Parental Height Differences Predict the Need for an Emergency Caesarean Section

Gert Stulp1,2*, Simon Verhulst2, Thomas V. Pollet1, Daniel Nettle1,3, Abraham P. Buunk1,4

1 Department of Psychology, University of Groningen, Groningen, The Netherlands, 2 Department of Behavioral Biology, University of Groningen, Groningen, The Netherlands, 3 Centre for Behaviour and Evolution, Institute of Neuroscience, Newcastle University, Newcastle, United Kingdom, 4 Royal Netherlands Academy of Arts and Sciences, Amsterdam, The Netherlands

Abstract

More than 30% of all pregnancies in the UK require some form of assistance at delivery, with one of the more severe forms of assistance being an emergency Caesarean section (ECS). Previously it has been shown that the likelihood of a delivery via ECS is positively associated with the birth weight and size of the newborn and negatively with maternal height. Paternal height affects skeletal growth and mass of the fetus, and thus might also affect pregnancy outcomes. We hypothesized that the effect of newborn birth weight on the risk of ECS would decrease with increasing maternal height. Similarly, we predicted that there would be an increase in ECS risk as a function of paternal height, but that this effect would be relative to maternal height (i.e., parental height differences). We used data from the Millennium Cohort Study: a large-scale survey (N = 18,819 births) with data on babies born and their parents from the United Kingdom surveyed 9 to 12-months after birth. We found that in primiparous women, both maternal height and parental height differences interacted with birth weight and predicted the likelihood of an ECS. When carrying a heavy newborn, the risk of ECS was more than doubled for short women (46.3%) compared to tall women (21.7%), in agreement with earlier findings. For women of average height carrying a heavy newborn while having a relatively short compared to tall partner reduced the risk by 6.7%. In conclusion, the size of the baby, the height of the mother and parental height differences affect the likelihood of an ECS in primiparous women.

Introduction

Obstructed labor, a failure to progress due to a mismatch between fetal size and the mother’s pelvis [1], accounts for 8% of maternal deaths worldwide. Only a minor part of these maternal deaths, i.e. the death of a woman during or shortly after pregnancy [2], occur in the developed world, but obstructed labor is nonetheless a common obstetrical problem. For example, in England more than 30% of all pregnancies require some form of assistance at delivery [3], of which an emergency Caesarean section (ECS) is the most common form (12.7% of all deliveries).

Short maternal stature is associated with adverse pregnancy outcomes, such as stillbirths [4], low birth weight newborns [5], low APGAR scores (a quick assessment of health directly after delivery, based on Appearance, Pulse, Grime, Activity and Respiration; [6]), and perinatal mortality [7]. Despite having smaller neonates [5,8], shorter mothers are also at a higher risk for obstructed labor, resulting in an assisted delivery, in particular ECS [2,9]. Obstructed labor is related to the narrower pelvisses of shorter women [10–12], through which the head (i.e. cephalo-pelvic disproportion) or shoulders [13,14] of the baby is hindered.

Fetus size is also a well-known risk factor for obstructed labor. Heavier and larger newborns increase the likelihood of difficult deliveries (such as an ECS [9,15–20]) or assisted deliveries resulting from shoulder dystocia [14,20,21]. A short woman with a heavy and/or large newborn seems particularly at risk for obstructed labor [15,22–24]. In contrast, for taller women, for whom the increased size of the newborn is less likely to lead to obstructed labor [22,24], a low birth weight newborn seems more predictive of adverse pregnancy outcomes [15]. In the latter situation, operative deliveries are more a result of fetal distress, preeclampsia, or fetal malformations, rather than size-related obstetrical problems [15].

Although the effects of maternal height and birth weight on ECS risk are well established, it is currently unknown whether or not there is an effect of paternal height on the likelihood of having an ECS. Paternal height may influence pregnancy outcomes, as it has a positive effect on neonatal body size [25,26]. Whereas the height of the mother is especially associated with the size of the newborn through the adiposity of the fetus, the height of the father predicts skeletal growth and fat-free mass of the newborn [25–28]. Specifically, research has shown an effect of paternal height on neonatal fat-free mass, but not on fat mass [25,26], on the length of the baby [26,28], on neonatal bone mineral content [29], on placental volume [30], and on head circumference [26,28]. This is relevant because the skeletal structure of the baby is more

Citation: Stulp G, Verhulst S, Pollet T, Nettle D, Buunk AP (2011) Parental Height Differences Predict the Need for an Emergency Caesarean Section. PLoS ONE 6(6): e20497. doi:10.1371/journal.pone.0020497

Editor: Rebecca Sear, Durham University, United Kingdom

Received March 3, 2011; Accepted April 28, 2011; Published June 29, 2011

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Funding: The Millennium Cohort Study was commissioned by the Economic and Social Research Council (ESRC), whose funding has been supplemented by a consortium of government departments and the Wellcome Trust. This research was supported by grants to APB and DN from the Royal Netherlands Academy of Arts and Sciences and an NWO Veni grant to TVP (451.10.032). The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

Competing Interests: The authors have declared that no competing interests exist.

* E-mail: g.stulp@rug.nl
predictive of birth problems than birth weight [9,24]. For instance, head circumference is more important in predicting problems at delivery than birth weight [23,24]. The effect of paternal height on the structural size of the baby may therefore affect the risk for adverse pregnancy outcomes.

Much of the research on size and complications at birth in humans is mirrored by research on obstetric complications in animal research. In cattle, feto-pelvic disproportion, the disproportion between calf size and the size of the birth canal of the cow is the major cause of problems at birth [31–33]. In line with the findings on humans, both the size of the cow as well as the size of the calf is a determinant of difficult delivery [31–33]. Furthermore, the sire also affects this risk, as pairing cows to sires bred for heavy birth weight calves (versus low birth weight calves; [31,32]) and sires bred for meat (which are bigger, versus bred for dairy; [34]) increases the risk of difficult delivery. Additionally, as found in humans, the skeletal size of the calf seems more important than the birth weight of the calf for the risk of difficult delivery [32].

In this study, our aim was to test the hypothesis that in addition to maternal height and birth weight, paternal height also affects the risk of ECS. We use the Millennium Cohort Study (MCS) to test this hypothesis. In line with previous findings [15,22–24], we predict that maternal height would interact with birth weight, such that a relatively short woman with a heavy newborn would be most at risk. Furthermore, we extend earlier findings and hypothesize that paternal height also influences the risk for ECS, but that the effect of paternal height would be dependent on the height of the mother. We predict that with increasing parental height differences, the risk for ECS would increase.

Materials and Methods

The Millennium Cohort Study (MCS) is a survey that gathered information from the parents of 18,819 babies born in the year 2000/2001 in the United Kingdom. Interviews were carried out when the babies were around 9–12 months. Detailed information on the pregnancy and birth was collected as well as anthropometric (maternal and paternal height, age, and birth weight), social and economic information (all self-reported) from the mother and where possible from the father. Self-reported measures of height have been shown to be very reliable in women of reproductive age [35]. The sample was selected from a random sample of electoral wards, disproportionately stratified to ensure adequate representation of all four regions of the UK, areas with higher minority ethnic populations, and deprived areas. The overall response rate was 68% [36]. We used the first Wave of data from the MCS.

For the analyses presented here, we only included White parents for which height data were available who had their first, singleton child (of which the birth weight was available), leaving 4,363 cases. Only White parents were included in the analyses as ethnicity relates to maternal pelvic size, which might influence the risk of ECS [8]. We chose to include only first births, because parity has been shown to be a strong determinant of ECS [18,37]. This was also evident in our sample, as primiparous women had an average risk of 27%, whereas parous women only had a risk of 9% for an ECS. In addition, obstetrical problems resulting from the large size of the newborn are largely confined to primiparous women [18,37]. For instance, when delivering a macrosomic baby (i.e. an extremely heavy newborn; >4.5 kg), 39.8% of primiparous women had a normal vaginal delivery, whereas 24.2% had an ECS [37]. In contrast, 81% of multiparous women had a normal vaginal delivery when delivering a macrosomic baby, and only 5.7% had an ECS [37]. Therefore, we restricted our sample to primiparous women.

We performed logistic regressions on our key dependent variable; whether the delivery was normal (i.e. vaginal without complications) or by ECS, leaving in total 3,165 cases. We excluded Caesarean delivery on request (N=266), assisted breech delivery (N=9), assisted forceps (N=376), assisted vacuum extraction (N=503), water births (N=11) and other problems without specification (N=5). However, including these cases (i.e. resulting in a dependent variable vaginal without complications versus any form of assistance) did not change our key results. To examine the effects of maternal and paternal height on birth weight, we performed a linear regression. All analyses were performed in SPSS 17.0.

Occurrence of the various pregnancy outcomes in the Millennium cohort was comparable to national statistics. In our entire sample the occurrence of a normal vaginal delivery and ECS were 68.5% and 12.2% respectively, whereas the national statistics for England for 2000 to 2001 are 66.6% and 12.7% respectively [3].

Results

Descriptive statistics

Table 1 provides descriptive statistics of the entire cohort as well as our restricted sample of White couples with singleton, first births for which information on maternal and paternal height and birth weight of the newborn was available (see Table S1 for more descriptive statistics on the sample used for our analyses). As expected, maternal and paternal height were positively correlated, indicating that taller women had taller partners (Pearson r=0.11; p<0.0001; N=5,165). Furthermore, taller mothers and fathers had heavier newborns, as both maternal and paternal height positively and independently affected the birth weight of the newborn, with the maternal effect being 66% stronger than the paternal effect (Table 2).

Table 1. Characteristics (mean ± standard deviation or %) of the entire cohort and the sample used for our analyses.

<table>
<thead>
<tr>
<th></th>
<th>Entire sample</th>
<th>Restricted sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Maternal height (cm)</td>
<td>163.5±7.0</td>
<td>18,217</td>
</tr>
<tr>
<td>Paternal height (cm)</td>
<td>177.8±7.4</td>
<td>12,617</td>
</tr>
<tr>
<td>PHD^b (cm)</td>
<td>14.1±9.2</td>
<td>12,617</td>
</tr>
<tr>
<td>Birth weight (kg)</td>
<td>3.34±0.6</td>
<td>18,484</td>
</tr>
<tr>
<td>Delivery outcomes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal delivery</td>
<td>68.5%</td>
<td>12,666</td>
</tr>
<tr>
<td>Emergency CS</td>
<td>12.2%</td>
<td>2,260</td>
</tr>
<tr>
<td>Planned CS</td>
<td>9.4%</td>
<td>1,742</td>
</tr>
<tr>
<td>Other forms of assistanceb</td>
<td>9.9%</td>
<td>1,828</td>
</tr>
</tbody>
</table>

The sample used for analyses was White parents (for which height data were available) who had their first, singleton child (of which birth weight was available) through a normal vaginal delivery or an emergency Caesarean section.

^PHD: Parental height differences (paternal minus maternal height).

bOther forms of assistance: assisted breech delivery, assisted forceps, assisted vacuum extraction, water births and other problems without specification.

doi:10.1371/journal.pone.0020497.t001
Effects of parental height differences

In this study, we have shown that the size of the newborn, the height of the mother and parental height differences all predict the risk of an emergency Caesarean section in primiparous women.
Table 3. Logistic regression parameter estimates (± s.e.) of the effects of maternal height, height$^2$, birth weight, birth weight$^2$, parental height differences and their interactions on the probability of an emergency Caesarean section.

<table>
<thead>
<tr>
<th>Model</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>4.46 (±6.60*10^-1)**</td>
<td>54.25 (±15.03)**</td>
<td>46.50 (±15.21)**</td>
<td>44.16 (±15.40)**</td>
<td>114.75 (±29.03)**</td>
<td>116.53 (±29.01)**</td>
</tr>
<tr>
<td>Birth weight</td>
<td>-3.75 (±4.14*10^-1)**</td>
<td>-4.03 (±4.20*10^-1)**</td>
<td>3.76 (±1.67)*</td>
<td>4.23 (±1.69)*</td>
<td>4.63 (±1.72)*</td>
<td>1.36 (±2.31)</td>
</tr>
<tr>
<td>Mat. Height</td>
<td>-5.51<em>10^-1 (±1.83</em>10^-1)**</td>
<td>-6.15<em>10^-1 (±1.84</em>10^-1)**</td>
<td>-6.03<em>10^-1 (±1.86</em>10^-1)**</td>
<td>-1.45 (±3.50*10^-1)**</td>
<td>-1.40 (±3.50*10^-1)**</td>
<td>4.76<em>10^-3 (±1.07</em>10^-3)**</td>
</tr>
<tr>
<td>Mat. height$^2$</td>
<td>1.51<em>10^-2 (±5.57</em>10^-4)**</td>
<td>2.21<em>10^-2 (±5.75</em>10^-4)**</td>
<td>2.22<em>10^-2 (±5.80</em>10^-4)**</td>
<td>4.76<em>10^-3 (±1.07</em>10^-3)**</td>
<td>4.44<em>10^-3 (±1.08</em>10^-3)**</td>
<td>4.44<em>10^-3 (±1.08</em>10^-3)**</td>
</tr>
<tr>
<td>Mat. height * Birth weight$^2$</td>
<td>-4.95<em>10^-1 (±1.03</em>10^-2)**</td>
<td>-5.22<em>10^-1 (±1.05</em>10^-2)**</td>
<td>-5.49<em>10^-1 (±1.07</em>10^-2)**</td>
<td>-3.60<em>10^-1 (±1.39</em>10^-2)**</td>
<td>-3.60<em>10^-1 (±1.39</em>10^-2)**</td>
<td>-3.60<em>10^-1 (±1.39</em>10^-2)**</td>
</tr>
<tr>
<td>PHD</td>
<td>5.21<em>10^-3 (±5.70</em>10^-5)***</td>
<td>-2.21 (±5.61<em>10^-5)</em>**</td>
<td>2.61<em>10^-2 (±6.89</em>10^-3)***</td>
<td>2.64<em>10^-2 (±6.90</em>10^-3)***</td>
<td>2.64<em>10^-2 (±6.90</em>10^-3)***</td>
<td>2.64<em>10^-2 (±6.90</em>10^-3)***</td>
</tr>
<tr>
<td>Height*PHD</td>
<td>2.61<em>10^-2 (±2.14</em>10^-5)***</td>
<td>-7.65<em>10^-5 (±2.14</em>10^-5)***</td>
<td>-7.85<em>10^-5 (±2.14</em>10^-5)***</td>
<td>2.07<em>10^-2 (±9.79</em>10^-3)*</td>
<td>2.07<em>10^-2 (±9.79</em>10^-3)*</td>
<td>2.07<em>10^-2 (±9.79</em>10^-3)*</td>
</tr>
</tbody>
</table>

Height in centimeters, weight in kilograms. PHD is parental height differences (= paternal height − maternal height).

*p < 0.05;

**p < 0.01;

***p < 0.001 (significance based on Wald test statistic with df = 1).

We also ran models which included all two-way interactions with maternal height$^2$ and birth weight$^2$. None of these terms were significant (all p > 0.12). We always included the underlying (interaction with the) linear term when including a(n interaction with a) squared term in the model.

doi:10.1371/journal.pone.0020497.t003
We replicated the finding that both lower and higher birth weight newborns increase the risk of ECS [15,17,18]. Whereas the increased risk for heavy weight newborns is likely to be a consequence of size-related obstetrical problems, the increased risk for low birth weight newborns may be more a result of fetal distress, preeclampsia and fetal malformations rather than size-related obstetrical problems [15]. In line with previous studies [9,38], we also found that shorter women are at a higher risk for an ECS and that with increasing height the decrease in risk became progressively weaker. Maternal height interacted with birth weight: shorter women were especially susceptible to the effect of newborn weight on ECS risk (in line with earlier studies [15,22–24]). When carrying a heavy newborn (one SD above average weight), short women were more than twice as likely to need an ECS than tall women. For taller women, for which the overall risk of ECS is lowest, the increased size of the baby had little effect on ECS risk and a low birth weight newborn seems more predictive of an adverse pregnancy outcome for reasons discussed above.

Furthermore, to our best knowledge, we documented for the first time that the height of the father, specifically parental height differences, also affected the occurrence of ECS. The effect of the

![Figure 1](link1)

**Figure 1.** The effect of birth weight (means and 95% confidence intervals of raw data) on the risk of ECS. Birth weight in bins of 0.5 kg and bins lower than 2.5 and higher than 4.5 kg were pooled. The confidence interval was determined using the Agresti-Coull method [43]. doi:10.1371/journal.pone.0020497.g001

![Figure 2](link2)

**Figure 2.** The effect of maternal height, parental height differences and birth weight on ECS risk. The effects (means and 95% confidence interval of raw data) are shown for (a) maternal height, (b) maternal height and birth weight (c) parental height differences and (d) parental height differences and birth weight. Height is divided into bins of 5 cm (bins lower than 145 for maternal height and higher than 180 and 35 cm were pooled) and birth weight was divided into tertiles. The confidence interval was determined using the Agresti-Coull method [43]. doi:10.1371/journal.pone.0020497.g002
Parental height differences on ECS was, however, dependent on the height of the mother and the birth weight of the newborn. Women with tall compared to short partners relative to their own height, had an increased ECS risk when carrying an average weight and heavy newborn, but not when carrying a light weight newborn, and this effect was most pronounced in average height and tall women. For shorter women, the overall ECS risk was highest, and parental height differences had little additional influence on ECS risk. Average height and tall women giving birth to a heavy newborn were at higher risk when their partners were relatively tall (respectively 32.6% and 25.0%) compared to short (respectively 25.9% and 19.4%). As the structural size of the baby has been shown to be more important in predicting problems at birth than birth weight [24] and the height of the father predicts the structural size rather than the adiposity of the fetus [25,26], having a tall partner relative to the height of the mother, will result in a relatively larger (in structural size) fetus for that mother, which in turn increases the risk for ECS. Particularly, having a high birth weight newborn with large PHD suggests that the structural size of this baby is large, which causes most problems for the delivery. The mismatch between the size of the fetus and the mother results in adverse pregnancy outcomes [15,22–24]. Unfortunately, in our sample no data were available on the structural size (e.g. head circumference, length) of the newborn, and we thus have no finer grained measures to further substantiate our results.

The finding that differences in height between father and mother influence pregnancy outcomes partly explains the increased risk of assisted deliveries for shorter women. Shorter women have partners who are on average much taller than themselves and with increasing female height, the difference in height between partners decreases strongly. Thus, the higher risk for adverse pregnancy outcomes for shorter women is partly due to the fact that the difference in height between mother and father is smaller for shorter women than for average and tall women. Moreover, having a tall partner relative to the height of the mother will result in a relatively larger fetus for that mother, which in turn increases the risk for ECS. Particularly, having a high birth weight newborn with large PHD suggests that the structural size of this baby is large, which causes most problems for the delivery. The mismatch between the size of the fetus and the mother results in adverse pregnancy outcomes [15,22–24]. Unfortunately, in our sample no data were available on the structural size (e.g. head circumference, length) of the newborn, and we thus have no finer grained measures to further substantiate our results.

### Table 4

Model predictions for the risk (%) of an emergency Caesarean section for A short, average height, and tall mothers and, B average height women with small, average, and large parental height differences for low, average and high birth weight newborns.

<table>
<thead>
<tr>
<th>Birth weight newborn</th>
<th>Low</th>
<th>Average</th>
<th>High</th>
<th>RR[^a]</th>
<th>OR[^a]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal height</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short</td>
<td>24.5</td>
<td>29.4</td>
<td>46.3</td>
<td>1.89</td>
<td>2.66</td>
</tr>
<tr>
<td>Average</td>
<td>19.7</td>
<td>20.5</td>
<td>30.6</td>
<td>1.55</td>
<td>1.80</td>
</tr>
<tr>
<td>Tall</td>
<td>18.7</td>
<td>16.6</td>
<td>21.7</td>
<td>1.16</td>
<td>1.20</td>
</tr>
<tr>
<td>RR[^b]</td>
<td>1.31</td>
<td>1.78</td>
<td>2.13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR[^b]</td>
<td>1.41</td>
<td>2.10</td>
<td>3.11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parental height differences</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small</td>
<td>19.2</td>
<td>18.6</td>
<td>25.9</td>
<td>1.35</td>
<td>1.47</td>
</tr>
<tr>
<td>Average</td>
<td>18.9</td>
<td>19.7</td>
<td>29.1</td>
<td>1.54</td>
<td>1.76</td>
</tr>
<tr>
<td>Large</td>
<td>18.8</td>
<td>20.9</td>
<td>32.6</td>
<td>1.73</td>
<td>2.09</td>
</tr>
<tr>
<td>RR[^c]</td>
<td>0.98</td>
<td>1.12</td>
<td>1.26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR[^c]</td>
<td>0.97</td>
<td>1.16</td>
<td>1.38</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[^a]: Comparison between high and low birth weight newborns.
[^b]: Comparison between short and tall mothers.
[^c]: Comparison between large and small parental height differences.

### Table 5

Logistic regression parameter estimates (± s.e.) of the effects of maternal height, height^2, parental height differences and their interactions on the probability of an emergency Caesarean section.

<table>
<thead>
<tr>
<th>Model</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>49.56 (±14.54)**</td>
<td>47.53 (±14.70)**</td>
<td>100.85 (±28.07)**</td>
</tr>
<tr>
<td>Height</td>
<td>−5.73<em>10^{-1} (±1.77</em>10^{-1})**</td>
<td>−5.57<em>10^{-1} (±1.79</em>10^{-1})**</td>
<td>−1.19 (±3.34<em>10^{-1})</em>**</td>
</tr>
<tr>
<td>Height^2</td>
<td>1.61<em>10^{-3} (±5.38</em>10^{-4})**</td>
<td>1.58<em>10^{-3} (±5.43</em>10^{-4})**</td>
<td>3.48<em>10^{-3} (±9.91</em>10^{-4})**</td>
</tr>
<tr>
<td>PHD</td>
<td>7.54<em>10^{-3} (±5.54</em>10^{-4})</td>
<td>−1.74 (±5.55*10^{-1})**</td>
<td></td>
</tr>
<tr>
<td>Height*PHD</td>
<td></td>
<td>2.09<em>10^{-2} (±6.79</em>10^{-2})**</td>
<td></td>
</tr>
<tr>
<td>Height^2*PHD</td>
<td>−6.19<em>10^{-5} (±2.10</em>10^{-5})**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>3,275</td>
<td>3,165</td>
<td>3,165</td>
</tr>
</tbody>
</table>

Height in centimeters, weight in kilograms. PHD is parental height differences (= paternal height − maternal height).

**p<0.01;
***p<0.001 (significance based on Wald test statistic with df= 1).

doi:10.1371/journal.pone.0020497.t004
doi:10.1371/journal.pone.0020497.t005
to the fact that they are more likely to have a partner much taller
than themselves.

The finding that parental height differences predict the need for
ECS is also consistent with a study investigating cross-national
variation in height differences between the sexes [39]. This study
found that “maternal death caused by deliveries and complications
of pregnancy (a variable known to be size related) could be a key
determinant explaining variation in sexual stature dimorphism
[sex differences in height] across populations” ([39]; p 2529).

According to these authors, tall mothers would more likely survive
childbirth, which would result in females getting taller relative to
males, thereby decreasing the average height differences between
the sexes. Based on our data, the reverse association is also likely:
the cross-national variation in height differences between the sexes
might explain the variation in maternal deaths caused by deliveries
and complications during pregnancy. When average height
differences between the sexes are large, fetuses would be relatively
large for the mothers carrying them, resulting in more complica-
ations at birth.

A potential limitation of our study is the nature of the sample, in
particular the oversampling of individuals from deprived areas.
However, controlling for socio-economic status with several
indicators (household income, National Vocational Qualifications
(NVQ levels) / National Statistics Socio-economic Classifications
(NS-SEC)) did not change our results, which suggests that the
effects of maternal and parental height differences on the risk of
ECS are independent of socioeconomic status. Another limitation
is that the data are self-reported, through interviews approximately
9 months after birth. However, national health statistics regarding
rates of assisted deliveries for England in 2000–2001 are comparable
to the rates in our sample. In addition, it seems unlikely that there is a systematic error in reporting problems at
birth associated with height; there is little reason to assume that
women of a certain height or women with a partner of a certain
height would be more likely to over- or underreport complications
such as an ECS.

The incidence of ECS may be an imperfect index of obstructed
labor, as a physician bias related to maternal height might have occurred [40]. The need for assistance at delivery may be
ovaerated for short women, due to physicians’ expectations of
difficulty at delivery. This potential bias might have influenced our
results for the risk of ECS for short women, but it seems an
unlikely explanation for the effects of the parental height
differences on ECS risk as this effect is also present for women
of average height and for tall women.

From a functional perspective, documented preferences for
partner height among men and women (e.g. [41,42]) are consistent
with our finding that parental height differences predict the
likelihood of ECS. Whereas women prefer men taller, but not too
tall, men prefer women shorter but not too short. Our results
suggest that these mate preferences could be adaptive as a male
partner too tall or a female partner too short will both result in an
increased risk for obstructed labor.

References
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Supporting Information
Figure S1 Model predictions for the effect of maternal height on the risk (\%)
of an emergency Caesarean section for mothers carrying low (mean – s.d.), average (mean) and high (mean + s.d.)
birth weight newborns.

Figure S2 Model predictions for the effect of parental height differences on
the risk (\%) of an emergency Caesarean section for short (mean – s.d.), average (mean) and tall (mean + s.d.) mothers
having an average birth weight newborn.

Figure S3 Model predictions for the effect of parental height differences on the risk (\%)
of an emergency Caesarean section for average height mothers carrying low (mean – s.d.), average (mean) and
high (mean + s.d.) birth weight newborns.

Table S1 Characteristics (mean ± standard deviation or \%) of the
sample used for our analyses.

Table S2 Model predictions for the risk (\%) of an emergency Caesarean section for
low (mean – s.d.), average (mean) and high (mean + s.d.) birth weight newborns having (a) short (mean –
s.d.), average height (mean), and tall (mean + s.d.) mothers and (b)
small (mean – s.d.), average (mean), and large (mean + s.d.)
parental height differences for short, average height (c) and tall
mothers (d).

Table S3 Logistic regression parameter estimates (± s.e.) of the
effects of maternal height, height\(^2\), parental height differences
(PHD), birth weight, their interactions, and control variables on
the probability of an emergency Caesarean section.

Table S4 Logistic regression parameter estimates (± s.e.) of the
effects of maternal height (cm), height\(^2\), birth weight (kg), birth
weight\(^2\), parental height differences (cm) and their interactions, on
the probability of an emergency Caesarean section when light
birth weight newborns (<2.5 kg) are excluded.

Table S5 Model predictions for the risk (\%) of an emergency
Caesarean section for short, average height, and tall mothers with
small, average and large parental height differences (PHD).

Acknowledgments
We would like to thank all of the Millennium Cohort Study families for
their cooperation and the Millennium Cohort Study team at the Centre for
Longitudinal Studies, Institute of Education, University of London. We
thank Ian Rickard and an anonymous reviewer for their helpful comments.

Author Contributions
Conceived and designed the experiments: GS SV TVP DN APB. Analyzed
the data: GS DN. Wrote the paper: GS SV TVP DN APB.


