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PREGNANCY, LABOUR AND DELIVERY: A JOURNEY TO BE MADE SAFE

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Statistics on maternal mortality show the persistent inequity existing for women of the developing world and remain the indicator with the greatest gap between the western, industrialized world and many countries in Africa, Asia and Latin America, where more than 95% of all deaths occur. The difference between the more and the less fortunate women is abysmal: in the west, death rates fluctuate around 10 per 100'000, whereas in certain parts of Africa they reach 1'500 per 100'000. While, in 1990, there were no deaths attributable to pregnancy, labour or delivery in Iceland, Luxembourg and Malta, in certain areas of Africa the lifetime risk of dying because of pregnancy-related causes, is 1 in 7. The World Bank has reported that, in developing countries, maternal mortality is the most important health problem for women aged 15-44, accounting for 18% of the total burden of disease.

In addition, maternal mortality must be recognized as the tip of an iceberg made of human suffering because of sequelae of maternal morbidity; WHO has estimated that between 15 and 20 million women each year suffer long-term disabilities because of child-bearing and delivering. Although no firm statistics exist, it is guessed that vesico-vaginal fistulae alone affect over 2 million young women of Africa and Asia and that only a fraction of those are repaired.

Maternal mortality and morbidity should not be ranked with other diseases and set aside because of low figures compared to malaria or tuberculosis, because child bearing is not a disease. It is the means through which every species, including the human, propagates. For this reason a global ethical consideration imposes an obligation upon society to avoid those almost totally preventable deaths.

FIGO, the International Federation of Obstetrics and Gynecology, has recently decided to make the journey through pregnancy, labour and delivery a safe one for all women; to this end, it is mobilizing the obstetricians-gynecologists of the world to join the fight against maternal mortality and morbidity, utilizing the skills existing in its member societies in the industrialized world to help those from the most affected countries. We hope that all obstetricians-gynecologists will join this fight.

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ORGANISATION OF PERINATAL CARE IN DEVELOPING COUNTRIES

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Everyone acknowledges that maternal and perinatal mortality in developing countries represents an appalling and shameful disrespect for mankind – figures speak for themselves. The question, however, is what has been done about it? The answer is nothing. What can be done? The answer is a lot.

Although perinatal care is a medical problem it is also, and primarily, a social-political affair. The first step is education. To try to deliver medical services to an illiterate population with a great preponderance of women is a pointless exercise. It is then a Public Health matter to provide minimal housing and sanitation without which it is fruitless to even attempt to have any sort of health care; to improve nutritional status of women of reproductive age; to implement a nationwide vaccination schedule for mothers-to-be; to eradicate malaria and other parasital infections; to instruct women on HIV infection and transmission (whether they will have any choice is a different matter); to identify and train 2-3 midwives per 1000 inhabitants in the communities, providing them with the skills for family planning, antenatal care and advice, applying scientific knowledge to local customs; to advise mothers on simple but very important issues of personal hygiene; to encourage mothers to breastfeed and kangaroo mother care; to create small personalised health centres ("Day Hospitals") with minimal facilities for a normal birth in safety and make them available to the population; to initiate immunisation schemes for babies immediately after birth; to supervise the welfare of mothers and babies by offering postnatal consultations and follow-up clinics for children which can easily be run by trained nursing personnel under the regular supervision of medical officers.

These measures should start at local level and then spread regionally, establishing priorities and goals. Most pregnancies and deliveries are normal and physiological - efforts should be made to keep them that way. Once a risk pregnancy has been identified regional services should then make arrangements to provide advice and care in loco.

With these simple measures some women and many babies will, of course, continue to die - but a lot more will be saved. It can be argued that the organisation of perinatal care in developing countries is a total and unrealistic utopia and this may be true. However, many of the past attempts and failures are not just due to the lack of financial resources but also due to indiscriminate misuse, to permissiveness, to greed and corruption, often with the blessing of the Western World. It should be emphasised that the organisation of perinatal care in developing countries does not include the availability of high technologies which, I am convinced, will make no difference whatsoever to the overall perinatal scene at this stage.

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THE ROLE OF PERINATAL CENTER ON NEONATAL SURGERY FOR GIS

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The fetus with an anomaly requires a team of specialists working together. A multidisciplinary team includes perinatologists experienced in fetal diagnosis and intrauterine interventions, geneticists, obstetrical sonologists experienced in the diagnosis of fetal anomalies and a pediatric surgeon and neonatologist who will manage the infant after birth. Fetal therapy is a team effort needing varying amounts of input from all team members.

The options for perinatal management of a fetus with gastrointestinal malformation cover a wide spectrum, depending on the type and the severity of the lesion and on the probability of associated malformations. Most correctable defects are best managed by maternal transport to an appropriate center and delivery near term. Some may benefit from change in timing or mode of delivery to minimize postnatal morbidity and mortality.

Esophageal duodenal or jejunoileal atresias, anorectal malformations, enteric ovarian mesenteric or choledochal cysts, uncomplicated meconium ileus and small intact omphalocele are best corrected after delivery.

Gastrochisis or ruptured omphalocele, intestinal ischemia-necrosis secondary to volvulus, meconium ileus etc. may benefit from induced preterm delivery for early correction ex utero.

Giant omphalocele, large sacrococcygeal teratoma or a cervical cystic hygroma may benefit from cesarean delivery.

Congenital gastrointestinal malformations comprise a relatively small proportion of all fetal anomalies (less than 10%) and prenatal ultrasound is commonly used to detect them. Duodenal and high intestinal obstructions are more readily diagnosed. The ability of prenatal ultrasound to detect esophageal atresia depends on the presence of a trachea esophageal fistula. The diagnosis of pure esophageal atresia is relatively easy. However midgut abnormalities and hindgut abnormalities are difficult to diagnose. The commonly reported sonographic appearance of "echogenic" bowel is usually nonspecific. Those involved in prenatal scanning must be aware of limitations of ultrasonography. It is important to ensure that the level of diagnostic uncertainty is communicated to parents and those responsible for the postnatal care of the infant.