Title: Increasing caesarean section delivery: A threat to urban women's health?

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Introduction:

A consistent increase has been observed in the rate of caesarean section deliveries in most of the developed countries and in many developing countries including India over the last few decades derivate a matter of concern among the social scientists. In recent years, especially in parts of world, it is often argued that with thriving private practice, obstetricians increasingly prefer for medicalised birth than normal birth. In addition, there is also some evidence from Western countries on increasing preference from women who want to deliver their child through the c-section.

The rates of caesarean section in many countries have increased beyond the recommended level of 5-15 % by WHO, almost doubling in the last decade. In high income countries like Australia, US, Germany, Italy and France, the rates have gone phenomenally (Sufang et.al, 2007). The present data shows 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). Similar trends have also been documented in low income countries such as Brazil, China and India, especially for births in private hospitals (Potter et al. 2001; Cai et al. 1998; Mishra and Ramanathan, 2002). In a developing

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[*] Here the term caesarean delivery and c-section delivery are used interchangeably.

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-'85 (Kabra et al. 1994). Studies also suggest that one of the important factors behind performance of c-section could be high education background of women, more presence of private hospitals or sometime interplay between doctors' motivation and financial incentives of the hospitals behind such trend.

The current paper, thus, will be an attempt to discuss the ongoing debate on caesarean section scenario in India and with special emphasis to medicatiozation of maternal health in urban areas. While doing so, it also tries to throw light on current trend on c-section births in India and states, particularly focusing on urban areas. An attempt has also been made to explore the voices of others who had caesarean births to understand the mechanism of performance of c-section even without any medical reason.

Why urban women?

Until recently, urban health was not the main focus of public health policies in most developing countries since the majority of the population lived in rural areas (Gupta et.al.

2009). It was often assumed that the heavy concentration of health facilities and personnel in urban areas, particularly in the private sector, would automatically take care of the increasing urban population and its health needs. However, the rapid growth of cities in developing countries, together with the growth of the urban poor and inequities created within cities, made this position untenable (Rossi-Espagnet, 1984). The urban population also has access to a wider range of health care options, particularly in large cities, due to the better-developed health infrastructure. However, accessibility to these services and the quality of the services vary greatly between cities and within cities (Poel, O'Donnell, and Doorslaer, 2007; Lalou and LeGrand, 1997). Moreover, what is more critical to discuss here that the over use of health facilities, most of the times, creates concern for health of the urban people and more specifically urban women.

Medicalisation of maternal health and Caesarean delivery:

The rising trend in c-section rate in both developed as well as developing countries, increasing preference from medical professionals rightly points towards growing medicalisation of health in the society. This growing reliance on medicine also appeared to be occurring in other aspects of life such as childbirth, 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 during childbirth have gone up to combat with maternal and child death. Hence, a growing number of deliveries are taking place through surgical intervention resulted in a high rate of c-section in both developed as well as developing countries. It is well known fact that the maternal and neonatal deaths have significantly come down in the last century in large part as a result of the increased application of technology during labour and childbirth (Sen, 1994). But what is more

concerning is the overuse or misuse of the medical technology for profit motive or risk avoiding in health care facilities.

Objectives of the paper:

In light of the above situation the current paper tries to explain

- ⇒ the current scenario of caesarean births in India and states and
- ⇒ the urban context of increasing caesarean delivery within the medicalisation framework.

Data and Method:

For the purpose of the current paper, a mixed method has been used. The first part of the analysis is based on analysis of secondary data from National Family Health Survey (All 3 rounds, from 1992-2006) to explore the current trend and level in c-section births in India and states. The next step involved a qualitative approach to understand the decision making for the performance for caesarean births.

Discussion:

<u>Emerging pattern in caesarean births in India and states:</u>

For the present analysis data is taken from the National Family Health Survey (NFHS) of three consecutive periods (1992-1993, 1998-1999 and 2005-2006). In NFHS, mothers were asked whether they had caesarean delivery during three years preceding the survey. The data analyzed for three surveys to see the trends in c-section delivery in India and states.

Reliable data on the incidence of c-section is available in India only from the first round of NFHS conducted during 1992-93. Hence, the trend of c-section deliveries analyzed from 1992-93 to 2005-06 which shows that there has been an upward trend in c-

section rates in India. Figure 1 presents the trends in c-section deliveries in India for the periods 1992-93 to 2005-06. At all India level, the rate has increased from 2.9 percent of the childbirth in 1992-93 to 7.1 in 1998-99 and further rise to 10.2 percent in 2005-06. The difference in c-section delivery from NFHS-1 to NFHS-3 is relatively high in states like Andhra Pradesh, Goa, Kerala, Tamil Nadu, West Bengal and Punjab. A rapid increase in c-section rates have occurred in these states from 1992 to 2006. The rate is highest (27 percent) in the state of Andhra Pradesh in 2005-06 (although the rate was as low as 4.4 percent during 1992-93 in the state).

Figure 1 Percentage of C-section delivery from 1992-93, 1998-

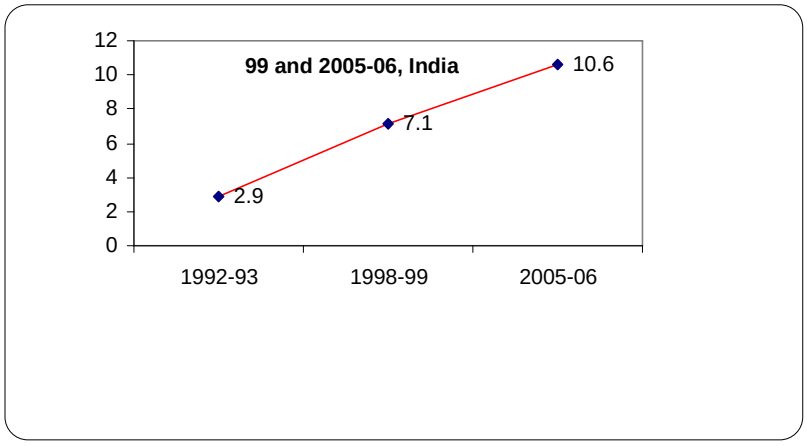

Figure:1 Trend in caesarean section delivery over the decade:

However, this scenario itself can not be considered as a sharp increase, nor the figure exceeds the tolerable limit specified by the WHO. In fact, the rate of increase has marginally declined if we compare 1992-93 to 1998-99 with 1998-99 to 2005-06. What has been alarming in the case of India is the wide heterogeneity in the incidence of c-section across states and regions. It is evident from the analysis in Table 1, that in 2005-

06, 7 out of 19 states reporting over 15 percent or more caesarean child birth. Over the last 15 years the increase in c-section delivery has been substantial in many states in the country. Interestingly, all the southern states in India recorded c-section delivery as high as that of recorded in countries with highest level of c-section in the world. The rates recorded in Kerala, Andhra Pradesh and Goa is alarming. The data indicate that, states with marked demographic transition also records high incidence of c-section rate, although, the real cause of such increase would be different.

Table 1: Percentage of women who had undergone caesarean section delivery by states*, from NFHS-1, NFHS-2 and NFHS-3.

States	*Percentage of women who have caesarean delivery*			
	NFHS-1 (1992-'93)	**NFHS-2** (1998-'99)	**NFHS-3** (2005-'06)	**Diff from NFHS-1**
Uttar Pradesh	0.6	2.7	5.9	5.3
Haryana	2.3	4.2	5.0	2.7
Himachal Pradesh	1.6	6.8	13.1	11.5
J&K	5.7	10.6	14.1	8.4
Punjab	4.2	8.3	14.4	10.2
Delhi	4.6	13.4	12.0	7.4
Gujarat	2.7	8.6	8.8	6.1
Rajasthan	0.7	3.0	4.2	3.5
Madhya Pradesh	0.7	3.0	6.8	6.1
Maharashtra	3.4	9.9	15.6	12.2
Goa	13.7	20.0	25.5	11.8
Orissa	1.5	5.2	6.1	4.6
West Bengal	3.3	13.5	15.0	11.7
Assam	2.3	5.0.	6.5	4.2
Bihar	1.1	3.0	4.1	3.0
Andhra Pradesh	4.4	14.7	27.5	23.1
Tamil Nadu	7.1	17.5	23.0	15.9
Karnataka	3.7	11.0	15.3	11.6
Kerala	13.2	29.8	30.1	16.9
India	**2.9**	**7.1**	**10.6**	**7.7**

** Percentages have given for major states only.*

Another striking feature of the data points towards a marked rural-urban difference in case of c-section births in almost all the states. Table 2 presents percentage of birth by c-section for rural and urban areas. It reflects from the table that the percentage of birth by c-section is much higher in urban areas than in rural areas and in states like Andhra Pradesh, Kerala and West Bengal over 30 percent of the delivery in urban areas takes place through c-section. Interesting to see that there is a large difference between rural and urban c-section rates in West Bengal, with rural area accounts for only 5.8 percent by c-section against the urban rate of above 30 percent. Higher rates in urban areas may be a reflection of combination of factors, advanced health facilities to take care of risk factors, higher levels women's choice and wide prevalence of private sectors and its competition for profit. Moreover, referral hospitals are usually located in and they are more likely to deal with pregnancy complications which include both rural as well as urban patients.

Table 2: Percentage of births in rural and urban areas by caesarean section delivery:

States	Percentage of women who have caesarean delivery		
	Total	**Rural**	**Urban**

Andhra Pradesh	27.5	19.4	32.2
Arunachal Pradesh	3.0	2.5	4.3
Assam	6.5	3.7	17.4
Bihar	4.1	2.5	7.6
Chhatisgarh	5.7	1.3	18.6
Delhi	12.0	5.0	12.6
Goa	25.5	23.7	27.3
Gujarat	8.8	5.5	14.7
Haryana	5.0	3.1	12.1
Himachal Pradesh	13.1	12.3	15.4
Jammu & Kashmir	14.1	9.2	29.0
Jharkhand	4.9	1.9	12.6
Karnataka	15.3	11.6	22.2
Kerala	30.1	28.4	33.5
Madhya Pradesh	6.8	1.9	13.6
Maharashtra	15.6	7.7	19.9
Manipur	10.1	6.2	16.3
Meghalaya	5.3	2.6	11.8
Mizoram	6.0	2.8	10.1
Nagaland	3.0	0.7	6.3
Orissa	6.1	3.9	12.8
Punjab	16.4	14.8	19.6
Rajasthan	4.2	2.2	9.9
Sikkim	14.5	10.1	24.9
Tamil Nadu	23.0	19.8	26.0
Tripura	13.6	11.1	23.3
Uttar Pradesh	5.9	2.4	12.7
Uttaranchal	8.4	5.3	17.5
West Bengal	15.0	5.8	30.1
India	10.6 (N=51,555)	6.2	17.8

NB: The data have been analyzed based on NFHS-3, India and States

In recent time, the demographic dynamics of India perhaps points toward a changing perspective on women's reproductive health. With increasing institutionalized births and growing privatization in health care, the current health status of women experiencing a transitional phase whereby, on the one hand there exists lack of proper institutional care during childbirth, on the other, increasing technology during child birth question towards health of mother.

The Urban phenomenon?

High incidence of caesarean intervention in many developed countries and developing countries creates concern about maternal health. In developing countries like India, it has been noticed that there exists a large rural-urban difference in the rates of c-section births. This may be due to existence of good health facilities in urban areas, more number of private hospitals etc. With this backdrop in mind we wanted to analyze the proportion of c-section births in major cities in India. It can be seen from the table 3 that most of the cities poses high incidence of c-section births. Hyderabad represents highest proportion of births by caesarean (35.2 percent) followed by Kolkata (31.3 percent) and Chennai (30.2 percent).

Table: 3 Rates of c-section delivery in all major cities in India:

Name of the City	*Proportion of C-section births*		*Total numbers of women*	
	NFHS-3	**DLHS-RCH-3**	**NFHS-3**	**DLHS-RCH-3**
New Delhi	12.6	15.7	1148	249
Kolkata	31.3	33.5	600	161
Meerut	13.3	12.3	1193	391
Indore	16.7	NA	785	NA
Chennai	30.2	18.6	586	204
Mumbai	13.7	19.7	620	238

Nagpur	27.4	20.4	776	206
Goa	NA[‡]	22.8 (N), 30.7 (S)	NA	407
Trivandrum	NA	31.6	NA	193
Hyderabad	35.2	36.9	977	198
Bangalore	NA	32.0	NA	206
Total	21.6		6685	

Factors contributing to the rise in c-section rates in Urban areas:

It is often uncertain the reasons for such growing incidence of medical intervention at childbirth. On the one hand, some studies consider it purely in terms of over use of health care facilities due to financial benefits for the hospital; on the other hand, there is an alternative view in terms of an increasing demand from women for c-section delivery even in developing countries. But in a micro perspective, the decision to perform surgical intervention involves interplay of different factors, institutional as well as familial decision. The institutional factors include growing medical intervention during pregnancy and delivery, reliance on technological intervention during childbirth among medical professionals. Moreover, the increasing scenario of this medical intervention in urban areas and private hospitals create suspicion about the efficacy of this procedure without any medical emergencies. Hence, it is true that with the advances in anaesthetic services and improved surgical techniques, the morbidity and mortality of this medical intervention have come down considerably. This has, indeed, wrongly, emboldened obstetricians to perform more and more caesarean section, even in case without any medical emergencies. Point to be noted here that, this over relying on technological intervention has been defined by many medical sociologists as medicalisation of society

[‡] Data is not available for these cities in NFHS 3

which can be viewed from institutional angle of medical profession and on the other hand, from lay human society.But truly speaking, the medicalisation of childbirth in India was much more prevalent in the urban areas, where institutional births have become the norm.

Increasing trend in Institutional delivery and birth by caesarean section:

It is noteworthy to mention that the chances of caesarean delivery is directly proportional to the accessibility and availability and utilization of health services which on the other hand signifies the process of medicalisation in Indian society. The data on the percentage of births delivered in health institutions and proportions of mothers underwent c-section clearly supports this argument. The rapid increase evidenced from the states like Andhra Pradesh, Kerala, Tamil Nadu, and West Bengal. Moreover, with the higher proportion of births in health facilities, the rate of c-section intervention also grew up.

Role of health facilities in performing c-section intervention:

Most often the private hospitals are the targets of criticism for enhanced c-section delivery as financial motives are inherent in the private medical system. Studies are also found, in general, point toward higher incidence of caesarean deliveries in private hospitals compared to public hospitals (Peterson, 1990). This suggests that non-medical factors such as economic gain and pressures of private practice may motivate doctors to perform surgical deliveries. The high rate of c-section deliveries in urban areas probably indicates growing privatization in health care in urban areas and financial benefits behind this surgical procedure in private health care facilities.

Table 4 presents data on percentage of c-section deliveries in private and public health facilities. It is evident from the analysis that the rate of caesarean childbirth is

more in the state with high institutional birth. More interestingly, the proportion of caesarean birth is more in private health facilities than public one which may be the reflection of increasing privatization and profit motive in health care facilities in recent time. Nearly half of the births that are taken place in private health institution are by c-section.

Table 4: Trend in Institutional births in India and major states:

Percent distribution of live birth in health institution and birth by states, from NFHS-2 and NFHS-3.

	NFHS-2			NFHS-3		
	Inst_Del*	**Public**	**Private**	**Inst_Del**	**Public**	**Private**

Uttar Pradesh	15.5	7.2	8.0	24.7	6.4	18.3
Haryana	22.4	6.0	16.4	34.6	13.2	21.2
Himachal Pradesh	28.9	23.2	5.7	49.1	42.3	6.7
J&K	35.6	35.6	5.9	51.1	41.7	9.5
Punjab	37.5	7.6	29.8	51.2	12.3	38.8
Delhi	59.1	29.1	29.7	52.7	27.5	25.1
Gujarat	46.3	11.2	35	52.5	13.9	38.7
Rajasthan	21.5	15.7	5.6	31.6	20.0	11.6
Madhya Pradesh	20.1	13.1	7.0	38.3	20.8	17.5
Maharashtra	52.6	24.3	28.3	71.2	34.3	37.1
Goa	90.8	38.5	51.4	92.2	44.0	48.4
Orissa	22.6	19.1	3.4	39.1	30.6	8.7
West Bengal	40.1	31.6	8.5	51.9	37.8	14.2
Assam	17.6	11.7	5.9	26.2	14.7	11.4
Bihar	14.6	3.8	10.8	25.1	4.8	20.4
Andhra Pradesh	49.8	12.3	37.3	75.6	27.7	48.1
Tamil Nadu	79.3	37.4	41.1	90.1	53.8	36.5
Karnataka	51.1	27.6	23.3	64.1	34.8	29.5
Kerala	93.0	36.3	56.7	99.3	35.6	63.8
India	**33.6**	**16.2**	**16.7**	**44.8**	**23.4**	**21.4**

* Institutional delivery (Delivery in health facilities, such as, public which includes govt. hospital, dispensary, primary health centres etc and private health facilities and NGOs or trust hospitals).

Different rates of c-section in public and private hospitals suggest that non-medical factors, such as economic gain and pressures of private practice, may motivate doctors to perform surgical deliveries (Potter et al. 2001). At the all India level nearly 30 percent of the caesarean births are in private health facilities. Where as, states like West Bengal, Andhra Pradesh, Goa, Karnataka, Kerala, Tamil Nadu, Himacha Pradesh, Gujarat, Orissa the rates are in alarming situation. In all these states proportion of c-section births in private health facilities are above 30 percent. Moreover, in some states difference in c-section rates between urban and rural areas are prominent. Analysis shows

that the difference is highest in West Bengal (29.5 percent). Interesting to see that, in state like Kerala, which represents highest proportion of c-section birth, the difference between public and private hospitals is relatively less as compared to other states. This probably points to the facts that private hospitals solely can not be blamed for increasing trend in c-section delivery. Although, the heterogeneity in different states clearly indicates a number of non-medical factors operate in the medical intervention. Moreover, it is possible that in urban areas, a combination of private profit motive mechanism and demand from women drive the current trend in c-section delivery in India. Hence, to understand the mechanism of decision making for the performance of c-section, a qualitative study has been carried out in the state of West Bengal, where we found that caesarean the rural urban difference in caesarean birth is highest (Ghosh and James, 2009).

Elective Caesarean Section or Caesarean by choice: **From the voices of women**

One of the most important factors of increasing caesarean births is non-medical reasons such as preferences from women or her family members, doctor's motivation or some time merely matter of profit motive from health facilities (Ash and Okah, 1997; Belizan et al. 1999).

The performance of caesarean birth in present medico-social domain is more attributed to non-medical reasons rather than medical one. Such phenomenon of women choosing to deliver by caesarean section in the absence of any medical indication is most popularly known as **caesarean by choice**. Caesarean delivery on maternal request (commonly known as CDMR) is a medically unnecessary caesarean section, where the conduct of childbirth through caesarean intervention is requested by pregnant mother.

Analysis of the secondary data in the earlier chapter reflects on different factors of performance of c-section intervention during childbirth. But how in a changing socio-economic realm of the society delivery decision takes place is beyond the scope of secondary data. Hence, for a better understanding of the phenomenon an empirical study has been carried out in the city of Kolkata.

Maternal request for c-section

Caesarean sections performed without medical intervention, are commonly known as caesarean section by demand or maternal request caesarean sections. The belief that many women are demanding caesarean sections in the absence of clinical indications has been prevalent for many years (Jane et.al. 2007). Caesarean delivery on maternal request is defined as a primary caesarean delivery done on the request of the mother in the absence of any medical or obstetric indication (Minkoff, 2003 in Robin Kalish). Although, many times, this preference involve several other preferences for a woman's family members or husband.

The current section deals with aspect of 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. In my field study an attempt has been made to elicit the information of how the decision making takes place in a family and also in the birth place of a child. The case studies bring out the aspect of decision making for on caesarean delivery based on the experiences of women who had caesarean birth. Though, it is hard to differentiate between demands from woman purely or demand from her family member or doctor under whom she is in treatment. Most of the time it is a very

complex interplay in a family set-up. Therefore, an attempt has been made to depict different aspects of demand which are interlinked with each other in the following discussion. This section mainly deals with demand from a woman to prefer caesarean intervention for various reasons which are discussed bellow. For a better understanding, the analysis of the case studies has been explicated in different dimensions as follows.

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 in-depth interviews with the women who had this medical intervention during childbirth. In my field study I have come across some interesting findings of c-section delivery on maternal choice. It has been found from the field study that the request for caesarean delivery comes from would be mother or her family members due to several reasons such as:

i) Fear of pain in labour

ii) Fear of foetal distress in labour

iii) Religious factors

iv) Dependency and trust on doctor

Details of the factors supported by the case studies are discussed bellow:

<u>i) Fear of pain in labour</u>

One of the most important causes for requesting caesarean is fear of pain or apprehension during delivery. Avoiding pain during delivery has become more common among the pregnant mother. In current scenario, the technological advances have turn out to be a major decisive mechanism to avoid pain during labour. In many instances mothers do no longer want to bear the massive pain, therefore resulting into preference for c-section.

The fear for labour pain could arise because of woman's previous experience or fear could also induced in woman through comments made by health professionals, family members or friends.

As we see in the case of Ruma, the preference was due to fear of pain in last pregnancy. She already had child by normal delivery and experienced unbelievable pain during the childbirth. In her words..

"It was a horrendous delivery…in the end it was forceps delivery, and it was very traumatic. In less than a year after that I discovered I had a prolapse, and I went to see the doctor and he said it was a bladder prolapse. He also assured me it was nothing at all to do with giving birth, but….I can only think that all that squeezing and pushing must have done it…and then when I became pregnant with the second child, all I could think of was going through all that again…..therefore…I just requested doctor to perform the caesarean….now I am happy that my child is also ok…."

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.

On the other hand, in some cases the fear of pain can be due to neighborhood effect. Rita's preference for c-section delivery motivated by her friend, who suffered a lot due to normal delivery. Rita delivered her male child in BNR hospital by c-section. She didn't have any health problem. But she had the fear of normal birth.

In her words…

"Didi I have seen people suffering from heavy pain during childbirth. Oh my God…That is really painful. When I came to hospital, doctor told me that I can deliver my child normally. But I didn't agree with that. I told doctor please you do operation and save my male child. At the time of delivery I was unable to get labour pain. And time was over. So doctor performed caesarean delivery. I am so happy. My child is safe and I am also ok".

Although, she is from low income family and school final pass but she had the preference for caesarean so much, she requested doctor that she will deliver her child through caesarean section only.

Another respondent Parna (name changed, age: 22 yrs) who is a school teacher by profession, was very much in favour of c-section. She belongs to high economic strata and her husband was a businessman. She heard that giving birth normally is a painful and harmful to the baby. According to her, "*…how I formed the opinion of giving birth was really through my sister and my mother, talking to them, and I remember particularly my mother saying how painful the normal delivery. She told that if she was given the option to have a caesarean she would definitely go for that. But at that time this procedure was not that popular and highly developed, which is not in my case. In my case we went to a good Gynaecologist in the city and did not hesitate to pay for this surgery as we both wanted our child delivered safely".*

We are thus left with a paradoxical situation where, on the one hand, women with good educational background prefer this procedure as they consider it as safe option to give birth. Whereas, on the other hand, it is also evident that, women from poor economic as well as educational background also prefer this mode as painless way to give birth.

ii) Fear of foetal distress in labour:

In many cases mothers want c-section as this is safe procedure for the child. It may be caused due to late pregnancy or previous pregnancy failure such as miscarriage or still birth. One of my respondents Sunita (name changed, 38 yrs), shared her experience with me regarding her first pregnancy after nine years of marriage. Sunita is MA in Anthropology and belongs to good economic background. She found caesarean delivery as safer procedure than normal birth for high age mother like her. In her words, "*I am 38 years old and did not have any child for last nine years after my marriage. We visited a famous Gynaecologist who suggested me to go for caesarean birth. I also had a fear that my child will suffer in this late pregnancy or in delivery. So why to take chance? Then I and my husband decided to go for c-section just to save the life of my child. I have read things where I have heard that it's better for the baby, to have a caesarean; they are not getting squashed all the way along the birth canal. And I also have heard that it's relatively easy surgery in respect of the baby.*

In India, caesarean section is widely perceived as safer than vaginal birth for babies. Any risk associated to caesarean section are usually minimized and described as risks to the mother.

"I just felt the caesarean was safer for the baby ……although the risks to me were it was going to take longer to get over and all the rest of it, the risk of infection and stuff like that. But I still felt that, that at least the baby will be safe. I knew I could recover all that, because, I was quite fit and a healthy person. Now I am happy to see that my baby boy is ok. (Chobi Mahato, 25 Yrs.)

The fear of foetal distress and loss of child make a huge tension for family members. In the decision making process, family members play important roles which

sometime motivate woman to opt for medical intervention. As in the case of Lata (already discussed in previous section), the pressure from in-law's family and her own family for male child through a safe procedure triggered off for caesarean section.

iii) Religious factors.

Another factor related to decision making for caesarean is giving birth in auspicious time or in some special day. In a country like India, where religion and religious believes takes place prior to any other things, childbirth in an auspicious day perhaps an important factor for opting surgical intervention. In my study, two respondents wanted to ask for caesarean section to have some control over the timing of the birth, but neither voiced her request to hospital staffs. Aparna and her family members, especially her mother-in-law wanted a child crazily on Saturday morning in a special star combination. Though, doctors did not agree with this as her labour induction[§] was not started. It has also been noticed from the voices of women that preference for having birth on some special day for religious and cultural reasons exists which sometime comes from family members or woman herself opt.

iv) Dependency on doctor:

Trust is clearly a significant aspect of maternity care for many women. According to Gilson (2003) trust in health care institution can be defined as dependency in relationships that occur in the context of inequality such as that between health care provider and patient. Most of the women interviewed emphasized on the fact that they trusted their doctors implicitly, not just in terms of their clinical expertise but also as a

[§] Labour Induction: This is a procedure where labour pain starts normally

care giver during pregnancy and delivery. One of my respondents shared her experience with her Gynaecologist in the following way.

"I feel more comfortable being in the care of a specialist obstetrician as well. And my doctor is the head of the department of the hospital and a professor. He is someone who is specialized and done more than 15 years of research and practice in this field. I knew that whatever decision he took for my child it was right. We trusted him implicitly. And you know when he did the surgery it was so painless and without any complication".

Moreover, women would never question their obstetrician's advice as; there exists common notion of medical world being more knowledgeable and thus powerful. This relationship between knowledge and power addressed by French Philosopher Foucault who argued that, over the time, the medical power is a disciplinary power that provides guideline about how patients should understand, regulate and experience their bodies (Foucault, 1975).

But, on the other hand, the dependency may be caused due to medical emergency rather than preference of women. As we take the case of Rajyashri, the delivery of her child was in medical emergency. Rajyashri, aged 29 years was from lower middle income family delivered her premature female child after nine years of marriage in BNR hospital. She had some problem in getting pregnant. She was under the treatment of Sr. Gynaecologist, BNR. After a laparoscopy she was able to bear child. At the time of delivery she faced major problems. On the last month of pregnancy amneutic fluid came out and she was in danger. She immediately admitted to the hospital and doctors decided to perform c-section. According to the doctor, she had to undergo c-section otherwise both the lives would be in danger.

In her words,

"Doctor saved our lives. I am so happy. I know that without c-section delivery it was not possible to see the face of my child, although I was not informed about the c-section".

If we look into the case of Mina, the caesarean was performed to save the child. Mina had been advised to undergo c-section because of breech presentation of child. According to her,

"C-section is safe mainly for baby. And during emergency it is important to save the life of child. Today there are so many options so that we don't have to worry."

It is a common traditional belief that, caesarean delivery is a life saving procedure for the neonates in most of the cases. And moreover, strong believe on medical technology and knowledge of doctor it is hard for patient or her family members to go against medical set-up.

Conclusion: 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 cesarean, 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 more represents the quality of care but speaks on the unhealthy trend developing both at the level of the medical profession and also at community level. 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).

However, in current situation we notice that in India, there is an accelerating trend in c-section births in urban areas many of which is due to non-medical reasons. This scenario perhaps creates concern for health of urban women in a larger context. On the one hand, over use of this surgical mechanism without any medical reasons creates alarm to women's health. On the other hand, it generates a paradoxical situation on difference in utilization of health care in rural and urban areas.

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