Strategic measures to reduce the caesarean section rate in Brazil

Quality health care during deliveries and births is essential for reducing maternal and neonatal morbidity and mortality. Birth should not be treated as a set of medical procedures, but as a physiological act, an important family and cultural event, and a unique time between mother and child. In Brazil, 98% of women have their babies in hospitals.1,2 Such progress has not, however, ensured more favourable perinatal outcomes and public policies need to be adopted to ensure quality maternal health care.

Within this context, the national Born in Brazil survey was done in 2011 and encompassed 83% of the births in the country. The survey identified an excess of unnecessary and possibly iatrogenic interventions and sparked debate among academics, professional associations, civil society, and government about the need for changes.3 In 2011, the Stork Network was implemented in hospitals from Brazil’s Unified Health System (SUS) to ensure access to quality care for deliveries and births to reduce maternal and neonatal morbidity and mortality. This strategy also aims to restructure the health-care network and provide evidence-based care to reduce unnecessary procedures, such as caesareans without obstetric indication.4

As the Lancet Series5–7 on optimising caesarean section use shows, a caesarean with obstetric indication and under ideal conditions is a safe procedure with a low rate of serious complications. Caesarean sections can be life-saving and must be accessible to women who need the procedure. A caesarean section done for clinical reasons is effective in reducing maternal and perinatal risks and has a positive impact on morbidity and mortality. There are data from countries where rates of caesarean section are close to zero because women do not have access to this procedure and there is an increased risk of death for mother and infant.

In other settings, high rates of caesarean section have been identified that are associated with increased risk of perinatal morbidity and mortality compared with vaginal deliveries. To ensure feasibility and safety of low rates of the procedure, the influence of population-related factors must be taken into account. On the basis of WHO’s Instrument C-Model8 the reference caesarean rate adjusted for the Brazilian population should be around 25–30%.9,10

High rates of caesarean section continue to be an important challenge in Brazil. Between 2000 and 2014, the caesarean rate increased from 38·02% to 57·07%.1 Since this period, the first fall in the caesarean section rate occurred in 2015, with a national rate of 55·55% and, in 2016, of 55·44% for all the public and private services together.1 A selective analysis showed that, in 2016, caesarean rates in SUS health-care facilities were 41% compared with 83% in private facilities.1 The causes of these high rates are complex and include issues related to the organisation of the health-care network, the model of health care for deliveries and births, and sociocultural factors.

Brazil’s Ministry of Health published the Clinical Protocol and Therapeutic Guidelines for Cesarean Deliveries in 20169 and the Clinical Protocol and Therapeutic Guidelines for Natural Deliveries in 2017.11 These documents guide evidence-based clinical decisions for less interventional care that must be transdisciplinary and focused on the physiology of the birth and on the central role of the woman during the delivery. The health care process should centre on the mother and baby. From this perspective and to reduce caesarean section rates in Brazil’s private health-care facilities, the National Regulatory Agency
for Private Health Insurance and Plans, the Albert Einstein Hospital, and the Institute for Healthcare Improvement, with the support of the Brazilian Ministry of Health, have implemented the Adequate Delivery Project, with results that have already indicated a reduction of 10,000 unnecessary caesarean sections. Additionally, the Project for Improvement and Innovation in Care and Teaching in Obstetrics and Neonatology, launched in 2017, aims to strengthen the best obstetric and neonatal practices in university hospitals to encourage quality care during deliveries and births.

The Careful Delivery Project has been implemented in Brazil since 2018 to make available to managers in health-care units and in different levels of governance in the health-care network an instrument to monitor and assess delivery and indicators of birth quality, including rates of caesarean section. The Ministry of Health is also studying financial incentives to encourage local managers to motivate the health workforce to support more natural births.

The Ministry of Health is intensifying efforts to raise awareness and mobilise all the stakeholders involved. Jointly with the scientific societies, women’s movements, civil society, and human rights and health councils, it has implemented strategic measures to ensure high quality antenatal care, deliveries, and post-partum care, with reproductive planning guaranteed. Brazil has made international commitments related to the 2030 Sustainable Development Goals to reduce maternal and neonatal mortality rates, with a focus on ensuring quality care during deliveries and births and humanised care for women, children, and families during this unique time.

**Lancet Commission on the Value of Death**

Without death every birth would be a tragedy. “We die so that others may live, we grow old so that others may be young”, writes the poet Kate Tempest. Yet medicine continues to strive to keep patients with life-limiting illnesses alive, often beyond the point of benefit. Many people in high-income countries, and those in poorer countries who are able to access quality health care, have an uneasy relationship with death, unlike some traditional societies. Serious people hold out the prospect of immortality, while dying baby boomers want as long a life as possible, symptom control, and a personalised death—a combination that may be unachievable. Yet many people around the world die without access to morphine or any care, illustrating the gross disparities that surround death.

Has medicine gone wrong in the way it deals with death?