Recent studies reaffirm earlier World Health Organization recommendations about optimal cesarean rates. The best outcomes for mothers and babies appear to occur with cesarean rates of 5% to 10%. Rates above 15% seem to do more harm than good (The Lancet, October 28, 2006).

The national U.S. cesarean rate was 4.5% and near this optimal range when first measured in 1965. Similarly, large groups of healthy, low-risk American women who have received care that enhanced their bodies’ innate capacity for giving birth have achieved 4% cesarean rates and good overall birth outcomes (BMJ, June 18, 2005; New England Journal of Medicine, December 28, 1989). However, the cesarean rate has increased steadily over the past decade, reaching record levels each consecutive year in the present century. About one mother in three now gives birth by cesarean, with no end to the increase in sight.

Most pregnant women are healthy and have good reason to anticipate uncomplicated childbirth. Cesarean section is major surgery and increases the likelihood of many short- and longer-term adverse effects for mothers and babies (some of these harms are listed below). There are clear, authoritative recommendations for more judicious use of this procedure. So why does a pregnant woman's chance of having a cesarean keep going up?

Two myths about the rising cesarean rate

To explain this steady rise, health professionals and journalists often point the spotlight on mothers themselves. Many assume that leading factors in the trend are: 1) more and more women are asking for cesareans that have no medical rationale, and 2) the number of women who genuinely need a cesarean is increasing. Neither appears to account for a large portion of the increase.

Despite a lot of talk about "maternal request" cesareans and some high profile "celebrity request" cesareans, few women appear to be taking this step. Childbirth Connection's national Listening to Mothers survey of women who gave birth in hospitals in 2005 was the first study to poll women about these decisions in the United States. Just one woman among nearly 1600 survey participants reported that she had had a planned first cesarean with no medical reason at her own request. Those who have looked at this question in other countries have found similar results.

Many have also pointed to changes in the population of childbearing women, such as more older women who have developed medical conditions and more women with extra challenges of multiple births. While there are some overall changes in this population, researchers have found that cesarean rates are going up for all groups of birthing women, regardless of age, the number of babies they are having, the
extent of health problems, their race/ethnicity, or other breakdowns. In other words, there is a change in practice standards and professionals are increasingly willing to follow the cesarean path under all conditions. In fact, one quarter of the Listening to Mothers survey participants who had cesareans reported that they had experienced pressure from a health professional to have a cesarean.

**Reasons for the rising cesarean rate**

The following interconnected factors are pushing the cesarean rate upward.

**Low priority of enhancing women's own abilities to give birth.** Care that supports physiologic labor, such as a doula or other companion providing continuous support during labor or use of hands-to-belly movements to turn a breech (buttocks or feet first) baby to a head-first position at the end of pregnancy, reduces the likelihood of a cesarean. The decision to switch to cesarean in labor is often made when caregivers could use watchful waiting, positioning and movement, comfort measures, oral nourishment and other approaches to facilitate labor progress. Increased use of such care could greatly lower the cesarean rate.

**Side effects of common labor interventions.** Current research suggests that some labor interventions make a cesarean more likely. For example, labor induction among first-time mothers or when the cervix is not soft and ready to open appears to increase the likelihood of cesarean birth. Continuous electronic fetal monitoring has been associated with greater likelihood of a cesarean. Having an epidural early in labor or without a high-dose boost of synthetic oxytocin ("Pitocin") seems to increase the likelihood of a cesarean.

**Refusal to offer the informed choice of vaginal birth.** Many health professionals and/or hospitals are unwilling to offer the informed choice of vaginal birth to women in certain circumstances. The Listening to Mothers survey found that many women with a previous cesarean would have liked the option of a vaginal birth after cesarean (VBAC) but did not have it because health professionals and/or hospitals were unwilling. Nine out of ten women with a previous cesarean are having repeat cesareans in the current environment. Similarly, few women with a fetus in a breech position have the option to plan a vaginal birth.

**Casual attitudes about surgery and cesareans in particular.** Our society is more tolerant than ever of surgical procedures, even when not medically needed. This is reflected in the comfort level that many health professionals, insurance plans, hospital administrators and women themselves have with cesarean trends.
Limited awareness of harms that are more likely with cesarean. Cesarean section is a major surgical procedure that increases the likelihood of many types of harm for mothers and babies in comparison with vaginal birth. Short-term harms for mothers include increased risk of infection, surgical injury, blood clots, emergency hysterectomy, intense and longer-lasting pain, going back into the hospital and poor overall functioning. Babies born by cesarean are more likely to have surgical cuts, breathing problems, difficulty getting breastfeeding going, and asthma in childhood and beyond. Perhaps due to the common surgical side effect of “adhesion” formation, cesarean mothers are more likely to have ongoing pelvic pain, to experience bowel blockage, to be injured during future surgery, and to have future infertility. Of special concern after cesarean are various serious conditions for mothers and babies that are more likely in future pregnancies, including ectopic pregnancy, placenta previa, placenta accreta, placental abruption, and uterine rupture.

Providers' fears of malpractice claims and lawsuits. Given the way that our legal, liability insurance, and health insurance systems work, caregivers may feel that performing a cesarean reduces their risk of being sued or losing a lawsuit, even when scientific evidence supports vaginal birth.

Pressure to practice efficiently. Many health professionals are feeling squeezed by tightened payments for services and increasing practice expenses. The flat "global fee" method of paying for childbirth does not provide any extra pay for providers who patiently support a longer vaginal birth. Some payment schedules pay more for cesarean than vaginal birth. A planned cesarean is an especially efficient way for professionals to organize hospital work, office work and personal life. Average hospital charges are much greater for cesarean than vaginal birth, and may offer hospitals greater scope for profit.

These factors contribute to a national cesarean section rate that passed 31% in 2006, despite scientific data recommending a safe rate of no more then 10%.

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