COMMENTARY

PREGNANCY RELATED CAUSES OF DEATHS IN GHANA

The woman plays an indispensable role in the home and childbirth, which should normally bring about joy can rather be tragic for the family and society.

Der *et al*[1] have produced an excellent paper that shows the gravity of maternal deaths at the Korle Bu Teaching Hospital. The 5-year study (2004-2008) shows that though the mortality rate in women in the reproductive age has reduced to (634) 12%, the pregnancy-related deaths have increased. What is equally worrisome is the finding that (517) 81% were coroner's. Fifty- four out of 55 (98%) deaths resulting from ectopic pregnancy were recorded as coroners. Also recorded as coroner's were (27) 96.3% of cases of ruptured uterus, which would have followed prolonged labour preventable with the aid of the partograph.

Unsafe abortion accounted for 131 deaths. With the introduction of misopristol and the manual vacuum aspiration (MVA), an elective abortion in the first trimester has become safer. Second trimester abortion is associated with more complications and health care providers should be conversant with the techniques.

Haemorrhage, hypertension and infections have always been the other leading causes of mortality in many developing countries. They are a reflection of the quality of care and the level of the standard of living in the country. As general health of the community improves deaths attributable to indirect causes such as sickle cell disease, anaemia, diabetes and HIV/AIDS would also reduce.

It is general knowledge that soldiers are sent to war after adequate preparations, yet women, in an effort to replenish the human race, are sent to labour with little preparation. Our national preparedness for labour and delivery was the subject of study in 2011 titled, "National Assessment of Emergency Obstetric and Neonatal Care (EMONC)".[2] A set of 9 lifesaving services ("signal functions") were used to assess the facilities. The availability of antibiotics, oxytocics, anticonvulsants, and the capacity to perform manual removal of placenta, removal of retained product of conception, assisted vaginal delivery, caesarean section, blood transfusion and neonatal resuscitation were assessed. Ghana with a population of about 24million had only 13 basic facilities and 76 comprehensive facilities instead of the prescribed 485 basic and 121 comprehensive facilities

The MDG5 focused on maternal health particularly the reduction of maternal mortality rate by 75% from the year 1990-2015. We are still far from the targets. The maternal mortality rate is quoted as 340 per 100,000 births. In the advanced countries the confidential enquires are yielding fewer and fewer deaths. So the concept of near-miss mortalities has been developed to take a critical look at the patients who nearly died but survived severe morbidities. The bigger number of women affords better statistical analysis into the severe morbidity and mortality.

About 1 in 20 women in developing countries compared with 1 in 10,000 women in developed ones lose their lives because of complications associated with pregnancy. To the obstetricians in the developing world, the subject of maternal mortality is an Achilles' heel in their practice.

Antenatal coverage in Ghana is good. However supervision of labour and delivery is not as efficient. All tertiary centres should have an ICU unit dedicated to obstetrics in order to take care of difficult cases such as eclampsia, disseminated intravascular coagulation and pulmonary oedema.

Beyond the hospital audit as provided by Der et al[1], a qualitative study of the social, cultural and economic factors could make the study more comprehensive.

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