ECRONICON OPEN ACCESS

EC GYNAECOLOGY
Editorial

Improving Access to and Use of Safe and Appropriate Cesarean Section in Low Resources Settings

Babulal S Patel*

Senior Professor, Department of Obstetrics and Gynecology/SVPIMSR, SMT. N.H.L Municipal Medical College, Ellise Bridge, Ahmedabad/Ph.D. Scholar, Gujarat University, India

***Corresponding Author:** Babulal S Patel, Senior Professor, Department of Obstetrics and Gynecology/SVPIMSR, SMT. N.H.L Municipal Medical College, Ellise Bridge, Ahmedabad/Ph.D. Scholar, Gujarat University, India.

Received: June 19, 2022; **Published:** June 28, 2022

In my published Article 'Where is the "M" in MCH?' by WHO Regional Health Forum,2000, most appreciated sentence "Our journey to Moon or Mars may be safe, but a Fetus - a new human being's journey of only 6 inches through the maternal pelvis is not always safe".

C-Section Technical Consultation Report, 2017 published by the Office of Maternal and child Health, U.S. Agency for International Development (USAID) has observed the same situation at present time, too.

Underuse and overuse - the Challenge of as "Optimal" C-Section Rate: Overuse: the 'cesarean pandemic'.

Increasing rates globally were at a point of concern, described as a "pandemic". Specifically, in LMIC settings (urban), cesarean section rates have risen quickly, at a population level in one Indian state, Telangana, is 58% right now. Such huge rates bring important population based health concerns - like, increased risk for placental accreta disorders and subsequent life-threatening hemorrhage in future pregnancies. Poor clinical decision driven overuse certainly reflects poor quality of care; the 15 fold variation in CS rate among United States Hospitals are in favor of decision making for indications other than medical ones. Neel Shah (Arindne Labs) has studied the reasons behind increasing cesarean section rates in the United States. Barring After a brief decline due to the initial promotion for trial of labor after cesarean delivery in the 1990s, the cesarean rate has increased steadily in United States (by 500% since the 1970s). Almost 50% of the cesarean sections in the United States are unnecessary, resulting in increased risks, complications and implications for future pregnancies. In addition, the high rate of cesarean section in the United States brings large financial costs - 0.6% of the US GDP is spent on inpatient management of women for childbirth.

Underuse, especially among rural and poor women

In many settings, population - level CS rates remain low. Presenters have described concerns regarding overuse and underuse in same countries: Data from facilities in Pakistan showed a 3% urban c-section rate in Balochistan, compared to 33% in Islamabad. Similarly, in Bangladesh, more than 50% of births among the richest population of women are deliveries by cesarean section, compared with only 7% among the poor population. These dissimilarities within the single country show concern for those addressing fetomaternal and perinatal outcome. Malawi has just 3 - 5% CS rate. High levels of maternal and newborn mortality are still a concern, and the healthcare faces professional gaps in training and a lack of motivation. The number of CS in LMIC settings has increased over a period of time. But there is good evidence that many c sections are being done in setting where standards of safety and quality are not even minimum. Genital Fistulas, sepsis, adhesions and other lifelong morbidities are common.

How can we make accessible to essential care without increasing unnecessary cesarean section deliveries? Is there an optimal CS rate?

A challenge is in the part that there is no "optimal" CS rate by evidence based studies. WHO (2015) statement on CS, has noted no reduction in mortality above 10% population CS rate; however maternal and newborn morbidity were not taken into account, which may continue to decline at higher rates. While overuse of CS may be affected by factors that the professional/SAO academic/nongovernmental organization (NGO) communities can handle, Underuse of the same is likely to be affected by larger economic and structural factors, like general infrastructure, transportation, poverty, which require a different set of factors to be addressed.

The rates of CS in some hospitals in India, Bangladesh, and Zambia are showing that using the Robson Classification, the figures of CS rates are not matching as per requirements with evidence-based care and management. The issue is what can be done to increase institutional delivery access without overuse and with safety emphasis.

What should/can be done to improve the safety and quality of CS in low-resource settings:

1. Encourage the safe surgery communities and maternal health to fill gaps jointly, provide guidance, improve training curricula, and achieve higher efficiency.
2. Ensure access to best-quality midwifery care throughout her pregnancy, including antenatal care, birth preparation, delivery, and postnatal care and labor.
3. Invest in surgical and obstetric workforce, addressing rural and urban disparities.
4. Produce user-centered, evidence-based guidelines for safe, high-quality, decision making, and CS services, labor management, keeping in mind the adaptability for low and high-resource settings and "two patients".
5. Strengthen use of referrals which are well facilitated among sites providing different levels of routine as well as emergency obstetric care (e.g. a through use of information/communication technologies).
6. Raise demand among women for higher quality maternity care, including good community-level normative change efforts and counseling during reproductive health/antenatal care.
7. Campaign against CS over-use where appropriate and possible- raising awareness about health impacts of rising CS rates for both the general population and the clinical community.
8. Strengthening of various local health information systems and processes to collect and use standardized data for quality improvement, accountability and research across public as well as private facilities.
9. With private as well as public hospitals showing very low use of vaginal births after CS (almost 100% CS rate at the private hospitals and a rate of 92% at the public hospitals). A key challenge is prevention of the first CS if it is not absolutely clinically indicated.

"We as a community have been promoting institutional delivery as a means to improving health outcomes. We are now realizing that just providing access to care doesn't necessarily improve outcomes".

-Ana Langer, Women and Health Initiative.

"The modern art of surgery does not change the older art of Obstetrics, but it is of gentler kind".

-Marshall, 1955.

"The number one predictor for (a woman's) chance of having cesarean section is what door she walks through. We are struggling to work within the complexity we created in obstetric care, but some tools, such as prioritization logic, will help find a way through this situation".

-Neel Shah, Ariadne Labs.

Volume 11 Issue 7 July 2022