Cesarean Fact Sheet

These facts are presented by the ICEA Cesarean Options committee with the hope that parents, childbirth educators, nurses, midwives and doctors together can effectively reduce the rate of unnecessary cesarean sections and consequently, their effects.

- A cesarean section is major abdominal surgery. When a cesarean is necessary, it can be a life saving technique for both mother and infant.
- The World Health Organization (WHO) states that no region in the world is justified in having a cesarean rate greater than 10 to 15 percent.
- In the past twenty years, the cesarean section rates have nearly quintupled in the US to 23.8% in 1989 and nearly quadrupled in Canada to 18.3% in 1987-8.
- A cesarean section poses documented medical risks to the mother's health, including infections, hemorrhage, transfusion, injury to other organs, anesthesia complications, psychological complications, and a maternal mortality two to four times greater than that for a vaginal birth.
- An elective cesarean section increases the risk to the infant of premature birth and respiratory distress syndrome, both of which are associated with multiple complications, intensive care and burdensome financial costs. Even mature babies, the absences of labor increases the risk of breathing problems and other complications.
- Cesareans can delay the opportunity for early mother-newborn interaction, breastfeeding and the establishment of family bonds.
- In the US and Canada, over one-third of all cesareans are repeat cesareans. The American College of Obstetricians and Gynecologists (ACOG) recommends that the concept of routine repeat cesarean be replaced by a specific indication for surgery, and that most women can be counseled and encouraged to labor and have a vaginal birth after a cesarean (VBAC).
- In 1989, 81.5% of all US women with a previous cesarean had a repeat cesarean. The VBAC rate was 18.5%. The VBAC rate is greater in every eastern and western European country.
- The "once a cesarean, always a cesarean rule is outdated now that most of uterine incisions are low and horizontal and the risk of rupture of the old scar is almost nonexistent. A review of all VBAC literature from 1985-1990 found a rupture rate of 0.22% for low transverse scars in 22,000

planned labors after cesarean. (In developed nations the rupture rate was 0.18%.) By comparison, the incidence of other childbirth emergencies, such as prolapsed cord, placental separation, or sudden fetal distress is 1-3%.

- ACOG states that the hospital requirements for VBAC are the same standards for all obstetrics. These include the capacity to respond to acute obstetric emergencies by performing a cesarean within 30 minutes. However, many hospitals in North America that offer maternity care do not allow or encourage women to labor and have a VBAC.
- In a review of all the medical reports published on VBAC from 1926-1990, 75% of all women who planned labor after a cesarean gave birth vaginally. Several medical studies record VBAC rates of over 90%.
- The latest statistics indicate that 967,000 cesareans were performed in the US in 1989. The Public Health Citizen's Research Group estimates that over one-half the cesareans performed in 1987 were unnecessary and resulted in 25,00 serious infections, 1.1 million extra hospital days and a cost of over $1 billion. About 500 women a year die from bleeding, infections and other complications of cesarean sections, although these may be related to the reasons the operation was performed and not just to the procedure itself.
- A cesarean costs nearly twice as much as a vaginal birth ($7,186 average vs. $4,334 average in 1989 in the US). It has been estimated that in Quebec, Canada, if the current rate of cesareans (18.8%) were reduced to that of Finland (11.9%), costs incurred by the provincial health care system could be reduced approximately $19 million per year.
- The four most common medical causes contributing to the increase in cesarean section rates in North America are: routine repeat cesareans; dystocia (non-progressive labor); breech presentation; and fetal distress. Some reports suggest that more careful diagnosis and management of dystocia could halve the primary section rate. Combined with fewer cesareans for breech presentation (along with more cephalic versions), careful diagnosis of fetal distress and active encouragement of VBAC, these efforts have resulted in lowering cesarean rates to less than 12% in various parts of the world.
- Up to 77% of women for whom the indication for cesarean delivery was a non-progressive labor (sometimes diagnosed as cephalopelvic disproportion or CPD) and who tried labor again, had a VBAC for a subsequent birth. Approximately one-third of these women gave birth to babies that were larger than their previous "CPD" baby.
- ACOG states that a woman with two or more previous cesareans deliveries with low transverse incisions who wishes to plan a VBAC should not be discouraged from doing so in the absence of contraindications.
- Cesarean rates are influenced by non-medical factors. Rates are higher for women who have private medical insurance, are private rather than public clinic patients, are older, are married, have higher levels of education and are in a higher socio-economic bracket.

- In 1989, a medical study done in Houston, Texas, concluded that epidural analgesia is associated with significant increases in the incidence of cesarean section for dystocia in women having their first labor.
- Cesarean sections are sometimes performed for other than maternal or fetal well-being, such as avoidance of patient pain, patient or provider convenience, provider legal concerns or provider financial incentives.
- Although rare, there have been reports of court-ordered cesareans performed on women against their will. One such case was appealed, supported by 118 US organizations, claiming that the decision was unconstitutional and raises complex legal, moral and religious issues. The appeal judge issued a forceful decision asserting that "in virtually all cases the question of what is to be done is to be decided by the patient - the pregnant woman- on behalf of herself and her fetus."
- In March 1990, an ACOG survey of 2,213 obstetricians documented the changing attitude about VBAC in the US. The survey reported that women under the care of younger physicians and physicians in practice for fewer years were more likely to accept the option of VBAC than women under the care of older physicians and those in practice the longest.
- Of 11,814 women admitted for labor and delivery and attended by midwives to 84 free standing birth centers in the US, 15.8% were transferred to the hospital and 4.4% had a cesarean section. Although the women were lower than average risk of a poor pregnancy outcome, their cesarean rate is one-fifth of the national average.

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