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POLICY BRIEF

UNNECESSARY CAESAREAN SECTIONS IN KOSOVO

AMC
Action for Mothers and Children

INTRODUCTION

The aim of this policy brief is to discuss the situation regarding high rates of unnecessary caesarean sections (CS) in Kosovo and the underlying factors behind this health issue. Moreover, this policy brief aims to provide some key facts and recommendations to reduce the rate of unnecessary CS in order to improve the health of women and children in Kosovo.

CS rates have steadily increased worldwide in the last three decades, and this has concerned countries and international health organizations[1]. In a study conducted in Kosovo about health system factors and sections, it was confirmed that CSs are being overused and being performed in the absence of complications during delivery[2]. Caesarean sections have been associated with long term risks such as increased chances of asthma and obesity in children, and various complications in subsequent pregnancies for women[3]. Due to these risks, it is important that action be taken upon this health issue by relevant stakeholders.

KEY FINDINGS

Between 2000 and 2015, CS rates have more than tripled in Kosovo, increasing from 7.5% to 27.3%. Recent findings show that more than 20% (178 cases out of 859) of all low-risk births were delivered via CS. Findings also point to several health system factors that could be responsible for increasing CS rates, as outlined below.[2]

Action for Mothers and Children (AMC) is a non-for-profit foundation with the foremost goal to save the lives of children and improve the health care for mothers in the Republic of Kosovo through developing better systems for the care of pregnant women and their children.

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[1]Betrán A, Merialdi M, A Lauer J, Bing-Shun W, Thomas J, Van Look P, et al. Rates of caesarean section: Analysis of global, regional and national estimates 2007. Fq. 98-113
[2]Hoxha I, Fejza A, Aliu M, et al. Health system factors and caesarean sections in Kosovo: a cross-sectional study. BMJ Open 2019;0:e026702. doi:10.1136/bmjopen-2018-026702
[3]WHO recommendations non-clinical interventions to reduce unnecessary caesarean sections. Gjenevë: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO.

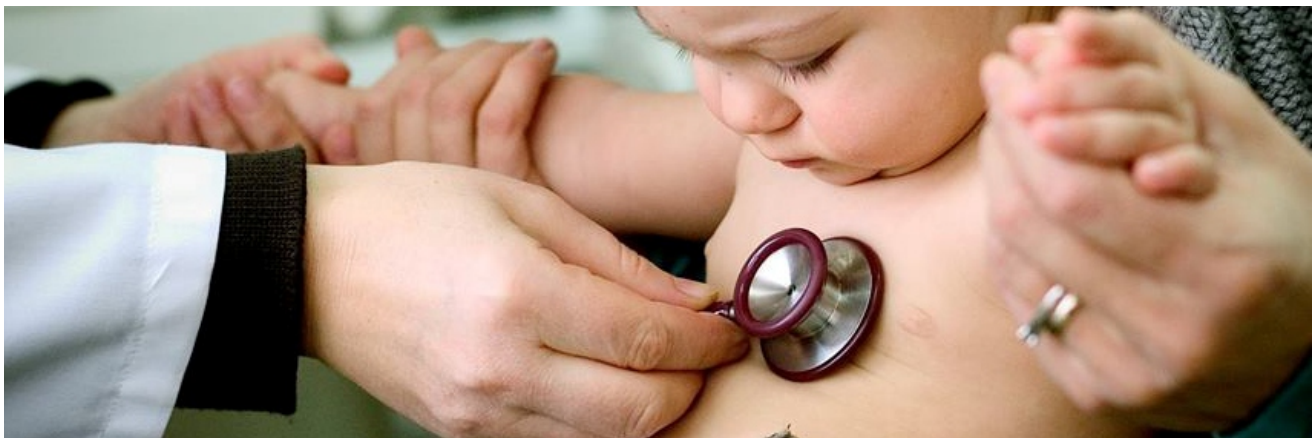
KEY FINDINGS

1. **Increased CS odds for women possessing private health insurance coverage and women with personal monthly income.** From a study conducted in Kosovo's five largest hospitals, it was found that women with monthly personal income and women with private health insurance had increased odds for CSs.[2]These findings might be influenced by the perception of a patient's socioeconomic status rather than the provider's financial incentives associated with disbursement. However, research has shown that women with private coverage may be directed towards clinical decisions that directly benefit the hospital and physician[4]. On the other hand, the disparity related to income is not unique to Europe or the Balkans as an observational study of 72 low- and middle-income countries, including South Sudan, the Dominican Republic, Egypt and Colombia, found that CS rates were lowest in the poorest fifth and highest in the richest fifth.[5]

2. **Increased CS odds for women who preferred to deliver via CS.** This could reflect a number of influences coming from individual, societal and organizational levels. At the individual level, fear of pain during labor and birth, cultural beliefs around luck and fate, and the desire to retain an intact structure and function of the perineum might influence a woman's preference.[2] There is also speculation that societal perceptions relating to prestige may affect a woman's request for a CS. Convenience, fear of litigation and financial incentives also create circumstances that encourage physicians to more readily adhere to patient demands (i.e. preference) for CSs.[5]

3. **Increased CS odds for women who gave birth under a physician that provided antenatal care and if the delivery occurred during office hours, while decreased odds for CS in a teaching hospital.** This finding may speak to the interplay of financial incentives in Kosovo, one of which could be related to informal health service fees. In some cases, women may perceive caesarean sections at a public Kosovar hospital as a "reward" for receiving antenatal care from one particular physician. The higher odds for CS during office hours indicated that the primary drivers for the election of CS may be physician convenience, hospital resource planning, attempts to contain costs, and/or alignment of contractual arrangements with the physicians. Conversely, lower rates of CS in teaching hospitals may be explained by enhanced accountability and professional capacity through more intense interactions during clinical decision-making, systematic review of clinical decisions, and higher compliance with clinical guidelines.[2]

4. **Decreased CS odds for women instructed by a midwife during delivery.** This reflects practice patterns among midwives that tend to avoid labor technology or their own personal patience in their delivery of care compared to more anxious physicians[2]. A midwife-led care model for reducing caesarean rates was explored in China and has led to reduced CS rates. Furthermore, midwife care increased overall self-confidence which made women face distressing labor fearlessly.[6]



[4]B Hoxha I, Syrogiannouli L, Braha M, Goodman DC, da Costa BR, Jüni P. "Caesarean sections and private insurance: systematic review and meta-analysis." BMJ Open. 2017;7(8):e016600. Botuar më 21 gusht 2017. doi:10.1136/bmjopen-2017-016600

[5]Boatin AA, Schlotheuber A, Betran AP, et al. "Within country inequalities in caesarean section rates: observational study of 72 low- and middle-income countries." BMJ. 2018;360:k55. Botuar më 24 janar 2018. doi:10.1136/bmj.k55.

[6]B Wang, Zhihua, Wenchao Sun, and Hong Zhou. "Midwife-led care model for reducing caesarean rate: A novel concept for worldwide birth units where standard obstetric care still dominates." Journal of Medical Hypotheses and Ideas 6, no. 1 (2012): 28-31. 30.

RECOMMENDATIONS

There are strong indications that caesarean sections without clinical necessity are being overused in Kosovo's public hospitals and the underlying factors causing this overuse should be examined. Research is required in order to clarify the interactions of physicians with patients and to further explore the incentives that may be driving the over-provision of CS. Even so, there is already sufficient evidence which can be used to address this health issue. Below are listed some policy directions that could aid policy makers and relevant stakeholders in taking action.

1. **More research to better understand the issues.** More research should be conducted in order to illuminate the interactions of physicians with patients and to further understand the incentives that may be driving the over-provision of CS. This information is crucial in informing decision-making processes. Methods to distribute and discuss the research findings should be enacted.

2. **Health financing scheme provides an opportunity for regulation of incentives.** With the advent of a new national Health Insurance Fund (HIF), Kosovo will hopefully start to see controlled out-of-pocket patient expenditures, fixed prices, predictable hospital fees and improved financial sustainability. This provides an opportunity to address incentivized structures that may be driving the over provision of CS, with several possible methods of implementation. Revising payment structures that reduce the disparity between CS rates in women with and without personal income have brought about positive results in other countries and should be considered in Kosovo's case[7]. Equal pay for delivery, regardless of the procedure, can also escalate CS rates; therefore strategies that reduce incentives for CS provision in favor of normal deliveries should be considered.[2,4,8,9] Physicians should not be reimbursed via fee-for-service which encourages physicians to provide more CS. Providing financial incentives to healthcare professionals who only perform CSs in necessary cases or taxing physicians who perform CSs in unnecessary cases should also be considered[10]. At the hospital level, natural births can be set as a financial indicator. In such a set-up, higher rates of CSs will adversely affect financing for hospitals and will ideally reduce the number of unnecessary CSs.

3. **Educational sessions for pregnant women.** The foundation Action for Mothers and Children has already established Women's Health Resources Centers (WHRC) in 12 municipalities in Kosovo. WHRCs educate mothers regarding healthy pregnancies, and also address misconceptions surrounding vaginal births. These centers provide education and counseling directly to women and their partners. Women learn from videos, educational handouts, small group sessions, and direct counseling with a midwife, nurse, or gynecologist. In a culturally sensitive manner, peer educators should build awareness around the benefits of vaginal delivery and outline the consequences of performing unnecessary CSs. Such sessions are in conformity with non-clinical intervention guidelines proposed by the WHO for the reduction of unnecessary CSs.[3] It is recommended that the Ministry of Health supports such efforts and coordinates with public and private hospitals to initiate free educational sessions for pregnant mothers and their partners.

4. **Support adherence to clinical practice guidelines (CPGs) by medical staff.** In order to lower cesarean section rates among Kosovar women, it is imperative that physicians and medical staff adhere to the clinical practice guidelines which regulate the conditions for CS administration. A focus group study regarding proposed guidelines by WHO on postpartum maternal health found various barriers such as: the lack of understanding and engagement in the guideline development process, lack of capacity to document and monitor clinical practice, lack of training, and lack of communication between the Ministry of Health and clinical organizations.[11] Suggested solutions for these barriers by relevant stakeholders were to create a centralized system for data collection across clinical settings, creation of a monitoring system for guideline adherence, incentives for staff to encourage guideline adherence, and increasing communication between relevant stakeholder groups through activities such as guideline development

[7]Barber, Sarah, Frederic Bonnet, and Henk Bekedam. "Formalizing under-the-table payments to control out-of-pocket hospital expenditures in Cambodia." Health Policy and Planning 19, no. 4 (2004): 199-208.
[8]Brown JR, Chang CH, Zhou W, et al. Health system characteristics and rates of readmission after acute myocardial infarction in the United States. Journal of the American Heart Association 2014;3(3):e000714. doi: 10.1161/jaha.113.000714 [publikuar së pari online: 2014/05/23]
[9]Brown JR, Sox HC, Goodman DC. Financial incentives to improve quality: skating to the puck or avoiding the penalty box? Jama 2014;311(10):1009-10. doi: 10.1001/jama.2014.421 [publikuar së pari online: 2014/03/13]
[10]Mohammadshahi, Marita, Hasan Hematyar, Masoumeh Najafi, Minoo ALIPOURI SAKHA, and Abolghasem Pourreza. "Caesarean Section vs. Normal Vaginal Delivery: A Game Theory Discussion in Reimbursement Interventions." Iranian journal of public health 47, no. 11 (2018): 1709.

RECOMMENDATIONS

committees.[11]

These same solutions can aid in addressing and lowering the high rates of CS among Kosovar women. Having a transparent system where data can be collected, such as the reasons for CS administration, coupled with a monitoring mechanism binds guidelines to actions and creates accountability. In cases of an indicated CS, a strategy of a mandatory second opinion structure by senior clinicians is recommended to reduce births via CS.[3]
Furthermore, creating incentives for medical staff that follow guidelines will reinforce adherence and accountability. Making the development process of guidelines inclusive to relevant stakeholder groups, will raise awareness and understanding in regard to the importance of such guidelines. Finally, the Ministry of Health and relevant clinical organizations should consider the creation of a working group that directly addresses the high rates of CS by acting as the facilitator for the above, but not limited to, suggestions.

5. Greater involvement of midwives in deliveries. It has been shown that women who were instructed by a midwife during delivery preparation had decreased odds for CS[2]. In light of this, it is crucial to ensure a greater involvement of midwives in hospitals and family medical centers in order to allow for more frequent interactions between pregnant mothers and midwives. This will not only permit midwives to practice their profession, but to also build trust between them and pregnant mothers as Kosovars generally lack trust in midwives. Changing this perception can also be achieved by providing educational sessions to women about the role of midwives during pregnancy and delivery. Training should be provided for midwives in order to improve and update their skills and tools in performing safe deliveries. Implementing such strategies will ultimately aid the reduction of CS rates among women in Kosovo via a more extensive involvement of midwives during pregnancy and deliveries.

Photos by Vedat Xhymshiti

[11]Moore, Julia E., and Sharon Straus. GREAT (Guideline-Drive, Research Priorities, Evidence Synthesis, Application of Evidence, and Transfer of Knowledge) Interim Project Report/Findings from Focus Groups and Consensus Meeting in Pristina, Kosovo. Li Ka Shing Knowledge Institute, St. Michael's Hospital, Dec. 2012.

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