

What initially seems to be a democratic or “liberal” stance in awarding all the same access to healthcare technology could in actuality be a conservative and medically radical solution to the social inequalities that have led to an increase in caesarean section rates. Additional research is needed in settings where the economically based distribution of caesarean sections is not as discrepant as in Brazil. Even modest inequalities in healthcare provision might create a market for unnecessary interventions among women who feel marginalised from access to medical technology.

Contributors: see bmj.com

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What is already known on this topic

Women's preferences for caesarean sections are understood to result from lack of knowledge and psychological aptitude to handle vaginal delivery and its consequences

Efforts to reduce the demand for caesarean sections have focused on providing consumers with correct information on the relative risks associated with vaginal and operative deliveries

What this study adds

In Brazil, many women prefer caesarean sections because they consider it good quality care

Rich women are more likely to have caesarean sections, supporting the notion that medical intervention represents superior care

Poor women may implement a series of medicalised practices that justifies the need for greater medical intervention during birth

Interventions for reducing caesarean sections by educating physicians and patients about risk factors associated with birthing procedures are not sufficient

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Episiotomy rates in primiparous women in Latin America: hospital based descriptive study

Fernando Althabe, José M Belizán, Eduardo Bergel

Current scientific evidence shows that routine episiotomy is not justified: it has no benefit for mother or infant, increases the need for perineal suturing and the risk of complications to the healing process at seven days post partum, produces unnecessary pain and discomfort, and has potentially harmful long term effects.¹⁻³ We report rates of episiotomy in primiparous women in Latin American hospitals according to characteristics of hospitals and caregivers.

Participants, methods, and results

We conducted a hospital based descriptive study based on data routinely collected in a perinatal information system.⁴ We analysed data from 122 hospitals in 16 Latin

American countries that had reported 416 852 deliveries between 1995 and 1998. We selected hospitals reporting more than 35 spontaneous vaginal deliveries in primiparous women, which is the sample size required to give a 95% confidence interval of 10% either way for an episiotomy rate of 90%. This selection comprised 105 hospitals in 14 countries, which reported 94 472 spontaneous vaginal deliveries in primiparous women. We report episiotomy rates by hospital, with medians (interquartile ranges) as a summary measure.

In 91 hospitals (87%) episiotomy rates were higher than 80% and in 69 hospitals (66%) they were higher than 90%. The overall median rate was 92.3%, and median rates by country varied between 69.2% and 96.2% (table). Episiotomy rates were similar in primary,

Editorial by Langer and p 942

Correspondence to: F Althabe althabef@clap.ops-oms.org
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Latin American Center for Perinatology, Pan American Health Organization, World Health Organization, Casilla de Correos 627, Montevideo 11000, Uruguay
 Fernando Althabe researcher in perinatology
 José M Belizán director
 Eduardo Bergel epidemiologist

Episiotomy rates in primiparous women with spontaneous vaginal deliveries in Latin America, 1995-98

Location	No of hospitals	No of deliveries		Median rate (interquartile range) of episiotomies (%)
		Total	Median	
Mexico	2	1 375	688	69.2 (45.7-92.7)
Panama	1	55	55	81.8
Argentina	36	32 454	354	85.7 (78.7-91.3)
Colombia	3	3 496	1314	86.2 (85.7-88.5)
Nicaragua	1	146	146	86.3
Bolivia	3	1 811	351	90.8 (88.5-95.2)
Paraguay	4	3 933	1116	91.5 (90.7-92.5)
Honduras	2	888	444	92.0 (90.7-93.2)
Brasil	3	406	123	94.2 (47.2-98.9)
Peru	9	7 134	918	94.4 (93.1-94.8)
Dominican Republic	1	5 368	5368	94.9
Uruguay	38	31 456	403	95.1 (93.3-96.4)
Chile	1	5 020	5020	95.9
Ecuador	1	930	930	96.2
All countries	105	94 472	439	92.3 (86.3-94.9)

secondary, and tertiary hospitals (89.8%, 91.6%, and 92.7%, respectively) and for public, private, and social security hospitals (90.2%, 96.4%, and 95.6%, respectively). The rates were also similar according to who attended the delivery (doctors in 91.4%, midwives or nurses in 93.6%, and students in 93.7%).

Comment

Nine in every 10 primiparous women who gave birth spontaneously in hospitals in Latin America between 1995 and 1998 had an episiotomy. This figure was similar in public and private hospitals, primary care and referral hospitals, and deliveries attended by doctors or midwives. If a rate of 92% is applied to the 2.35 million primiparous women giving birth spontaneously in Latin American hospitals per year, this means that 2.17 million primiparous women per year receive an episiotomy.

The results were obtained from a database in which routine data are collected, and therefore have some potential limitations. The rates might have been affected by different outcome definitions among hospitals, but in maternity health services, episiotomy has a unique definition. In view of the high rates, it is possible that episiotomy rates are over-reported by recording perineal tears as episiotomies. But this is unlikely in the perinatal information system, because outcomes are marked separately in the data collection form. The rate of missing values in this dataset was below 1%.

Seventy one per cent of hospitals in the database were located in Argentina and Uruguay. The results

might therefore represent standards of care in hospitals in those two countries rather than elsewhere. The similarities between hospitals in rates of episiotomy are, however, unlikely to be indicative of bias in hospital selection but of a common standard practice in the use of the procedure in most of Latin America's hospitals.

This situation is inadmissible in the light of the current evidence. The challenge now is to design and test an original intervention directed to women and caregivers to change the use of episiotomy in Latin American hospitals.

We thank all health workers and health related workers in many settings of Latin America and the Caribbean for their efforts to collect and send the data from the perinatal information system.

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One hundred years ago Advertising

One last word on the question which lies at the root of this matter—that of the medical etiquette which forbids the recommending of a doctor save by another medical man. On this point, Sir, I know I cannot expect to obtain the agreement of a medical journal—*ex officio*, you are bound to be against me; but you have many lay as well as professional readers, and to them I would say, Can you honestly say that it is not for the public interest, not for the greatest good of the greatest number, that information should be obtainable by uninstructed persons as to

who are leading specialists, or, in the ordinary phrase, the “best people to go to,” in this or that medical emergency—I will not even say the best, but good people? To whom could such information do harm? And is it not the case that the single argument against it is the unworthy argument above commented on—the argument that such information might not be unprejudiced. That, Sir, can be urged against every kind of information whatsoever which is given to the public.

(*BMJ* 1902;i:486)