Factors of Neonatal Morbidity at the Provincial Hospital Center of Missour

**Authors**: Doukkali Loubna, MD, PhDs1 ; Bennani Mechita Nada2 ; Lahlou Laila2 ; Laamiri Fatima Zahra, PhD1 ; Habibi MOUNA, PhDs1 ; Barkat Amina, PhD1

1 Faculty of Medicine and Pharmacy of Rabat, Research Team in Maternal and Child Health and Nutrition, Mohammed V University, Rabat, Morocco
2 Laboratory of Biostatistics and Clinical Research and Epidemiology, Faculty of Medicine and Pharmacy, Rabat, Morocco

**INTRODUCTION**

Although neonatal mortality decreases in different regions of the world, it is still a major problem in developing countries and particularly in Morocco.

The aim of our study was to assess the importance of the situations of precariousness among pregnant women and their consequences on the state of health of newborn and to determine the principal causes of death of newborns in the Missour provincial hospital.
METHODS AND MATERIALS

- The first study is a retrospective study of 1108 women who gave birth in the maternity of the provincial hospital center of Missour current 2012 which is a maternity type II with a number of annual births assessed to 1200. This provincial hospital Center is a subdivision that mostly receives patients from the rural area of the Moroccan region of Fez-Boulemane, and which covers an area of 14.600 Km2 with a population estimated to 202.000 inhabitants and of which 23.250 (namely 11.5%) are originating in commons with difficult access in winters.

- For each newborn, an information sheet was filled by doctors that analyzes the characteristics of delivery and child characteristics.

- A healthy newborn was defined as any birth with good adaptation to extra-uterine life (Apgar > 7) and bears no clinically detectable malformation.

- Early neonatal death is a death occurring within 24 hours of delivery.

- In the Second prospective Study 194 parturients were studied in the Maternity during the first three months of 2013 for which other sociodemographic parameters have been analyzed.
RESULTS

The first study:

- 1121 newborns were analyzed pregnancies. 49 newborns (4.3%) had neonatal morbidities to the delivery room whose 31 (2.7%) newborns were hospitalized Pediatric.14 (1.2%) were referred to the Fez University Hospital Center for emergency neonatal due to lack of resources at the provincial hospital. The neonatal mortality rate was estimated at 0.6% corresponding to 6 premature infants died within 48 hours of hospitalization and newborn at term died at the maternity hospital. The causes of death are dominated by hyaline membrane disease (2 cases), neonatal infection (2 cases) and neonatal asphyxia (3 cases). 11 congenital malformations corresponding to 0.9% were noted.
The main factors of neonatal morbidity are preterm birth (< 33 weeks), low birth weight (< 1500G), the neonatal infection and neonatal distress.
DISCUSSION

• Our results confirm the importance of economic determinants, especially joblessness and low income of the parents. Poor prenatal care quality is a promoting factor of this morbidity. Nevertheless, a late screening of certain maternal conditions and the use primarily of traditional healers services probably unacknowledged by our women in labor because of their cultural penchants, are all elements causing neonatal complications including malformations.

• The fight against neonatal mortality could be exempted by essential care for maternal and neonatal health through better neonatal care, the implementation of regional perinatal networks responsible for hospital inter transfers as well as continuous training of teams in the field.

• Unfortunately, they are not always available in Missour maternity because to the lack of equipment and qualified staff (one pediatrician for the whole Province as well as two gynecologists). Indeed, we noticed a lack of proper technical equipment of neonatal reanimation and nursing is not always worthy of an intensive care unit; the only neonatal respiratory support available is the oxygen therapy. The transfer to a first class service is sometimes impossible due to the lack of space in the reference center or too risky taking into consideration the conditions of the newborn and the precarious means of transport (only one poorly equipped ambulance ). Some parents refuse the hospitalization of those newborn because of their inability to pay.

• The indications of regional hospitalization must submit to the criteria which take into account the capacity of reception of the reference centers. A decentralized cooperation is expected to decongest higher level centers by giving all the possible opportunities to the newborn by a qualified support close to his birthplace. The strengthening of medical and social support of these women who are mostly housewives with low school attendance rates, the education of young women of child-bearing age and pregnancy monitoring by the midwives should be priorities.
CONCLUSION

• It is necessary to stress the vital role of community mobilization enabling vulnerable women in precarious social situation, designate priority issues and advocate local solutions to better prevent obstetric pregnancy complications as infection and neonatal suffering.

• Networking with midwives will reduce the expenses of the public health and will surely allow the enlargement of the public offer and promote the health and comfort of women in labor.

REFERENCES


