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NCT Briefing for Journalists: Caesarean Birth

What is a caesarean?

A caesarean section is an operation in which the baby is born through incisions in a woman's abdomen and uterus.

How many babies are born by caesarean each year?

According to 2005 maternity statistics, 697,946 babies were born in the UK between April 2004 and March 2005. Of these, around 25% were born by caesarean section.[1,2,3,4] Statistics vary across the UK:

- 23.5% of babies were born by caesarean in England in 2006[5]
- 24.9% of babies were born by caesarean in Scotland in 2005 (2006 figures are not yet available)[3].
- 26.2% of babies were born by caesarean in Wales in 2006[6]
- 28.4% of babies were born by caesarean in Northern Ireland in 2005 (2006 figures are not yet available).[4]

The National Sentinel Caesarean Section Audit found that there was considerable variation in caesarean rates between different regions of England and that use of agreed clinical standards for best practice was highly variable.[7]

Is the caesarean rate too high?

In 1985, the World Health Organisation (WHO) recommended that 'there is no justification for any region to have a higher caesarean rate than 10-15%', noting that 'countries with some of the lowest perinatal mortality rates in the world have a caesarean rate of less than 10%'.[8] Although the original statement from WHO was made in 1985, NCT correspondence with WHO has confirmed that WHO are aware of no evidence to support a higher rate.

Caesarean rates for all four countries of the UK are now close to one in four births, with Northern Ireland and Wales above that rate. In the 12 year period 1989/90 – 2001/2002 the caesarean rate in England doubled from 11% to 22% of all births, far exceeding the 10-15% rate suggested by the WHO.[5] In the four years since then, for which statistics are available, there have been further increases in all but one year.

Commenting at the launch of the National Sentinel Caesarean Section Audit Report in 2001, Professor Bill Dunlop, President of the RCOG said:

'We know that the caesarean rate has been on the increase over the last decade and we all need to understand the implications of this. Women, midwives and doctors still need more information

about the chance of complications arising from this major abdominal surgery so that women can make informed decisions about their delivery.'

'The audit shows evidence of marked variations in rates across the country and the obstetricians are rightly concerned that the caesarean rate in the UK may be too high.'

'We need to make sure that when caesarean sections are carried out they are done in the appropriate circumstances.'

The National Institute for Clinical Excellence (NICE) guideline on caesarean section,[9] published in April 2004, sets out the evidence about:

- the risks and benefits of caesarean section
- specific indications for caesarean section
- effective management strategies which avoid caesarean section
- anaesthetic and surgical aspects of care
- interventions to reduce morbidity from caesarean section and
- aspects of organisation and environment which affect caesarean section rates.

Why are caesarean section rates so high?

Many factors contribute to rising rates of caesarean section. The greater the number of first (primary) caesareans, the greater the repeat caesarean section rate, as women who have had one surgical birth are more likely to have another. This in turn increases the overall caesarean rate. Repeat caesareans account for approximately a quarter of the overall caesarean rate – over 40,000 women in the UK will have more than one caesarean birth.[7]

Increasing normal vaginal births in first-time mothers is important if the overall caesarean rate is to be reduced.

The culture in a maternity unit, including the extent to which normal birth is valued and supported, affects caesarean section rates.[10] Where units follow evidence-based guidance to promote normality and minimise interventions to a level consistent with positive outcomes for mothers and babies, caesarean rates are lower.[10] It is known that having one-to-one support throughout labour makes a difference to whether a woman has a straightforward vaginal birth or needs forceps, ventouse or an emergency caesarean.[11] Other factors contributing to high emergency caesarean section rates include liberal use of induction for post-term pregnancies,[10] the use of continuous electronic fetal monitoring for women with a normal pregnancy,[9] and a high presence of junior doctors on the labour ward with insufficient support and supervision.[12] Healthcare for London has recommended a consultant obstetrician on the labour ward in obstetric hospitals in London for 98 hours a week to ensure that their expertise is available immediately during the wards' busiest times.[13]

What is VBAC?

A vaginal birth after caesarean is usually shortened to VBAC – pronounced 'vee back'. There is considerable scope for more women to plan for a VBAC. Studies show that on average 80% of women who plan for a VBAC have a vaginal birth, rather than a repeat caesarean.[14] In line with this finding, the NHS Institute for Innovation and Improvement recommends that 80% of women with a previous caesarean should be opting for a VBAC.[15]

Will the National Services Framework (NSF) for Children and Maternity Services make a difference in England?

The NSF for England, published in September 2004, encourages all NHS maternity care providers and primary care trusts to ensure that birth environments in all settings promote the normality of childbirth.[16]

'We want to see women being supported and encouraged to have as normal a pregnancy and birth as possible, with medical interventions recommended to them only if they are of benefit to the woman or her baby'.

Commitment to the promotion of normal birth is also expressed by the Westminster Government in *Maternity Matters,*[17] the latest maternity services policy document for England, published in 2006, which:

'emphasises the need for all women to be supported and encouraged to have as normal a pregnancy and birth as possible'.

How are caesareans classified?

Official statistics have recorded all caesareans as either emergency or elective.

What is an elective caesarean?

'Elective' simply means a caesarean that has been planned in advance and usually, although not always, takes place before labour has started. Most elective or planned caesareans occur because a doctor has advised the woman that there is a medical reason why she or her baby may benefit from a surgical birth. Contrary to popular misconception, an 'elective' or planned caesarean is NOT usually one that has been chosen by the woman. Indeed, many women object strongly to the term 'elective' caesarean when it applies to a caesarean that they did not want. It is wrong to assume that women who have an elective caesarean are "too posh to push".

The NCT prefers to use the term *planned* caesarean, rather than *elective* caesarean, because this is a more accurate description.

- 9.3% of babies were born by planned caesarean in England in 2006[5]
- 9.5% of babies were born by planned caesarean in Scotland in 2005[3]
- 10.8% of babies were born by planned caesarean in Wales in 2006[6]
- 13.3% of babies were born by planned caesarean in Northern Ireland in 2005 [i]

What is an emergency caesarean?

An 'emergency' caesarean is a caesarean that was not planned in advance, as the need was not anticipated. The decision may be made as little as ten minutes or up to a few hours before the baby is born.

- 14.1% of babies were born by emergency caesarean in England in 2006[5]
- 15.4% of babies were born by emergency caesarean in Scotland in 2005[3]
- 15.6% of babies were born by emergency caesarean in Wales in 2006[6]
- 15.1% of babies were born by emergency caesarean in Northern Ireland in 2005[i]

It is possible to compare and contrast planned and emergency caesarean rates for different maternity units on the BirthChoiceUK website – www.birthchoiceuk.com

Why are caesareans carried out?

There are very few incontrovertible indications for caesarean section. In some situations there is clear evidence that a caesarean is necessary to prevent the death or long-term damage to the mother or the baby. In most situations the evidence is less clear and judgements vary as to the likely benefits and risks of surgery.

Clear evidence

The following are examples of clinical situations in which there is clear evidence that a caesarean is needed:

- **Cord prolapse -** When the umbilical cord comes down into the vagina in front of the baby
- **Placenta praevia -** When the placenta lies across the cervix towards the end of pregnancy or when labour starts
- **Severe pre-eclampsia -** A life-threatening condition and can only be treated by delivering the baby[18]

Divided opinion

The following are examples of clinical situations in which there is divided opinion about the balance of benefits and risks of a vaginal birth compared with a caesarean section:

- **Breech position –** When the baby lies bottom down instead of head down
- **Failure to progress –** When the cervix opens very slowly
- **Expecting twins.**

Women's choice

Some caesareans are planned because the woman has stated a preference for a caesarean birth. In many of these cases, the woman involved is fearful of childbirth, sometimes because of a previous experience of childbirth trauma or sexual abuse. Where there is a psychological need, this is a legitimate clinical reason. In 2001 the National Sentinel Caesarean Section Audit found that maternal request was the primary indication reported by clinicians in 7% of caesareans, though in some of these cases there were also medical reasons.[7] Altogether, 7% of caesareans taking place primarily due to maternal request is equal to 1.5% of all births; a very small minority.

How safe is a caesarean?

Caesarean births are now safer than they have ever been, which is one reason why the 'tolerance threshold' has been lowered.[19] Despite the reduction in complications associated with surgery, there are still risks involved.

For babies there is an increased risk of breathing difficulties, and an increased need for nursing in a special care baby unit, which involves separation from their mother. Abdominal pain can make it more difficult for some mothers to establish breastfeeding after surgery, and important opportunities for skin-to-skin contact, known to help breastfeeding, may be diminished if the baby is in special care. There is also an up to 3% chance that the baby will be cut during surgery.[20]

Babies delivered by planned caesarean section are more at risk of breathing difficulties. The risk decreases as the baby matures, so NICE recommends that planned caesareans should not routinely be carried out before 39 weeks. Babies born by caesarean have a greater incidence of breathing problems – 35 babies out of every 1000 born by caesarean suffer from breathing difficulties compared with 5 babies out of every 1000 born by vaginal birth.[9]

Complications for the mother are more common. The main consequence affecting the largest number of women are the practical effects of looking after a newborn baby after major abdominal surgery, including tiredness, tenderness and pain. Many women are advised not to drive for up to six weeks after surgery, which can be both inconvenient and isolating.

More serious consequences affecting fewer women include wound infections, damage to their bladder or bowel; and DVT (Deep Vein Thrombosis). Routine use of drugs to prevent complications has reduced the incidence of DVT and infections. However, hospital-acquired

antibiotic-resistant infections, such as MRSA (Methicillin-Resistant Staphylococcus Aureus), are a growing concern in all large maternity units. There are longer term risks as well as immediate ones, as caesarean birth is associated with a small but significant increase in future infertility, stillbirth and placental problems.

Women's experiences of caesarean birth are important, yet there has been little qualitative research. Some women feel disfigured by their scar and a few suffer long-term pain.

Can the caesarean rate be reduced?

The National Childbirth Trust (NCT) campaigns for a reduction in caesarean rates as research shows that most women want to have a normal birth if possible, and there are many unwanted consequences of high caesarean rates.

The NCT wants women to be given information about the health implications of different kinds of care and ways of giving birth. Women need access to home birth and midwife-led maternity units, as well as conventional hospital units, so that they can make informed decisions about a range of options for labour and birth.

In 2003, for the first time in 20 years, there was no rise in the caesarean rate in England. However, since then the caesarean rate in England has continued to rise each year, to 23.5 % in 2006.[5] So, action is needed by government, by commissioners of maternity services and by health professionals to address the causes of increasing caesarean rates and take action to prevent unnecessary surgery. There is still wide variation in caesarean rates between hospitals. St Mary's Hospital in Manchester, which is a tertiary referral centre with high rates of deprivation, keeps its caesarean rate well below 20%.[21] And several large maternity units, including Leeds Teaching Hopsitals NHS Trust, Kings College Hospital London and Northwick Park Hospital London have recently achieved significant reductions in their caesarean rates. Leeds Teaching Hospitals NHS Trust reduced caesarean rates from 24-27% to 18-20% between 2003-4 and 2005-6,[22] Kings College London from 27.9% to 22.8% between 2003 and 2006[23] and at Northwick Park hospital the rate has recently fallen from 33% to 25%.[24] This demonstrates that change can be achieved where there is a focus on promoting normality and/or improving quality of care.

There is now a self-assessment toolkit to help NHS trusts in England to improve the quality and value of maternity care and reduce caesarean sections.[10] It reveals a general belief amongst senior obstetricians and midwives that caesarean rates could and should be lower, and that if maternity units apply best practice to pregnancy, labour and birth, they should achieve a CS rate below 20% and have aspirations to reduce this further to 15%.[10]

Further information and support

- NCT publications:
    - *Caesarean Birth – Your Questions Answered*
      Available from NCT Sales for £6.50 (plus 65p postage and packaging) on 0870 112 1120, via the NCT Sales website - www.nctsales.co.uk or by emailing shop@nctsales.co.uk
    - *Straightforward Birth, Breech Baby* and *Vaginal Birth After Caesarean* information sheets, available from NCT Sales for 50p each (plus 50p postage).
- Websites:
    - www.nct.org.uk
    - www.nice.org.uk
    - www.caesarean.org.uk
    - www.birthchoiceuk.com/
- The NCT has a network of Caesarean Birth and VBAC Co-ordinators who can offer help and information to women. Many of the NCT's local branches have caesarean birth groups or caesarean birth contacts. Most branches also have antenatal teachers who are able to discuss

caesarean matters before and after the birth. For further information, please call NCT Enquiries on 0870 444 8707

- **If you are planning to write about caesareans or birth in general, or would like to set up interviews with NCT experts and case studies of women who have had caesareans, please contact the National Childbirth Trust Press Office on 0870 770 3238 or email press@nct.org.uk**

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