Chapter-VIII

Summary and Conclusion

8.1 Summary:

The study attempts to understand the current scenario of caesarean childbirth in India with focus on West Bengal. It also addresses the possible inter-linkages between different factors leading to the conduct of caesarean section. While doing so, the study intends to throw light on the various aspect of medicalisation of childbirth and its effect on decision making during delivery from both institutional, societal, family and gender perspectives.

Childbirth is a natural event; yet for many thousands of women, it is becoming a matter of great pain and concern due to over-medicalisation of their bodies. The rising trend in c-section rate in both developed as well as developing countries and increasing preference of medical professionals adopting this technology point towards growing medicalisation childbirth in the society.

According to the WHO guidelines, modified in 1994, the caesarean birth rate in any population should range between 5 to 15% (World Health Organization, 1994). It is suggested that no additional benefit accrues to the children or to the mothers when the rates exceed this level. However, currently the caesarean birth rates in many developed and developing
countries far exceed the tolerable limit specified by the WHO indicating unnecessary use of this intervention.

The impact of caesarean section delivery on maternal and child health, and the high cost of this medical procedure compared to normal delivery, is a serious public health issue. Studies have shown that, over the past few decades childbirth has become increasingly under the influence of medical technologies. Even the normal birth has become too ‘medicalised’ and the higher rates of unnecessary obstetrical intervention raise serious concern for mother’s health (Johanson et.al. 2002).

It is interesting to note that, over the past few years there has been a consistent increase in the rate of c-section deliveries in most of the developed countries and in a few developing countries including India. In some countries like Brazil, Mexico, and United States, the rates of c-section are alarmingly high (Potter et al. 2001; Cai et al. 1998). In India, with the increase institutional births, the c-section births are also on the rise (Mishra and Ramanathan, 2002). Studies show that in the case of India the caesarean deliveries are mostly occurring in the private institutions rather than in public institutions.

However, the causes of the increasing trend in c-section in countries like India still remain unclear. There are possibly two general explanations to this trend. First, it is mostly considered that the increase in c-section births worldwide is the result of overuse of healthcare facilities for the profit motive.
by the hospitals. Second, it is also considered that there is an increasing demand from women even in developing countries for C-section to avoid pain. With the increasing economic and educational advancement and access to improved medical technologies, women’s decision making power in matters relating to pregnancy and childbirth have undergone radical changes. The preference for increasing c-section intervention during childbirth may, therefore, be an outcome of these changes. The theoretical debates in literatures on the contributing factors of such medical intervention mainly focuses on two aspects; motivated by health care professionals and demand evaluated from women. Most of the studies emphasized the role of health-care institutions in augmenting the c-section delivery. The changes taking place within family and community and its likely consequences on c-section delivery has not received adequate attention yet. Therefore, for a better understanding of the issues, there is a need to integrate the traditional debate with the modern changes taking socio-economic transformation of the society into consideration.

With this backdrop, the present study attempts to understand the role of demand side and the institutional factors contributing to the conduct of c-section delivery in the context of West Bengal (as it represents one of the most urbanized cities), India. It also focuses on the possible interlinkages between different factors which influence the performance of caesarean section. While doing so, the study also intends to throw light on the aspect of medicalisation of childbirth and its role in decision making during delivery from both
institutional as well as societal perspectives. Effort also was made to understand the consequences of c-section among households in general and for mothers in particular.

The study uses both secondary and primary data to achieve the objectives. Qualitative data collection methods are adopted to capture information from women who have undergone C-section. The women were selected from different hospitals (both private and public) in Kolkata. In addition, in-depth interview of health professionals are also carried out.

8.1.1 The debate over medicalisation of human health: A theoretical review

The second chapter reviewed the theoretical literature on medicalisation of human body. On the one hand, there is strong school of thought that medicalisation has taken control over human life. But at the same time, there is an alternative view that over the time, medical power helps to eradicate disease and act for the wellbeing of the society. Therefore, it is necessary to understand the important aspects of this debate before specifically focusing on the caesarean section deliveries.

A number of studies mainly focused their attention towards over medicalisation of childbirth and considered increasing trend of caesarean delivery as an example of such changes. In recent years, especially, it is often argued that with thriving private practice, obstetricians increasingly prefer c-section birth than normal birth. The debate on the medicalisation mainly focuses on three aspects; 1) Orthodox medicalisation critique, 2) Concept of
power in medical domain and 3) Medicalisation of reproduction and childbirth.

In sum, the medicalisation debates bring out some interesting aspects of medical technology that affects human beings constantly in an effort to keep good health. While the debate as such is successful in depicting the problem from a completely institutional angle, it has not largely touched upon the changing socio-economic environment and the resultant emphasis on technological use for health problems from the population at large. The debate, however, provides a good picture of medicalisation from an institutional perspective.

8.1.2 Trends in caesarean delivery in India:

This chapter portrays the current scenario of c-section deliveries in the context of growing incidence of institutionalized births in India. It is found from the analysis that there is a consistent increase in the rate of caesarean birth over the past decades. Moreover, what has been alarming in the case of India is the wide heterogeneity in the incidence of c-section across states and regions. Over the last 15 years the increase in c-section delivery has been substantial in many states in the country (7 out of 19 states reporting over 15 percent or more caesarean child birth). Interestingly, all the southern states and Goa with marked demographic transition record high incidence of c-section rate.

Another striking difference in c-section rates as observed in India is the rural urban disparity in the occurrence of caesarean births. It is evident from
the analysis of NFHS data that in 1998-99, the percentage of c-section had been around 4.8 percent in rural areas and 14.9 percent in urban areas. It has increased to 6.2 percent in rural areas and 17.8 percent in urban areas during the period of 2005-06. Interesting to note that, the state of West Bengal is having the highest rural-urban difference in c-section rate. To understand the level of this medical procedure analysis of caesarean births for major cities in India was carried out. The results from the analysis show that most of the cities have very high incidence of caesarean birth of which Hyderabad represents highest (35.2 percent) followed by Kolkata (31.3 percent).

Undoubtedly, growing institutionalized birth was also accompanied by and high incidence of c-section rate in many states. For instance, the states like Kerala, Andhra Pradesh and Goa with high incidence of c-section delivery have also recorded most deliveries taking place in hospitals. The analysis on the type of hospitals reveals that high incidence of caesarean childbirth mostly noticed in private hospitals in almost all the states. Most often the private hospitals are the targets of criticism for increased c-section delivery as financial motives are inherent in the private medical system. Although the rate of c-section delivery is higher among private hospitals than the public, the study also observed higher incidence of c-section even among public hospitals in some states beyond the expected range. This suggests that many non-medical factors motivate doctors to perform surgical deliveries.

5 Analysis based on NFHS 3 for major cities in India.
Unraveling the reasons for such a trend necessitate in-depth studies on the factors leading to c-section.

The West Bengal Scenario: It is learnt from the secondary data analysis that the rate of c-section childbirth in West Bengal is relatively high although not among the high incidence states in India. However, the rural-urban difference in c-section birth is highest in the state and over 30 percent of the deliveries in urban areas are taking place through c-section. Analysis of caesarean births in major cities in India shows that Kolkata ranked second highest among all the cities (after Hyderabad) in the conduct of c-section deliveries. Moreover, the private sector contribution to the caesarean births is also very high in West Bengal.

8.1.3 C-section deliveries: The determinant factors:

This chapter focuses on the interplay between different factors such as medical or socio-economical as well as institutional in determining the performance of caesarean intervention in India and more specifically West Bengal. The effects of different factors considered in the framework are analysed with the help of both bivariate and multivariate analysis.

Risk factors: Analysis of secondary datasets with both bivariate as well as multivariate methods reflects that mother’s age plays an important role in performance of c-section. Mothers aged 30 or more are having more chances of caesarean baby than their younger counterpart. Women today marry late and pregnancy is also delayed resulting in more chances of undergoing
caesarean delivery. Studies also suggest that women are more prone to complications as the age of pregnancy and delivery advances (Taffel et al. 1985). Another important factor for the performance of c-section is large size of baby at birth. Larger size babies are at higher risk of delivered by c-section.

**Socio-economic (demand) factors:** The study found from the analysis that socio-economic factors play an important role in the current high incidence of caesarean section delivery in India. The most important socio-economic factors that influence c-section are mother’s education and place of residence. Multivariate analysis shows that, controlling other factors, mothers with higher education experienced high caesarean intervention, which elucidate that women from high educational background, perhaps, are able to make decision on their own health care.

**Institutional factors:** The analysis considered proportion of deliveries in public or private hospital as the variable to capture institutional angle of c-section delivery. The logistic regression analysis shows that in India and West Bengal births in private hospitals are more likely by c-section than their public hospital counter part.

Thus the three sets of indicators considered for the multivariate analysis provided vital information on the factors that have contributed to the high incidence of c-section delivery. From the available secondary data, it was not possible to consider all the variables in framework due to data constraint.
8.1.4 Caesarean delivery – the context of Medicalisation:

This chapter investigates nuances of the complex decision making process taking place for the performance of c-section delivery at the hospitals. This chapter examines only the institutional angle from a medical perspective. For this purpose, in-depth interviews with the doctors of both private and public hospitals were carried out. Another important aspect of medicalisation of childbirth is the relationship between doctors and their patients. Hence, the study also explains how the perception of doctors and their patients on the role of medical profession on illness changes with time.

Interviews with the Gynaecologists enlightened on some important issues. Firstly, all of them agreed on the increasing caesarean childbirth in recent times, though factors for such increase are different. Secondly, there exists disagreement on the factors for such an increase. Doctors from public hospitals stressed on medical factors for the current scenario. Whereas, doctors from private health facilities were of the opinion that social and economic factors are more important for the increasing c-section birth.

Another interesting area of discussion is what factors trigger the medical professionals to opt for caesarean for their patients even without any medical emergencies. The most debated and discussed cause for preference of caesarean delivery is perhaps the risk aversion among medical professionals. Today, this medical intervention received lot of attention among obstetricians and gynaecologists for a safer mode of delivering the child and to avoid
maternal mortality. In the interview the question was asked that why doctors feel caesarean is safe. They were of the opinion that as technology improved a lot and use of the medical gadgets increased, the caesarean intervention has become easier technique than it was earlier. This situation, many times gives rise to concept of medical convenience for the preference of caesarean section. The availability of different medical staffs related to surgery, particular time preference of doctors motivates the obstetrician to take decision for surgery. Adding to this, another important factor which portrays as an underlying cause to perform c-section without any medical reason is fear of litigation or anxiety among the medical profession.

Conversation with the medical professionals indicates changing medicalisation scenario which is mainly manifested in the increasing evidence of medical intervention in women’s health. It also points towards changing notion of patient-doctor relationship which were earlier thought to be a one sided process. Interviews with the doctors also revealed the fact that the recommendation for the mode of delivery whether it is normal or surgical entails interplay between several factors. Hence, it is important to analyze the other part of the story which entails with preference for caesarean birth from a demand perspective.

8.1.5 Elective Caesarean Section or Caesarean by choice:

This chapter deals with the empirical exploration of how delivery decisions take place and how the preference for opting caesarean childbirth ensues
between professional medical world and family set-up. Moreover, the economic consequences impinge on families by this surgical procedure has also been discussed. The chapter also focuses on the preference for caesarean option by a woman to deliver her child. Interesting to point out that, the demand for a medical intervention or caesarean can be purely woman’s own preference or many time familial decisions made by husband or mother-in-law.

**Reasons for preferring caesarean as mode of delivery:**

An empirical and conceptual exploration of how delivery decisions takes place in a family set up has been done based on the case studies of the women who had this medical intervention during childbirth. Following are some of the factors which lead to preference for caesarean births in absence of any medical reason.

*Maternal request for caesarean births:*

It has been found that a number of factors such as fear of pain during labour, fear of child loss play very crucial role in preferring this mode of delivery. Women who had experienced previous vaginal deliveries felt that the pain of labour can be avoided only through surgical intervention. They also believed that caesarean is a painless way to give birth, although, none of theme were aware about the post operative pain.
Role of family in pathway of decision making:

Family plays an important role in the decision making process of caesarean births. From the voices of the case studies it appears that during the journey from marriage to pregnancy and to delivery, whether it becoming pregnant or delivery of child or even sex of the child, familial opinion plays a crucial role. The preference for any surgical procedure by family members mainly involved preference from a woman’s husband or her mother-in-law. The preference can occur mainly due to avoid death of a boy child during delivery or number of religious factors the family believes in.

Doctor’s motivation behind the decision making

Another interesting factor for preference for c-section birth is motivation from health professionals. It is often argued that, the decision to perform a surgical intervention mainly motivated by a doctor rather than the patient. The complex negotiation between medical professional and patient interaction, can be viewed from the prism of power. In many cases, demand for caesarean delivery largely dominated by preference from doctor with or without any medical reason, where, beside the medical factors, doctor’s interest determine the choice of c-section.

Economic consequences of caesarean delivery

Increases in caesarean section rates worldwide have raised questions about the economic implications of caesarean section. A number of studies
commonly noticed a higher incidence of caesarean deliveries in private hospitals compared to public sector hospitals (Petrou et. al. 2001; Behague et. al. 2002) due to non-medical factors such as economic gain and pressures of private practice may motivate doctors to perform surgical deliveries. The current study provides a picture which shows that Indian cities are portraying an increasing scenario of caesarean child birth mostly in private health facilities rather than public health facilities. This implies an unhealthy practices prevailing in private health care for profit motive. The study also reveled huge financial burden inflicted upon the family due to c-section delivery. But many families are ready to accept this cost given the fact that they themselves opted for this and also delivery has become a rare events due to drastic reduction in the desire for the number of children.

**8.2 Conclusion:**

The overall study brings out the current trends and pattern and the major causes of increasing incidence of caesarean section delivery in India with focus on West Bengal. Moreover, it also analyses through in-depth interviews the decision making process both from institutional and women’s perspective. An empirical and conceptual exploration of how delivery decisions take place between the professional medical world and society has been brought out.

The analysis of national level data points towards an increasing trend in caesarean births in the country. States with marked demographic transition shows an increasing trend of caesarean intervention. With the
increase in institutional delivery, there has been commensurate growth in caesarean intervention as well which creates concern for maternal health. Thus the increasing use of medical intervention, perhaps, is unwarranted and further generates concern for maternal health.

It is evident that there has been a change in the outlook towards c-section both within the society as well as from medical professionals. From field study, it is understood that women have very definitive opinions about the use of caesarean intervention as a mode of childbirth. What is pertinent to observe here are the views of medical professionals on use of caesarean section. It appears that medical profession no more considers it as technology that should be used only in the case of medical emergency but indicates the flexibility based on the need. However, it is not merely the medical profession but the society, at large, are also responsible for the rapid increase in c-section currently. Often only the medical profession’s motive behind increasing c-section comes out in open. This study clearly indicates that the rapid socio-economic changes and the outlook towards medical intervention by the women, families and society are increasingly responsible for the current high incidence of c-section in many states and urban centres in the country.

8.3 Policy Implication

It is too early to be ‘for’ or ‘against’ women’s access to caesarean delivery in the absence of any medical indications as there are strong argument
supporting and opposing such trends. The right question is not whether a c-section delivery is necessary or not, but, rather, making sure that the value of women’s autonomy in decision making around birth are completely protected. It is important that guidelines and appropriate practices to promote women’s autonomy in the birth process are brought out. The social conditions need to be generated to ensure such autonomy. This study indicates that there should be a two pronged approach which can do justice for well-being of women on their health during pregnancy and childbirth.

On the one spectrum it is important to consider women’s opinion on their mode of delivery, whereas, on the other sphere it is also important to justify the overuse of any medical procedure which is not at all necessary. It is not only the doctors who need to be re-socialized into a new way of thinking on relating their patients on decision making for any medical intervention, but the women also need to be made aware their rights, and their own knowledge and feelings about childbirth are valuable to take appropriate decisions.

8.4 Limitations of the study:

This study also has many limitations. Firstly, due to data constrain it was not possible to include some of the important medical risk factors in the framework while analyzing the determinants of caesarean section delivery. Secondly, the in-depth interviews with the medical professionals and case studies of women who had caesarean births are based on few selected
samples; therefore, generalizing the issue may not be appropriate. Thirdly, the study narrates the experience of only those women undergoing c-section. Perhaps, there may be alternative story of those women having natural birth despite provocation. However, the study could not capture those instances.