

## EDITORIAL COMMENTARY

### **PERIPARTUM COMPLICATIONS OF UNDIAGNOSED TWIN PREGNANCY AT KBTH, ACCRA**

#### **A DESCRIPTIVE CLINICAL SURVEY OF 228 PERINATAL DEATHS AT KBTH**

*God blessed them and said to them, "Be fruitful and increase in number; fill the earth and subdue it". Gen. 1:28a*

The inevitability of death means that successful procreation is the major key to the survival of any species of living organism. Underlying fulfillment of the simple commandment to humankind "to multiply and fill the earth" are very complex and elaborate processes that begin with germ cell production and end with the successful birth of a child who survives the neonatal period and grows to adulthood to reproduce his/her kind. Equally important in this regard is the survival of the mother in the process of childbirth. Several factors, some modifiable others not, interplay to affect the success of the processes involved in procreation. These factors behave like "time-bombs" programmed to go off at an "appointed time" to cause fetal and/or maternal loss or impair successful fetal development.

Parental factors such as cultural beliefs and practices, attitudes and education among others are modifiable but inheritable genetic abnormalities cannot be modified. While fetal conditions such as twin-twin transfusion, malposition and hypoxia/distress are modifiable other fetal factors such as genetic abnormalities arising during embryogenesis, failure of organogenesis and developmental abnormalities of the placenta are not. Environmental and third party factors (iatrogenic factors) are largely modifiable and preventable. Studies and surveys on factors affecting the success of procreation often reflect on the coverage and components of ante-, intra- and immediate post-partum fetal and maternal monitoring and management. Aspects of antenatal and peripartum care are the subjects of two papers<sup>1,2</sup> in this edition of the GMJ.

In the first, Obed et al describe a clinical survey of 228 perinatal deaths at the Korle Bu Teaching Hospital<sup>1</sup>. The commonest causes of perinatal deaths

were respiratory distress syndrome (30.4%), birth asphyxia (24.6%) and sepsis (18.8%). The commonest associated maternal and labour complications were hypertension, antepartum haemorrhage, premature rupture of membranes with or without chorioamnionitis and fetal malpresentation/malposition. These findings are largely in agreement with the results of previous studies<sup>3,4</sup>. The effects on the fetus of all these complications are on the whole modifiable with early commencement and regular antenatal attendance, vigilance and better fetal and maternal monitoring. Hospital staff were to blame in about 82% of cases for which responsibility was assigned!

In the second, Obed looks at the peripartum complications of undiagnosed twin pregnancies at the Korle Bu Teaching Hospital<sup>2</sup>. The study provides very disturbing and worrying results. His analysis shows that 68 out of 181 undiagnosed twin mothers had antenatal care at various institutions without specialist obstetrician care and none had an ultrasound scan. The only reason one could think of why the 68 did not have ultrasound scans is the lack of knowledge of the practitioners. Of the rest of the mothers 35 (34%) were seen by traditional birth attendants and 78 (43%) had no antenatal care at all. There were significantly more peripartum maternal and fetal complications in the undiagnosed twin mothers than in diagnosed mothers. Indeed there were no significant differences between undiagnosed attendant and non-attendant twin mothers as regards these complications suggesting that the main reason for the differences in complications is undiagnosed twin pregnancy.

The findings in both studies underscore the poor state of our maternal and child health delivery system, which is a part of the rapidly deteriorating health service. The medico-legal implications of both papers are very worrying, to say the least.

Continuing professional development should now be mandatory for all health professionals (both in public and private sectors) so that knowledge and skills will be upgraded and kept abreast with recent advances in health care delivery and best practices. Inadequate facilities may exonerate a practitioner in a medico-legal case but lack of knowledge will not. It is tempting to suggest the training of more suitably qualified personnel to take the place of traditional birth attendants. However, with poor remuneration and conditions of service and very low morale this is bound to fail because the brain drain will continue and the country will continue to be the loser with a poor health care delivery system. Health education should be made a necessary part of school curriculum at all levels. Knowledge empowers and a knowledgeable population will demand and receive the quality of health care they need and desire. Too many Ghanaians "perisheth for the lack of knowledge".

A committee of practitioners is urgently needed to recommend for legislation minimum standards of good practice for various categories of health facilities delivering maternal and child care. Perhaps it may seem too much to suggest the establishment of a committee of experts to undertake confidential enquiry into maternal and perinatal deaths with the view to making recommendations for legislation to

prevent or reduce to the barest minimum such deaths. However, this proposal should be looked at and examined very carefully.

## REFERENCES

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Why do our babies die?

What do we do to save our babies as our heirs to promote the future health, wealth and happiness of our nation, especially our women? The authors of the two articles have done well to provide some of the answers to the above questions.

We would like to emphasize two points from the articles; first, the useful role of the perinatal morbidity and mortality rates as indices of the effectiveness of Obstetric and Neonatal care and secondly, the role of preventive obstetrics in the community under the Primary Health Care (PHC) system.

One solution to the problem of improving the health of our women and babies is the setting up of comprehensive postgraduate training programmes in the country without the attendant risk of the exodus of doctors.

It is gratifying to note that the main author of both articles hailed from the unique 'Ghana Postgraduate

OB-GYN Programme' which was set up in Ghana in 1989, over a decade ago. Formerly termed 'The Ghana (USA & UK) - Ghana Postgraduate OB-GYN Project', it is a comprehensive programme with an Innovative Community Fourth Year which comprises three parts:

1. Rural District Posting (6months) - since a large majority ( ) of the people live and work in the rural areas of Ghana.
2. External Medical Electives Programme Tenable in the UK or USA (3months)
3. Health Administration Course (2months) with leadership roles and computer skills.

So far (October/November, 2000) the programme has produced 19 good Ob-Gyn Specialist, all of whom are working in Ghana today.

The 'success story' in Education and Training offers a solution to some of the problems raised in the two articles (see references below).



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