Letters

Caesarean birth as a component of surgical services in low- and middle-income countries

We were very pleased to see further attention drawn to the issue of surgery as a global public health issue in low- and middle-income countries by Ozgediz et al. in the August 2008 edition of the *Bulletin*.[1] We write to draw attention to one component of surgical services, Caesarean birth, which has been well documented relative to other types of surgery. Nationally representative data on Caesarean birth are available for approximately 90% of births in developing countries. Similar results from two separate compilation exercises have been published[2,3] for the years around 2000 and efforts are underway to compile data for 2005. Many but not all of these data come from Demographic and Health Surveys, which also allow disaggregation by socioeconomic status.[4]

Moreover, substantial efforts have gone into determining the unmet need for Caesarean birth by defining indications for Caesarean that are "absolutely" life-threatening.[5] Women who experience these problems are unlikely to survive if they do not receive a Caesarean. Absolute maternal indications include severe antepartum haemorrhage due to placenta praevia or abruptio placentae, major cephalopelvic disproportion, transverse lie and brow presentation. Several studies have now estimated the met need for Caesarean section in urban areas with good access to emergency obstetric care,[6] and the population-based incidence for the conditions suggested above range between 1–2% of births. Caesarean birth rates falling below 1% are thought to reflect a real deficit in access to life-saving Caesarean section.

Data on indications for Caesarean exist at the facility level but are rarely reported in routine health information systems and virtually never reviewed at higher levels. A standard categorization of indications for Caesarean is now available, separating absolutely life-threatening indications from other indications.[7] Given the rapidly increasing trends in Caesarean birth in many developing countries, and the occurrence of non-medically indicated Caesarean, we recommend the inclusion of Caesarean deliveries broken down by absolute and non-absolute indications into routine reporting systems, even where national rates are high.

Thus, we write this letter to draw attention to the fact that progress has been made regarding the mortality component of the "numerator" of disease burden avertable by Caesarean. We encourage researchers to explore adaptation of the approach used by the Unmet Obstetric Need Network for other surgical services and we welcome their ideas for expanding the met need concept to encompass morbidity. ■

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References

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