Safe Prevention of Primary Cesarean Delivery

About one in three women now gives birth by cesarean section (C-section) — the nation's most common operating room procedure.[1] More than half of primary cesarean deliveries were based on abnormal labor and abnormal or indeterminate fetal heart rate (FHR) tracings.

The variation in rates of nulliparous, term, singleton, and vertex cesarean births indicate that clinical practice patterns affect the number of cesarean deliveries performed.

What are the most common indications?

In order of frequency, these are the most common indications:

- Labor dystocia
- Abnormal or indeterminate (formerly nonreassuring) FHR tracing
- Fetal malpresentation
- Multiple gestations
- Suspected fetal macrosomia

Footnote:

1 National Partnership for Women & Families. (2016). "Why is the U.S. cesarean section rate so high?" Retrieved from **http://www.nationalpartnership.org/our-work/resources/health-care/maternity/why-is-the-c-section-rate-so-high.pdf**.

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How can we reduce cesarean delivery rates?

We know a broad range of evidence-based approaches are necessary to reduce cesarean delivery rates. These approaches differ by level — hospital systems, hospitals, practices, and patients. At the provider level, keep the following in mind:[1]

- Suspected fetal macrosomia is not an indication for cesarean delivery.
- Counsel women with vertex presenting twin to attempt vaginal delivery. Evidence shows when the first twin is cephalic presentation, outcomes are not improved by cesarean delivery.
- For women with a history of the herpes simplex virus, administer acyclovir at or beyond 36 weeks gestation for viral suppression, even in the absence of outbreak, to prevent cesarean delivery due to outbreak.
- Cervical-ripening methods should be used when labor is induced in women with an unfavorable cervix.
- For a breech presenting fetus, offer and perform an external cephalic version whenever possible and appropriate.
- Before diagnosing a failed induction — when maternal/fetal status allows — consider a longer duration in the latent phase (up to 24 hours or more) and administer oxytocin for at least 12 to 18 hours after rupture of membranes.
- Before diagnosing arrest of labor, allow two hours of pushing in multiparous women and at least three hours in nulliparous women. A longer duration may be appropriate on an individual basis.
- Continuous one-on-one support during labor and delivery, such as a doula, is one of the most effective tools in reducing cesarean delivery rates.

Did you know?

Recent data from the Consortium of Safe Labor indicates contemporary labor progresses at a rate substantially slower than what was historically taught.[1]

For questions:

Contact **Provider Services**

Phone: **844-594-5072**

Footnote:

1 American College of Obstetricians and Gynecologists. (2014). "Safe prevention of primary cesarean delivery." Retrieved from **acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2014/03/safe-prevention-of-the-primary-cesarean-delivery**.

2 American College of Obstetricians and Gynecologists. (2014, Reaffirmed 2023). "Safe prevention of primary cesarean delivery." Retrieved from **https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2014/03/safe-prevention-of-the-primary-cesarean-delivery**.