to individual women (62,63). Physicians may push their patients toward requesting caesarean section with remarks that imply that it may be needed. The result of one European study exploring the attitudes of obstetricians showed that > 75% of German and British obstetricians accepted CBMD, as did even 22% of obstetricians in the Netherlands where the caesarean rate was lowest (64). Wax and colleagues found that 8.3% of obstetricians surveyed cited convenience as a reason for giving birth by CBMD. Timing of caesarean deliveries is important to physicians. Lo has suggested that an increased rate of caesarean sections in the United States of America may occur in the last week of December so parents can take advantage of a tax deduction (65). Physicians have to juggle office visits, surgeries and deliveries during the day. Vaginal deliveries and emergency caesarean deliveries may keep a physician awake all night and result in significant fatigue. Planned elective caesarean deliveries can improve the schedule of the physician who schedules deliveries at their convenience (66). A caesarean section takes about 30 minutes compared to assisting with vaginal birth, which may take up to 12 hours or more (67). In summary, physicians play an important role in a woman’s decision to request a caesarean section. Convenience, physician fatigue and legal issues play a role in the attitude of physicians to encourage women to request a caesarean section.

**Study limitations**

There were some limitations to this review. First, the quality of studies that were analysed in this review was not examined. Second, some of the studies evaluated women’s preferences and not actual demand for caesarean section. Therefore, the actual factor behind CBMD cannot be inferred from those data.

**Conclusion**
This review may have implications for the health system, researchers and clinicians. The results suggest that the following factors may influence women’s childbirth decisions: fear of vaginal birth pain, concern about infant safety, fear of urogenital trauma during vaginal birth, prior complicated vaginal childbirth, recommendation of family and friends, and opinion of healthcare providers (obstetricians or midwives). Considering the key reasons for caesarean section, providing effective interventions such as educational programmes to gain appropriate knowledge, enhancing the quality of vaginal birth services, and solutions to reduce the healthcare providers’ recommendation for unnecessary and not-indicated caesarean sections are important.

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