Hanoi, 16 May 2018

WHO recommendations on non-clinical interventions to reduce unnecessary caesarean sections

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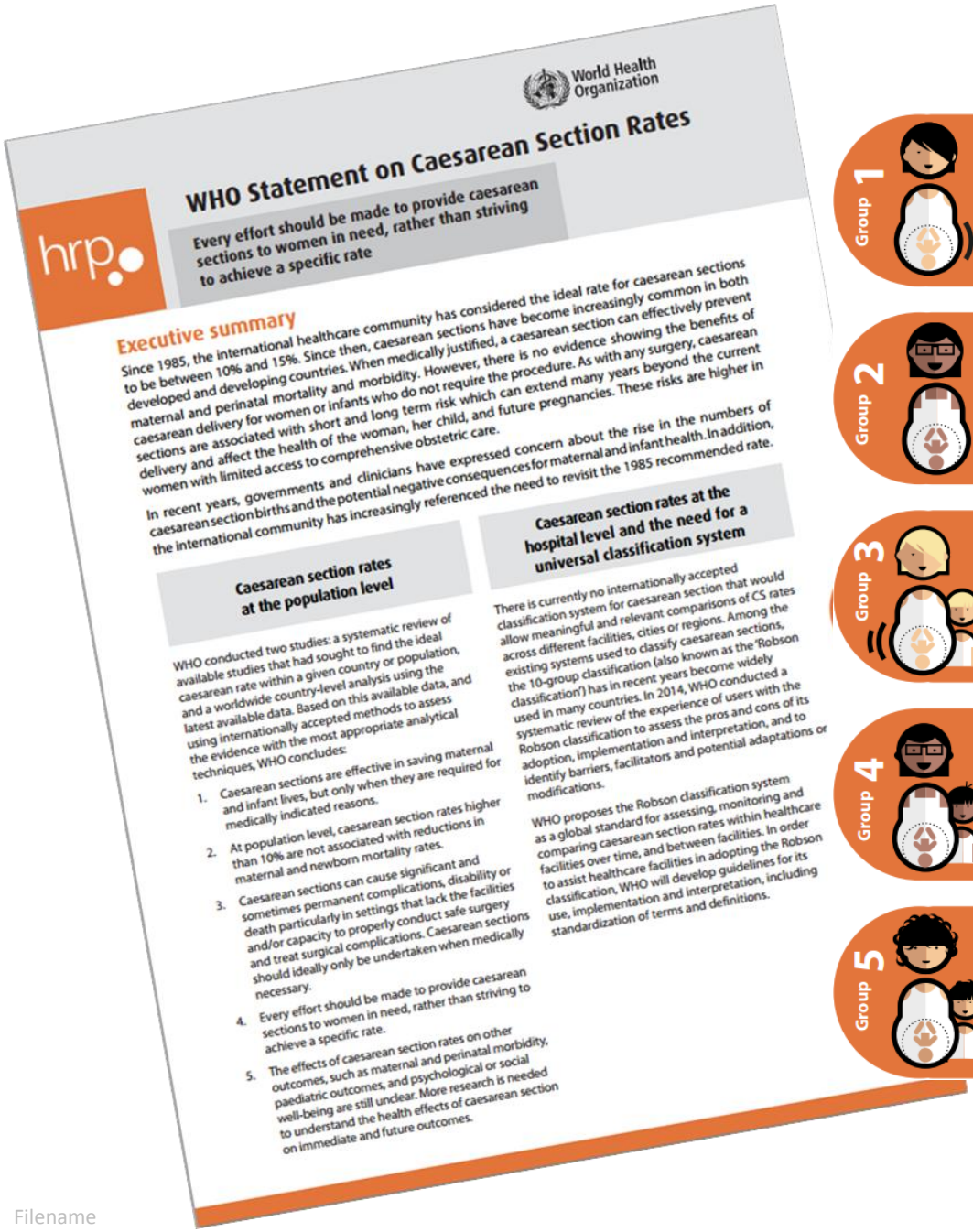
Clasificación de Robson (10-grupos)



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WHO Statement on Caesarean Section Rates

Every effort should be made to provide caesarean sections to women in need, rather than striving to achieve a specific rate

Executive summary

Since 1985, the international healthcare community has considered the ideal rate for caesarean sections to be between 10% and 15%. Since then, caesarean sections have become increasingly common in both developed and developing countries. When medically justified, a caesarean section can effectively prevent maternal and perinatal mortality and morbidity. However, there is no evidence showing the benefits of caesarean delivery for women or infants who do not require the procedure. As with any surgery, caesarean sections are associated with short and long term risk which can extend many years beyond the current delivery and affect the health of the woman, her child, and future pregnancies. These risks are higher in women with limited access to comprehensive obstetric care.

In recent years, governments and clinicians have expressed concern about the rise in the numbers of caesarean section births and the potential negative consequences for maternal and infant health. In addition, the international community has increasingly referenced the need to revisit the 1985 recommended rate.

Caesarean section rates at the population level

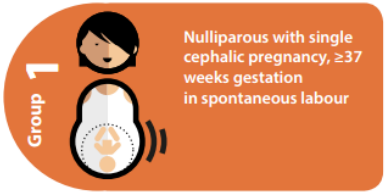
WHO conducted two studies: a systematic review of available studies that had sought to find the ideal caesarean rate within a given country or population, and a worldwide country-level analysis using the latest available data. Based on this available data, and using internationally accepted methods to assess the evidence with the most appropriate analytical techniques, WHO concludes:

1. Caesarean sections are effective in saving maternal and infant lives, but only when they are required for medically indicated reasons.
2. At population level, caesarean section rates higher than 10% are not associated with reductions in maternal and newborn mortality rates.
3. Caesarean sections can cause significant and sometimes permanent complications, disability or death particularly in settings that lack the facilities and/or capacity to properly conduct safe surgery and treat surgical complications. Caesarean sections should ideally only be undertaken when medically necessary.
4. Every effort should be made to provide caesarean sections to women in need, rather than striving to achieve a specific rate.
5. The effects of caesarean section rates on other outcomes, such as maternal and perinatal morbidity, paediatric outcomes, and psychological or social well-being are still unclear. More research is needed to understand the health effects of caesarean section on immediate and future outcomes.

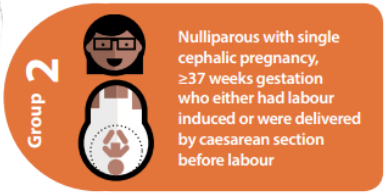
Caesarean section rates at the hospital level and the need for a universal classification system

There is currently no internationally accepted classification system for caesarean section that would allow meaningful and relevant comparisons of CS rates across different facilities, cities or regions. Among the existing systems used to classify caesarean sections, the 10-group classification (also known as the 'Robson classification') has in recent years become widely used in many countries. In 2014, WHO conducted a systematic review of the experience of users with the Robson classification to assess the pros and cons of its adoption, implementation and interpretation, and to identify barriers, facilitators and potential adaptations or modifications.

WHO proposes the Robson classification system as a global standard for assessing, monitoring and comparing caesarean section rates within healthcare facilities over time, and between facilities. In order to assist healthcare facilities in adopting the Robson classification, WHO will develop guidelines for its use, implementation and interpretation, including standardization of terms and definitions.

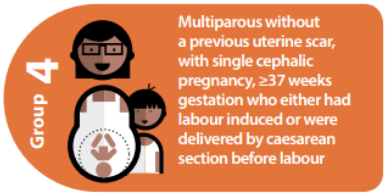


Nulliparous with single cephalic pregnancy, ≥37 weeks gestation in spontaneous labour



Nulliparous with single cephalic pregnancy, ≥37 weeks gestation who either had labour induced or were delivered by caesarean section before labour

Multiparous without a previous uterine scar, with single cephalic pregnancy, ≥37 weeks gestation in spontaneous labour



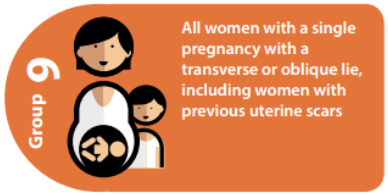
Multiparous without a previous uterine scar, with single cephalic pregnancy, ≥37 weeks gestation who either had labour induced or were delivered by caesarean section before labour

All multiparous with at least one previous uterine scar, with single cephalic pregnancy, ≥37 weeks gestation

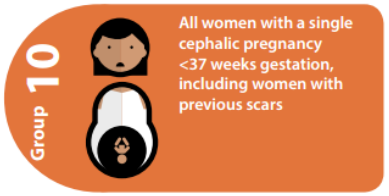
All nulliparous women with a single breech pregnancy

All multiparous women with a single breech pregnancy, including women with previous uterine scars

All women with multiple pregnancies, including women with previous uterine scars



All women with a single pregnancy with a transverse or oblique lie, including women with previous uterine scars



All women with a single cephalic pregnancy <37 weeks gestation, including women with previous scars

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1. Women

2. Health professionals

3. Health systems, organizations

Interventions targeted at women, families, communities

Recommendation	Type of recommendation
Recommendation 1: Health education for women is an essential part of antenatal care. Additional educational interventions and support programmes (childbirth training workshops, nurse-led applied relaxation training programmes, psychosocial couple-based prevention programmes and psychoeducation) are recommended to reduce unnecessary caesarean sections only with targeted monitoring and evaluation.	With targeted monitoring and evaluation
Recommendation 2: When considering educational interventions and support programmes targeted at women to reduce caesarean births, no specific format is recommended as more effective	No recommendation

What do women say about educational interventions - Qualitative evidence

- ✓ Learning new information about birth can be empowering
- ✓ Women want educational tools and welcomed multiple formats although "paper format" is needed to reflect on with family, friends and health professionals
- ✓ Educational materials should not provoke anxiety and need to be consistent with advice from health professionals
- ✓ Provide the basis for more informed dialogue with health professionals
- ✓ Women want emotional support alongside the communication of facts and figures about birth

Interventions targeted at health professionals

Recommendation 3: Implementation of evidence-based guidelines combined with structured, mandatory second opinion for caesarean section indication is recommended to reduce caesarean births in settings with adequate resources and senior clinicians able to provide mandatory second opinion for CS indication.	Context-specific recommendation
Recommendation 4: Implementation of evidence-based guidelines, caesarean section audits and timely feedback to health professionals are recommended to reduce caesarean births.	Recommended

What do health professional say about interventions targeted at them - Qualitative evidence

- ✓ Lack of training, skills or experience are a barrier to change ➔ it is important that interventions have a training component tailored to local needs
- ✓ Evidence supported audits of indications of caesarean sections; however, the GDG emphasized the need to assess all aspects of caesarean sections in audits such as underlying health professional factors, women factors (e.g. maternal request) and organisational factors

Interventions targeted at organisations, facilities, systems

Recommendation 5: For the sole purpose of reducing caesarean rates, a model of staffing based on care provided primarily by midwives with a 24-hour obstetrician back-up who provides in-house labour and delivery coverage without other competing clinical duties is recommended only in the context of rigorous research.	In the context of rigorous research
Recommendation 6: For the sole purpose of reducing caesarean rates, financial strategies (i.e. insurance reforms equalising physician fees for vaginal and caesarean sections) for health professionals or health organisations are only recommended in the context of rigorous research.	In the context of rigorous research

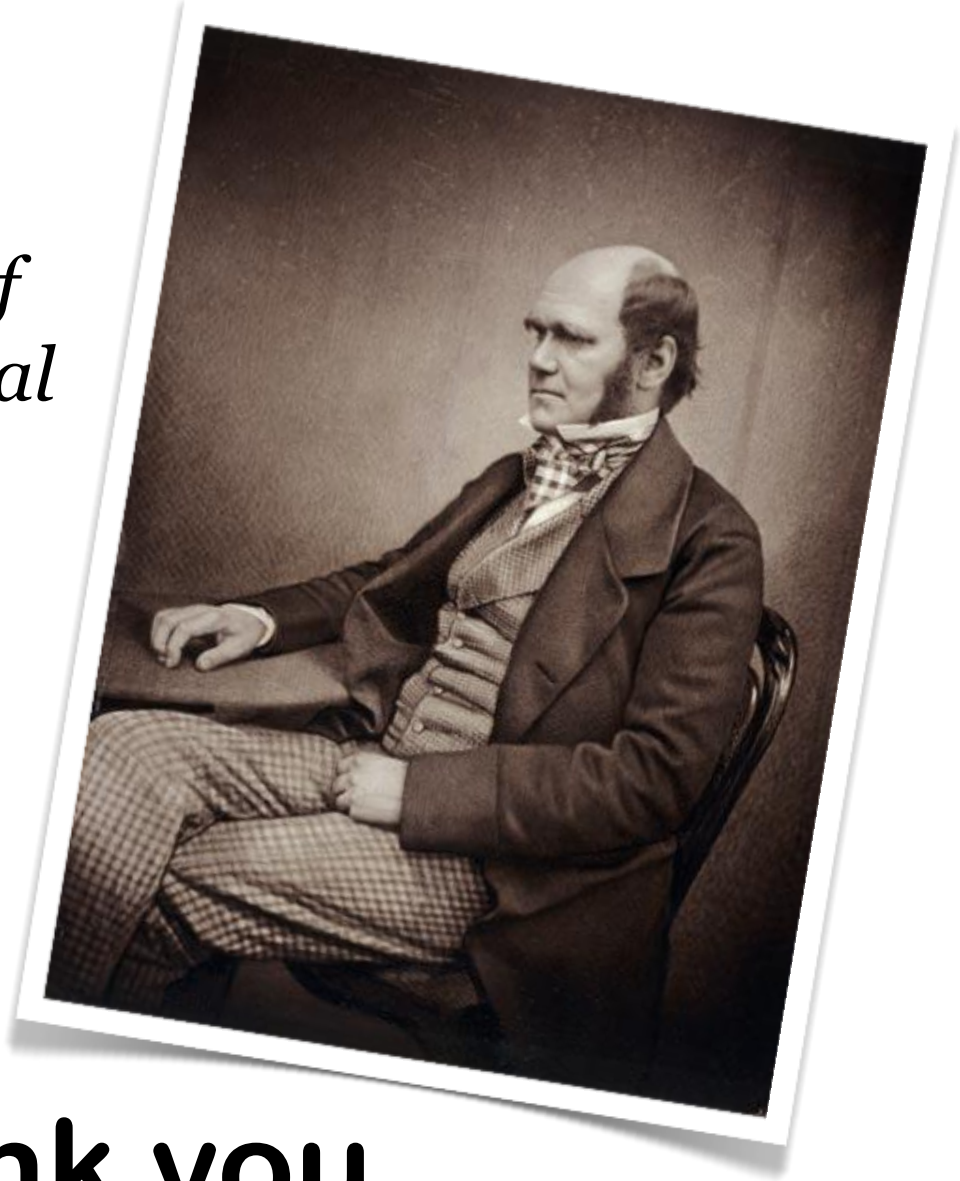
What do stakeholders think about interventions targeting systems - Qualitative evidence

- ✓ Dysfunctional teamwork within the medical profession and lack of communication are important barriers that need to be addressed in the context of fostering change
- ✓ Marginalization of midwives is recurrent across settings as an important barrier in reducing CS
- ✓ Respectful and collaborative multidisciplinary teamwork is fundamental

Previous WHO guidelines

Care option	Recommendation	Category of recommendation
Care throughout labour and birth		
Respectful maternity care	1. Respectful maternity care – which refers to care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth – is recommended.	Recommended
Effective communication	2. Effective communication between maternity care providers and women in labour, using simple and culturally acceptable methods, is recommended.	Recommended
Companionship during labour and childbirth	3. A companion of choice is recommended for all women throughout labour and childbirth.	Recommended
Continuity of care	4. Midwife-led continuity-of-care models, in which a known midwife or small group of known midwives supports a woman throughout the antenatal, intrapartum and postnatal continuum, are recommended for pregnant women in settings with well functioning midwifery programmes.[a]	Context-specific recommendation

"It is the long history of humankind (and animal kind, too) those who learned to collaborate and improvise most effectively have prevailed."



Thank you