How do Women's Decisions Process to Elective Cesarean? : A Qualitative Study

1Mansoureh Jamshidi Manesh, 2Leila Jouybari, 3S. Fatemeh Oskouie, 4Akram Sanagoo

1Faculty of Nursing and Midwifery, Tehran University of Medical Sciences and Health Services, Tohid SQ, East Nosrat St, Tehran, Iran.
2Assistant Professor in the Department of Nursing, Faculty of Medical Sciences, Ghorgan University of Medical Sciences, Ghorgan, Iran.
3Associate Professor Center for Nursing Care Research & School of Nursing and Midwifery, Tehran University of Medical Sciences, Tehran, Iran.
4Assistant Professor in the Department of Nursing, Faculty of Medical Sciences, Ghorgan University of Medical Sciences, Ghorgan, Iran.

Abstract: Background: Nowadays cesarean delivery has become a challenging issue in terms of women’s decision making accuracy. In Iran, the rate of cesarean section is higher than that has been determined by World Health Organization as standard rate. Like other societies in Iran it is unknown how women make decision in undergoing cesarean procedure. The aim of this study was to explore and describe the women's decision making process regarding elective cesarean delivery. Method: Twenty six pregnant women in their third trimester were selected purposively. Women were recruited from various settings: a public maternity-only hospital and two private clinics in Tehran Capital of Iran. Using the semi-structured individual in-depth interviews data were collected from 2006 to 2007. All data were audio taped and transcribed. Thematic and grounded theory was employed to analyze the data. Findings: The main categories were: “fear of mysterious”, “physical and spiritual comfort” and “sharing experiences”. We extract subthemes to describe the major themes. "worry of complication","communication staff", "loneliness and death", "infant's safety" Continuous analysis data identified the women for balancing to purpose obtaining the best decision pass across process's to examine, Conclusion: We suggest appropriate decision making process: making the process clear; agency of women and strategies for relieving pain and developing self-esteem would be provided. The women should be helped to make correct decision, because it is important to encourage vaginal delivery.

Key words: cesarean, vaginal delivery, viewpoint of women, qualitative study, decision making process, content analysis

INTRODUCTION

Over the past two decades, caesarean section rates have shown a steady increase worldwide. While most developed countries have experienced a gradual rise, cesarean rates have skyrocketed in Brazil. Rate of cesarean in United Kingdom (22%) (Carla Finger, 2003) and United States (26.1%) by 2002 (Barbara, 2004) was somewhat higher that the 10 -15% acceptable level recommended by WHO (Cesarean Fact Sheet). Brazil tops the list with the world’s highest cesarean rates, 30% in public hospitals and more than 70% in private hospitals and maternity clinics (Saisto, 2003). In Iran, cesarean rates are threefold to fivefold (Based on statistics, 2008) more than other places in world. In university hospitals, about 30-40 percent of births are by cesarean, as it is 50-60% (Pour Reza M, 2007) in private hospitals. Whereas 90-95 percent of the clients are regarded as though they have some problems, they can experience normal childbirth (Ghofrani M, 2007). Majority of cesarean section in the world are performed due to medical related problems while cesarean happens by the family or the woman's own decision For example, in a study that was selected for cesarean section in Isfahan one of cities in Iran is a high statistics %43(8). Sometimes women make decision without a proper concealing and enough knowledge. Cesarean complications are more than those of normal delivery, some of which are related to anesthesia, such as aspiration, hypotension, and headache, and some others as...
massive bleeding, uterus hypotension, and also complications resulting from operation incision such as injury to urinary and digestive system (Rated frequency, 2002). In Iran, midwives play an important role in process of delivery, so they are in the best position to help pregnant mothers in prenatal care. Midwives are in the best position to eliminate factors that could influence women's viewpoint about cesarean, thereby, improve health status in baby and mother as the most vulnerable social categories. Quantifying the factors influencing women's decision making in cesarean would not explore the process of making the decision in undergoing the operation. In contrast, a qualitative researcher arrives at understanding and interpreting phenomena and also people's life conditions (Williams, 2005) Although quantitative studies can explain causality and events. In this paper we describe women's decision making process in selecting cesarean as preferred mode of delivery.

**Method:**
Ethic's approval for this qualitative study was obtained from the Iran University of Medical Sciences Ethic's Committee. Grounded theory was used to analyze data from 2006 to 2007. Using purposive sampling method, 26 women aged 21 to 34 years in their third trimester were recruited for in-depth interview. These women had a tendency toward caesarian section procedure. After obtaining the informed consent the interviews were conducted in a selected training and educational hospital. We chose this hospital because of its popularity in Tehran and the high range of customers referred to this setting. The interviews were preceded 40- 60 minutes averagely. The interviews were conducted in Persian language and all conversations were audio taped. Using grounded theory approach, content analysis was employed to extract themes and sub-themes. Free coding was carried out line by line (Rubin, 1995), (Polit, 2001), and comparative analysis of the excerpts was performed (Morse, 2002) in two phases. In the first phase, categories and themes were identified and grouped into domains. The coding process was interprative, and categories and themes evolved (added, deleted and merged) as re-readings were completed and analyses progressed. In the second phase, the categories and domains were regrouped into major themes. Credibility was enhanced through member checking by researcher triangulation. Two female researchers coded and re-coded the data to ensure trustworthy of the findings.

**RESULTS AND DISCUSSION**

The process of women's decision making toward cesarean procedure is identified by three major themes. The first describes how women make their decision based on fear in an evasive construct. The second inter-related theme points out how women are seeking for "physical and spiritual comfort" by selecting cesarean mode of delivery. The third theme: "sharing experiences" was identified as a determinant in leading women to justify their final decision.

Majority of the informants' decisions were shaped in the family institution from the beginning of the pregnancy. Our informants are mainly influenced by the others' lived experiences. Incapability of the informants to make sense of the others stories created a shadowy context to make a right decision. This was due to different experiences people can have during delivery. In Iranian culture the family members particularly husband and in-laws have strong impact on women's decision making process when it comes to selecting deliver mode.

"Fear of mysterious"

The words such as fear, fright, heavy and big problem were frequently used by participants. Whenever they were asked, "what comes to your mind when you hear the phrase vaginal delivery", they responded by phrases and statements such as "fear", "I really frighten", "vaginal delivery is painful", "it is horrible", "it is really hard", "it is difficult".

One of the participants stated, "I fear so much, I really accept to take one thousand pills rather than having any injection, so I fear so much. Because of this fear I didn't have any child until 5 years after marriage. so I was afraid of vaginal delivery. It isn’t anything in my mind. I wish I have cesarean delivery... My mind is not good towards pain and fear... vaginal delivery is for me very heavy, hard indeed, child will be born very hard".

In this study, all of the participants reported their fear from pain in various forms. The other examples are as follows:

"Fear resulted from unawareness" was frequently a fanciful and imaginative feeling and some of them never experienced it. Some participants said that their family women like to have cesarean delivery. For example:

"Three or four women of our family are already pregnant. We are more comfortable with cesarean,

The other participant stated: "My sister underwent cesarean, because we would like so.” Also, another
one said: “I think I don’t have patience (required for NVD).”

“Physical and spiritual comfort”

Vaginal delivery was equivalent to pain and cesarean was equivalent to painlessness, “more comfortable”, “misunderstanding what is happen around me”, and “sleeping”. In all cases, women’s understanding of vaginal delivery was pain. For example: “The first thing comes to my mind is pain”.

Most women appreciated shorting time of suffering pain with sentences such as “Cesarean was very good for me. I really was comfortable …, I suffered pain for one day at least, then after they injected sedative for me.”, Or “I think cesarean is more comfortable than vaginal delivery …. My cousins described that they did not feel any pain with cesarean and afterwards, they hadn’t any problem …. they said that you are confined to bed only for a few days and then you will be discharged”.

Most of the women were pleased with cesarean, “In cesarean you did not understand pain, and you are unconscious or numbed.”

The participants remembered that lack of orientation to surrounding is an advantage of cesarean: “Because I don’t want to understand what happen around me”, “In the beginning, they make you unconscious you do not understand anything”.

“Sharing experiences”

Previous undesirable experience such as pain and conveying the others experience and suggestions had caused that most of participants decide to have cesarean section. For example; one of them stated: “Because of menstrual pain, I feel that vaginal delivery is worse”, “Since I was admitted for two days in seventh month of pregnancy and I saw that women screamed, I fear so much.”, “While I am afraid of an injection, how can I do vaginal delivery”.

Although all of the women stated that they were not under pressure at all for selecting the type of delivery by their husband, family and the other people, but it is apparent from interviews that public view could be incentive or obstructive for women in decision making for type of delivery. One participant spoke of the experience of other people such as family members or other parturient in hospital and the fact that to what extent it is influential on women’s choice. One of the participants addressed acceptability of cesarean, its lesser complications and recommendations from others as criteria for selection of cesarean delivery: “I usually ask of old women, for example; my mother who has had three to four pregnancy that is normal delivery good or not?, She says that cesarean is good.” The other said “Since people said that vaginal delivery is bad, so, I don’t want to have it (normal delivery)”. Or “Yes, since my brother’s wife had normal delivery. She said that it is very horrible and painful. She screamed”.

The information revealed that the experiences are foundations for making decision.

"worry of complication"

For example; “I heard that medicine students want to learn, they may hurt the bladder leading to urinary incontinency. I don’t know. They said that normal delivery has these disadvantages”. Or “most women like me who have had vaginal delivery suffered from uterine prolapse. My mother herself has already uterine prolapse ... so she always emphasizes me to have cesarean”.

Inappropriate medical staff communication
The frequent examination makes normal delivery undesirable and also inappropriate behavior of medical staff is another obstructive factor for normal vaginal delivery makes women afraid of labor. Some of the participants describe normal delivery as bothering. “When a woman experiences labor, she is bothering, for example; when you are in labor ward, the nurses replace frequently. They examine you so much, you must suffer too much … I was three nights in hospital, I suffered pain. The examination was painful. It was very bad, but cesarean wasn’t in this manner … When I went hospital, in the beginning they took me to operation ward and made me unconscious, then I was comfortable”. Or “After ninth month, the examination is harder … They examined me so frequently that I couldn’t walk”. “Examination for normal delivery is very frequent. The doctors replace too much, they are careless, if there is good behavior, labor pain would be more tolerable, and then it is going better very soon”.

The feeling of dying and loneliness

“When I was in childbirth, my water bag was ruptured; all the nurses said that you must help yourself. I really was going to die, you must push so much, but cesarean was very comfortable”. Or “I screamed so much in later moments. My voice and larynx became so re. I prefer to have cesarean. Vaginal delivery is painful”.

Infant health:

Anxiety without any reason and hearing rumor from others are another factor. For example; “I heard of them that the baby’s neck hurt, probably because they go where that is not well known, “I heard that baby spinal may cut, but baby is safe by cesarean”. Or “there may be problem for my baby that I may not know. I wish that my baby go out very soon. Of course, I did like to have normal delivery in early pregnancy, but I fear now, because of my baby safety. My doctor has said that baby’s movements have slowed and I fear now.” Altogether, the codes are “hearing and seeing normal delivery advantages and disadvantages”. “unconsciousness”, “unseeing”, “misunderstanding”, “timidity”, “fear of pain”, “fear of labor”, “inability for normal delivery”. “Comfort”, “trust”, “don’t trust midwife and doctor”. They were repeated frequently within text. Continuous data analysis indicated whenever women wanted to make choice about the mode of delivery, they entered searching process and they involved for exceeding comfort actively. In order to get the best result, this process was called making balance. This process has three phases; to examine, to make legal, to make choice

On the other hand the data revealed that women’s decision for cesarean depends on previous experiences. Women’s decision making process is changing. This thought can be related to the time when they were single, before or after marriage or before pregnancy. This thought often starts with pregnancy and it was changing by seeing, hearing and experiencing. The findings revealed that the women wish to have comfort and safety. Women’s understanding of cesarean is strongly related to safety for their baby. They compare benefits and disadvantages of cesarean and vaginal delivery and then make appropriate decision. The effective barriers of normal delivery include the feeling of loneliness or not having support during childbirth or easy availability, public acceptability of cesarean, good hospital with facilities or nice and gentle staff is the factors for positive viewpoint of women towards vaginal delivery.

Discussion:

Although normal delivery is the best method of childbirth, unfortunately, cesarean rate have recently raised. For example, a study in Iran revealed that 12 percent of 46 percent of cesareans was based on women’s desire (Clark, 1992). The results of current study showed that the “fear due to not having knowledge” was a substantial theme in decision making regarding the method of delivery. In another study, thirty three of women wanted cesarean by personal desire, whereas it wasn’t necessary from doctors point of view and the reason of 28 of women were their previous experiences of labor pain and baby’s health (Faramarzi, 1999) Saisto reported that six percent of women experience fears of delivery that it could raise cesarean rate to 8% to 22% (Ryding, 1993). Similar other studies, the results of this study revealed not only the women didn’t receive their information from doctors or media but also they rely to their relative and friends information. The reason may staff shortage or numerous referrals of women and inadequate time for every women educating in prenatal clinics or private doctors’ offices. The results of this study conforms to those of a study in Turkey, mean that the women had heard negative stories about childbirth (Saisto et al., 2001). The knowledge of women should be increased in order to decrease cesarean rate and operation complications. The other study revealed that the midwives talk with the mothers and their husband when they admitted for childbirth and they were prepared and encouraged for proper choice (Pinar, 2007)

The women in this study showed that some women who had previous experiences of admission in labor
room and heard the voices of other women screamed cause them to become afraid. General hospitals do not have private rooms during labor, but are all together in one large room (Saisto, 2001).

In this study when the women asked “if there was a painless method for childbirth, do you again select cesarean?” They answered “yes”. Another study also revealed the women who had normal delivery; they described delivery as “tormenter”, “death”, and “horror” and the women who undergone operation described it as “fall asleep” and “senseless”. In that study the researcher suggested strategies to decrease pain, and stated that not only pathophysiology recognition of pain isn’t sufficient but also recognizing the meaning of that is necessary (Anderson, 1996; Joybary, 2002).

Implications for practice:
Pain relief and control is certain right of everyone, but the control of labor pain has become an issue nowadays. The most important factor in this study was the feeling of inability against labor pain. The absence of self confidence is important to which we should pay attention. It is suggested that the health care personnel teach the mothers educated that pain is a normal phenomenon and should be confronted appropriately. Holding educational sessions in health care clinics by midwives or obstetrics is suggested to improve self confidence in women and their family. Also, positive experiences of mothers who have had normal delivery would help. The researcher suggest providing facilities for presence of husband or a relative in labor room and reeducating staff about pain relief methods .

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