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REAL DATA

Why we all need to know how many C-sections each hospital in India is conducting

The rising number of c-section is driven not by necessity but by hospital profits or convenient schedules.

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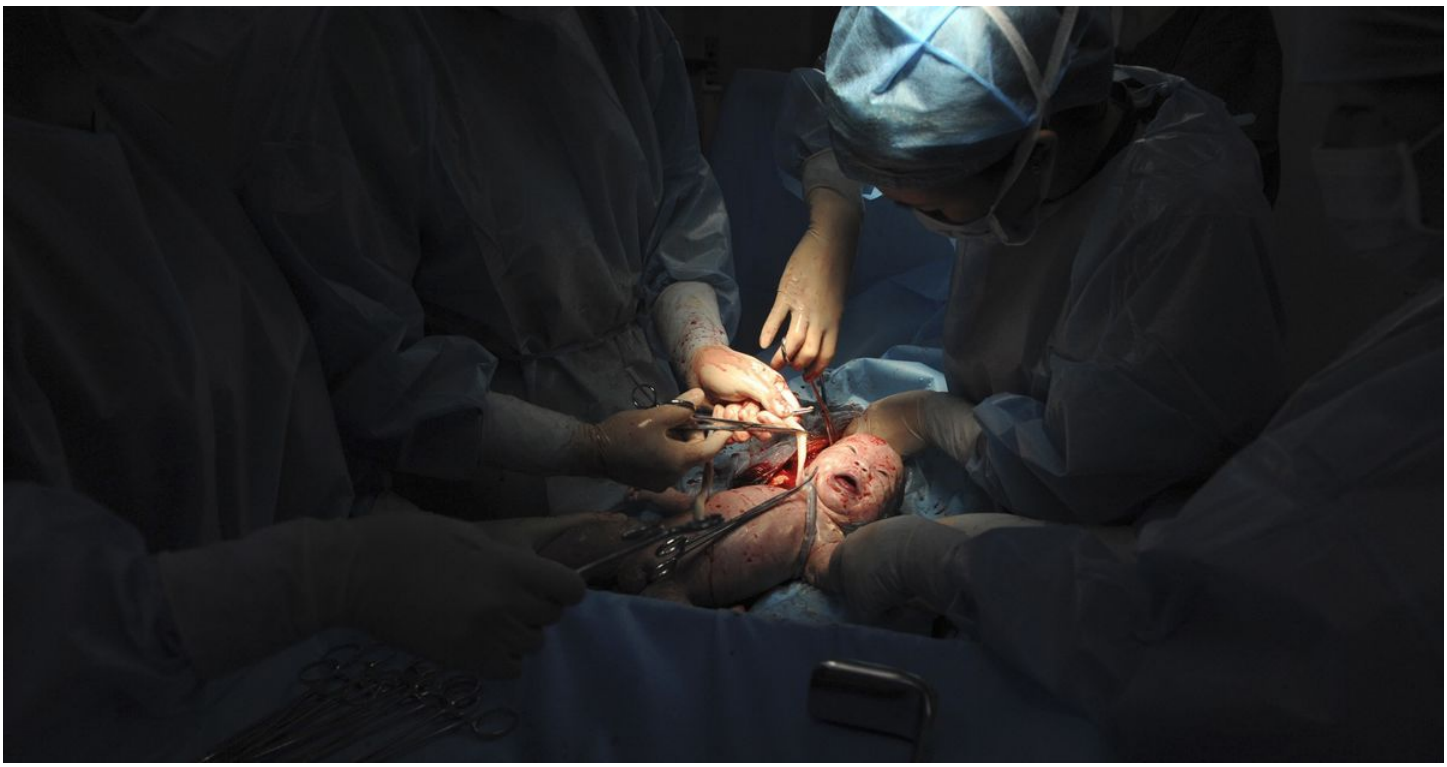

A doctor cuts the umbilical cord of a newborn baby during a caesarean section | Reuters

A petition to make it mandatory for all medical institutions to publicly declare their percentage of Caesarean sections against all live births in that facility has elicited heated discussions. The Minister for Women and Child Development Maneka Gandhi has supported the move while some doctors have protested it. In fact, the World Health Organisation recognised the need to make such numbers public in a statement in 2015.

The number of C-section deliveries has been rising across the world and an expert panel met in October 2014 in Geneva to deliberate on this trend. They revisited the recommended WHO norm of keeping c-section rates at between 10% and 15% – a figure that was arrived at in 1985 on the basis that maternal and infant mortality improves as the percentage of C-sections rises to about 10%.

After reviewing country-level studies and analysing worldwide data, this panel agreed that while no woman who needs a c-section should be denied access to it just to maintain a particular rate, neonatal or maternal mortality rates in a population did not decline further when C-section rates rose above 10%. In other words, saving lives cannot be cited as the primary cause for Caesareans when the rates cross the 10 to 15 per cent mark. The expert panel confirmed and reiterated the 1985 norm.

The number of C-section for a region or country gives important information about access to life-saving interventions and emergency obstetric resources, which is critical to maternal health. Health systems can, however, be overburdened if expensive interventions like C-sections are performed when they are not absolutely needed. This also affects equal access to healthcare across all sections of a society. Thus, monitoring macro-level data on C-sections rates for an entire population helps policymakers.

However, data required to make these macro-level calculations are generated at a micro-level or at the level of individual medical facilities. In order to compare trends and find solutions, a standardised system of data generation must be followed. The WHO has provided this standardised system in the form of the 10 group Robson classification that helps doctors classify the C-section surgeries along five distinct parameters – whether the woman is giving birth for the first time or has given birth previously with or without a C-section, the onset of labour, whether the foetus has come to term, the position of the foetus and whether there is more than one foetus.

Every woman undergoing the surgery can be classified along these parameters, making the data easy to assess and compare. Whether at the secondary or tertiary level of care, this data clearly tells us whether clinical management protocols are followed in a facility. The WHO also recommends that the results of the Robson classification categories be available to the public, as does the petition to the government.

The information gap

National Family Health Survey data clearly reveals that the percentage of C-section births is higher in the private facilities across states. The pressures of profiteering, the convenience of being able to schedule a birth or sometimes even have a baby born at an “mahurat” or auspicious time can supercede medical requirement and turn a regular vaginal birth into a surgical event. C-sections have becomes so common that instead of being a life-saving, emergency recourse, it is now being accepted as the new “normal” and a supposedly pain-free, risk-free, modern way of childbirth. This perception is the result of a huge information gap. Few are aware the mother faces risks of excessive blood loss, blood clots, heart attacks, difficulty in breastfeeding and increased chances of repeat c-section births. The baby has higher risk of asthma, obesity and diabetes. Unfortunately, when doctors discuss risks associated with childbirth only selectively, mothers cannot make informed decision. This gap needs to be addressed by making information easily and publicly available.

A Harvard Medical School report by assistant professor Dr Neel Shah states that an important determinant of whether a C-section is performed “may simply be which hospital a mother walks into to deliver her baby”. If each hospital published its c-section trends, a mother might be able to make a

better informed decision. Declaring data publicly and providing the midwifery model of care, have been identified as key factors in reducing avoidable interventions during childbirth.

The biggest challenge is to ensure reproductive health without compromising the reproductive rights of women. Women's felt experiences of pregnancy and birth are often undermined. Even WHO acknowledges that there is lack of evidence of the relationship between the mode of delivery and psychological and social wellbeing of women. From being a life-event, birth is now treated like a disease. Alienating women from the experience of birth facilitates control over women's bodies and choices and the mechanism of power is "technology". While technology is important and potentially life-saving, using technology as a blanket response cannot work.

More than just medicine

Fertility, reproduction and birth have always been a socially-defined territory. The socio-economic, political and cultural conditions in which technology is used make a big difference. In a culture where silencing is a part of socialisation, voicing one's need for information to protect the right to informed consent, autonomy and self-determination during childbirth may seem like a war cry to many. It is a challenge to an elite club that believes that it has exclusive rights over information about medically-assisted childbirth.

It is high time that women's voices get heard and women are put at the centre of maternity care, everywhere. The petition to declare c-section rates of medical facilities is rooted in the concern about heightened intervention and increasing costs, but it does not seek to destroy the fine balance defining the symbiotic relationship between care-providers and care-seekers. This may well be a significant step for medicine to look beyond the scientific and become more social.

The writer is the petitioner who has asked for all hospitals to publicly declare their Caesarean section percentages. She volunteers for the NGO Birth India and is a scholar at Research Centre for Women's Studies, SNDT Women's University.