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Global Epidemiology of Use of and Disparities in Caesarean Sections

In their Series on optimising caesarean section (CS) use, Ties Boerma and colleagues[1] report on 98·4% of the world's births in 2015 from 169 countries. They found that CS use in some low-income and middle-income countries was more frequent in private health-care facilities than in public health-care facilities.[1] In this respect, the Series paper singles out Brazil as a country where CS is the predominant delivery mode in private facilities.[1] Gilberto Magalhães Occhi and colleagues[2] contrasted the rates of CS in Brazil in private facilities (83% of all deliveries) versus public facilities (41%; with public facilities being those hospitals registered in the Unified Health System) for the year 2016. South Africa's use of CS in private facilities mirrors that of Brazil, with CS being the delivery mode in greater than 90% of women in most private facilities in 2010–14,[3] and thus the country should also have been singled out by Boerma and colleagues. However, South Africa was grouped with countries which had the lowest CS rates,[1] which masked the overuse of CS in its private facilities. The result of this grouping is that an opportunity for this timeous paper to highlight CS overuse in South Africa's private facilities has unintentionally been missed, with potential negative consequences. Firstly, CS overuse in South Africa's private facilities might remain unidentified by international bodies such as WHO and the International Federation of Gynaecology and Obstetrics. Secondly, unnecessary numbers of newborn infants and their mothers might continue to have unanticipated complications resulting from CS overuse, as outlined in a related paper in the same Series.[4] Thirdly, the South African public and law profession (particularly litigants of medicolegal cases) might continue to believe

that CS is the safest mode of delivery. Finally, concerted efforts facilitated by relevant and accurate data to decrease the use of non-indicated CS might remain uninitiated. CS use in South Africa should be analysed differentially and programmes to stem CS overuse in private facilities should be initiated as a matter of urgency.

I declare no competing interests.

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1 Boerma T, Ronsmans C, Melesse DY, et al. Global epidemiology of use of and disparities in caesarean sections. *Lancet* 2018; **392:** 1341–48.

2 Occhi GM, Netto TdLF, Neri MA, Rodrigues EAB, Fernandes AdLV. Strategic measures to reduce the caesarean section rate in Brazil. *Lancet* 2018; **392:** 1290–91.

3 Competition Commission South Africa. Health market inquiry: provisional findings and recommendations report. July 5, 2018. http://www.compcom.co.za/wp-content/uploads/2018/07/Health-Market-Inquiry-1.pdf (accessed May 5, 2019).

4 Sandall J, Tribe RM, Avery L, et al. Short-term and long-term effects of caesarean section on the health of women and children. *Lancet* 2018; **392:** 1349–57.