# Letters

## Evidence-based reproductive health care

***Editor*** – In the December 2005 issue of the *Bulletin*, Tita et al. published an article in which they reported the suboptimal use of evidence-based interventions in obstetric care.[1] They mentioned that their findings are consistent with those of a hospital-based study in China, which concluded that obstetric practice did not follow the best available evidence.[2] We would like to draw your attention to similar findings that we reported recently in a study carried out in Uruguay.[3] The objective of these three studies was to obtain information about the prevalence of use of certain reproductive health interventions. Tita et al.'s study assessed the use of 13 practices by 328 health workers in Cameroon, while our study assessed the use of eight beneficial and five harmful practices by examining 773 hospital records obtained from 10 of Uruguay's 19 provinces. Five of the interventions assessed were the same in both studies (antenatal corticosteroids for prematurity, uterotonics to reduce bleeding, periconceptional folate supplementation, social support during labour, and episiotomy). The prevalence of use of each one of these practices was different in the two study countries, with Uruguay having better levels for use of antenatal corticosteroids for prematurity (18% versus 10%) and for provision of social support during labour (90% versus 28.7%). In contrast, Cameroon had better levels of use of uterotonics to reduce bleeding (71.5% versus 10%); periconceptional folate supplementation (26.9 % versus 0%), and selective use of episiotomy (85.8% of physicians in Cameroon answered that they try to avoid its use, while 40% of the women in Uruguay didn't receive it).

The general lack of implementation of evidence-based health care practices in these two developing countries is evident. Efforts should be made in order to offer continuous medical education and training programmes in settings where resources are constrained, in order to achieve better health-care quality indicators. In addition, new strategies, such as attempting to persuade providers to adoption of best practices, should be explored.[4] ■

**Competing interests:** none declared.

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1. Tita A, Selwyn B, Waller D, Kapadia A, Dongmo S. Evidence-based reproductive health care in Cameroon: population-based study of awareness, use and barriers. *Bull World Health Organ* 2005;83:895-903.
2. Qian X, Smith H, Zhou L, Liang J, Garner P. Evidence-based obstetrics in four hospitals in China: an observational study to explore clinical practice, women's preferences and providers' views. *BMC Pregnancy Childbirth* 2001;1:1. Available from: http://www.biomedcentral.com/1471-2393/1/1
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### Corrigenda

In Vol. 84, issue number 4, 2006, page 307, in the penultimate line of column 2 the > [more than] symbol should be ⩾ [more than or equal to]. On page 309, in the 9th, 10th, 19th and 20th rows of Table 4 and in footnotes [b] and [c], the > [more than] symbol should be ⩾ (more than or equal to).

In Vol. 84, issue number 5, 2006, page 417: "local working" should read "non-working". On page 418: "Linking compulsory licensing to R&D by domestic firms would be a reasonable way to stimulate innovation and encourage voluntary cross-licensing." should read: "The patent system could thus serve as the infrastructure for developing local R&D and business."

"Despite the small number of cases, the mere possibility of arbitration would have altered the cross-license bargaining process in favour of downstream patent holders, similar to the threat of compulsory licensing." should read "Despite the small number of cases, the mere possibility of arbitration would have altered the cross-license bargaining process in favour of downstream patent holders."

"... the hurdle on patentability." should read "... the hurdle on patentability - in particular, inventive step."

In reference 1: "Aiko R" should be "Aoki R".

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