

Dr. Archer's letter is based upon inaccurate assumptions. First, while the ELISA is highly sensitive and specific, it is not correct that "false positives can be eliminated by supplementary tests." The predictive value of the ELISA and supplementary tests in a low-risk population—such as in premarital screening—is not as high as has been suggested. Our group at the Harvard School of Public Health estimates that use of the Abbott ELISA and Western Blot in a low-risk population would produce a 28 per cent false positive rate.⁴

Second, while use of barrier contraception is not entirely safe, it does provide important protection. Frequent use of barrier protection clearly attenuates the rate of seroconversion.⁵ Public health officials and educators should certainly encourage regular use of condoms for those who will not abstain from sexual relations.

Proposals for the use of mandatory legal powers do not go to the heart of the epidemic and would divert resources from much-needed programs to prevent the spread of HIV.⁶

REFERENCES

- Centers for Disease Control: Recommended additional guidelines for HIV antibody counseling and testing in the prevention of HIV infection and AIDS. Atlanta, GA: CDC, April 30, 1987.
- World Health Organization: Report of the consultation on global criteria for HIV screening programs. Geneva: WHO, May 20–21, 1987.
- Gostin L, Curran WJ, Clark M: The case against compulsory casefinding in controlling AIDS—testing, screening and reporting. *Am J Law Med* 1987; 12:1–47.
- Barry MJ, Cleary PD, Fineberg HV: Screening for HIV infection: Risks, benefits, and the burden of proof. *Law, Med, Health Care* 1987; 14:259–267.
- Fischl MA, Dickinson GM, Scott GB, *et al*: Evaluation of heterosexual partners, children and household contacts of adults with AIDS. *JAMA* 1987; 257:640–644.
- Gostin L: Viewpoint: The nucleus of a public health strategy to combat AIDS. *Law, Med, Health Care* 1987; 14:226–230.

Larry O. Gostin, JD

William J. Curran, JD, LLM, SMHyg

Mr. Gostin is Executive Director, American Society of Law & Medicine, 765 Commonwealth Avenue, Boston, MA 02115; Mr. Curran is Professor of Law and Medicine, Harvard University, Boston.

TABLE 1—Cesarean Deliveries in Different Types of Obstetric Units, Latium Region, Italy, 1985

Type of Obstetric Units	Total Births	Proportion of Cesareans (%)	Crude Rate Ratios	Adjusted Rate Ratios	95% CI
NHS Public Hospitals	34,785	20.7	1.0	1.0	
Private Clinics*	9,615	26.0	1.26	1.26	1.21–1.31
Private Obstetric	2,842	32.3	1.56	1.44	1.35–1.55
Unknown	255				

*Private obstetric units under special agreement with the NHS whereby patients pay part of medical expenses.

Cesarean Section Rates in Italy

Recent reports on cesarean section rates in the United States¹ and several other countries² reflect a consistent increase over the past two decades. Data on cesareans from southern European countries are scanty in the international literature. We are able to provide 1985 data from one Italian region (Latium), obtained through the Birth Registration System run by the Epidemiologic Unit of the Regional Health Authority.

In 1985, 47,497 live births were registered; nearly all deliveries (99.9%) occur in hospitals. The cesarean section rate was 22.5 per 100 deliveries, comparable to the 1985 rate reported for the USA (22.7%).¹ The proportion of cesarean sections is higher among babies weighing less than 2,500 grams (32.3%) and multiple births (37.4%). Cesarean sections were performed in 71.8% of breech presentations. The pattern of cesarean rates according to age and birth order is similar to that observed in other countries, the highest rates being among first births (23.2%) and women 35 years of age and over (34.9%). No information is available on the proportion of repeat cesareans among the total cesarean deliveries.

We classified the births according to the type of maternity service where the delivery took place. In our region, there are three types of obstetric units: National Health Service (NHS) public hospitals, private clinics, and clinics run by private organizations under a special agreement with the NHS. In the latter, the patients pay part of the medical expenses, whereas the public hospitals are free and the private clinics charge the patients all medical expenses.

Data are summarized in Table 1. Rate ratios were adjusted for maternal age, birthweight, and parity³ with public hospitals taken as the reference category. There were no differences among maternities in breech presentations and plural birth rate.

Data show a marked difference among cesarean rates by type of maternity service, with the highest rate in the private units. This association suggests that in our region type of obstetric care may be an important determinant of mode of delivery; however, because of lack of information in the Italian birth certificate, we cannot evaluate the role of other obstetric factors (maternal diseases, dystocia, fetal distress, previous cesareans). Our data confirm the findings of Haynes de Regt R, *et al*,⁴ on the relationship between public and private care at birth and cesarean section frequency.

REFERENCES

- Placek JP, Taffel SM, Moien M: Cesarean rate increases in 1985. *Am J Public Health* 1987; 77:241–242.
- Notzon FC, Placek JP, Taffel SM: Comparisons of national cesarean-section rates. *N Engl J Med* 1987; 316:386–389.
- Mantel N, Haenszel W: Statistical aspects of analysis of data from retrospective studies of disease. *JNCI* 1959; 22:719–748.
- Haynes de Regt R, Minkoff HL, Feldman J, Schwarz RH: Relation of private or clinic care to cesarean birth rate. *N Engl J Med* 1986; 315:619–624.

Roberto Bertollini, MD, MPH

Domenico Di Lallo, MD

Elisabetta Rapiti, MD

Carlo A. Perucci, MD

Epidemiologic Unit, Latium Region, Via G. Carducci, 4, 00187 Roma, Italy