

# Cesarean Section Overuse, Clinical Decision-Making, and Patient Trust in Somalia's Predominantly Private Maternal Health System: A Commentary on Quality, Equity, and the Human Experience of Birth

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**Abstract:** Cesarean section is an essential obstetric intervention when clinically indicated, but global rates have risen markedly, raising concerns about overuse, inequities, and misaligned incentives in some settings. Somalia represents a fragile health system context in which cesarean decision-making occurs within a predominantly private maternity sector shaped by variable governance, uneven intrapartum monitoring capacity, and high out-of-pocket costs. This commentary synthesizes published literature and institutional reports, together with contextual clinical experience, to examine drivers of cesarean escalation, community perceptions of decision-making, and the implications for trust, autonomy, respectful care, and equity. It argues that improving childbirth outcomes in Somalia requires a balanced approach that protects timely access to life-saving cesarean section while reducing avoidable surgery through better documentation, clearer communication, strengthened intrapartum assessment, and feasible quality-improvement measures.

**Keywords:** cesarean section, maternal health, obstetric decision-making, private health facilities, Somalia, quality of care, CTG interpretation, respectful maternity care

## Introduction

Cesarean section is an essential obstetric intervention when clinically indicated, but global rates have risen markedly, raising concerns about overuse, inequities, and misaligned incentives in some settings.<sup>1</sup> The World Health Organization has noted that population level cesarean rates above approximately ten to fifteen percent are not associated with further reductions in maternal and neonatal mortality, emphasizing the importance of appropriate use rather than numerical targets.<sup>2</sup>

Somalia is a fragile health system context with a high maternal mortality burden, and improving childbirth outcomes requires both timely access to life saving cesarean section and the avoidance of unnecessary surgery that may increase preventable harm.<sup>3</sup> In such settings, potentially avoidable operative delivery can magnify perioperative risks and impose additional financial and resource burdens that may widen inequities in access to safe childbirth care. National survey reporting indicates that private facilities provide the overwhelming majority of facility based maternity care, which creates a decision making environment shaped by market driven service delivery, variable governance, and uneven intrapartum monitoring capacity.<sup>4-6</sup>



This commentary synthesizes published literature and institutional reports, together with contextual clinical experience, to examine drivers of cesarean escalation and community perceptions of decision making, including communication, consent, and the lived experience of childbirth in Somalia in predominantly private maternity care, and to propose feasible quality improvement actions that protect women's autonomy, respectful care, and equity.

## **Clinical Decision-Making in a Predominantly Private Maternal Health System**

Within predominantly private maternity systems, clinical decision-making may be shaped by a combination of structural and perceptual pressures. In settings with limited regulatory oversight, variable documentation standards, and substantial out-of-pocket expenditure, decisions surrounding urgent cesarean delivery may be scrutinized not only clinically but also socially. This is particularly relevant in Somalia, where women and families may encounter large financial consequences from operative delivery while simultaneously relying on private facilities for access to institutional childbirth care.

Interpretation of urgent indications also deserves careful consideration. In many settings, suspected fetal compromise, abnormal cardiotocography parameters where available, prolonged labor, previous cesarean scar, cephalopelvic disproportion, and failure to progress are commonly cited reasons for surgery. However, in fragile or resource-constrained environments, late presentation, incomplete labor documentation, inconsistent use of standardized intrapartum tools, limited blood availability, and shortages in anesthesia or neonatal support may lower the threshold for operative intervention. Rising cesarean use can therefore reflect not only patient risk but also changing clinical thresholds for labor anomalies and decision-making under uncertainty.<sup>7</sup>

These realities do not mean that urgent cesarean decisions are inappropriate. Rather, they suggest that the clinical threshold for surgery may be influenced by the interaction between genuine obstetric risk, system constraints, and concern about delayed intervention. In such an environment, overly simple narratives that attribute all cesarean increase to either patient need or financial motivation alone are unlikely to capture the full picture.

## **Trust, Autonomy, and the Human Experience of Childbirth**

Concerns about cesarean overuse are not only clinical or policy issues. They also affect how women and families experience childbirth, understand medical advice, and judge the trustworthiness of healthcare institutions. In Somalia, reported community concerns that some cesarean deliveries may be encouraged for financial reasons can erode confidence in facility-based maternity care, especially when communication is brief, counseling is inconsistent, or the rationale for urgent surgery is not clearly explained. These concerns should be interpreted cautiously because nationally compiled Somalia-specific qualitative evidence remains limited, yet they remain important as perceptions that shape care-seeking behavior and informed consent.

The human experience of childbirth in Somalia is closely linked to communication, dignity, and autonomy in an environment where many households pay directly for services. When decisions are made under time pressure and counseling is limited, women and families may feel excluded from the decision-making process and may interpret urgency as coercion. Respectful maternity care therefore becomes central to quality improvement, not only because it is ethically necessary, but also because it can strengthen trust, improve comprehension of risk, and support timely acceptance of medically indicated intervention. Global evidence on mistreatment and poor communication during childbirth underscores how experience and outcomes are deeply connected.<sup>8</sup>

## **Implications for Quality Improvement and Equity**

The goal in Somalia is not to lower cesarean section use indiscriminately, because underuse and delayed access to life-saving surgery remain serious threats in fragile settings. Instead, the priority is to promote appropriate, timely, and evidence-informed use. This requires practical interventions that can improve transparency and consistency without assuming resources that are not currently available in every facility.

Improved documentation of indications, periodic audit using feasible classification approaches, better support for intrapartum assessment, and targeted training in interpretation of fetal monitoring may reduce avoidable variation in

decision-making.<sup>7,9,10</sup> Equally important are stronger counseling practices, clearer communication of urgency and alternatives, and greater transparency around facility charges. These measures can help reduce the perception that cesarean recommendations are economically driven while supporting women's autonomy and shared understanding of risk.

Midwife-led or midwife-supported continuity approaches may also improve women's childbirth experience and reduce unnecessary intervention where workforce capacity permits.<sup>11</sup> However, recommendations for Somalia must remain grounded in feasibility. Resource constraints, workforce shortages, referral delays, and uneven governance mean that improvement efforts should be staged, locally adapted, and linked to realistic facility-based quality-improvement processes rather than idealized regulatory models.

## Conclusion

Cesarean section overuse in Somalia should be understood as a health systems and women's health issue shaped by clinical uncertainty, structural constraints, financial vulnerability, and the social meaning of trust in a predominantly private maternal care environment. This commentary does not present primary data and does not claim nationally quantified trends beyond available published reports. Instead, it highlights plausible drivers, patient-centered implications, and practical areas for improvement. Future empirical research and routine reporting are needed to better quantify cesarean rates, indications, and private–public patterns in Somalia and to inform interventions that protect both timely access to life-saving surgery and women's autonomy, dignity, and equity in childbirth care.

## Abbreviations

CS, cesarean section; CTG, cardiotocography; WHO, World Health Organization.

## Ethics Approval and Consent

Not applicable. This article is a commentary and did not involve human participants, patient data, or identifiable personal information.

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## Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, analysis and interpretation, or in all these areas; took part in drafting, revising, or critically reviewing the article; gave final approval of the version to be published; agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

## Disclosure

The authors report no conflicts of interest in this work.

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