



Published in final edited form as:

*BJOG*. 2011 March ; 118(4): 391–399. doi:10.1111/j.1471-0528.2010.02793.x.

## Women's preference for caesarean section: a systematic review and meta-analysis of observational studies

Agustina Mazzoni<sup>1</sup>, Fernando Althabe<sup>1</sup>, Nancy H Liu<sup>2</sup>, Ana M Bonotti<sup>3</sup>, Luz Gibbons<sup>1</sup>, Alejandro J Sánchez<sup>4</sup>, and José M Belizán<sup>1</sup>

<sup>1</sup>Mother and Child's Health Research Department. Institute for Clinical Effectiveness and Health Policy (IECS). Viamonte 2146. 3rd. Floor, (C1056ABH). Buenos Aires, Argentina

<sup>2</sup>National Institutes of Health/Fogarty Scholar. 238 Burnett Hall. City Campus University of Nebraska-Lincoln. NE 68588-0308. United States of America

<sup>3</sup>Officer. Maternal and Child Health Program, Ministry of Health. 483 1/2 7<sup>th</sup> Avenue (1900). La Plata, Buenos Aires Province, Argentina

<sup>4</sup>Biomedical Informatics Coordinator at the Training and Research Program, Ministry of Health. Monasterio 480, PB (C1284AEJ). Buenos Aires City, Argentina

### Abstract

**Background**—The striking increase in caesarean section rates in middle and high-income countries has been partly attributed to maternal request. We conducted a systematic review and meta-analysis of women's preferences for caesarean section.

**Objectives**—To review the published literature on women's preferences for caesarean section.

**Search strategy**—A systematic search of MEDLINE, EMBASE, LILACS and PsychINFO was performed. References of all included articles were examined.

**Selection criteria**—We included studies that quantitatively evaluated women's preferences for caesarean section in any country. We excluded articles assessing health providers' preferences and qualitative studies.

**Data collection and analysis**—Two reviewers independently screened abstracts of all identified citations, selected potentially eligible studies, and assessed their full-text versions. We conducted a meta-analysis of proportions, and a meta-regression analysis to determine variables significantly associated with caesarean section preference.

**Main Results**—38 studies were included (n= 19,403). The overall pooled preference for caesarean section was 15.6% (95% CI: 12.5–18.9). Higher preference for caesarean section was reported in women with a previous caesarean section versus women without a previous caesarean section (29.4% – 95% CI: 24.4 to 34.8 - versus 10.1% – 95% CI: 7.5 to 13.1), and those living in a

---

Corresponding author, Agustina Mazzoni, Address: Viamonte 2146. 3rd. Floor, (C1056ABH). Buenos Aires, Argentina., Telephone number: +5411 4 953 4058 (ext. 18), agustina.mazzoni@gmail.com.

#### Disclosure of interests

All authors declare that there are not conflicts of interest.

#### Contribution to Authorship

AM, FA and JMB conceived and designed the study. AMB, AJS, NHL, and AM collected the data. LG analyzed the data. AM, FA, JMB, LG, AMB, AJS, and NHL interpreted the data. AM drafted the manuscript in collaboration with FA, NHL, and JMB.

#### Ethical approvals

Ethical approval for the research protocol was not required.

middle-income country versus a high-income country (22.1% –95% CI: 17.6 to 26.9 -versus 11.8% – 95% CI: 8.9 to 15.1).

**Conclusions**—Only a minority of women in a wide variety of countries expressed a preference for caesarean delivery. Further research is needed to better estimate the contribution of women’s demand to the rising caesarean section rates.

### Keywords

“Caesarean section”; “delivery; obstetric”; “childbirth”; “request”; “prefer”; “choice”

## Introduction

Over the past three decades, there has been a striking increase in caesarean section (CS) rates in middle- and high-income countries around the world.<sup>1–3</sup> CS rates continue to rise despite evidence that there is no associated improvement to maternal and perinatal mortality and morbidity; rather, it can increase the risk of complications, such as maternal mortality, vesical injury, ureteral tract injury and hysterectomy.<sup>3–6</sup> There are several and complex reasons for this increasing trend, with maternal request being one of the most frequently mentioned.<sup>3, 7</sup> While the rise in CS rates is often attributed in part to requests from women without a medical indication<sup>8</sup>, there is evidence that few women actually prefer CS.<sup>9–15</sup>

Although numerous studies have examined women’s preferences for mode of delivery, only a handful of reviews have systematically and comprehensively synthesized this information,<sup>16–20</sup> but none of them have quantitatively summarized the results performing a meta-analysis. These reviews report a wide variation in CS rates and the factors associated with women’s preferences. Differences in preference are partially attributed to parity and country-specific characteristics, among others. Furthermore, a clearer understanding of the rates and factors related to women’s preferences are limited by study characteristics, including methodological constraints, inclusion of qualitative and quantitative studies, timing of preference elicitation (e.g., prenatal versus postnatal) and women’s characteristics, such as parity and previous history of CS (i.e., nulliparous, multiparous, and multiparous with previous CS).

The aim of this article is to review and summarize the published literature on women’s preferences for CS, and to assess the factors associated with a higher preference for CS. To this aim, we conducted a systematic review and meta-analysis of studies reporting the rate of women preferring CS.

## Methods

We followed the Meta-analysis of Observational Studies in Epidemiology (MOOSE) Group guidelines to conduct this systematic review and meta-analysis.<sup>21</sup>

### Type of studies

We included all research articles that quantitatively evaluated preferences for CS and contained original data. We did not restrict our search by country, study design or methodology. We restricted the search to articles written in English, Spanish, French, German, Portuguese and Chinese. The following authors were reviewers: NL assessed articles in Chinese; AM evaluated articles in French; AM and AMB evaluated articles in Portuguese; and AM, AMB, AJS and NHL evaluated articles in Spanish and English. Two consultants assessed articles in German. We excluded articles that assessed health care

providers' preference for mode of delivery, editorials, Letters to the Editor, commentaries, and purely qualitative studies.

### Electronic searches

We conducted a systematic literature search of the following major electronic databases: MEDLINE, EMBASE, LILACS and PsychINFO. We evaluated articles published until March 1, 2009, without setting a lower date limit. The oldest citation identified by our search was published in 1967. A highly sensitive search strategy was performed by a professional librarian, using the following terms: “caesarean section”, “parturition”, “partum”, “delivery, obstetric”, “childbirth”; with “request”, “prefer”, “patient satisfaction”, “patient participation”, “decision”, “perception”, and “choice”. To broaden our search, we also used truncated forms of each term. Reference lists of all retrieved full-text articles were examined for additional references.

The full electronic search strategy used for MEDLINE was the following: ((Delivery, Obstetric[Mesh] OR Parturition[Mesh] OR cesarea\*[tiab] OR caesarea\*[tiab] OR parturition\*[tiab] OR C Section\*[tiab] OR partum[tiab] OR childbirth[tiab]) AND ((Patient Satisfaction[Mesh] OR Patient Participation[Mesh]) OR (Patient[tiab] OR woman[tiab] OR women[tiab] OR pregnan\*[tiab] OR mother\*[tiab]) AND (request[tiab] OR Prefer\*[tiab] OR satisfact\*[tiab] OR decision\*[tiab] OR perception\*[tiab] OR choice\*[tiab] OR particip\*[tiab])) AND humans[mesh]) NOT Pregnancy Complications[Mesh]

### Selection of eligible articles and Data abstraction

Two reviewers independently (NHL, AMB, AJS and AM) pre-screened the titles and abstracts of all identified citations and selected potentially eligible studies. Full-text versions of all potentially eligible articles were independently assessed by two reviewers to evaluate whether they met inclusion criteria. Any discrepancies were resolved by consensus in both phases. A flow chart diagram of this process is presented in Figure 1.

Data was abstracted using a previously piloted electronic chart, including the following headings: region, country, country income level, study design, year of the study, population, parity, history of CS, period of reproductive life when preference was evaluated, type of instrument used to assess the preference, primary results, total number of women in study, number of women preferring CS, and finally, risk of bias in the study. AMB and NL extracted the data from all included studies, and AM confirmed the accuracy of the data abstraction, reviewing each article and comparing the information with the data abstracted in the data abstraction form.

Those studies including women of all parities and not reporting the CS preference separately for nulliparous and multiparous women were assigned to the multiparous category if more than 50% of the women in the study were multiparous. Otherwise the study was categorized as a nulliparous study. The same criterion was applied to the subgroup analysis examining the history of CS: if more than 50% of the women had a previous CS, the study was categorized as performed in women with previous CS. In the case of studies including women of different subgroups (e.g. nulliparous and multiparous, with and without previous CS) that reported CS preference separately for each group, we included the data from each specific subgroup as if derived from separate studies in the corresponding subgroup analysis. For example, in a study including both nulliparous and multiparous women and reporting CS preference by parity subgroup, the data from the nulliparous and multiparous women were included as two separate studies in the by parity subgroup meta-analysis.

We used the World Bank classification to classify countries according to income per capita.<sup>22</sup>

## Statistical analysis

We conducted a meta-analysis of proportions. An arc-sine transformation was applied to establish the variance of proportions (Freeman-Tukey variant of the arc-sine square-root of transformed proportions method).<sup>23</sup> The pooled proportion was calculated as the back-transformation of the weighted mean of the transformed proportions, using inverse arcsine variance weights for the fixed and random effects model. We applied DerSimonian-Laird weights for the random effects model where heterogeneity between studies was found.<sup>24</sup> We calculated the  $I^2$  statistic as a measure of the proportion of the overall variation in the proportion that was attributable to between-study heterogeneity. Stats-direct and STATA 8.0 were used for all analyses.<sup>25,26</sup>

We also estimated the proportion of women preferring CS in subgroups according to study characteristics (i.e., study region, country income level, and year of the study); and to women's characteristics (i.e., history of CS, parity, and period of reproductive life when preference was evaluated).

To evaluate if the assignment to categories of parity and history of CS (considering the 50% or more criterion we used) was reliable, we conducted a sensitivity analysis considering only those studies that include 100% of nulliparous women versus studies including 100% of multiparous women; and studies including 100% of women with a previous CS versus studies including a 100% of women without a previous CS.

Additionally, we applied a random-effect meta-regression analysis<sup>27</sup> in order to determine which variables were significantly associated with CS preference. The regression analysis included the above-mentioned variables.

## Quality assessment of included studies

The methodological quality of all included observational studies was assessed based on the checklist of essential items stated in the Strengthening the Reporting of Observational studies in Epidemiology (STROBE) statement<sup>28</sup> and the results of a systematic review evaluating tools for assessing quality and susceptibility to bias in observational studies.<sup>29</sup>

We considered four criteria for quality assessment:<sup>29</sup> 1) appropriate methods for selection of study participants *or* explicit definition of inclusion and exclusion criteria; 2) appropriate methods for measuring outcome variables; 3) design-specific sources of bias (appropriate methods outlined to deal with any design-specific issues such as recall bias or interviewer bias); and 4) statistical methods (excluding confounding). Methods to control for confounding were not considered as we included only descriptive studies. Each criterion was given one point and we considered "low risk of bias" those studies that scored three or higher.

We performed a sensitivity analysis comparing the overall pooled CS preference considering only the 14 studies categorized as having "low risk of bias" with the overall pooled preference considering the 38 studies.

## Results

The search strategy identified a total of 5937 citations. After review of titles and abstracts, 5807 references were excluded (concordance for inclusion between reviewers was 98%) and 134 studies were potentially eligible (Figure 1). After revision of all full-texts, 38 studies met the inclusion criteria and were included for data abstraction (concordance for inclusion between reviewers was 90.4%).

## Description of studies

Table 1 summarizes the major characteristics of the included studies. See Table S1 for a full description of the 38 included studies.

## CS preference

Table 2 shows the overall results and by subgroups. The overall pooled preference for CS was 15.6% (95% CI: 12.5 to 18.9). As the preference for CS in the studies is heterogeneous, the significance of the overall preference is relative. In the subgroup meta-analysis by region, the highest preference for CS was found in the Americas (21.3%; 95% CI: 16.4 to 26.7). Latin American studies showed a higher preference for CS than those from US & Canada (24.4%; 95% CI: 19.4 to 29.8 versus 16.8%; 95% CI: 7.9 to 28.1 respectively). Highest CS preference was found among studies conducted in middle-income countries (22.1%; 95% CI: 17.6 to 26.9), and conducted before 2000 (19.4%; 95% CI: 13.8 to 25.7) compared to the other respective subgroup categories.

Similarly, in the analysis performed by women's characteristics, highest CS preference was found among multiparous women (17.5%; 95% CI: 13.4 to 21.8), women with a previous CS (29.4%; 95% CI: 24.4 to 34.8), and women for whom preferences were evaluated post-partum (22.0%; 95% CI: 15.2 to 29.6).

In the sensitivity analysis considering only the 14 studies categorized as low risk of bias, the overall pooled preference for CS was similar (14.9 %; 95% CI: 10.9 to 19.3) to that considering the 38 studies (15.6%; 95% CI: 12.5 to 18.9)

Regarding categorization of parity and previous CS, the sensitivity analysis showed that if we consider only the 11 studies including 100% of women with a previous caesarean section, the CS preference is 31.7 %, versus 29.4% for the studies also including the "attributed" previous CS (more than 50% of the women had a previous CS). Regarding parity, the preferences for CS are also similar comparing only those studies assessing the preference in 100% of nulliparous women (14 studies: 9.3%) versus the total number of studies also including the "attributed nulliparous women" (17 studies: 10.2%).

The meta-regression revealed that history of CS, country income level, parity and period of reproductive life showed statistically significant associations in the univariate analysis. In the multivariate meta-regression, women with previous CS ( $\beta$  coefficient = 0.48, 95% CI 0.33 to 0.62), and women from middle-income countries ( $\beta$  coefficient = 0.18, 95% CI 0.05 to 0.31) remained statistically significant after adjustment for the other characteristics, compared against women with no history of CS and women from high-income countries respectively. Figure 2 shows a Forest Plot of the proportion of women preferring CS stratified by previous CS.

## Discussion

The available evidence shows that across a diversity of countries approximately 16% of women prefer CS for mode of delivery. However, since the preference for CS was shown to vary according to different subgroups (ranging from 7.2% to 29.4%), the value of the overall pooled preference should be considered with caution. Higher preference for CS was reported in women with a previous caesarean section (29.4%), and those living in a middle-income country (22.1%).

This review has several strengths. First, we considered both English and non-English published literature, evaluating abstracts and full-text articles written in English, Spanish, Portuguese, French, Italian, German and Chinese. Our final analyses included four non-

English articles.<sup>30, 33, 38, 52</sup> Second, we adhered strictly to the rigorous and most current recommended standards for systematic reviews of observational studies.<sup>21</sup> Third, we only included articles which quantitatively reported preference for CS and conducted a meta-analysis of proportions, which is a valid and robust approach to summarizing this literature. Finally, the meta-regression technique applied to the subgroup analyses allowed us to identify relevant factors associated with women's preference for CS.

There were some limitations to this review. We have summarized studies evaluating women's preferences, not actual requests for CS. Therefore, the actual CS rates due to maternal request cannot be inferred from the data. Future studies should examine this topic across both qualitative and quantitative studies.

To our knowledge, three other systematic reviews of studies evaluating women's preferences for mode of delivery have been published.<sup>17, 18, 20</sup> None of them included articles published in languages other than English or performed a meta-analysis to summarize the CS preference rates of the included studies. Moreover, two of these reviews included both quantitative and qualitative studies,<sup>18, 20</sup> and the third included studies evaluating outcomes that were not strictly women's preferences for a particular mode of delivery.<sup>17</sup> These characteristics make it difficult to directly compare them with our review. Nevertheless, the conclusions of two of these systematic reviews are consistent with our findings. Kingdon et al. included nine studies evaluating nulliparous women's views on planned CS.<sup>18</sup> The studies' median rate of women requesting CS in the absence of clinical indication was 9%. Mc Court et al. systematically reviewed 17 studies evaluating women's preferences or requests for CS, and concluded that preferences for CS range between 0.3% and 14%.<sup>20</sup> Finally, Eden et al. evaluated childbirth preferences in women with a previous CS. They reported a wide range for women's preferences for trial of labour: between 22% and 90% - in the six studies reporting this outcome -.<sup>17</sup>

This review shows that only a minority of women in a great variety of countries and situations expressed a preference for CS. Although CS on demand has been suggested as a relevant factor for the increasing CS rates,<sup>862</sup> it seems unlikely that this explains the high CS rates in some countries and regions. In Latin American countries, where most women prefer vaginal delivery, and also where most are not allowed to play a role in the decision of the mode of delivery, around 29% of childbirths are done by CS.<sup>5</sup>

We believe that further qualitative and quantitative studies are needed to assess the role of women in the decision of mode of delivery, and to better estimate the contribution of CS on demand on the CS rates. The obstetric community is looking with caution at the increase in CS rates and the current rates in median and high-income countries. A comprehensive approach evaluating the role of both health providers and users in the decision of mode of delivery is needed. These studies would contribute to a more rational use of a surgical intervention that can cause more harm than good when non-medically indicated.

## Conclusion

Only a minority of women in a wide variety of countries and situations expressed a preference for CS. Further research is needed to assess the role of women in the decision-making for mode of delivery and to better estimate the contribution of CS on demand to the rising CS rates.

## Supplementary Material

Refer to Web version on PubMed Central for supplementary material.



## Acknowledgments

We thank Daniel Comandé for his help in the electronic search; Agustín Ciapponi for his help in the methodological quality evaluation of articles; Eiman Jahangir for English editing of the article, and Patricia Aruj and Gonzalo Calomarde for assessing articles in German.

### Funding

This study was funded by the Fogarty International Clinical Research Scholars Program/Fogarty International Center/National Institutes of Health (Grant 5R24 TW007988-03); and the International Clinical, Operational, and Health Services Research and Training Award (ICOHRTA)/Fogarty Training Program (Grant D43 TW007784). The Institute for Clinical Effectiveness and Health Policy provided additional support. The researchers were independent from funders.

## References

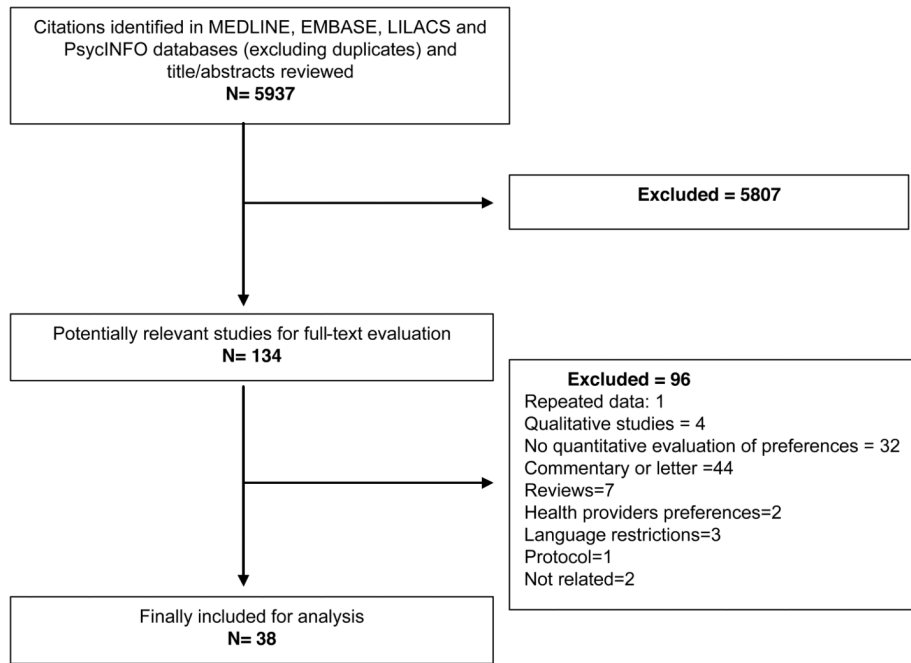
1. Arias E, MacDorman M, Strobino D, Guyer B. Annual summary of vital statistics 2002. *Pediatrics*. 2003; 112:1215–30. [PubMed: 14654589]
2. Belizan JM, Althabe F, Barros FC, Alexander S. Rates and implications of caesarean sections in Latin America: ecological study. *BMJ*. 1999; 319:1397–400. [PubMed: 10574855]
3. Belizan JM, Althabe F, Cafferata ML. Health consequences of the increasing caesarean section rates. *Epidemiology*. 2007; 18:485–6. [PubMed: 17568221]
4. Althabe F, Sosa C, Belizán JM, Gibbons L, Jacquerioz F, Bergel E. Caesarean section rates and maternal and neonatal mortality in low-, medium-, and high-income countries: an ecological study. *Birth*. 2006; 33(4):270–7. [PubMed: 17150064]
5. Betrán AP, Merialdi M, Lauer JA, Bing-Shun W, Thomas J, Van Look P, Wagner M. Rates of caesarean section: analysis of global, regional and national estimates. *Paediatr Perinat Epidemiol*. 2007; 21(2):98–113. [PubMed: 17302638]
6. Belizán JM, Cafferata ML, Althabe F. Risks of patient choice cesarean. *Birth*. 2006; 33:167–169. [PubMed: 16732786]
7. Villar J, Valladares E, Wojdyla D, et al. Caesarean delivery rates and pregnancy outcomes: the 2005 WHO global survey on maternal and perinatal health in Latin America. *Lancet*. 2006; 367 (9525): 1819–29. [PubMed: 16753484]
8. Dobson R. Caesarean section rate in England and Wales hits 21 percent. *BMJ*. 2001; 323:951. [PubMed: 11679375]
9. Gamble JA, Health M, Creedy DK. Women's preference for a cesarean section: incidence and associated factors. *Birth*. 2001; 28:101–110. [PubMed: 11380381]
10. Hildingsson I, Radestad I, Rubertsson C, Waldenstrom U. Few women wish to be delivered by caesarean section. *BJOG*. 2002; 109:618–623. [PubMed: 12118637]
11. Potter JE, Berquo E, Perpetuo IH, et al. Unwanted caesarean sections among public and private patients in Brazil: Prospective study. *BMJ*. 2001; 323:1155–1158. 28. [PubMed: 11711406]
12. Osis MJ, Padua KS, Duarte GA, Souza TR, Faundes A. The opinion of Brazilian women regarding vaginal labor and cesarean section. *Int J Gynaecol Obstet*. 2001; 75(Suppl 1):S59–66. [PubMed: 11742644]
13. Angeja A, Washington A, Vargas J, Gomez R, Rojas I, Caughey A. Chilean women's preferences regarding mode of delivery: which do they prefer and why? *BJOG*. 2006; 113:1253–1258. [PubMed: 17014679]
14. Pang SM, Leung DT, Leung TY, Lai CY, Lau TK, Chung TK. Determinants of preference for elective caesarean section in Hong Kong Chinese pregnant women. *Hong Kong Med J*. 2007; 13:100–105. [PubMed: 17406036]
15. Chong ES, Mongelli M. Attitudes of Singapore women toward cesarean and vaginal deliveries. *Int J Gynaecol Obstet*. 2003; 80:189–94. [PubMed: 12566197]
16. Gamble JA, Creedy DK. Women's request for a cesarean section: A critique of the literature. *Birth*. 2000; 27(4):256–263. [PubMed: 11251511]
17. Eden KB, Hashima JN, Osterweil P, Nygren P, Guise JM. Childbirth preferences after cesarean birth: a review of the evidence. *Birth*. Mar; 2004 31(1):49–60. [PubMed: 15015993]

18. Kingdon CK, Baker L, Lavender T. Systematic review of nulliparous women's views of planned cesarean birth: the missing component in the debate about a term cephalic trial. *Birth*. 2006;229–237. [PubMed: 16948723]
19. Gamble J, Creedy DK, McCourt C, Weaver J, Beake S. A critique of the literature on women's request for cesarean section. *Birth*. 2007; 34:331–340. [PubMed: 18021149]
20. McCourt C, Weaver J, Statham H, Beake S, Gamble J, Creedy DK. Elective cesarean section and decision making: a critical review of the literature. *Birth*. Mar; 2007 34(1):65–79. [PubMed: 17324181]
21. Stroup DF, Berlin JA, Morton SC, Olkin I, Williamson GD, Rennie D, et al. Meta-analysis of observational studies in epidemiology: a proposal for reporting. Meta-analysis Of Observational Studies in Epidemiology (MOOSE) group. *Jama*. 2000; 283(15):2008–12. [PubMed: 10789670]
22. The World Bank Group. Gross National Income Data by Country. [siteresources.worldbank.org/DATASTATISTICS/Resources/GNIPC.pdf](http://siteresources.worldbank.org/DATASTATISTICS/Resources/GNIPC.pdf)
23. Freeman MF, Tukey JW. Transformations related to the angular and the square root. *Ann Math Stat*. 1950; 21:607–11.
24. DerSimonian, Laird N. Meta-analysis in Clinical Trials. *Control Clin Trials*. 1986; 7(3):177–88. [PubMed: 3802833]
25. StatsDirect statistical software. England: StatsDirect Ltd; 2009. <http://www.statsdirect.com>
26. StataCorp. Statistical Software: Release 8.0. College Station, TX: Stata Corporation; 2001.
27. Meta-regression Approaches: What, Why, When, and How?. Agency for Healthcare Research and Quality. U.S Department of Health & Human Services; <http://www.ahrq.gov/CLINIC/tp/metaregtp.htm>
28. Altman, D.; Egger, M.; Pocock, S.; Vandembroucke, JP.; von Elm, E. Strengthening the reporting of observational epidemiological studies. STROBE Statement: Checklist of Essential Items Version 3. September. 2005 <http://www.strobe-statement.org/Checkliste.html>
29. Sanderson S, Tatt I, Higgins J. Tools for assessing quality and susceptibility to bias in observational studies in epidemiology: a systematic review and annotated bibliography. 2007; 36(3):666–76.
30. Barbosa GP, Giffin K, Angulo-Tuesta A, et al. Cesarean sections: who wants them and under what circumstances? *Cad Saude Publica*. Nov–Dec; 2003 19(6):1611–1620. [PubMed: 14999328]
31. Behague DP, Victora CG, Barros FC. Consumer demand for caesarean sections in Brazil: informed decision making, patient choice, or social inequality? A population based birth cohort study linking ethnographic and epidemiological methods. *Bmj*. Apr 20; 2002 324(7343):942–945. [PubMed: 11964338]
32. Bracken JN, Dryfhout VL, Goldenhar LM, Pauls RN. Preferences and concerns for delivery: an antepartum survey. *Int Urogynecol J Pelvic Floor Dysfunct*. Nov; 2008 19(11):1527–1531. [PubMed: 18633559]
33. Dias MAB, Domingues RMSM, Pereira APE, et al. Trajetória das mulheres na definição pelo parto cesáreo: estudo de caso em duas unidades do sistema de saúde suplementar do estado do Rio de Janeiro. *Ciênc saúde coletiva*. 2008; 13(5):1521–1534.
34. Dodd J, Pearce E, Crowther C. Women's experiences and preferences following Caesarean birth. *Aust N Z J Obstet Gynaecol*. Dec; 2004 44(6):521–524. [PubMed: 15598289]
35. Donati S, Grandolfo ME, Andreozzi S. Do Italian mothers prefer cesarean delivery? *Birth*. Jun; 2003 30(2):89–93. [PubMed: 12752165]
36. Edwards GJ, Davies NJ. Elective caesarean section - The patient's choice? *Journal of Obstetrics and Gynaecology*. 2001; 21(2):128–129. [PubMed: 12521878]
37. Faisal-Cury A, Menezes PR. [Factors associated with preference for cesarean delivery]. *Rev Saude Publica*. Apr; 2006 40(2):226–232. [PubMed: 16583032]
38. Gao SY, Jing RW, Jin LM, Xu C. A questionnaire investigation on the way of delivery and its related factors in 415 women at child bearing age in one hospital. *Zhonghua Liu Xing Bing Xue Za Zhi*. Sep; 2004 25(9):799–801. [PubMed: 15555364]
39. Geary M, Fanagan M, Boylan P. Maternal satisfaction with management in labour and preference for mode of delivery. *J Perinat Med*. 1997; 25(5):433–439. [PubMed: 9438948]



40. Hopkins K. Are Brazilian women really choosing to deliver by cesarean? *Soc Sci Med.* Sep; 2000 51(5):725–740. [PubMed: 10975232]
41. Johanson RB, El-Timini S, Rigby C, Young P, Jones P. Cesarean section by choice could fulfil the inverse care law. *Eur J Obstet Gynecol Reprod Biol.* Jul; 2001 97(1):20–22. [PubMed: 11435002]
42. Koken G, Cosar E, Sahin FK, Tolga Arioiz D, Duman Z, Aral I. Attitudes towards mode of delivery and cesarean on demand in Turkey. *Int J Gynaecol Obstet.* Dec; 2007 99(3):233–235. [PubMed: 17673239]
43. Lee SI, Khang YH, Lee MS. Women's attitudes toward mode of delivery in South Korea--a society with high cesarean section rates. *Birth.* Jun; 2004 31(2):108–116. [PubMed: 15153130]
44. Mancuso A, De Vivo A, Fanara G, Settineri S, Triolo O, Giacobbe A. Women's preference on mode of delivery in Southern Italy. *Acta Obstet Gynecol Scand.* 2006; 85(6):694–699. [PubMed: 16752261]
45. Manthata AL, Hall DR, Steyn PS, Grove D. The attitudes of two groups of South African women towards mode of delivery. *Int J Gynaecol Obstet.* Jan; 2006 92(1):87–91. [PubMed: 16266706]
46. McClain CS. Patient decision making: the case of delivery method after a previous cesarean section. *Cult Med Psychiatry.* Dec; 1987 11(4):495–508. [PubMed: 3691163]
47. Murray SF. Relation between private health insurance and high rates of cesarean section in Chile: qualitative and quantitative study. *Bmj.* Dec 16; 2000 321(7275):1501–1505. [PubMed: 11118176]
48. Pakenham S, Chamberlain SM, Smith GN. Women's views on elective primary cesarean section. *J Obstet Gynaecol Can.* Dec; 2006 28(12):1089–1094. [PubMed: 17169232]
49. Pevzner L, Goffman D, Freda MC, Dayal AK. Patients' attitudes associated with cesarean delivery on maternal request in an urban population. *Am J Obstet Gynecol.* May; 2008 198(5):e35–37. [PubMed: 18199421]
50. Rouhe H, Salmela-Aro K, Halmesmaki E, Saisto T. Fear of childbirth according to parity, gestational age, and obstetric history. *BJOG.* Jan; 2009 116(1):67–73. [PubMed: 19055652]
51. Tatar M, Gunalp S, Somunoglu S, Demiroglu A. Women's perceptions of cesarean section: Reflections from a Turkish teaching hospital. *Social Science and Medicine.* May; 2000 50(9):1227–1233. [PubMed: 10728843]
52. Tedesco RP, Maia Filho NL, Mathias L, et al. Fatores determinantes para as expectativas de primigestas acerca da via de parto. *Rev bras ginecol obstet.* 2004; 26(10):791–798.
53. Thurman AR, Zoller JS, Swift SE. Non-pregnant patients' preference for delivery route. *Int Urogynecol J Pelvic Floor Dysfunct.* Sep–Oct; 2004 15(5):308–312. [PubMed: 15580415]
54. Thomas, J.; Paranjothy, S. National Sentinel Cesarean Section Audit Report. London: RCOG Press; 2001. Royal College of Obstetricians and Gynecologists Clinical Effectiveness Support Unit; p. 19
55. Wiklund I, Edman G, Ryding EL, Andolf E. Expectation and experiences of childbirth in primiparae with cesarean section. *BJOG: An International Journal of Obstetrics and Gynaecology.* Feb; 2008 115(3):324–331. [PubMed: 18190368]
56. Abitbol MM, Castillo I, Taylor UB, Rochelson BL, Shmoys S, Monheit AG. Vaginal birth after cesarean section: The patient's point of view. *American Family Physician.* 1993; 47(1):129–134. [PubMed: 8418576]
57. Hellmers C, Schuecking B. Primiparae's well-being before and after birth and relationship with preferred and actual mode of birth in Germany and the USA. *Journal of Reproductive and Infant Psychology.* 2008; 26(4):351–372.
58. Murphy DJ, Liebling RE. Cohort study of maternal views on future mode of delivery after operative delivery in the second stage of labor. *Am J Obstet Gynecol.* Feb; 2003 188(2):542–548. [PubMed: 12592269]
59. Pang MW, Lee TS, Leung AKL, Leung TY, Lau TK, Leung TN. A longitudinal observational study of preference for elective cesarean section among nulliparous Hong Kong Chinese women. *BJOG: An International Journal of Obstetrics and Gynaecology.* May; 2007 114(5):623–629. [PubMed: 17355362]

60. Potter JE, Berquo E, Perpetuo IH, et al. Unwanted caesarean sections among public and private patients in Brazil: prospective study. *Bmj*. Nov 17; 2001 323(7322):1155–1158. [PubMed: 11711406]
61. Weaver JJ, Statham H, Richards M. Are there “unnecessary” cesarean sections? Perceptions of women and obstetricians about cesarean sections for nonclinical indications. *Birth*. Mar; 2007 34(1):32–41. [PubMed: 17324176]
62. Langer A, Villar J. Promoting evidence based practice in maternal care. *BMJ*. 2002; 324:928–92. [PubMed: 11964324]



**Figure 1.**  
Flow chart of study selection process

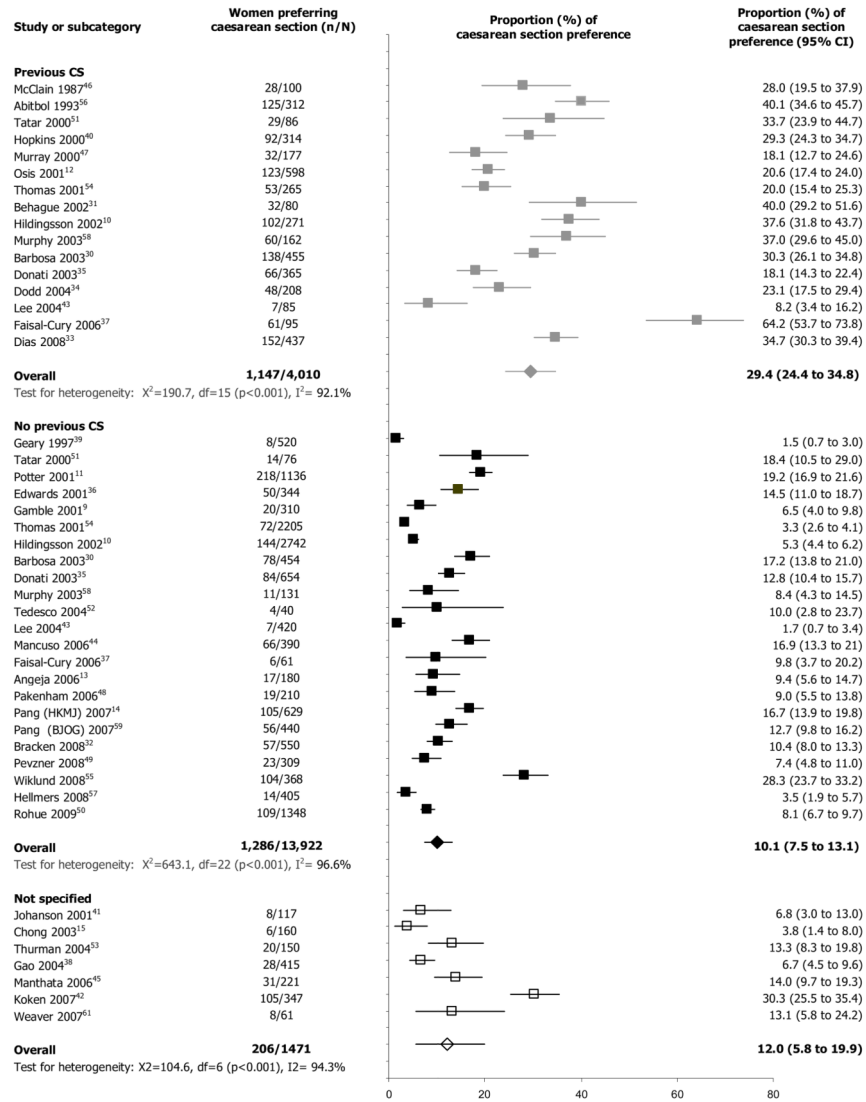


Figure 2.

**Table 1**

## Characteristics of the included studies

		Number of studies	Studies
<b>Study design</b>	Cross-sectional	32	9, 10, 12–15, 30–55
	Cohort	6	11, 56–60
<b>Methodology for preference assessment</b>	Self-administered questionnaire	24	9, 10, 15, 30, 32, 34, 36, 37, 39–42, 44, 45, 48, 49–51, 53–55, 57, 59
	Interviewer-based questionnaire	12	11–14, 31, 33, 35, 38, 46, 47, 52, 58
	Telephone-based questionnaire	1	43
	Other	2	56, 60
<b>Region</b>	Latin America	10	11–13, 30, 31, 33, 37, 40, 47, 52
	North America	6	32, 46, 48, 49, 53, 56
	•USA	5	32, 46, 49, 53, 56
	•Canada	1	48
	Europe	12	10, 35, 36, 39, 41, 44, 50, 54, 55, 57, 58, 60
	Asia	7	14, 15, 38, 42, 43, 51, 59
	Africa	1	45
Australia	2	9, 34	
<b>Country Income Level</b>	High-income	23	9, 10, 15, 32, 34–36, 39, 41, 43, 44, 46, 48, 49, 50, 53–59, 60
	Middle-income	15	11–14, 30, 31, 33, 37, 38, 40, 45, 47, 51, 52
	Low-income	0	-
<b>Year of conduction</b>	2000 or after	23	12–15, 32–34, 37, 38, 41, 42–45, 48–50, 52–55, 57, 59
	Before 2000	14	9–11, 30, 31, 35, 36, 39, 40, 46, 51, 56, 58, 60
	Not specified	1	47
<b>Time of preference elicitation</b>	During Pregnancy	24	9, 10, 11, 13–15, 32, 36–38, 41, 44–46, 48–50, 52, 54–57, 59, 60
	Post-partum	11	12, 30, 31, 33–35, 39, 40, 47, 51, 58
	Non-pregnant women	3	42, 43, 53
<b>Sample size</b>	More than 2000 women	2	10, 54
	1000–2000 women	3	11, 35, 50
	500–1000 women	6	12, 14, 30, 32, 39, 43
	100–500 women	24	9, 13, 15, 33, 34, 36–38, 40–42, 44–49, 51, 53, 55–59
	Less than 100 women	3	31, 52, 60
<b>Risk of bias</b>	Low risk of bias	14	10, 11, 13, 35, 40, 46, 47, 50, 51, 54, 55, 57, 59, 60
	High risk of bias	24	9, 12, 15, 30–34, 36–39, 41–45, 48, 49, 52, 53, 56, 58, 59

	Number of studies	Studies
<b>Total</b>	<b>38</b>	



Table 2

Caesarean section preference by subgroup

	Number of studies	Number of women	Caesarean Section Preference	
			%	95% CI
<b>Overall †</b>	<b>38</b>	<b>19403</b>	<b>15.6</b>	<b>12.5 – 18.9</b>
Region				
America	16	5658	21.3	16.4 – 26.7
•USA - Canada	6	1631	16.8	7.9 – 28.1
•Latin America	10	4027	24.4	19.4 – 29.8
Asia	7	2658	12.7	6.3 – 21.0
Australia	2	518	13.8	2.0 – 33.6
Europe	12	10348	11.0	7.6 – 15.0
Africa	1	221	14.2	9.9 – 19.1
Country Income Level				
High-income	23	13602	11.8	8.9 – 15.1
Middle-income	15	5801	22.1	17.6 – 26.9
Year of Study				
Before 2000	14	8689	19.4	13.8 – 25.7
2000 or later	23	10597	13.8	10.1 – 17.9
Non Specified	1	177	7.2	3.3 – 12.5
Previous Caesarean Section*				
Yes	16	4010	29.4	24.4 – 34.8
No	23	13922	10.1	7.5 – 13.1
Non Specified	7	1471	12.0	5.8 – 19.9
Parity*				
Nulliparous	17	6161	10.2	6.8 – 14.1
Multiparous	29	12677	17.5	13.4 – 21.8
Non Specified	2	565	9.7	4.2 – 17.1
Period of Reproductive Life				
Non-pregnant	3	1002	13.7	1.2 – 36.4
Pregnancy	24	13684	13.1	10.1 – 16.5
•First and second half	13	9748	11.2	8.0 – 15.0
•Second Half	11	3936	15.5	10.2 – 21.8
Post-Partum	11	4717	22.0	15.2 – 29.6

$I^2 = 97.3\%$ . The range of  $I^2$  of the different subgroups is between 82.2% and 98.5%.

\* Number of studies is greater than total number of included studies because preference is reported in subgroups