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Why do primigravidae request caesarean section in a normal pregnancy? A qualitative study in Iran

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ABSTRACT

Objective: to gain a deeper understanding of why Iranian primigravidae request caesarean section without any medical indication.
Design: qualitative study. Data were gathered through semi-structured interviews, and thematic analysis was undertaken.
Setting: four health care centres at Hamadan University of Medical Sciences, Hamadan, Iran.
Participants: 14 primigravidae who requested caesarean section without any medical indication.
Findings: reasons for requesting caesarean section were related to fear of childbirth (labour pain, injury to mother or infant), complications after vaginal delivery (vaginal prolapse, urinary incontinence, sexual dysfunction), trust in obstetricians, and lack of trust in maternity ward staff.
Key conclusions and implications for practice: the main reasons given for requesting caesarean section show that there is urgent need for effective antenatal assessment to enable pregnant women to ask questions and express their concerns. In order to promote vaginal birth, there is a need to develop antenatal education and strategies to enhance women's knowledge, confidence and competence about vaginal birth. Health care providers should be re-educated about the observance of medical ethics and professional rules in their practices, and change their attitudes and behaviours to vaginal birth. Evaluation, improvement and change in maternity care policies are recommended to promote natural childbirth.

Introduction

The use of technology and interventions in the birthing process has increased despite the unchanged basic physiology of birth (Kolip and Buchter, 2009), and the rate of caesarean section (CS) has increased in many countries (Villar et al., 2006; Belizán et al., 2007). Despite the known risks of this procedure (Declercq et al., 2007; Liu and Yang, 2007), the rate is much higher than the acceptable rate of 10–15% recommended by the World Health Organization (World Health Statistics, 2011).

In Iran, the CS rate is approximately 30–40% in public (teaching) hospitals and 50–60% in private hospitals (Pour Reza, 2007). On the basis of statistics from 2008, these rates are three to five fold higher than the rates in other countries such as Finland, the Netherlands, Oman, Ukraine and Indonesia. In Hamadan province, west Iran, the CS rate is 47.5% in public hospitals and 79.1% in private hospitals (Hamadan University of Medical Sciences, Statistics, 2011).

Maternal request is one of the main reasons for elective CS without any medical indication (Nerum et al., 2006; Young, 2006; Weaver et al., 2007; Zwelling, 2008). Perceptions of fear of childbirth, concern about fetal safety and well-being, and convenience (Bryant et al., 2007; Fenwick et al., 2008; Pevzner et al., 2008) lead to variance in the CS rate (Cheung et al., 2006). In addition, change in the attitudes of midwives and obstetricians towards CS is another factor leading to an increased CS rate (Bergholt et al., 2004; Klein, 2005; Monari et al., 2008).

The continuous rise in the CS rate has become a major public health issue worldwide (National Institutes of Health, 2006). It is now recognised that performing a CS 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 with vaginal birth (McFarlin, 2004; Armson, 2007).

A primary CS increases the CS rate in future births; 89.4% of all CSs are repeat CSs (Menacker, 2005). Furthermore, health outcomes and the economic effect of elective CS should be considered (Tracy and Tracy, 2003).

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The most common reason for choosing CS is fear of labour pain (Eriksson et al., 2006). A study by Wiklund et al. (2007) in Swedish primiparous women who requested CS showed that fear of childbirth was their primary concern, and concern over the well-being of the infant and their own health was their secondary concern.

Most primiparae and multiparae believe that CS is safe for mother and infant (Zwelling, 2008), and believe that vaginal birth carries risks of complicated or prolonged labour and physical trauma (Pakenham et al., 2006; Waldenström et al., 2006; Wiklund et al., 2008).

It is also common for multigravidae to choose CS because of a previous CS or negative birth experience and complications during pregnancy (Pakenham et al., 2006; Waldenström et al., 2006; Weaver et al., 2007).

Pelvic floor injury is another reason why women request CS. Urinary incontinence, vaginal prolapse and sexual dysfunction are known complications following vaginal birth (Niino, 2011). Women believe that vaginal birth will change their sexual life due to deformation of the body, and believe that CS prevents vaginal injuries and sexual dysfunction (Kwee et al., 2007; Wiklund et al., 2007).

Sercekus and Okumus (2009) found that primigravidae in Turkey were concerned about unsuitable behaviour and insufficient care in maternity wards, lack of support during labour and childbirth, and the environment of the maternity ward. Saisto and Halmesmaki (2003) reported that the most common reason for fear was lack of trust in obstetric staff.

Discussion on the reasons why primigravidae request CS is scanty (Saisto et al., 2001). The lack of information highlights the continuing need to identify reasons why women request CS (National Collaborating Centre for Women's and Children's Health, 2004; Weaver et al., 2007; Robson et al., 2008).

There are knowledge gaps regarding why Iranian women prefer CS, so there is a need to gain a clearer picture of this issue. In addition, the majority of the studies mentioned above were undertaken in developed countries. As such, there is a need to investigate why primigravidae request CS in the absence of any known medical indication in developing countries such as Iran through a qualitative study.

Methods

The aim of this study was to determine why Iranian women request CS during their first pregnancy in the absence of any known medical indication. A qualitative approach is well suited for the determination of an individual's feelings, interactions, perceptions and behaviours (Holloway and Wheeler, 2010). The present study used in-depth semi-structured interviews with thematic analysis to describe and extend information about the reasons for requesting CS (Nieswiadomy, 2008).

Setting and sample

Four health care centres were selected from four municipal areas of the city. All healthy primigravidae who were in the third trimester and had no known risks were approached by the first author during a regular antenatal care visit. Primigravidae who requested CS without any medical indication were identified and asked to participate in the study.

Purposive sampling weighted by a variety of specific criteria is often used in qualitative research (Holloway and Wheeler, 2010). Five primigravidae declined to participate in this study for personal reasons and the others agreed, resulting in 14 women who agreed to be interviewed.

This was an adequate sample because no new information was presented after 14 interviews, and repetition and confirmation of previously collected data occurred (Speziale and Carpenter, 2003; Merriam, 2009). It is not the goal of a qualitative study to find a representative sample, but to reach saturation with a purposeful sample (Brown and Lloyd, 2001).

Ethical considerations

The Hamadan University of Medical and Health Sciences Ethics Committee reviewed and approved the study. The primigravidae were given verbal and written information about the purpose of the study, and given the opportunity to ask any questions. Each woman was notified about the interview after agreeing to participate in the study, and they were given the opportunity to ask any questions about the study. They were reassured that their care would not be affected if they chose not to participate in the study. Moreover, the women were informed that they could withdraw from the study at any stage, without any explanation. All participants gave written consent, which included permission to be interviewed. The interview date was arranged to suit the participant once written consent was obtained.

Demographic and contact information was recorded, and the subjects were assured that their names would remain confidential. To ensure participant confidentiality, any identifying material was removed, and numbers (e.g. P1) were used to label each audiocassette and interview transcript.

Data collection

Data were collected via semi-structured face-to-face interviews with the first author in a private room. Semi-structured interviews allow for flexibility, and make it possible to ask additional and more detailed questions to clarify or elaborate on participants' responses (Merriam, 2009; Holloway and Wheeler, 2010).

Each interview took between 40 and 90 minutes, depending on the responses, with an average time of 60 minutes. The interviews were tape-recorded with the participant's permission, and subsequently transcribed to facilitate data collection and analysis.

Three questions were asked:

- Please tell me why you requested CS?
- What do you consider to be the benefits of CS?
- What do you consider to be the risks of vaginal birth?

These questions used simple terms to avoid confusion.

Data analysis

Interview audiotapes were transcribed, checked and annotated with pauses, overlaps and non-verbal expressions. Transcripts were checked and corrected against the tapes. Data were analysed during data collection (Speziale and Carpenter, 2003). All respondents were offered copies of their transcripts. They were also given the opportunity to make changes if they felt that the transcript did not reflect their meaning. Only two participants asked for changes; one about describing her pain and another about her feeling towards midwives.

An initial coding frame was developed from issues arising in the appropriate research literature and from repeated reading and rereading of the final transcripts. Line-by-line coding was employed and thematic analysis was used (Merriam, 2009; Holloway and Wheeler, 2010).

The women's statements were coded independently by three individuals (NM, ZK and a midwife) (Merriam, 2009). The codes were compared, and the differences were discussed between ZK and the midwife and re-evaluated until shared codes and categories were created to promote reliability (Graneheim and Lundman, 2004; Merriam, 2009). The study findings were validated through peer