

Association between Multiple Pregnancy and Preterm Birth

Dr. Zinat Ara Ferdous^{1*}, Dr. Sohely Akter², Dr. Jesmin Kabir³, Dr. Quazi Mahzebeen Akter⁴

¹Associate Professor, Department of Obstetrics and Gynaecology, Dhaka Medical College Hospital, Dhaka, Bangladesh

²Assistant Professor, Department of Obstetrics and Gynaecology, Directorate General of Health Services (DGHS), Dhaka, Bangladesh

³Assistant Professor, Department of Obstetrics and Gynaecology, Dhaka Medical College, Dhaka, Bangladesh

⁴Junior Consultant, Department of Obstetrics and Gynaecology, Dhaka Medical College Hospital, Dhaka, Bangladesh

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*Corresponding author: Dr. Zinat Ara Ferdous

Associate Professor, Department of Obstetrics and Gynaecology, Dhaka Medical College Hospital, Dhaka, Bangladesh

Abstract

Background: Preterm birth is a major contributor to perinatal morbidity and mortality, with substantial immediate and long-term consequences for newborns. The present study was undertaken to assess the association between multiple pregnancy and preterm birth and to compare gestational age at delivery between singleton and multiple pregnancies among women attending a tertiary-care hospital in Bangladesh. **Methods:** This hospital-based observational study was conducted at the Department of Obstetrics and Gynaecology, Dhaka Medical College Hospital, Dhaka, Bangladesh, from January to June 2019 among 60 pregnant women. Sociodemographic and pregnancy-related data were collected, and preterm birth was defined as delivery before 37 completed weeks. Data were analyzed using frequencies, percentages, and the chi-square test, with $p < 0.05$ considered statistically significant. **Results:** Among 60 participants, most were aged 21–25 years (35.0%), urban residents (56.7%), had secondary education (41.7%), and were multigravida (55.0%). Singleton pregnancies comprised 75.0%, while multiple pregnancies comprised 25.0%. Overall, 41.7% delivered preterm, predominantly at 32–36 weeks (28.3%). Preterm birth was significantly higher in multiple than singleton pregnancies (80.0% vs. 28.9%, $p < 0.001$), with multiple pregnancies showing a greater concentration of deliveries before 37 weeks. **Conclusion:** Multiple pregnancy was significantly associated with an increased risk of preterm birth and earlier gestational age at delivery.

Keywords: Preterm Birth, Multiple Pregnancy, Singleton Pregnancy, Gestational Age, Pregnancy Outcomes.

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INTRODUCTION

Preterm birth (PTB) refers to delivery occurring before the completion of 37 weeks of gestation [1]. It remains an important complication of pregnancy because of its considerable consequences for both newborns and mothers. Infants born prematurely are at increased risk of mortality during the early neonatal period as well as morbidity that may continue into later life. PTB is also a major determinant of perinatal morbidity and mortality and accounts for approximately 35% of deaths within this population [2]. At the global level, approximately one in every ten babies is born prematurely, while PBRs have shown little overall improvement during the past decade and have even increased in some regions. The immediate and long-term consequences of prematurity, together with its associated healthcare and economic costs, make PTB an important public health problem and a major challenge in perinatal medicine [3,4].

Multiple pregnancy, defined as a pregnancy involving two or more fetuses, including twin and higher-order pregnancies such as triplets and quadruplets, has increased considerably over recent decades, with a 76% rise reported since 1980 [5]. Multiple pregnancies are considered high-risk pregnancies because they are associated with a greater likelihood of complications affecting both the mother and fetus, and the risk generally becomes greater as the number of fetuses increases [6,7]. Twin pregnancies, in particular, are associated with increased perinatal morbidity and mortality. Compared with newborns from singleton pregnancies, infants from twin pregnancies have a higher risk of several adverse outcomes, including congenital anomalies, cerebral palsy, intrauterine growth restriction, and stillbirth. A substantial proportion of the perinatal mortality associated with multiple pregnancy is related to prematurity.

The development of premature birth in multiple pregnancies involves several interacting mechanisms and cannot be attributed to a single factor. Increased uterine stretching, cervical changes, and greater pressure exerted on the cervix may promote premature contractions and subsequent delivery. In addition, placental complications, including placental abruption and placenta previa, may necessitate early delivery. Maternal complications that occur more frequently in multiple pregnancies, such as gestational diabetes and preeclampsia, may also contribute to preterm birth. Furthermore, fetal complications, including fetal growth restriction and complications specific to twin pregnancies, may require delivery before term [8,9]. Thus, the increased uterine and cervical distension associated with multiple gestation, together with placental insufficiency and a higher frequency of maternal and fetal complications such as pre-eclampsia, gestational diabetes, and fetal growth restriction, may collectively increase the likelihood of premature delivery [10-12]. Growth restriction, premature birth, and fetal death are among the important fetal complications associated with multiple pregnancy, with fetal death reported to be five times more frequent in twin pregnancies than in singleton pregnancies.

Evidence from different populations has demonstrated the substantial burden of preterm birth among multiple pregnancies. In Scotland, approximately 50% of twin pregnancies result in delivery before 37 weeks of gestation, while approximately 20% are delivered before 34 weeks of gestation [13]. Similarly, data from the USA demonstrated a preterm birth rate of 56.6% among twins compared with 9.7% among singletons, representing a 12-fold higher rate in twin pregnancies (OR 12.8, 95% CI 12.6–12.9) [14]. Although previous research has consistently demonstrated higher rates of PTB among multiple pregnancies [15], relatively few studies have specifically investigated the association between multiple pregnancy and PTB. Moreover, existing studies have generally demonstrated an increased occurrence of PTB in multiple pregnancies without adequately defining the magnitude of the risk associated with multiple gestation in comparison with singleton pregnancy. This highlights the need for further evaluation of the relationship between pregnancy type and preterm birth, particularly within specific hospital-based populations. To address this gap, the present study was undertaken to assess the association between multiple pregnancy and preterm birth and to compare the gestational age at delivery between singleton and multiple pregnancies among women attending a tertiary-care hospital in Bangladesh.

Objective

To assess the association between multiple pregnancy and preterm birth.

METHODOLOGY & MATERIALS

This prospective observational study was conducted at the Department of Obstetrics and Gynaecology, Dhaka Medical College Hospital, Dhaka, Bangladesh, from January 2019 to June 2019. A total of 60 pregnant women were included in the study based on predefined eligibility criteria. Participants were categorized according to pregnancy type as singleton or multiple pregnancy to assess its association with preterm birth and gestational age at delivery.

Inclusion Criteria

- i. Pregnant women admitted to the Department of Obstetrics and Gynaecology during the study period.
- ii. Women with singleton or multiple pregnancies.
- iii. Women with a documented gestational age at delivery.
- iv. Women who fulfilled the predefined study criteria and provided informed consent.

Exclusion Criteria

- i. Women with pregnancies complicated by known major fetal congenital anomalies.
- ii. Women with incomplete or unavailable obstetric records.
- iii. Women who did not provide informed consent.
- iv. Pregnancies with unavailable or unreliable gestational-age information.

Data Collection

Relevant sociodemographic, obstetric, and pregnancy-related data were collected using a structured data collection form. Sociodemographic variables included age, residence, and educational status. Obstetric and pregnancy-related variables included parity, pregnancy type, mode of conception, antenatal care visits, and history of previous preterm birth. Gestational age at delivery was recorded for all participants.

Assessment of Pregnancy Type

Pregnancy type was determined from the available obstetric records and categorized as singleton or multiple pregnancy. Multiple pregnancy was defined as a pregnancy involving two or more fetuses.

Assessment of Gestational Age and Preterm Birth

Gestational age at delivery was recorded in completed weeks and categorized as <28 weeks, 28–31 weeks, 32–36 weeks, and ≥37 weeks. Preterm birth was defined as delivery before 37 completed weeks of gestation, while delivery at ≥37 weeks was considered term birth.

Study Variables

The primary independent variable was pregnancy type (singleton or multiple), and the primary outcome variable was preterm birth. Other variables assessed included maternal age, residence, educational

status, parity, mode of conception, antenatal care visits, and history of previous preterm birth.

Statistical Analysis

Data were entered, tabulated, and analyzed using appropriate statistical methods. Categorical variables were presented as frequencies and percentages. The association between pregnancy type and preterm birth was assessed using the chi-square test. A p-value <0.05 was considered statistically significant.

Consent and Confidentiality

Participation in the study was voluntary, and informed consent was obtained from all participants before inclusion in the study. The confidentiality of participants' information was maintained throughout the study.

RESULTS

Table 1: Sociodemographic Characteristics of the Study Participants (n = 60)

Characteristics		Frequency (n)	Percentage (%)
Age (years)	≤20	8	13.3
	21–25	21	35.0
	26–30	20	33.3
	>30	11	18.3
Residence	Urban	34	56.7
	Rural	26	43.3
Educational status	Primary or below	15	25.0
	Secondary	25	41.7
	Higher secondary or above	20	33.3
Parity	Primigravida	27	45.0
	Multigravida	33	55.0

The majority of participants were aged 21–25 years (21 participants, 35.0%), followed by those aged 26–30 years (20 participants, 33.3%), while 11 participants (18.3%) were older than 30 years and 8 (13.3%) were aged 20 years or younger. Urban residents predominated (34 participants, 56.7%) compared with rural residents (26 participants, 43.3%). Regarding

educational status, 25 participants (41.7%) had secondary-level education, followed by 20 (33.3%) with higher secondary education or above and 15 (25.0%) with primary education or below. Multigravida women constituted the majority of the study population (33 participants, 55.0%), while 27 (45.0%) were primigravida.

Table 2: Pregnancy Characteristics of the Study Participants (n = 60)

Characteristics		Frequency (n)	Percentage (%)
Pregnancy type	Singleton	45	75.0
	Multiple	15	25.0
Mode of conception	Spontaneous	52	86.7
	Assisted conception	8	13.3
Antenatal care visits	<4 visits	18	30.0
	≥4 visits	42	70.0
History of previous preterm birth	Yes	7	11.7
	No	53	88.3

Singleton pregnancy was observed in 45 participants (75.0%), while 15 (25.0%) had multiple pregnancies. Most participants conceived spontaneously (52 participants, 86.7%), whereas 8 (13.3%) conceived through assisted conception. The majority of participants had ≥4 antenatal care visits (42 participants, 70.0%), while 18 (30.0%) had fewer than 4 visits. A history of previous preterm birth was reported in 7 participants (11.7%), while 53 (88.3%) had no such history.

The majority of participants delivered at ≥37 weeks of gestation (35 participants, 58.3%). Among those delivering preterm, 17 participants (28.3%)

delivered at 32–36 weeks, 6 (10.0%) at 28–31 weeks, and 2 (3.3%) before 28 weeks. Overall, 25 participants (41.7%) delivered before 37 weeks of gestation.

Preterm birth occurred in 12 of 15 participants (80.0%) with multiple pregnancies, compared with 13 of 45 participants (28.9%) with singleton pregnancies. Conversely, term birth was more common among singleton pregnancies (32 participants, 71.1%) than multiple pregnancies (3 participants, 20.0%). The difference in the occurrence of preterm birth between singleton and multiple pregnancies was statistically significant ($p < 0.001$).

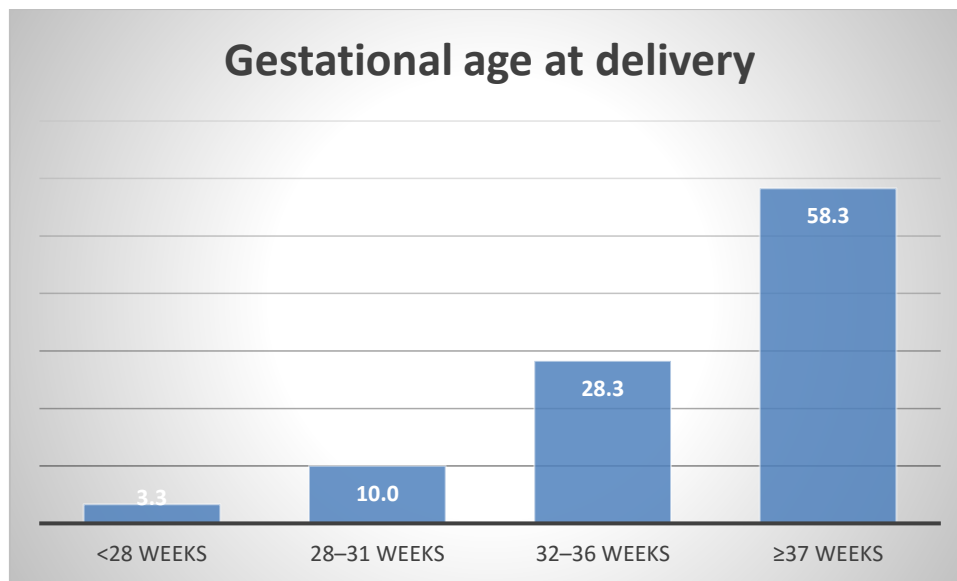


Figure 1: Distribution of the Study Participants According to Gestational Age at Delivery (n = 60)

Table 3: Association Between Pregnancy Type and Preterm Birth Among the Study Participants (n = 60)

Pregnancy type	Preterm birth n (%)	Term birth n (%)	Total n (%)	p-value
Singleton	13 (28.9)	32 (71.1)	45 (100.0)	<0.001
Multiple	12 (80.0)	3 (20.0)	15 (100.0)	
Total	25 (41.7)	35 (58.3)	60 (100.0)	

Table 4: Gestational Age at Delivery According to Pregnancy Type (n = 60)

Gestational age	Singleton n (%)	Multiple n (%)	Total n (%)
<28 weeks	1 (2.2)	1 (6.7)	2 (3.3)
28–31 weeks	3 (6.7)	3 (20.0)	6 (10.0)
32–36 weeks	9 (20.0)	8 (53.3)	17 (28.3)
≥37 weeks	32 (71.1)	3 (20.0)	35 (58.3)
Total	45 (100.0)	15 (100.0)	60 (100.0)

Among women with multiple pregnancies, 8 participants (53.3%) delivered at 32–36 weeks, 3 (20.0%) at 28–31 weeks, and 1 (6.7%) before 28 weeks, while only 3 (20.0%) delivered at ≥37 weeks. In comparison, among women with singleton pregnancies, 32 (71.1%) delivered at ≥37 weeks, while 9 (20.0%) delivered at 32–36 weeks, 3 (6.7%) at 28–31 weeks, and 1 (2.2%) before 28 weeks.

DISCUSSION

In this prospective observational study conducted at the Department of Obstetrics and Gynaecology, Dhaka Medical College Hospital, multiple pregnancy was strongly associated with preterm birth compared with singleton pregnancy. Women with multiple pregnancies showed a greater tendency toward earlier delivery, particularly during the 32–36-week gestational period, highlighting the importance of close antenatal monitoring and timely management of multiple gestations to reduce the burden of preterm birth.

The sociodemographic profile of the present study showed that most participants were aged 21–25 years (35.0%), followed by those aged 26–30 years

(33.3%), with 68.3% being aged 21–30 years. Urban residents constituted the majority (56.7%), while 41.7% had secondary-level education and 33.3% had higher secondary education or above. Multigravida women slightly predominated over primigravida women (55.0% vs. 45.0%). These findings are broadly comparable with those of Du *et al.*, [16], who reported that among 602 twin pregnancies, the majority of women in the preterm group were younger than 35 years (87.9%), lived in urban areas (76.6%), and had university-level education or above (58.9%), indicating a similar predominance of relatively younger and urban women. Likewise, Li *et al.*, [17], in a cohort of more than 3,000 twin pregnancies, found that women aged 25–34 years constituted the largest age group (72.6%), which is consistent with the concentration of participants in the reproductive age range of 21–30 years in the present study. However, the parity distribution differed somewhat, as Li *et al.*, [17] reported a predominance of nulliparous women (63.7%) compared with pluriparous women (36.3%), whereas multigravida women constituted a slightly larger proportion in the present study (55.0%). These differences may reflect variations in population characteristics, reproductive patterns, and study settings.

Regarding pregnancy characteristics, singleton pregnancies constituted the majority of participants (75.0%), while multiple pregnancies accounted for 25.0%. Most participants conceived spontaneously (86.7%), whereas 13.3% had assisted conception, and 70.0% had received ≥ 4 antenatal care visits. A previous history of preterm birth was reported in 11.7% of participants. The proportion of multiple pregnancies in the present study was higher than that reported by Shah *et al.*, [18], who identified 835 multiple pregnancies among 32,126 births (approximately 2.6%), and by Seetho *et al.*, [10], where multiple pregnancies comprised 1.99% of 21,400 deliveries. The proportion of assisted conception in the present study (13.3%) was broadly comparable to the 16.63% IVF conception reported among women with multiple pregnancies by Seetho *et al.*, [10], whereas the prevalence of previous preterm birth was higher than the 2.58% reported in their study. Such differences may be attributable to variations in study populations, referral patterns, reproductive practices, and clinical settings. Nevertheless, these findings provide an important context for the present study, as multiple gestation and assisted conception are recognized characteristics relevant to the risk of preterm delivery.

The present study found that 41.7% of participants delivered before 37 weeks of gestation, with most preterm births occurring at 32–36 weeks (28.3%), followed by 28–31 weeks (10.0%) and <28 weeks (3.3%). This predominance of delivery during the later preterm period is broadly consistent with the findings of Guruprasad *et al.*, [19], who reported that among 493 preterm live-born twins, 71.6% were delivered at 32–36 weeks, 17.4% at 28–31 weeks, and 11.0% before 28 weeks. Similarly, Tingleff *et al.*, [20], in a large cohort of 481,176 nulliparous women including 8,727 twin pregnancies, reported that twin births were distributed as 3.6% extremely preterm, 18.2% very preterm, 33.0% late preterm, and 45.3% term. Their findings also demonstrated substantially higher risks of preterm delivery across all preterm gestational-age categories among twin pregnancies compared with singleton pregnancies. Thus, the predominance of births at 32–36 weeks in the present study is consistent with previous evidence showing that a substantial proportion of preterm deliveries in multiple gestations occur during the late preterm period.

The principal finding of the present study was the strong and statistically significant association between multiple pregnancy and preterm birth. Preterm delivery occurred in 80.0% of women with multiple pregnancies compared with 28.9% of those with singleton pregnancies ($p < 0.001$). This finding is consistent with Tingleff *et al.*, [20], who reported preterm birth before 37 weeks in 54.7% of twin pregnancies compared with only 6.1% of singleton pregnancies, with twin pregnancy remaining strongly associated with preterm birth after adjustment for potential confounders.

Similarly, Kalikkot *et al.*, [21], using the KID database, demonstrated a progressive increase in preterm birth with increasing plurality, occurring in 6.7% of singleton, 54.9% of twin, and 94.5% of triplet pregnancies; twins had substantially higher odds of preterm birth than singletons (OR 17.79, 95% CI 17.51–18.09; $p < 0.001$). Although the magnitude of the observed association and absolute preterm birth rates varied across studies, the consistent direction of the findings strongly supports the relationship between multiple gestation and preterm delivery. The higher preterm birth rate observed in the present study may reflect the small sample size, differences in case selection, referral patterns, or the clinical characteristics of the study population.

The difference in gestational age between singleton and multiple pregnancies further reinforced this association. Among women with multiple pregnancies, only 3 (20.0%) delivered at ≥ 37 weeks, whereas 12 (80.0%) delivered preterm, including 8 (53.3%) at 32–36 weeks, 3 (20.0%) at 28–31 weeks, and 1 (6.7%) before 28 weeks. In contrast, 32 (71.1%) women with singleton pregnancies delivered at ≥ 37 weeks, while only 13 (28.9%) delivered preterm. This pattern closely parallels the findings of Tingleff *et al.*, [20], who demonstrated a marked shift toward earlier delivery among twin pregnancies, with twin gestations having substantially higher proportions of extremely, very, and late preterm births than singleton pregnancies. Likewise, Guruprasad *et al.*, [19] found that preterm twins were more likely to be delivered at earlier gestational ages than preterm singletons, with 11.0% of twins delivered at 20–27.6 weeks and 17.4% at 28–31.6 weeks, compared with 4.9% and 14.9%, respectively, among singletons; most preterm births in both groups occurred at 32–36.6 weeks. The present findings therefore suggest that multiple pregnancy is associated not only with a higher overall frequency of preterm birth but also with a shift toward earlier gestational ages at delivery. This consistency across different populations strengthens the evidence that multiple gestation is an important risk factor for preterm delivery.

Limitations of the study

The study had a few limitations:

- The small sample size may limit the statistical power and generalizability of the findings.
- The single-center study design may limit the applicability of the findings to other clinical settings and populations.

CONCLUSION

Multiple pregnancy is an important obstetric risk factor associated with an increased likelihood of preterm birth and earlier gestational age at delivery. The present study demonstrated a significant association between multiple pregnancy and preterm birth, with multiple gestations showing a greater tendency toward earlier delivery than singleton pregnancies. These

findings highlight the importance of close antenatal surveillance, timely identification of complications, and appropriate obstetric management of women with multiple pregnancies to reduce the burden of preterm birth and its associated adverse outcomes.

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