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Commentary

Public Health Challenges in Caesarean Section Deliveries

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STUDY DESCRIPTION

The number of Caesarean Section (CS) use continues to rise worldwide, now counting 21% of all childbirths with a significant variation across the countries. The proportion is lower than 5% in 28 countries worldwide, over three quarter of them are located in sub-Saharan Africa, including Niger, Chad, Ethiopia, and Timor Laste. Only 10% of the total countries worldwide have the CS rate 10-15%, which is the World Health Organization recommendation to the significant reductions of motherly and child mortality. Over 100 countries worldwide have over 15% CS use, 43 countries indeed have their CS use level higher than 30%. This later group is geographically assorted and substantially developed countries.

Though, recent rise on CS rates is substantially being in low and Lower Middle Income Countries (LMICs) where enlightening maternal health is an ongoing challenge.

Around 42% of the total CS performed worldwide are without medical requirements, thus they do not have any benefactions in improving maternal and child health.

Furthermore, similar abusive use of CS can lead several public health burdens, including hemorrhage and bleeding as well as associated maternal mortality and commercial burden. This is also found to be linked with a long-term loss of women's productivity as well as accumulative hospitalization which further produce a burden in formal healthcare delivery system. The CS use in LMICs is generally linked to the level of development including women's education, fertility level, wealth, and the weight of the private healthcare amenities in furnishing CS.

Accordingly, a group of women could not access this service because of economic hardship whereas another group uses this service without medical necessity, a suggestion of the double burden of CS.

Furthermore, along with economic capacity, geographical variation of accessibility of this service as well as geographical difficulty to access services, similar as poor transportation, could also play a significant part in differencing the CS use. This indicates tripartite burden of CS, a common scenario for LMICs including Bangladesh. The primary reasons are attainability of formal health insurance exposure, sophisticated rate of poverty, and rurality, and the issues which are relatively significant in Bangladesh. This leads a portion of women in LMICs, and Bangladesh could not access this service indeed though a higher prevalence of anemia and nutritive burden are common in these groups. Thus, they are more likely to face pregnancy complications with a higher need of CS use.

Being exploration in LMICs and Bangladesh reported lower use of CS among poor and uncommon geographical regions. Still, such burden is typically been ignored in LMICs with rapid rising of CS use is always in the discussion of the health investigators and policy makers.

Researchers in LMICs including Bangladesh have been explored several factors associated with the CS use and the raising trend of CS use. Significant variations of CS use across factors, similar as wealth quintile, education, working status, and urban/rural and regions have also been identified. Though, their interaction effects on CS use are not yet explored. Therefore, the disadvantages groups of women who could not access this life saving services are substantially unknown. This increases the associated maternal and child mortality which is a challenge in achieving sustainable development goals target 3.7 (ensure universal reporting of sexual and reproductive health) by 2030. This study is to fill this gap by determining the interaction effects of women's disadvantage characteristics including place of residence, education, wealth quintile, working status on CS use.

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