CHAPTER ONE

INTRODUCTION

1.1 Introduction

The fragile health situation of developing countries due to scarce resources coupled with medicalisation of simple remedial health issues has become a serious concern leading to a debate on medicalisation of health. Developing countries, as other regions of the world, are faced with the challenge of making the best possible use of limited resources to improve the health for all and particularly of women and children. Therefore, it has been argued that the obstetrical interventions should be evidence based and should be confined to only high risk groups. Studies raised serious reservation in using this technology routinely without adequate medical reasons (Buekens, 2001). Morbidity and mortality caused by unnecessary interventions could be a significant problem, and a worldwide epidemic of obstetrical interventions could have a negative health impact on woman and her child.

It is noteworthy to mention that caesarean section is a life saving procedure firmly ensconced in obstetric practice. With the advances in anaesthetic services and improved surgical technologies, the morbidity and mortality of this procedure have come down considerably. This, albeit wrongly, buoyed up obstetricians to perform more and more caesarean sections, generating a universal upswing in caesarean section both developed
and developing countries. Unfortunately, given the resource constraints, India is hardly equipped to handle the repercussions of such an unprecedented increase in surgical intervention.

**1.2 Medicalisation of maternal health and Caesarean delivery:**

The rising trend in c-section rate in both developed and developing countries and the increasing preference from medical professionals rightly points towards growing medicalisation of health in general in the society. This growing reliance on medicine also appeared to be occurring in other aspects of life which are normally considered as natural, such as menopause and ageing (Zola, 1972, Freidson, 1970). A number of studies in this context elucidate that over the past few years, dependence on medical intervention have gone up significantly in many facets of life (Nettleton, 2006). This is particularly true in the case of maternal and child health (Einion cited in Squire Caroline, 2003). A growing number of deliveries in recent years are taking place through surgical interventions resulting in a high rate of c-section in both developed and developing countries (Stanton, 2006). It is well known fact that the maternal and neonatal deaths have significantly come down over the last century in large part of the world as a result of the increased application of technology during labour and childbirth (Sen, 1994). But the major concern is on the overuse or misuse of the medical technology with a profit motive by the health providers.
1.3 The History of medicalisation of maternal health in India:

In India, historically the arena of childbirth was one which was considered to be outside the purview of modern medicine and public health. Thus, the traditional midwife or birth attendant used to help women in their child delivery. The history of medical intervention in childbirth in India has began with the effort of Elizabeth Bielby, a ‘Zenana Missionary’ who spent her life in north India with a motive to save lives (Guha, 1998). This was also the beginning of the journey of Dufrin Fund which played a critical role in making Western medical knowledge acceptable and desirable among certain higher classes of Indian women. By bringing medical attention during childbirth in India, the missionaries were successful in bringing down the maternal mortality. Point to be noted here that the colonial state had not excessively concerned with the matters on women health, particularly in the early colonial period, until the Dufrin Fund receiving official patronage on training of the midwives at Government expenses (Guha, 1998). And slowly the scenario of child birth began to make the change from traditional birth attendants to institutionalisation. But truly speaking, the medicalisation of childbirth in India was much more prevalent in the urban areas, where institutional births have become the norm (Madhiwala, 2008).

1.4 The current situation in health care utilization and maternal health

Studies have shown that, over the past few decades childbirth has become increasingly influenced by medical technology. According to Johanson et.al,
(2002), the normal birth has become too ‘medicalised’ and the higher rates of unnecessary obstetrical intervention raise concern for mother’s health. Bruekens, (2001) in this context, argues that over medicalisation of maternal care has become a world wide epidemic. In fact, medicalisation, in general, has taken control over human life and maternal health comes also under its ambit.

1.5 What is caesarean section delivery?

A caesarean (si-‘zar-E-an) section is major abdominal surgery use for the delivery of an infant through an incision in the mother’s abdomen and uterus ((Sewell, 1993). According to a historian Pliny the Elder - AD 23 to 79 - the term cesarean was coined after the Emperor of the Roman Empire Julius Caesar himself was allegedly delivered this way.

Caesarean section is recommended when vaginal\textsuperscript{1} delivery might pose a risk to the mother or baby. This surgical procedure can be done by making an incision across the bottom of the abdomen. Until recently, the operation usually been used as a last resort because of a high rate of maternal complications and death. However, today, with the availability of antibiotics to fight infections and the development of modern surgical techniques, it has become nearly risk free and the maternal mortality rate due to this procedure has nearly become negligible. As a result, the caesarean childbirth rate has increased significantly.

\textsuperscript{1} Vaginal delivery - A delivery through the passage of vagina with or without the help of birth assistant.
1.6 A brief history of caesarean section delivery

From ancient time, caesarean section has been a part of human culture. The history of caesarean section can be understood best in the broader context of the history of childbirth and general medicine - histories that also have been characterized by dramatic changes. According to Greek mythology, Apollo removed Asclepius, founder of the famous cult of religious medicine, from his mother’s abdomen (Sewell, 1993). In Ancient Hindu, Egyptian, Grecian, Roman, Chinese and other European folklore we find numerous references to caesarean sections. Ancient Chinese engraving depicts the procedure on apparently living woman. Yet, the early history of caesarean section remains shrouded in myth and the accuracy was unsure. Even the origin of caesarean has apparently been distorted over time. It is commonly believed to be derived from the surgical birth of Julius Caesar (Sewell, 1993). At that time, the procedure was performed only when the mother was dead or dying as an attempt to save the child for a state wishing to increase its population. Until the sixteenth and seventeenth centuries the procedure was known as caesarean operation. This notion began to change following the publication in 1598 by Jacques Guillimeau’s book on midwifery in which he introduced the term “section”. From then the term operation increasingly been used as section (NIH, 1998).

During its evolution process, caesarean section has meant different things to different people at different times. The indication for it has changed dramatically from ancient to modern times. As already pointed out,
notwithstanding rare references to the operation on living women, the initial
purpose was essentially to retrieve the infant from a dead or dying mother.
Many a times, the infants were supposed to be buried separately from the
mother for some religious edicts. It was not until the 19th century that such a
possibility really came within the grasp of the medical profession. However,
there were sporadic early reports of heroic efforts to save women’s lives
(Sewell, 1993). Perhaps the first written record we have of a mother and baby
surviving a caesarean section comes from Switzerland in 1500. After several
days of immense pain in labour and unable to deliver a child the husband of
woman eventually gained permission from the local authorities to attempt a
caesarean. The mother lived and subsequently gave birth to five children
including twins.

Many of the earliest successful caesarean sections took place in remote
rural areas lacking medical staff and facilities. In the absence of strong
medical communities, operations could be carried out without professional
consultation in the 16th and 17th centuries. The first successful caesarean
section was recorded from British Empire by a woman doctor in late 18th
centuries. In the 19th century the budding medical interests in sexuality and
diseases of women have become more evident. Special hospitals for women
sprang up throughout the United States and Europe in the 2nd half of 19th
century. These institutions nurtured the emerging specialties and provided
new opportunities for medical practitioners, as well as new treatment of
patients. By the close of 19th century, a wide range of technological
innovations had enabled doctors to revolutionize and professionalize the medical market.

In addition to surgical advances, the development of caesarean section was influenced by the continuous growth in urbanization, significant demographic changes and growth of hospitals. However, currently this picture is somewhat differing from the positive impact of caesarean delivery which was used as life saving mechanism for both mother and child.

1.7 Benefits and risks associated with caesarean delivery:

**Benefits of Caesarean Delivery:** The most common indications for caesarean deliveries include failure to progress, non-reassuring foetal status, prior caesarean delivery or hysterectomy, and foetal mal presentation. These account for more than 70% of the indications for caesarean section. Undoubtedly, several of these conditions rely on a degree of clinical judgment and management style as to when the indication is present for the caesarean section to be performed. Some other less common indications for caesarean deliveries include abnormal placentation, mechanical obstruction of the birth canal, maternal infections (e.g., herpes, HIV), fetal bleeding diathasis, and cervical cancer (Churchill, 1997).

In several of the above circumstances, the benefits of caesarean delivery seem apparent although given that the diagnosis of these conditions is often not clear-cut, the benefit to the fetus is also not clear-cut. For example, the false-positive rate in the interpretation of fetal heart monitor tracings is
extremely high; many caesarean sections are performed needlessly to expedite the delivery of a fetus who is tolerating labour without difficulty.

There are also several indirect benefits of caesarean delivery given that the women in most countries are now engaged in economic activities. It helps, particularly, in planning their time more effectively. For example, knowing what day the baby will be born facilitates arranging childcare and planning when to return to work. Additionally, it helps to ensure that a specific provider will be present to perform the delivery. Although these benefits may seem trivial to some, for certain families these can be of utmost importance.

A planned cesarean delivery also guarantees that a pregnancy will not go post-term. As most are performed at 39 weeks of gestation, the risk of intrauterine fetal demise beyond 39 weeks is eliminated, and the risk of the development of post-maturity syndrome (meconium aspiration syndrome) is greatly reduced. Given the rarity of these disorders, however, many cesarean deliveries would have to be performed to avert a single adverse outcome due to one of these conditions.

*Risks Associated With Caesarean Delivery:* The risks associated with caesarean delivery can be divided into three groups; short term risks, longer term risks and risks relating to future pregnancies. There are also risks to the newborn that need to be considered. Certainly, the clinical situation that gives rise to the caesarean delivery has a great impact on the risk of complications as well.
The risk perception also varies substantially between a primary caesarean section performed for an average-weight woman who is not in labour and an emergency caesarean section performed on an obese woman who has been in labour for hours. In a similar vein, when interpreting studies of the risk of caesarean delivery one needs to consider that it may not be appropriate to compare women who delivered by caesarean with those with normal delivery. Most studies try to separate women who had planned caesarean deliveries from those who underwent caesarean sections in labour in order to compare situations of similarity than contrast.

1.7.1 Short-term Risks of Caesarean Delivery

A study that examined births between 1983 and 1992 in the Netherlands found that the risk of maternal death was 0.04 per 1000 vaginal births compared with 0.53 per 1000 caesarean deliveries; although the authors reported the risk directly attributable to the actual caesarean delivery as 0.13 per 1000 births (Stinkens et al. 1995). In this study, there were 57 deaths in the group of women who had delivered by caesarean and, of these, 10 were judged to be directly related to the surgery and 4 resulted from a complication of anaesthesia. Further, in 16 of these cases, it was believed that the caesarean contributed to the death. These data do not distinguish between the different clinical situations that may contribute to the risk of maternal mortality. Additionally, while the relative risk of mortality may be significant, the increase in the absolute risk is quite small. The results of another study of postpartum mortality among primiparas in Washington State conducted
between 1987 and 1996 suggest that rather than a risk factor for death, caesarean delivery may be a marker for pre-existing morbidities associated with increased mortality risk (Chlidbirth, 2004). Another major reasons for maternal mortality related to caesarean delivery is deep vein thrombosis resulting in pulmonary embolism (Chlidbirth, 2004). Ros and colleagues reviewed more than 1 million deliveries in Sweden from 1987 to 1995 and found that the relative risk of maternal mortality due to pulmonary embolism was four fold higher with caesarean delivery. This is consistent with another study of nearly 400,000 births that found approximately 4-fold higher rate of deep vein thrombosis in women undergoing caesarean delivery as compared to vaginal delivery. Other risk factors for thromboembolism are important to consider with caesarean delivery, as they may have additive risk for a given patient -- most importantly a history of thromboembolism and another factor that is more commonly encountered, maternal obesity.

Not only that there is higher risk of maternal mortality due to caesarean section delivery, but the morbidity due to this procedure is also relatively high. Blood loss during a caesarean delivery may be greater than during a vaginal delivery; however, the transfusion rate remains low at 1% to 2% of patients undergoing caesarean section. Planned caesarean deliveries have been associated with a lower risk of early postpartum hemorrhage compared with instrumental vaginal deliveries and unplanned caesarean deliveries in a population-based cohort study (Liu et al. 2007). It has also been found that the risk of hemorrhage requiring blood transfusion increases
substantially with increasing number of prior caesarean deliveries. Another cause of morbidity is the infection which is one of the most common complications of caesarean delivery. The rate varies dramatically according to the clinical situation, with rates as high as 85% for women undergoing caesarean section after an extended labour and as low as 4% to 5% for those undergoing a scheduled caesarean delivery (Liu et. al. 2007). Another common complication of caesarean delivery is wound infection. Wound infections may occur in 2.5% to 16% of caesareans. There are also possibilities of bladder injuries occurring at the time of caesarean delivery. Nevertheless, they are rare. Evaluating a series of nearly 15,000 caesarean deliveries, Phipps and colleagues reported that bladder injuries were encountered in 0.28% of deliveries (0.14% for primary caesarean sections and 0.56% for repeat procedures) (Phipps et.al. 2005). As a woman who has had a caesarean delivery typically remains hospitalized longer, there is an increased risk for readmission (Phipps et.al. 2005).

Studies also found that the risk of the need for hysterectomy after or during a caesarean delivery is greater than after a vaginal delivery. An important problem with any study that looks at this issue, however, is that they do not control for those women who had a trial of labour before their caesarean delivery. Thus, women undergoing a primary caesarean section who have not laboured may have a lower rate of emergent hysterectomy than those who laboured before their caesarean delivery. One study attempted to mitigate this issue by performing a case-control study of women who had a
hysterectomy postpartum (within 14 days of giving birth). Compared with a control group of women who did not have a hysterectomy, those who did have a hysterectomy were 13 times more likely to be delivered by caesarean section. Moreover, it is argued that there exists a poor birth experience due to caesarean section. In a meta-analysis of 43 studies published between 1979 and 1993, DiMatteo and colleagues found that women who delivered healthy babies by cesarean section (both planned and unplanned) were more likely to report dissatisfaction with their birth experience compared with those who delivered vaginally (DiMatteo et al. 1993).

1.7.2 Long-term Risks of Caesarean Delivery

Considerable evidence suggests that caesarean surgery, even among healthy women, is associated with increased rates of infection, haemorrhage, and other serious medical and psychological complications and hospital readmission (Elliott et al. 2011) Specifically, the long term risks for caesarean delivery poses on women in case of repeat caesareans. The most important of these risks include increased operative injuries related to adhesions and a much-increased risk of placental implantation abnormalities such as placenta previa and placenta accreta in future pregnancies, carrying with them a greater risk of catastrophic hemorrhage and hysterectomy (Silver et al. 2006). Women who undergo caesarean deliveries are more likely to report pain to be a problem in the first 2 months after delivery. A national survey of more than 1500 women who had delivered in the prior 24 months found that those who delivered by caesarean reported that incisional pain was a major problem 25%
of the time, and a major or minor problem 83% of the time (Declercq, 2002). This was in contrast to the 12% of women who delivered vaginally and reported that perennial pain was a major problem and a major or minor problem 44% of the time. The same study reported that at 6 months postpartum, 7% of women who delivered by caesarean continued to report that incisional pain was a problem compared with 2% of mothers who delivered vaginally and reported perineal pain (Declercq, 2002). Another study compared 116 patients undergoing laparoscopic evaluation for chronic pelvic pain with 83 asymptomatic women undergoing laparoscopic tubal legation. Those with pelvic pain were 3.7 times more likely to have had a prior caesarean delivery.

1.7.3 Risks for the Newborn of Caesarean Delivery

**Neonatal Death**: Although caesarean deliveries are typically performed for the benefit of the foetus, there are also risks for the newborn. In fact, a large observational study of more than 5,80,000 deliveries in California (that did not control for potential confounders) found that babies both born by planned as well as unplanned caesarean deliveries had a nearly 4-fold risk of dying before discharge compared with those delivered vaginally (8 deaths per 10,000 births for each planned or unplanned caesarean deliveries and 2 per 10,000 for those delivered vaginally (Robilio et al. 2007).

Several studies have reported an association between caesarean delivery and the later development of asthma. One of these studies examined
more than 40,000 children delivered by caesarean and found that those delivered either by planned or unplanned caesarean were approximately 30% more likely than those delivered vaginally to have been admitted to the hospital for asthma during childhood (Robilio et al. 2007)). This increased risk of asthma may persist into adulthood. In a study of more than 9700 Danish women, the authors found that those who were delivered by caesarean section were also approximately 30% more likely to report that they ever had asthma (Jackson et al, 2011).

1.7.4 Risks of Caesarean Delivery to Future Pregnancies

Clearly, the risk of primary caesarean delivery are only increased for repeat caesareans, and increase even more with third, fourth, and higher-order caesarean deliveries. A trial of labour after a prior caesarean delivery confers its own risks, including higher risks associated with a repeat caesarean delivery performed for a woman in labour (Robilio et al. 2007).

1.8 An overview of caesarean delivery in developed and developing countries:

In safe motherhood strategies it is universally accepted that provision of essential obstetric care and ensuring institutional delivery are the best options to reduce maternal mortality in all contexts. Institutional delivery provides an opportunity to deal with delivery complications. More importantly it also helps the doctor to decide on the type of delivery to be performed, normal or caesarean, based on the intensity of complication.
It is under these circumstances that the proportions of all deliveries that are by caesarean are captured as an indicator to measure the levels of complications and to understand the access to quality obstetric care in many population groups. However, the same indicator measuring the quality of obstetric care in a population (proportion of caesarean delivery) has currently turned out to be an indicator of concern for many countries. Because, it no longer represents the quality of care, but speak on the unhealthy trend developing both at the level of the medical profession and more importantly in society.

Therefore, increasing trend in caesarean delivery indicates that this procedure is used for reasons other than maternal complications. It also leads to risk to mother’s health and an inefficient use of resources (Millennium Development Goal, 2003). UNICEF, WHO, and UNFPA guidelines recommend that, as a general rule, a minimum of 5 percent of deliveries are likely to require a caesarean section in order to preserve the life and health of mother or infant. The World Health Organization advises that rates of caesarean delivery should, in general, not exceed 15 percent. Rates higher than 15 percent indicate inappropriate use of the procedure.

As against this, the current level of cesarean delivery in many countries is as high as 30 to 50 percent. The rising trend is highest in the United States and in some countries like Brazil and Mexico in Latin America. In United States the rate of caesarean delivery is drastically increasing over the years. US obstetric practices have changed dramatically over the past two decades,
with physician’s increased willingness to perform cesarean delivery in one out of every four deliveries (Taffel et al. 1989). The present data show that in United States, 1.2 million or 29.1 percent of life births were by c-section delivery in the year 2004 (NIHS, 2006). Of the 12 Latin American countries reviewed recently Brazil had the highest rate of c-section (Behague et al. 2002).

Even in a developing country like India there is an increasing trend of c-section delivery with increase in the institutional deliveries and growing access to gynaecological and obstetric care. A study by Indian Council of Medical Research (ICMR) in 33 tertiary care institutions noted that the average caesarean section rate increased from 21.8 percent in 1993-'94 to 25.4 percent in 1998-’99 (Kambo et al. 2002). According to the National Family Health Survey, 1992-’93, the two states - Kerala and Goa - have shown the highest percentage of c-section deliveries (Mishra and Ramanathan, 2002). A rising trend in c-section rates, from 11.9 percent in 1987 to 21.4 percent in 1996 have been reported from Kerala (Thankappan, 1999). Another study in Jaipur showed that c-section rates in a leading private hospital rose from 5 percent in 1972 to 10 percent in late 1970s and to 19.7 percent between 1980- and 1985 (Kabra et al. 1994).

1.9 Emerging pattern of caesarean deliveries:

A careful analysis of the studies carried out on c-section deliveries across countries brings out the following pattern observable in all societies.
Firstly, there is an increasing trend noticed in c-section delivery in many countries in recent years. Perhaps, the only exception being some of the European countries like the Netherlands where still there is predominance of home based delivery being attended by skilled personnel. The increase in c-section delivery is observed even in poor developing countries. It clearly indicates that there are several forces, other than clinical ones, that determine the decision to conduct caesarean section. Once a rare event, a caesarean delivery is now being performed frequently in most of these countries. In fact, caesarean delivery has become the most frequently performed major surgical procedure among women of childbearing age (National Centre for Health Services, 1987).

Secondly, it is also observed that concurrent with the rise of economic development there is a rising trend in caesarean delivery. In other words, the factors for increasing preference for c-section deliveries can be attributed to the increasing economic development and increasing per capita expenditure on health in both developed and developing countries (Phelps, 2003). With the rising GDP, the expenditure on health has increased over the years. This resulted in over medicalised health care in all sphere of public health including maternal health.

Thirdly, studies commonly noticed a higher incidence of caesarean deliveries in private hospitals compared to public sector hospitals. This suggests that non-medical factors such as economic gain and pressures of private practice may motivate doctors to perform surgical deliveries. The
incidence of caesarean deliveries in Brazil was found to be strongly associated with the occurrence of delivery in the private hospitals as opposed to a public facility (Chacham and Perpetuo, 1998). Study shows that in India, the rate of c-section delivery is relatively very high in private hospitals rather than public health facilities. For instance, Padmadas et. al (2000) observed in the case of India that the caesarean deliveries are mostly occurring in the private institutions rather than in public institutions.

Fourthly, there are several adverse consequences of caesarean delivery in comparison to normal delivery for women and to their households. The immediate consequence for the household is the economic burden of caesarean delivery. The economic cost of c-section far exceeds the cost of normal delivery. In addition, it is also found that the incidence of caesarean delivery without any medical and obstetric indications may sometime cause serious socio-psychological effects on women undergoing this method.

1.10 Background and need for the study:

The dramatic rise in the overall rate of c-sections, their high cost and the wide variation observed in rates among various populations has raised several interesting questions necessitating in depth understanding.

Although several studies have shown an increasing trend in c-section delivery the reasons for such an increase remains less researched. While some studies consider it purely in terms of over use of health care facilities due to financial benefits for the hospitals, there is also an alternative view in terms of
an increasing demand from women for c-section delivery even in developing countries. As already pointed out, at the global level, a perfect positive correlation has been noticed between c-section delivery and development indicators. It indicates that with increasing living standard, on an average, women tend to prefer c-section delivery. However, the demand side and institutional factors are often difficult to separate and is still unclear what determinates the decisions on c-section delivery in many contexts.

On the other hand, it is also believed that the increasing trend of the cesarean delivery in the developed countries attributes to the increasing demand from patients and informed decision making. Women's requests for caesarean section is considered to be an important determinant of birth outcome, particularly in countries with growing privatization and options for patient choice (Ash and Okah, 1997). It is often argued that, power for decision making in the home and seeking medicalised health care were associated with higher maternal education and family incomes (Potter et al. 2001).

For instance, Remez, (1991) shows that most of the c-sections performed in the developed countries are mainly due to the preference of c-section delivery by the women. In United Sates the rate is highest among the population from higher social strata. The economic development and educational attainment also enhance women’s decision making power and access to health care. Thus, it is generally concluded that, in the developed
countries, increasing performance of the caesarean delivery is mainly caused by increasing demand as well.

Over the last twenty years, there has been a disturbing increase in the rate of caesarean section in India. However, it is still unclear about the factors that determine rising c-section deliveries. In general, it is often argued that, beside the medical factors, physician’s interest determines the choice of c-section (Mishra and Ramanathan, 2002). The physician factors that affect c-section incidence include physician’s practice styles (Goyert et. al. 1989), the obstetrician’s clinical attitude and fear of litigation (Belizan et al. 1991), the physician’s convenience (De Regt et al. 1986) and, more importantly, the economic incentives. Of these, the economic incentives behind the performance of c-section are often given emphasis by various studies. A study by Keeler and Brodie (1993) pointed out that in many private hospitals, the hospital stay of patients and economic incentives may influence physician’s decision to perform a c-section rather than a normal delivery. Therefore, the increasing trend raises the question of appropriateness in the selection of cases for c-section (Pai, 2000). Because, in performance of the c-section delivery doctor’s decision dominates which sometimes overlook patient’s consent. Most of the time women are not able to recognize the need for c-section delivery. But over using of the method in some countries including India creates serious concern about the appropriateness of the selection of the method. Because, increasing the rate of caesarean deliveries is not a goal; but
rather, an indicator as a proxy for the extent to which the quality of health care facilities exist in a country.

On the contrary, as c-section delivery is also more of an urban upper class phenomenon, it is possible that there is an increasing demand for cesarean delivery in India. With the increasing economic development and educational attainment, women’s decision making power may increase the performance of c-section which results in more c-section deliveries.

This study is an attempt to understand the role of demand side and the institutional factors contributing to the performance of c-section delivery in the context of West Bengal, India. Attempt also will be made to understand the consequences of c-section among households in general and mothers in particular. More specifically, in this study, an attempt will be made to integrate the medicalisation and its impact on maternal health.

1.11 Objectives of the study

In this backdrop, main objectives of the current research are

- To analyze the trends in caesarean section delivery in India and states.
- To understand the larger context of increasing caesarean delivery within the medicalisation framework.
- To explore the role of individual, household and institutional level factors influencing caesarean section delivery and
- To explore the possible economic burden imposed on the household by the caesarean section delivery.
The first two objectives mainly based on the secondary data base and the other two are focusing on field study.

1.12 Organization of the chapters:

The thesis is organized into seven chapters as follows. The first chapter sets the stage for discussion of the research issue leading to the problem formulation. It brings forth the issue by discussing the current scenario of caesarean childbirth worldwide and its concern for the steady increase. The chapter also discusses about the aspect of medicalisation of childbirth and its effect in current scenario of caesarean intervention in both developed and developing countries. The second chapter discusses elaborately about the current discourse on medicalisation of society. The debate on medicalisation of human health by medical sociologists has been discussed in a theoretical manner. In the third chapter the discussion on methodology and data has been given to understand systematically the research issues. The fourth chapter deals with analysis of secondary data based on different rounds of NFHS (National Family Health Survey) and RCH (Reproductive and Child Health Survey) to examine the effects of different factors on current situation of caesarean childbirth in India and different states. The fifth chapter which is based on in-depth interview of the medical professionals deals with the aspect of medicalisation of childbirth from institutional angle by drawing examples from in-depth interviews of medical professionals. The sixth chapter examines the motivational factors behind a woman’s preference for caesarean intervention during her delivery. It also focuses on economic consequences on
a family due to this surgical procedure by drawing examples from case studies. The last and seventh chapter presents summary and findings. In this chapter, an attempt is made to synthesize the context of the study, approach to the research issue, key findings in the various areas of inquiry and emerging conclusions on the basis of the available findings. Moreover, the limitations of the present study are also discussed.