**A Comprehensive** **Survey of The Choice Of Delivery In Urban Women Community:Ethical challenge : an ethnographic research**

**Abstract**

**Introduction :**Nowadays , safe and healthy delivery is an important part of mother and child care programs and choosing normal delivery or cesarean section is one of the most important decisions made by mother and her family which draws special attention of health and treatment systems. Different factors with different intensities affect this decision making. In the present study, we tried to clarify the issue with vast investigations using an ethnographicresearch.

**Method:** The present qualitative research by data triangulation approach using an ethnographic method during two years in three phases. Our sample included hospital patients, medical staff and physicians. The sample size was determined by reaching the saturation level. In the first phase, observations were recorded and in the second phase, study participants were interviewed. Finally, the researchers made interventions as medical staff and recorded their observations in the third phase. Data analysis was performed cyclically in order to find cultural contents and metaphors.

**Results:** Five cultural and social contents were found which influenced the choice of delivery. Perspective of fear and difficult delivery. Cultural change and the vulnerability of women, social change and modernization, medical interventions and finally decision making in the public policy.

**Discussion:** Fear and experience of pain is one of the most effective items which affect the choice of delivery. The tendency toward luxurious life and social ostentation has penetrated modes of delivery as well and surgical operations are regarded as a kind of superiority. Changing in roles, accepting reproductive roles and views of health workers have also exacerbated the problem and the phenomenon of normal delivery somehow shifts to medicalization and frequent medical interventions result in an increasing tendency toward performing cesarean section.

**Conclusions:** Suitable propaganda on choosing no or less-pain labors is recommended. This culture should be created that normal delivery indicates a high social class. Healthcare staff’ view toward delivery should be changed that delivery is a normal issue and medical interventions are not always needed.

**Key words:** choice of delivery – urban society – ethnography

**Introduction**

In recent years cesarean section rate has increased in different countries due to several reasons. Removing delivery from its physiologic trend and the tendency toward medicalization, fear and difficult delivery are among the most important reasons of this increasing trend. Other reasons include demands of mothers and their families for cesarean section and suggestions made by some physicians in order to satisfy their clients (1, 2). It is necessary to notice that delivery is a physiological process and a part of women's reproductive life such as adolescence or menstrual cycle. But nowadays, this phenomenon has been remarkably influenced by different social, cultural, economical and medical factors.

Although different research done in Iran and other parts of the world indicated that women, their families and even healthcare staff had a desirable knowledge and attitude toward inappropriate medical interventions for normal and cesarean section deliveries (3), unfortunately demands for cesarean section have been increasing in Iran as in other parts of the world . WHO has recommended that cesarean section rate should only include %12 of the whole deliveries (4). The statistics proved to be higher in urban areas and big cities than rural areas and small cities. It is interesting that the level of knowledge about the effects of surgical operations like cesarean section in cities is usually more than rural areas while the tendency toward it is still more.

In past years, factors such as parity, age, previous delivery history and its desirability, place of childbirth, fear of labor pain, vaginal examination, mental stress, limited knowledge, mutual relationship with the physician and midwifery staff and comments from family members and husbands are reported to influence the choice of delivery as well (5-8).

Women's experience of decision making about mode of delivery is better posed in qualitative studies. In these studies, factors such as fear of labor pain and dealing with it, mother's level of knowledge, racial and cultural difference, fear of the unknown, social class and urban or rural place of residence, and role of husbands were mentioned as the effective factors in choosing the mode of delivery (9, 10). In some sociological studies, the impacts of medicalization of birth, social policies and choosing the place of delivery and physician or midwife’s interventions have been considered to influence the choice of delivery as well (11-13).

In all the studies that were mostly quantitative ones, people’s attitude toward the choice of delivery was being investigated but a comprehensive analysis has not been done on cultural and social factors. On the other hand, few papers presented a qualitative study which aims to investigate all aspects of the choice of delivery.

Therefore, decision making on the choice of delivery should be investigated in a way that all cultural and social factors are taken into account besides other effective maternal factors with a broader view.

**Method**

**Designing the research:** We designed this study based on critical ethnography method . We try to identify different elements of culture and their associations in order to be able to have a complete and clear image of them (14, 15). In this type of intellectual school, the researcher believes that there is no culture outside to be identified; the researcher and members of a group make a culture overview together (16).

**Research environment:** Three researchers in two educational hospitals of Shiraz University of medical sciences which offer services to women started to work from 2010 to 2012. The interviewers acted as observers and used different methods such as semi-structured ethnography interview and asking questions from the individuals present in women's labor, emergency, prenatal and postnatal departments.

**Samples:** Our samples included two groups by using data triangulation which entails gathering data through several sampling strategies . 53 women referring two medical centers, 14 health staff and 12 physicians present in hospital whose behavior and performance was recorded informally were included in the first group. The interviewees formed the second group including 12 midwives, 5 residents of OB&GYN and 7 women who had referred to hospital for different services.

**Ethical issues:** The study received ethics clearance through the Research Ethics Committees of jahrom university of medical sciences. Ethical issues related to this project involved inadvertent researcher dominance, inappropriateness or disrespect as a result of lack of awareness of and insensitivity to, cultural differences .All necessary information about the research method was given and required permissions were acquired by the research ethics committee. Informed consent was obtained from participants.

**Procedure:** This research was done in 3 time phases. In the first, researchers observed and recorded data from the environment and individuals and wrote down their views, feelings and performance by sitting among them without any interventions, during one year.

In the second year, our second phase of semi-structured interviews with medical staff, patients and midwives who were in charge of treatment and delivery of pregnant mothers started.

Finally, we made interventions as medical staff and recorded our observations by discussing the issue with medical staff and clients in the third phase (cooperative observation).

**Analysis:** Data analysis was performed cyclically and any new findings or questions needed to be posed or noticed during the project was entered in the research and was being analyzed. In fact, after data collection and classifying the framework of our primary data, required information were determined and collected after a more precise field analysis. Data collection continued until theoretical saturation occurred .Resulted findings from environmental and individual observations were being studied and interpreted along with the data collected through interviews and finally being analyzed with a critical view.

**Results**

**1) Fear and difficulty of labor:** According to women, another delivery is not a usual and physiologic process in their reproductive life. Different information and quotes among women have caused delivery to become a very difficult, horrible and painful phenomenon.

**Fear of labor pain:** Fear of pain depends on individual characteristics and pain tolerance threshold. Also, it is correlated with previous experience, level of knowledge and information from the environment. Therefore, a part of the individual choice depends on the knowledge of tolerating pain while another part is correlated with previous experiences of pain and information conveyed to them about delivery. A young woman said: *“I cannot tolerate a needle, how can I tolerate labor pain? “* Sometimes women are forced to describe painful events along with their fear of pregnancy and labor in order to magnify their role and the hardship they tolerated and sometimes surpassed each other to show that their experience was more important. A woman referred to the clinic said: *“All women in my whole family say “you don't know what kind of pain and torture we experienced during our delivery. Only those who do cesarean section feel comfortable"*. *Each one was worse than the other. I sympathized with them all. They asked me not to repeat their mistake”. That is why they lose confidence and don't find the ability to tolerate labor pain. “Delivery is like a cruel monster that you are disarmed before facing it”*. Thus, they desperately think of normal delivery. Nowadays people are less exposed to difficult and painful situations and for each problem a scientific or easy solution is expected and everything should be as possible as it can.

**Fear of the unknown:** some people believe that *“It's not clear what will happen to us during normal delivery"*. Crowdedness of governmental hospitals, limited spaces, and lack of medical staff and presence of different fields of medical sciences in hospitals intensify this feeling in patients. They frequently witness that unknown people come and go, sometimes talk about them, make decisions, and finally someone else take charge of their affairs. According to these women, most midwives and patients do not have a close relationship with them. A mother hospitalized in labor department said *“doctors come and say something different each time. Nurses do not take care of me and just exchange our files with each other on their shift. I really don't know what they do to me*”. Unknown people and environment and activities for which no explanation is given are factors that intensify the feeling of pain. Although doctors and medical staff had different views, lack of proper relationship caused an inappropriate concept in patient's minds. Also, despite the complete supervision of midwives on mother and her child’s health, shortage of medical staff causes this to fade in patient's mind. The staff believe that *“when you should take care of 2 to 3 people at the same time in every stage of delivery, from labor department to the end of giving birth and even breast feeding, and do the doctor’s commands, you will have no more time to be constantly present beside one mother*". It seems that in such hospitals, midwives resign from direct interventions in the process of labor and delivery in order to avoid legal problems since full responsibility of maternal and fetal health is taken by doctors. Allowing no one to visit the mother and absence of her husband cause more fear and anxiety for women in such an environment.

**Fear of the unknown process of labor and** **losing control**: One of the midwives said: *“when the mother does not know how normal delivery occurs and just has heard things from her mother or relatives and then comes to labor department, she is afraid of everything, becomes anxious and this causes her to feel more pain*.” During normal delivery, the mother completely experiences bleedings, examinations and sometimes manipulating her genital system. But in cesarean section the mother has none of the bad memories of the onset of labor, its pain and finally the unpleasant situation of the last stage of delivery (tearing the amniotic membrane and sometimes involuntary passage of fecal matters which cause many mothers to feel sorry or guilty and uncontrollably cry). The situation described causes women to feel they have no control on their behaviors. They scream uncontrollably with a disparate cry which is annoying for the people present in labor department. Sometimes they beg while they would never do this if they were not in such a situation. After giving birth, they consider their behavior or what happened to them as being shameful and embarrassing. These issues and experiences are quoted in private gatherings and they become fearful.

**Fear of endangered baby:** In our interviews and observations, none of the mothers or women talked about this issue. Senior physicians pay excessive attention to fetal heart situation and amniotic fluid as the main causes for choosing surgical operation. A young unmarried woman stated. *“Labor is not predictable. But when you choose cesarean section you know the exact day and time in which you and your infant will be delivered safe and healthy”*. Of course, it seems that women consider their child’s health as their own, not something separate.

**2) Cultural view**

Many cultural issues, education and individual positions especially for women have been changing in developing societies including Iran. Women’s feminine and maternal role taking and reproductive life have changed remarkably. In modern societies, women do not accept some of their roles as they observe developed societies and their cultures and any obligation for accepting these roles results in their opposition and whatever related to such roles are considered to be hard and intolerable.

A recently married woman who had not been pregnant yet said *“I’m not in the mood for pregnancy and bringing a child unless my husband forces me to bring one. What have we done for our mothers to expect our children to do for us! Suffering so much lab or pain, giving birth with a lot of problems and nothing at last. It is better not to become a mother. It is not worth trying.”*

Sometimes women try to find their position by becoming a mother. Becoming a mother does not has as much familial or cultural value as it had in the past. Women think that by bringing a child they become far from social activities and this has been an important issue in modern families.

Husbands' focus on spousal roles , marital relationships and new expectations from women have caused them to talk less secretly about their concerns about continuing marital relationships after normal delivery and express their views this way*:” this makes me scared that after normal delivery my husband does not enjoy our sexual intercourse and cause our marital relationship to ruin.”* Sometimes husbands' anxiety and concern is so effective on women that after normal delivery they have to do several surgical operations in order to repair their genital system to meet their husbands' expectations. An experienced midwife believed that: *“when you have to do several surgical operations to repair your genital system after one or two normal deliveries. You choose cesarean section from the beginning and you will have no problem with your husband*” Her colleague added: *“If you have a normal delivery after which your body is repaired well, your husband will have no problem. My mother had 4 normal deliveries and she had never any problems with my father”.* In fact, good labor is not discussed. Different views of men and women in the past and present about marital relations have been important which is of course a very private subject and discussed only in very intimate gatherings. It should be noted that in modern culture, all healthcare systems tend toward more education for women about pregnancy and prenatal cares. Healthcare centers, seminars, congresses, public media and online websites are trying to increase public knowledge. Along with the torrent of information, women focus on the effects of normal delivery's damages unconsciously which can influence their decision making. Positive views toward education and conveying information include the knowledge about painless methods, special pregnancy exercises, relaxation techniques and physiologic delivery which is unfortunately more faded than conveying experiences in familial relationships and informal findings. The culture of using supportive midwifery service in physiologic delivery has been neglected to a great extent so that tendency toward its effective role has been decreasing.

**3) Social changes**

In large urban communities, personal relationships and people’s knowledge about each other is based on some specific signs and appearances. The culture of luxurious life is rapidly replacing the culture of frugality and economic life. Therefore, sometimes people use special signs or factors in order to know others or introduce themselves. In large communities, people try to show that they are in a higher social position by enjoying certain life facilities such as car, house, etc. Nowadays people tend to give importance to private hospitals, famous specialists and expensive costs of cesarean section. This forms a part of familial social class and position. Cesarean section is regarded as a kind of priority and normal delivery especially in governmental hospitals is regarded as a low social class.

A woman said: *“I'm just here to be supervised by Doctor X. I've heard she is the best. I'm not like those in small cities to have a normal delivery in a governmental hospital. These days only poor people have to go to governmental hospitals”,* or another client said *“my cousin's husband did not pay attention to her. It was not important for him that his wife felt embarrassed in her family. At last my poor cousin had to come here to be delivered. We felt very shameful in the family”.*

**4) The phenomenon of medicalization** has changed the physiologic delivery to a pathologic form inappreciably which requires several interventions. Sometimes controlling and managing the delivery changes normal delivery to cesarean section by prescribing drugs that increase the pain. First year residents face a large amount of work and responsibility and they have little experience in dealing with normal delivery.

Their view is mostly medical, interventional and patient-based due to general education in medical courses. They view a pregnant woman as a patient suffering from labor pain that something should be done for her while mental supports and focus on the normal aspect of it are being neglected.

A senior resident said: *“Cesarean section in a certain time is less risky. You're not forced to take the mother to the operation room urgently by accepting more risk if her delivery is not a normal one are worried all the time that something may happen to the child as it becomes late”.*

Some interventions make the delivery seem harder such as frequent vaginal examinations, rupture of membrane when it is not still the time for it, causing dangers for mother and child, conveying the mother to delivery room before complete preparation for giving birth and locating her in an inappropriate position for a long time and using pressure on top of the uterus for faster discharge of the fetus. Low supports and education during the labor exacerbate the situation, on the other hand.

**5) The last critical discussion which is effective on the choice of delivery is the excessive tendency of policy makers for normal delivery** and reducing cesarean section rate. No effective operational or executive activity is done to change the tendency toward cesarean section in women except the educations offered simultaneously with prenatal cares and educational classes of physiologic delivery and just a series of guidelines and circular letters are issued to prevent preferred approach to cesarean section. In our observations, nothing existed as the autonomy of patient and principle of medical morality about offering all medical ways to the patient and suggesting the best curative way and finally respecting patient's choice.

**Discussion**

We found that feeling of pain, anxiety and labor pain is a point which cannot be ignored. This issue does not relate to individuals' culture or socioeconomic status; acceptance and threshold of tolerating pain is completely personal and depends on people and like with the results found by Saisto T and Pınar S (17, 18) it affects decision making for the choice of delivery and increases people's tendency for doing cesarean section. This issue is not greatly influenced by education. Modern young generation is greatly afflicted with reduced self confidence for normal delivery. They don't have enough power and ability to tolerate the process of delivery as they have heard many horrible stories about it.

Similar to the study done by Lows in 2000 (19), we indicated that labor pain, fear and concerns can influence women's view about choosing a safer and easier mode of delivery. For some people delivery is a tragic pain and resembles the feeling of facing with death. Therefore, a more serious look is needed toward the severe feeling of experiencing pain that is not related to women's level of culture, education and socio- economic situation. In some studies women described labor as a painful phenomenon and reported its pain as being agonizing. On the other hand, the effect of different mental factors on mother's perception about labor pain as a clinical phenomenon has been known well; this is one of the main factors of fear of labor (17, 18, 20). Women should experience painless or less-pain deliveries so that their mentality would change.

Like Macintyre (13) we observed that specialization and using specialists for doing every work is expected. It seems that for becoming up-to-date, everything which is related to old and traditional world should be put aside. Traditional normal delivery is considered to be troublesome and problematic and, therefore, is not accepted. In the minds of modern women, giving birth should be performed fast and comfortably in sub-specialized hospitals by female specialists. On the other hand, specialists consider medical interventions as the process of improving delivery since they mostly regard it as a disease.

Thus, by identifying the effects of cesarean section on the mother and fetal health, women prefer to be freed from the fear of attending an unknown place with unknown people that have no relationship with them and don’t pay attention to them and other unpredictable problems of delivery and hence have no painful experiences along with anxiety as found by Kasai (9). Therefore, maybe we ourselves cause deliveries to become medicalized unintentionally by removing the physiological trend of delivery and account for women's tendency toward cesarean section. Giving birth in the unknown environment of the hospital with the staff and physicians who pay the least attention to mental supports for reducing mother's pain and family members especially husbands who are not allowed to be beside them all the time would be annoying which is also stated in studies done by AbedSaeedi and Galotti (21, 22).

In the culture of modern urban communities, girls get married in older ages and decide to become pregnant later. We found that they have more tendencies for doing cesarean section. In younger ages, people have more self confidence, accept risks more and tissue repair occurs much better which can help them to bear labor pain to become less influenced by side effects of surgical operations which is also suggested in Pevzner's study (7).

Role taking has changed in modern communities. Accepting normal delivery as a usual feminine affair can increase pain tolerance and reduce the fear and concerns, as seen in the study done by Lubic & Flynn (23). Women oppose any factor which disrupts their future marital life. But if they are ensured that normal delivery would cause no damage or effect on them and their husbands receive necessary education, they will have less concern for normal delivery for sure.

Another important issue in modern cultural and social relationships is social ostentation in families. Women consider normal delivery as something related to people with a low social class and doing surgical operation is known as a higher and superior family. These have resulted in higher rates of cesarean section in urban communities than smaller cities and rural areas (24,25). In the study done by Lubic and Flynn (23), it was revealed that women who were in a higher special and economical class, preferred cesarean section while poor financial conditions make them refer to governmental centers for using normal delivery. On the other hand, factors that are related to the quality of offering healthcare services have more effects than other factors such as level of life and income, socio-economic factors and education that it has also been observed in the study of Feng (26).

As a result, neglecting mother's autonomy for choosing the method of delivery can cause women to refer to private hospitals in order to keep their rights and choose cesarean section without regarding the effects of surgical operations. Proper and adequate education, preparations for painless physiologic delivery and related education and appropriate propaganda should be performed.

**Conclusions**

According to our multidirectional survey, it is suggested that health workers’ view should change toward delivery and they should believe that delivery is a natural process and does not always need medical interventions.

If this belief develops in the whole society then one can hope that the tendency toward cesarean section among people will decrease. Also, expanding the possibility of using painless and physiologic deliveries and proper and effective presence of midwives or physicians with an appropriate view toward delivery from the beginning of pregnancy to take care of the mother beside her can be helpful.

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