Caesarean rates still too high

In order to tackle rising incidence of C-sections we need standardised comparison of rates and maternity practice, writes Deirdre Munro

IN 1985 the World Health Organization (WHO) recommended a Caesarean section rate of no more than 15%. Yet Caesarean deliveries are steadily rising and in some areas represent a quarter of all deliveries. Many countries have an increasing rate of Caesarean sections which may increase maternal risks and affect subsequent pregnancies.¹

Rates
The UK Caesarean section rate is 24.3%,² and Ireland 26%.³ In England one in four women have a Caesarean section.⁴

In the US the Caesarean section rate for 2006 was 31.1%, an increase of 50% over the past decade.⁴

In China births by Caesarean section increased from 8.9% in 1994 to 24.8% in 2002.⁵

An estimate of Caesarean section rates by the WHO in 2007 in Africa showed the lowest rate (3.5%). Latin America and the Caribbean showed the highest rate (29.2%). Rates differ between and within countries.⁶

In a retrospective analysis in 2006 by Ronsmans et al, Caesarean section rates were below 1% in the poorest countries, mostly in sub-Saharan Africa where large segments of the population have no access to life saving Caesarean sections.⁶

Why so many?
The Royal College of Obstetrics and Gynaecologists (RCOG) identifies changing demographic characteristics and increasing maternal age in childbirth as factors increasing Caesarean section rates. The RCOG identifies four major clinical determinants of Caesarean sections which have remained the same over the last 10-15 years.

The four major determinants are:

• Foetal compromise
• Failure to progress in labour
• Caesarean section for previous Caesarean section
• Breech presentation.

The fifth most common reason is reported to be maternal request.² According to the National Institute for Clinical Excellence guidelines maternal request on its own is not an indication for Caesarean section and specific reasons for the request should be explored, discussed and recorded.⁷

Weaver et al argue that existing evidence of large numbers of women requesting Caesarean sections in the absence of clinical indications is weak.⁸ A literature review by McCourt et al agrees; research between 2000 and 2005 shows evidence of very small numbers of women requesting a Caesarean section.⁹
Variations in practice
Wide variations in Caesarean section rates exist. Irish hospitals audit their Caesarean section rates annually. National rates in Ireland are not reported or compared as often.

Maternity statistics by the NHS Information Centre report wide regional variations of Caesarean section rates. There is no standardised manner of comparing Caesarean sections internationally.

The NHS focused on Caesarean sections in 2008. The NHS Institute for Innovation and Improvement launched a comprehensive toolkit to aid maternity units in achieving low Caesarean section rates while maintaining safer outcomes for mother and baby.

Perhaps now is the prime time to monitor and compare Caesarean section rates locally, nationally and internationally. This would implement the ‘divide and conquer’ algorithm of Caesarean sections.

Classification
Most Caesarean sections are classified according to the reason for the surgery.10–12

The Confidential enquiry into Maternal and Child Health13 uses the RCOG classification of Caesarean sections; emergency, urgent, scheduled, and elective, perinatal and post-mortem.13

In 2001 Dr Michael Robson, of the National Maternity Hospital, Dublin, proposed the new Ten Group Classification System (TGCS). These 10 groups are mutually exclusive, simple to use and read yet include the total sample.14

Theory–practice gap
The TGCS classification system was introduced in the National Maternity Hospital Dublin, University Hospital Galway, Ireland and also in the Royal Women’s Maternity Hospital Victoria, Australia. Brennan et al compared nine institutional cohorts around the world using this classification.15

The WHO recently applied the Robson 10 group classifications to a multi-country dataset.16

The Robson 10 Group Classification System facilitates comparative analyses of Caesarean sections between hospitals/centres nationally, internationally and globally.17

Relevance to midwifery
Groups 1, 2, 3 and 5 are of major interest in midwifery practice. I have micro-analysed Groups 1 and 2 even further; maternal age, public/private status, gestational age, reason for CS, emergency or elective CS, gender of baby and baby weight. This will be tackled in a future article.

Standardised classification
Implementing guidelines to reduce Caesarean section rates is a complicated task and begins with our own practice. The Robson 10 Group Classification System permits standardised auditing of Caesarean sections within and between hospitals.

Further analyses of women having Caesarean sections expected for normal vaginal birth in these groups may also be scrutinised further by the midwifery profession.

Analysis of local Caesarean section rates creates awareness and initiates discussion.14 Effective audits of labour management can reduce Caesarean section rates.18

The 10 Group Classification System sanctions the algorithm to ‘conquer and divide’ Caesarean sections.

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Robson’s 10 Group Classification System (TGCS)

- **Group 1**: Nulliparous, singleton, cephalic, >37/40, spontaneous labour
- **Group 2**: Nulliparous, singleton, cephalic, >37/40 induced or elective CS
- **Group 3**: Multiparous (excluding previous CS), singleton, cephalic, >37/40, spontaneous labour
- **Group 4**: Multiparous (excluding previous CS, singleton, cephalic, >37/40 induced or elective CS
- **Group 5**: Previous CS, singleton, cephalic, >37/40, induced or elective CS
- **Group 6**: All multiparous breech
- **Group 7**: All multiparous breech (including previous CS)
- **Group 8**: All multiple pregnancies (including previous CS)
- **Group 9**: All presentations other than cephalic or breech (including previous CS)
- **Group 10**: All singleton, cephalic, <36/40 (including previous CS)