WHO admits: There is no evidence for recommending a 10-15% caesarean limit

By Coalition for Childbirth Autonomy
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The World Health Organization has finally updated its 1985 recommendation on caesarean rates, admitting that "no empirical evidence for an optimum percentage" exists, an "optimum rate is unknown," and world regions may now "set their own standards."

In its latest 2009 publication, 'Monitoring Emergency Obstetric Care: a handbook',(1) the WHO states that, 'Both very low and very high rates of caesarean section can be dangerous, but the optimum rate is unknown. Pending further research, users of this handbook might want to continue to use a range of 5-15% or set their own standards.'
The statement continues, 'Earlier editions of this handbook set a minimum (5%) and a maximum (15%) acceptable level for caesarean section. Although WHO has recommended since 1985 that the rate not exceed 10-15%, there is no empirical evidence for an optimum percentage or range of percentages, despite a growing body of research that shows a negative effect of high rates.'*

In October 2008, the Coalition for Childbirth Autonomy (CCA) called on the WHO to re-examine what it described as an 'outdated and unsafe'(2) recommended 10-15% caesarean threshold, claiming that efforts to keep within that range 'could lead to increased morbidity for both mothers and infants.' The CCA cited a number of medical studies in support of its argument, and included sixteen examples of medical publications and cited opinion(3) that criticised the 1985 recommendation. The group maintained that 'the provision of truly unbiased information for women, with full disclosure of risks and benefits associated with all birth types, and crucially, respect for women's individual decisions was more important than any 'national efforts to reduce the incidence of one particular birth type.' They emphasised the importance of a mother's perception of her birth as being significant in her recovery, and that this ought to inform the decision-making process on birth mode.

Background information
Back in 1985, the World Health Organization recommended that there was no justification for a caesarean delivery rate higher than 10-15% in any world region. Since then, for 2009, the WHO has updated its 24-year-old recommendation, admitting that 'no empirical evidence for an optimum percentage' exists and an 'optimum rate is unknown'. It now recommends instead that world regions make a choice. They 'might want to continue to use a range of 5-15% or set their own standards.'

Almost a quarter of a century has passed since the WHO document 'Appropriate Technology For Birth'(4) was published, yet advocates of natural birth, members of the news media and government policies have continued to quote the figure 15% as an authoritative recommended caesarean rate threshold, and evidence of caesarean overuse. Worse still, this percentage range has been used to criticise rising national caesarean rates and encourage efforts to reduce the number of surgeries arbitrarily.

Nevertheless, caesarean rates in most of the developed world have long since risen above the 10-15% rate range suggested in 1985, with no concomitant rise in maternal mortality or foetal, perinatal and neonatal mortality. The removal of this arbitrary number at last leads us away from the idea that a target can be applied across the worldwide maternal population.

Ambiguity
Unfortunately, there remains a degree of ambiguity in what the WHO now recommends. It suggests that regions 'use a range of 10-15%' (even though there is no empirical evidence for such a range) *or* implement

their own standards. Consequently, it is perhaps inevitable that different birth advocate groups will take opposing views on what the new handbook statement actually means, and arguments over the credibility of an optimum caesarean rate (emergency and/or elective) will continue.

The CCA's view

As a group, the CCA have close contact with significant numbers of women for whom a planned caesarean would be their preferred birth choice. Some of these women exhibit a justifiable fear of childbirth (tokophobia), prior birth trauma or physical or sexual abuse, which causes them to fear vaginal delivery and in some cases can lead to abortion and the decision not to have children.

For these women the ability to make an informed choice for a planned caesarean would remove significant worry about the birth of their baby and reduce the likelihood of emotional trauma following their birth. Equally, there are women whose decision to plan a caesarean is based on an informed appraisal of the risks and benefits of planned surgery versus a trial of labour.

The risks associated with vaginal deliveries include genital tract trauma, subsequent reconstructive surgery and pelvic floor disorders.(5) Many women are more tolerant of caesarean risks and more comfortable with this birth experience. Yet for all of these women, this choice is not available.

Clearly, the WHO has now shifted its focus on caesarean sections away from regional limits and towards safe birth outcomes. 'Ultimately, what matters most is that all women who need caesarean sections actually receive them.' The CCA believe that their definition of 'need' should include those informed women who perceive the trauma of vaginal birth to be significantly greater than that of caesarean birth. This is not yet recognised by many practitioners. In fact in practice, many women are not given balanced information about childbirth; the benefits of planned vaginal delivery are often emphasised and the risks associated with planned caesarean delivery exaggerated.

*The CCA disputes the relevance of the 'growing body of research' referred to here. In short, the WHO cites three references that include mixed data; for example, emergency caesarean health outcomes are applied to planned caesarean data instead of the 'planned' vaginal delivery where they originated.

CONTACT INFORMATION

The birth groups listed here are working together to help better educate women about their birth decisions, and the risks and benefits associated with these different decisions. They also provide support for women who have had traumatic experiences before, during or after the birth of their child.

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About the Coalition for Childbirth Autonomy:
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