

Episiotomy Rates Around the World: An Update

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ABSTRACT: *Episiotomy, the unkindest cut of all, persists despite clinical practice guidelines recommending its restrictive use. The purpose of this paper was to compile international statistics on the use of this practice and examine whether current guidance on the restrictive use of episiotomy was being followed. Methods:* We searched government websites and the Internet, contacted colleagues for references, and checked the references of retrieved citations. **Results:** *Statistics from around the world revealed overall high rates of episiotomy with a decreasing trend in some countries. Considerable variation occurs in the use of the operation by country, within countries, and even within the same professional provider group. Conclusions:* Greater efforts are needed than currently in place to reduce the episiotomy rate, particularly in the developing world. (*BIRTH 32:3 September 2005*)

Over the past 20 years, evidence supporting the restrictive use of episiotomy has been disseminated. International acceptance of this approach to perineal management can be seen in policy statements and clinical practice recommendations issued by many prominent public health and professional bodies.

The World Health Organization recommends that episiotomy be used only for select indications (1–3). The Latin American Center for Perinatology and Human Development and the Pan American Health Organization recommend restrictive rather than routine use of episiotomy (4). The American College of Obstetricians and Gynecologists recommends that

episiotomy be used to aid in the management of delivery in some situations, but states that routine use of the procedure is not necessary (5). The American College of Nurse-Midwives recommends that episiotomy only be used to relieve fetal or maternal distress, or when the perineum is responsible for a lack of progress (6). The Society of Obstetricians and Gynecologists of Canada recommends that episiotomy only be used to expedite delivery in the case of fetal compromise or maternal distress and lack of progress (7). The Federal Department of Health in Canada also recommends that episiotomy only be used in the case of special fetal or maternal indications (8). The Royal College of Obstetricians and Gynaecologists in the United Kingdom recommends that routine episiotomy be abandoned and a policy of restricting use of episiotomy to specific maternal and fetal indications be adopted (9–10). Other organizations supporting the restrictive use of episiotomy include the Board on Global Health, a board of the U.S. Institute of Medicine, a component of the U.S. National Academy of Sciences (11), and Maternal and Neonatal Health, a USAID organization (12).

Although agreement about restricting the use of episiotomy is generally growing, no such consensus has emerged as to what constitutes an appropriate episiotomy rate. Based on their randomized controlled trial, Carroli and Belizán indicated that a rate above 30 percent could not be justified (13).

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Some have suggested a rate of 20 percent may be appropriate (14). Still others have suggested that it should be about 10 percent for primiparas and 5 percent for multiparas (15).

Methods

Interested in determining whether current guidance on the restrictive use of episiotomy was being followed, we set out to compile international statistics on the use of this practice. We located statistics by searching government websites and the Internet, contacting colleagues for references and checking the references of retrieved citations. We attempted to be comprehensive in our search, but statistics from some countries may have been missed.

Results

Although episiotomy is a common obstetrical procedure, statistics on its use are not always easily located. The haphazard way that statistics on episiotomy are often collected and reported, if they are collected and reported at all, indicates the lack of significance that has been placed on this operation by health officials. Furthermore, despite the well-known relationship between parity and the use of episiotomy (primiparous women having higher episiotomy rates), episiotomy statistics by parity is not systematically collected in many countries. Because the fertility rate influences the episiotomy rate, and the resulting proportion of the population that is primiparous and multiparous, caution must be exercised when interpreting an episiotomy rate that is provided for the entire childbearing population.

Table 1 presents episiotomy rates for the years 1995 to 2003 by selected regions and countries (16). Episiotomy rates that include *both* primiparous and multiparous women range from as low as 9.7 percent (Sweden) to 100 percent (Taiwan). Rates for *solely* primiparas range from 63.3 percent (South Africa) to 100 percent (Guatemala), demonstrating the overall greater likelihood that primiparas will undergo episiotomies. Episiotomy rates tend to be lowest in English-speaking and some European countries. In many parts of the world (e.g., Central and South America, South Africa, and Asia), episiotomy rates remain very high. For example, in much of Latin America, 9 of every 10 primiparas can still expect to receive an episiotomy (17).

Not only is there large variation in the use of episiotomy from country to country, often variation occurs within countries. In the United States the episiotomy rate varies from region to region. The highest rate in 2000 was in the Northeast, 38 percent, and the

lowest was in the West, 27 percent (18). The 2000–2001 episiotomy rate by Canadian province also revealed that the use of this surgery ranged from 3 percent (Nunavut) to 31 percent (Quebec) (19). Australian data from 2002 also reveal that the rate varied from 9.9 percent in the Northern Territory to 20.9 percent for the State of Victoria (20).

Similar observations about variation in the use of episiotomy have been made around the world. Within Ireland, total rates in 1998 varied between 7 and 47 percent. Rates for primiparas varied between 13.3 and 80 percent, whereas rates for multiparas varied between 2 and 40 percent (21). A study of 39 hospitals in the Netherlands found the 1995 episiotomy rate varied from 7.6 to 42.1 percent in spontaneous term deliveries (22). In Argentina, the total episiotomy rate for 1995 was found to range between a low of 33 percent and a high of 62.5 percent in different hospitals (23). Variation in episiotomy rates by hospital in Sweden was observed by Rockner et al in 1989 and 1995, although the variation was less in 1995 (24,25). A 1999 observational study of 4 hospitals in Shanghai, China, revealed that the episiotomy rate ranged from 65 to 93 percent (26). In England, little variation occurred in episiotomy rate by region; national statistics for 2002–2003 reveal the rate by region differed by only 3 percent (27).

Not only can episiotomy rates vary between and within countries, they can vary considerably within the same provider group in the same institution. In one study of 20 experienced labor ward midwives in Dublin, episiotomy rates by individual caregiver ranged from a low of 6 percent to a high of 84 percent (28). Similarly in England, Wilkerson studied 21 midwives in one hospital and observed huge variation among midwives, concluding that the variation suggested episiotomy was determined not by the condition of the mother or baby but by which provider was allocated to the case (29). In an observational study of 30 midwives in Denmark, the rate of episiotomies performed varied from less than 10 to more than 70 percent (30).

Discussion and Conclusions

This brief and selective review of episiotomy rates not only reveals overall high rates of episiotomy with a decreasing trend in some countries, but also considerable variation in the use of the operation by country, within countries, and even within the same professional provider group. Notwithstanding the limitations inherent in relying on official and unofficial statistics, these variations are not likely to be explained by differences in the childbearing population. This finding suggests that in many settings, use

Table 1. Selected Episiotomy Rates Per 100 Vaginal Deliveries by Region and Country, 1995–2003

<i>Region</i>	<i>Country/Reference</i>	<i>Year</i>	<i>Primiparas %</i>	<i>Total %</i>
North America	Canada (19)	2000–2001		23.8
	United States (18)	2000		32.7
Central and South America	Argentina (38)	1996	65.3	28.5
	Mexico (17)	1995–1998	69.2	
	Panama (17)	1995–1998	81.8	
	Colombia (17)	1995–1998	86.2	
	Nicaragua (17)	1995–1998	86.3	
	Bolivia (17)	1995–1998	90.8	
	Paraguay (17)	1995–1998	91.5	
	Honduras (17)	1995–1998	92	
	Brazil (17)	1995–1998	94.2	
	Peru (17)	1995–1998	94.4	
	Dominican Republic (17)	1995–1998	94.9	
	Uruguay (17)	1995–1998	95.1	
	Chile (17)	1995–1998	95.9	
	Ecuador (17)	1995–1998	96.2	
	Guatemala (12)	2001	100 (estimate)	
Northern Europe	Sweden (39)	1999–2000		9.7
	Denmark (40)	2002–2003		12
	Finland (41)	2003		33.9
Western Europe	England (42)	2002–2003		13
	Scotland (40)	2002–2003		16.3
	Netherlands (43)	1995		24.5
	Germany (40)	2002–2003		44.4
	Switzerland (44)	2004		46
	Ireland (39)	1999–2000		46
	France (40)	2002–2003		49.5
	Italy (39)	1999		58
	Turkey (45)	1999–2000		64
	Spain (46)	1995		87.3
Eastern Europe	Bulgaria (47,48)	1997	77.1	45.6
	St. Petersburg, Russia (49)	1997		46.2
Asia	Nepal (50)	2003		42.9–67.3
	China (26)	2001		82
	Taiwan (32)	2002		100 (estimate)
Middle East	Israel (51)	2001		37.6
Oceania	New Zealand (52)	2001		11
	Australia (20)	2002		16.2
Africa	Burkina Faso (53)	1998	37	14
	Nigeria (54,55)	2001	90	20
	Botswana (56)	1998–2000		20.7
	Zimbabwe (57)	1997–1998	54	27
	South Africa (58)	2003		63.3–67.5

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of episiotomies is still not guided solely by clinical indications, as suggested by practice guidelines recommending the restrictive use of episiotomy. It is unclear what factors can best explain the large variation in episiotomy rates. Some scholars point to the prevailing notions in some cultures of birth as pathological (31) and other attitudes and beliefs about the nature of birth and women's bodies (16) as key causes for the high rates. Others have suggested it may be

due to the medicalization of childbirth (32) and the importation of the United States' reliance on episiotomy because it was considered more progressive or superior to traditional approaches of restricting its use (33,34). Although the current maternity care climate, as measured by mounting research evidence (35), supports restrictive use of episiotomy, more efforts to reduce the episiotomy rate are clearly needed, particularly in the developing world (36,37).

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