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Determinants of Cesarean Section Decision-Making Beyond Clinical Indications: A Qualitative Study

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ABSTRACT
Cesarean section (CS) rates have increased substantially worldwide, with a growing proportion performed without clear medical indications, raising concerns about avoidable maternal and neonatal risks, healthcare costs, and health system inefficiencies. In Mataram City, Indonesia, hospital-based CS rates exceed 60%, substantially higher than national levels and international recommendations, yet evidence regarding the decision-making processes underlying this pattern remains limited. This study aimed to explore how clinical, sociocultural, and health system factors interact to shape CS decision-making in Mataram City. A qualitative case study was conducted from June to August 2025 using in-depth interviews with women who voluntarily chose CS without emergency indications, obstetricians, and nursing staff, as well as focus group discussions with midwives recruited purposively from public and private healthcare settings. Data were analyzed thematically using the Health Belief Model as an analytical framework. Five interrelated domains shaped CS decision-making: medical considerations, maternal and family perceptions, social interactions, healthcare provider authority, and childbirth financing mechanisms. Relative medical indications emerged as critical triggers that legitimized maternal preferences for CS by amplifying perceived risks within asymmetrical patient provider relationships. Overall, CS decision-making was shaped by the interaction of clinical assessments, sociocultural norms, provider authority, and health system financing. Strengthening shared decision-making, standardizing antenatal counseling, improving maternal health literacy, and addressing financial incentives may help reduce unnecessary CS while preserving maternal autonomy and ensuring maternal and neonatal safety.

Keywords: Cesarean Section, Decision-Making, Qualitative Study, Health Belief Model, Shared Decision-Making, Indonesia.

ABSTRAK
Angka persalinan melalui operasi sesar (cesarean section/CS) telah meningkat secara signifikan di seluruh dunia, dengan proporsi tindakan yang dilakukan tanpa indikasi medis yang jelas semakin besar, sehingga menimbulkan kekhawatiran terkait risiko maternal dan neonatal yang sebenarnya dapat dihindari, peningkatan biaya pelayanan kesehatan, dan ketidakefisienan sistem kesehatan. Di Kota Mataram, Indonesia, angka operasi sesar berdasarkan data rumah sakit melebihi 60%, jauh lebih tinggi dibandingkan angka nasional dan rekomendasi internasional, sementara bukti mengenai proses pengambilan keputusan yang mendasari kondisi tersebut masih terbatas. Penelitian ini bertujuan untuk mengeksplorasi bagaimana faktor klinis, sosial budaya, dan sistem kesehatan saling berinteraksi dalam membentuk pengambilan keputusan terkait persalinan melalui operasi sesar di Kota Mataram. Studi kasus kualitatif dilakukan pada Juni hingga Agustus 2025 melalui wawancara mendalam dengan perempuan yang secara sukarela memilih operasi sesar tanpa indikasi kegawatdaruratan, dokter spesialis obstetri dan ginekologi, serta tenaga keperawatan, disertai diskusi kelompok terarah dengan bidan yang direkrut secara purposif dari fasilitas pelayanan kesehatan publik dan swasta. Data dianalisis secara tematik menggunakan Health Belief Model sebagai kerangka analisis. Lima domain yang saling berkaitan memengaruhi pengambilan keputusan operasi sesar, yaitu pertimbangan medis, persepsi ibu dan keluarga, interaksi sosial, dominasi tenaga kesehatan, serta mekanisme pembiayaan persalinan. Indikasi medis relatif muncul sebagai pemicu penting yang melegitimasi preferensi ibu terhadap operasi sesar dengan meningkatkan persepsi subjektif terhadap risiko dalam hubungan pasien tenaga kesehatan yang tidak seimbang. Secara keseluruhan, pengambilan keputusan operasi sesar dibentuk oleh interaksi antara penilaian klinis, norma sosial budaya, otoritas tenaga kesehatan, dan pembiayaan sistem kesehatan. Penguatan pengambilan keputusan bersama, standardisasi konseling antenatal, peningkatan literasi kesehatan maternal, dan penanganan insentif finansial dapat membantu mengurangi operasi sesar yang tidak diperlukan dengan tetap mempertahankan otonomi ibu serta menjamin keselamatan ibu dan bayi.

Kata Kunci: Operasi Sesar, Pengambilan Keputusan, Studi Kualitatif, Health Belief Model, Pengambilan Keputusan Bersama, Indonesia.

INTRODUCTION

Pregnancy and childbirth represent major life transitions with implications extending beyond individual women to families, communities, and health systems. Although childbirth is often perceived as a natural and celebratory event, it is also a period of heightened physical, psychological, and social vulnerability that requires comprehensive, respectful, and evidence-based care. Contemporary maternal health frameworks therefore emphasize that safe motherhood should extend beyond maternal and neonatal survival to encompass equity, dignity, informed choice, and respect for women's autonomy throughout the continuum of maternity care (PP POGI, 2022).

Cesarean section (CS) is an essential surgical intervention for preventing maternal and neonatal morbidity and mortality when medically indicated. Nevertheless, the global expansion of CS utilization has raised concerns regarding levels that cannot be adequately explained by clinical need alone. Considerable variation in CS rates across and within countries reflects differences in access to maternity services, professional practice patterns, institutional norms, and health system incentives, in addition to differences in obstetric risk profiles (Betran et al., 2016; Eide & Bærøe, 2021). Although inadequate access to CS remains an important public health concern in some low-resource settings, excessive utilization in other settings has not consistently resulted in proportional improvements in maternal or neonatal outcomes (Cruickshank et al., 2025; Gebeyehu et al., 2022). This divergence highlights the importance of understanding not only whether CS is available, but also how and why decisions regarding its use are made.

According to the World Health Organization (2021), CS currently accounts for approximately 21% of all births worldwide and is projected to approach 29% by 2030 if current trends continue (World Health Organization, 2021). While CS can be life-saving when clinically justified, unnecessary CS, defined as procedures performed without clear medical indications, may expose women and newborns to avoidable short- and long-term consequences. These include increased maternal morbidity, prolonged recovery, complications in subsequent pregnancies, and substantial economic costs for health systems and households (Etcheverry et al., 2024). The WHO has estimated that millions of unnecessary CS procedures are performed each year globally, generating healthcare expenditures exceeding USD 2 billion without commensurate health benefits (WHO, 2018). The increasing prevalence of CS therefore represents not only a clinical issue but also a broader challenge involving healthcare decision-making, resource allocation, and the quality and appropriateness of maternity care.

Decisions regarding mode of birth are increasingly understood as complex and multidimensional processes shaped by interactions among women, families, healthcare providers, and the organizational and financial contexts in which maternity care is delivered. Previous studies have identified several factors contributing to increasing CS rates, including fear of labor pain, previous negative childbirth experiences, low confidence in vaginal birth, healthcare provider recommendations, institutional routines, and financial reimbursement mechanisms (Kitaw et al., 2021; De Angelis et al., 2023; Octavia, 2020). These factors may interact rather than operate independently, influencing women's perceptions of the risks and benefits associated with different modes of birth. Such processes are further reinforced by the medicalization of childbirth, through which CS may be perceived as a more predictable, controllable, and technologically secure option compared with the perceived uncertainty and pain associated with vaginal birth (Sinaga, 2022).

Indonesia reflects these broader global trends. National CS rates increased from 17.6% in 2018 to 25.9% in 2023, substantially exceeding the World Health Organization's recommended range of 10–15% (Badan Kebijakan Pembangunan Kesehatan, 2024). Within this national context, Mataram City represents an exceptionally high and insufficiently investigated setting. Hospital records from both public and private facilities indicate that CS rates consistently exceeded 60% between 2022 and 2024, markedly surpassing both the national average and international benchmarks (RSUD Kota Mataram, 2025). The magnitude of this disparity raises important questions regarding the mechanisms through which women and healthcare providers assess risk, interpret medical indications, negotiate preferences, and ultimately determine the mode of birth. Understanding these mechanisms is particularly important in settings where CS utilization substantially exceeds population-level expectations, as explanations based solely on clinical indications may be insufficient.

Despite increasing policy attention to the overuse of CS, empirical research in Indonesia has largely emphasized quantitative associations between sociodemographic characteristics and mode of delivery. Consequently, there remains limited qualitative evidence regarding how women, families, and healthcare providers perceive childbirth risks, interpret medical information, negotiate decision-making authority, and respond to social, institutional, and financial influences when choosing or recommending CS. This gap limits the development of context-sensitive interventions capable of addressing the underlying drivers of potentially unnecessary CS while maintaining women's autonomy and protecting maternal and neonatal safety. A deeper understanding of the decision-making process is therefore necessary to move beyond describing high CS rates toward identifying the mechanisms that sustain them.

This study aims to examine the decision-making processes surrounding cesarean delivery in Mataram City, Indonesia. Guided by the Health Belief Model and employing a qualitative approach, the study explores how clinical considerations, sociocultural norms, provider authority, and health system factors interact to shape decisions regarding mode of birth (Green, Murphy, & Gryboski, 2020). By examining these interconnected influences, the study seeks to generate context-specific evidence to inform strategies for strengthening shared decision-making, improving maternal health policy, and promoting appropriate, evidence-based maternity care while safeguarding women's autonomy and maternal and neonatal safety.

RESEARCH METHODS

This study employed a qualitative case study design to explore the decision-making processes surrounding elective cesarean section (CS) in Mataram City, Indonesia, from June to August 2025. Mataram City was selected as the research setting because of its persistently high CS prevalence, which exceeded 60%, and the availability of both public and private healthcare facilities with different models of maternity care. The study was theoretically informed by the Health Belief Model (HBM), which conceptualizes health-related decision-making through the interrelated constructs of perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy (Green, Murphy, & Gryboski, 2020). The HBM provided a sensitizing framework for exploring how participants perceived the risks, benefits, and barriers associated with vaginal and cesarean birth and how these perceptions interacted with interpersonal and health system influences.

Participants were recruited purposively to obtain diverse perspectives from individuals directly involved in cesarean delivery decision-making. A total of 19 participants were included, comprising eight mothers who had elected cesarean delivery in the absence of emergency indications, one spouse, two obstetricians, and eight midwives. The inclusion of mothers, spouses, obstetricians, and midwives enabled the study to examine decision-making from maternal, family, clinical, and midwifery perspectives. Eligible mothers had given birth in Mataram City within the preceding 12 months and were willing to participate in an in-depth interview. Participants were recruited from public and private healthcare settings to capture variation in maternity-care contexts. Recruitment and data collection continued until thematic saturation was achieved, defined as the point at which additional data no longer generated substantially new codes, concepts, or analytical themes (Pahleviannur et al., 2022). Written informed consent was obtained from all participants before participation, and participants were informed of their right to withdraw from the study at any stage without consequences.

Data were collected using semi-structured, in-depth interviews and a focus group discussion (FGD). Individual interviews lasting approximately 45–90 minutes were conducted with the mothers, spouse, and obstetricians, while an FGD lasting approximately 120 minutes was conducted with the midwives. The interview and FGD guides were developed based on the constructs of the HBM and were adapted to the local maternity-care context. The questions explored participants' perceptions of pregnancy and childbirth risks, perceived benefits and barriers associated with different modes of birth, sources of information and cues influencing delivery decisions, experiences with healthcare providers, family and social influences, and perceptions of the healthcare and financing systems. The interview guide was pilot-tested to assess clarity, comprehensibility, and contextual appropriateness before formal data collection. All interviews and the FGD were audio-recorded with participants' permission and transcribed verbatim. The transcripts were reviewed against the audio recordings to ensure accuracy and

completeness. Data were analyzed using the six-phase thematic analysis approach developed as described by Zuchri (2021). The analysis involved familiarization with the data, generation of initial codes, searching for potential themes, reviewing themes, defining and naming themes, and producing the final analytical account. Two researchers independently coded the transcripts and subsequently compared their coding. Differences in interpretation were discussed until consensus was reached, with the HBM constructs serving as an analytical framework while allowing themes emerging inductively from the data to be retained.

Methodological rigor was strengthened through multiple strategies to enhance the trustworthiness of the findings. Data triangulation was achieved by incorporating perspectives from mothers, spouses, obstetricians, and midwives and by using both individual interviews and an FGD. Member checking was conducted to verify the accuracy and interpretation of participants' accounts, while an audit trail was maintained to document key decisions throughout data collection, coding, theme development, and interpretation. Reflexive journaling was also undertaken to encourage researchers to critically examine their assumptions and potential influence on the research process. These procedures were used to strengthen the credibility, dependability, and confirmability of the findings. Ethical approval was obtained from the UNIQHBA Bagu Ethics Commission (No. 216/EC/FKES-UNIQHBA/YPPQH/V/2025). All participants provided written informed consent before data collection. Participant identities were anonymized, and confidentiality was maintained throughout data collection, transcription, analysis, and reporting. Data were handled exclusively for research purposes and were stored securely to protect participants' privacy.

RESULTS

This study explored factors influencing cesarean section (CS) decision-making from participants' perspectives. Data were collected through in-depth interviews, focus group discussions, and document review, then analyzed thematically. Five primary themes emerged: Medical Indications, Maternal and Family Perceptions, Social Interactions, Provider Dominance, and Financing.

Characteristics of Participants

Participants included eight mothers (aged 28–43 years, primipara and multipara, with education ranging from high school to bachelor's degree, employed or homemakers), two obstetricians (aged 40–45 years), and several midwives (aged 25–38 years, Diploma or Bachelor's degree). Two participants (M1, M2) did not disclose demographic details.

Table 1. Summary of participant characteristics.

Participant Type	Number	Age range (years)	Parity	Education	Employment	Setting
Mothers	8	28–43	Primipara / Multipara	High school / Diploma / Bachelor	Employed / Homemaker	Public / Private hospitals
Obstetricians	2	40–45	—	MD, OB/GYN	Employed	Mixed practice
Midwives (FGD)	8	25–38	—	Diploma / Bachelor	Employed	Primary & secondary healthcare

Note: *Data for two participants (M1, M2) were not disclosed.*

Themes, Subthemes, and Representative Codes

Analysis yielded five main themes with subthemes and representative codes (Table 2). Selected participant quotes illustrate key findings.

Table 2. Themes, subthemes, and representative codes.

Theme	Subthemes	Key Codes	Representative Quotes
Medical Indications	Absolute / Relative	Fetal distress; Preeclampsia; Hemorrhoids; Arrested labor	"There's no time for lengthy discussions…" "Doctor gave me options…"
Maternal & Family Perceptions	Patriarchal influence / Individual perceptions / Prior experiences	Husband's decision; Pain avoidance; Birth trauma	"As long as my husband does what he wants…" "Already have the experience…"
Social Interactions	Effective / Empathetic / Communicative	Family protection; Peer narratives; Social media exposure	"A precious child after 15 years…" "Social media makes it scary…"
Provider Dominance	One-way communication / Fear-based / Authority deference	Doctor recommendations; Frightening language; Limited alternatives	"Doctor said… I just followed…" "Midwife scared me…"
Financing	Insurance / Cost differences / Institutional incentives	BPJS coverage; Claim rate gaps; Operational costs	"BPJS won't cover if requested…" "Claims are too low…"

Medical Indications as a Foundational Determinant

Medical considerations are the main starting point in discussions about caesarean sections. However, the extent to which these factors limit or enable choice varies greatly, depending on whether the medical indications are absolute or relative.

Medical Indications as Primary Considerations

Medical considerations consistently functioned as the primary reference point in cesarean section (CS) decision-making. However, their influence varied substantially depending on whether the indication was classified as absolute or relative. These categories represented distinct decision-making contexts that shaped clinical pathways, communication patterns, authority distribution, and women's perceptions of available choices.

Absolute Medical Indications

Obstetric emergencies were uniformly described by participants as situations in which cesarean delivery was unavoidable due to immediate and serious threats to maternal or fetal survival. Midwives and obstetricians emphasized that clinical conditions such as fetal distress, severe preeclampsia, placenta previa, and cord prolapse provided no clinically acceptable alternative to surgical intervention. In such circumstances, CS was understood as a life-preserving measure rather than a preference-based option. As explained by Informant ID-1 (FGD) :

> *"When fetal distress occurs or maternal blood pressure reaches dangerous levels, there is no opportunity for extended discussion. The decision is focused solely on saving lives. Families are informed briefly, and the procedure proceeds immediately"* (ID-1).

This view was reinforced by Informant ID-2 (FGD):

> *"In emergency conditions such as placenta previa or cord prolapse, vaginal delivery is not a safe option. Although the situation is explained to the family, there is essentially only one medically appropriate course of action"* (ID-2).

In these emergency scenarios, decision-making authority was centralized with healthcare providers. Families provided consent within a highly constrained timeframe and primarily acted as recipients of information rather than active contributors to deliberation. Shared decision-

making (SDM) was therefore experienced as contextually limited and procedurally compressed, reflecting the ethical obligation to prioritize rapid intervention.

Relative Medical Indications

In contrast, relative medical indications conditions associated with elevated obstetric risk but not classified as emergencies emerged as the most analytically informative domain in this study. These cases revealed more complex and sometimes conflictual decision-making processes, exposing underlying power relations between women and healthcare providers.

Situations such as prolonged labor, premature rupture of membranes without cervical progression, suspected cephalopelvic disproportion, or non–life-threatening maternal conditions prompted discussions in which vaginal delivery remained clinically feasible yet was increasingly framed as unsafe :

Several participants reported being offered alternatives. One participant stated:

> *"During my second delivery, I chose a CS because I had hemorrhoids. The doctor explained that pushing could worsen the condition, but I was given options. We discussed the risks of both delivery methods"* (Informant D).

Similarly, another participant recounted:

> *"I experienced spotting and my membranes had ruptured, but cervical dilation did not progress after several hours. I was informed that we could continue waiting or proceed with CS. Both options were explained, and the decision was made together"* (Informant E).

Despite these narratives suggesting dialogue, further analysis indicated that relative indications often functioned as catalysts for heightened risk perception. Participants noted that once any complication regardless of severity was introduced into clinical discussions, vaginal birth tended to be perceived as dangerous, while CS was positioned as the safer and more controllable alternative. This pattern was acknowledged by an obstetric specialist :

> *"Many cases involve relative indications where vaginal delivery remains clinically feasible. However, once patients are informed of any complication, even minor, they often perceive vaginal birth as too risky and opt for the perceived certainty of CS"* (Informant H).

These findings suggest that the presence of any medical indication, irrespective of severity, can shift decision-making toward cesarean delivery when combined with pre-existing fears or personal preferences. Consequently, the boundary between medical necessity and maternal request becomes increasingly blurred, complicating efforts to distinguish clinically indicated CS from preference-driven procedures.

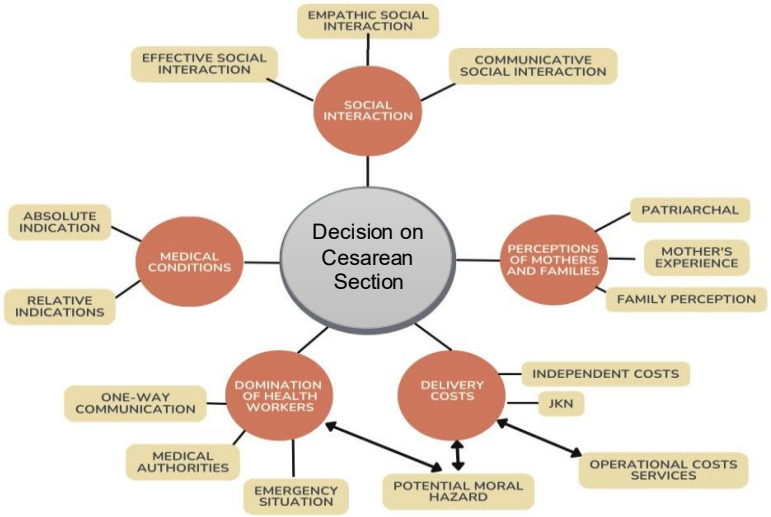

Figure 1. The complexity of decision-making domains in cesarean delivery.

The figure illustrates the complexity of cesarean section (CS) decision-making as the outcome of a dynamic, multidimensional interaction among medical, social, relational, and economic factors. Centered on the decision to undergo CS, this framework positions medical conditions as the normative foundation of decision-making; however, when indications are relative or inconclusive, non-medical factors become increasingly influential. Maternal and family perceptions shaped by social interactions, others' experiences, media exposure, and risk narratives surrounding vaginal birth often heighten anxiety regarding uncertainty, pain, and potential complications, thereby framing CS as a safer, more planned, and controllable alternative. These preferences are frequently reinforced by family support or direct requests, particularly from partners, functioning as a form of social indication within the deliberative process. This dynamic intersects with the professional authority of healthcare providers, who, through risk communication practices and medico-legal considerations, may intentionally or unintentionally position CS as a more predictable and clinically manageable option. Meanwhile, financial considerations act as a structural catalyst: the availability of insurance coverage or adequate financial capacity reduces barriers to surgical intervention and broadens acceptance of elective CS. Overall, the model underscores that the decision to perform a CS is rarely the consequence of clinical necessity alone; rather, it emerges from layered negotiations among mothers, families, and healthcare providers, wherein power relations, risk perceptions, and access to resources collectively shape the choice ultimately made.

DISCUSSION

The findings regarding absolute medical indications align with established obstetric practice guidelines emphasizing that emergency situations require rapid clinical decisions prioritizing maternal and fetal safety over extended deliberation (Leta et al., 2022). In such contexts, the dominance of provider authority represents appropriate clinical responsibility rather than paternalism, given that delayed intervention substantially increases morbidity and mortality risks.

Within the SDM framework, maternal involvement in absolute-indication scenarios is necessarily situational and limited (Probst et al., 2017). Healthcare providers function as primary decision-makers while families provide time-sensitive informed consent a process oriented more toward ethical and legal compliance than toward exploratory choice. Although imperfect from an autonomy perspective, this compressed SDM reflects the practical and ethical constraints inherent in emergency obstetric care (Loke et al., 2019; Miller & Danoy-Monet, 2021).

However, the findings related to relative indications reveal a significant gap between the ideal of shared decision-making and its implementation in practice. While relative indications theoretically allow collaborative decisions integrating patient values and preferences, several participants described experiences in which provider recommendations were presented with limited discussion of alternatives or associated risks. This pattern suggests that the presence of any medical indication even when non-urgent may trigger a provider tendency to favor CS rather than engage in authentically participatory decision-making (Belladiena et al., 2025; Hadizadeh-Talasaz et al., 2021; Yussuph & Alwy Al-Beity, 2023).

The literature on the medicalization of childbirth provides a useful lens for interpreting these dynamics. The World Health Organization has identified excessive medicalization as a major contributor to rising global CS rates, reflecting a growing tendency to view childbirth as inherently risky and requiring medical control even in the absence of clear indications (Angolile et al., 2023; Betran et al., 2016; Laurita Longo et al., 2020). The present findings support this perspective, as both mothers and providers frequently described CS as representing "certainty" and "control" compared with the perceived unpredictability of vaginal birth.

Medicalization appears to interact problematically with maternal anxiety and risk perception. Deng et al. (2021) reported that maternal request accounted for 23.38% of CS indications in their sample, often triggered by awareness of relative medical concerns. Similarly, this study found that mothers' subjective risk perceptions frequently exceeded objective clinical assessments, suggesting that relative indications can act as catalysts transforming latent preferences into definitive CS decisions (Colomar et al., 2021; Deng et al., 2021; Shawaar et al., 2023).

From a policy perspective, these findings underscore the need for clearer differentiation between absolute and relative indications within clinical practice guidelines, alongside stronger documentation of SDM processes. Such measures may help promote authentically informed choice while reducing unnecessary cesarean procedures.

CONCLUSION

This qualitative study demonstrates that cesarean section (CS) decision-making in Mataram City is shaped by the interaction of clinical, social, and institutional factors, extending beyond biomedical considerations alone. CS decisions emerge from the interplay of medical indications, maternal and family risk perceptions, sociocultural norms, provider authority, and health system financing. While absolute medical indications appropriately require clinician-led decisions in obstetric emergencies, relative medical indications represent a critical but inconsistently realized opportunity for shared decision-making. In practice, these situations are frequently characterized by heightened risk perception and authoritative provider guidance, resulting in CS being framed as the safest option despite the clinical feasibility of vaginal birth. CS utilization is further reinforced by patriarchal family dynamics, socially constructed beliefs favoring surgical delivery, and the enduring influence of previous childbirth experiences. Overall, the findings indicate that reducing non-medically indicated CS requires reforms that strengthen woman-centered care, rebalance decision-making power between providers and women, and address social and system-level determinants alongside clinical considerations. Healthcare providers should consistently implement shared decision-making and avoid fear-based communication that may unduly influence maternal choice. Structured antenatal counseling involving midwives, physicians, and family members is essential to support informed decision-making. At the policy level, reassessment of the INA-CBGs reimbursement framework is needed to align financial incentives with clinical appropriateness better. Efforts to improve reproductive health literacy and future mixed-methods research on clinical, social, and systemic drivers of CS remain important priorities.

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