



International News – February 2018

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World Breastfeeding Week 2017

World Prematurity Day, 17 November 2017, was an opportunity to call attention to the heavy burden of death and disability – as well as the pain and suffering – that is associated with preterm birth.

The World Health Organization (WHO) began its own marking of the day by issuing an updated statement and fact sheet, which includes highlight of the benefits of continuity of midwifery-led care:

- Every year, an estimated 15 million babies are born preterm: this number is rising
- Preterm birth complications are the leading cause of death among children under 5 years of age, leading to around 1 million deaths in 2015
- Three-quarters of these deaths could be prevented with currently available, cost-effective interventions
- Across 184 countries, the rate of preterm birth ranges from 5% to 18% of babies born.

More than 60% of preterm births occur in Africa and South Asia, but preterm birth is truly a global problem. In the lower-income countries, on average, 12% of babies are born too early compared with 9% in higher-income countries. Within countries, poorer families are at higher risk.

The 10 countries with the greatest number of preterm births are:

- India: 3,519,100
- China: 1,172,300
- Nigeria: 773,600
- Pakistan: 748,100
- Indonesia: 675,700
- United States of America: 517,400
- Bangladesh: 424,100
- Philippines: 348,900
- Democratic Republic of the Congo: 341,400
- Brazil: 279,300

The 10 countries with the highest rates of preterm birth per 100 live births are:

- Malawi: 18.1 preterm births per 100 births
- Comoros: 16.7
- Congo: 16.7

- Zimbabwe: 16.6
- Equatorial Guinea: 16.5
- Mozambique: 16.4
- Gabon: 16.3
- Pakistan: 15.8
- Indonesia: 15.5
- Mauritania: 15.4

Of 65 countries with reliable trend data, all but three show an increase in preterm birth rates over the past 20 years. Reasons for this may include better measurement resulting in more accurate reporting; increases in maternal age and underlying maternal health problems such as diabetes and high blood pressure; greater use of infertility treatments leading to increased rates of multiple pregnancies; and changes in obstetric practices such as more caesarean births before term.

There is a dramatic difference in rates of survival of premature babies depending on where they are born. For example, more than 90% of extremely preterm babies (less than 28 weeks) born in low-income countries die within the first few days of life; yet less than 10% of extremely preterm babies die in high-income settings.

Inequalities in survival rates around the world are stark. In low-income settings, half of the babies born at or below 32 weeks (2 months early) die due to a lack of feasible, cost-effective care, such as warmth, breastfeeding support, and basic care for infections and breathing difficulties. In high-income countries, almost all of these babies survive. Suboptimal use of technology in middle-income settings is causing an increased burden of disability among preterm babies who survive the neonatal period.

More than three quarters of premature babies can be saved with feasible, cost-effective care, such as: essential care during child birth and in the postnatal period for every mother and baby; provision of antenatal steroid injections (given to pregnant women at risk of preterm labour and under set criteria to strengthen the babies' lungs); kangaroo mother care (the baby is carried by the mother with skin-to-skin contact and frequent breastfeeding); and antibiotics to treat newborn infections.

In addition, continuity of midwifery-led care in settings where there are effective midwifery services has been shown to reduce the risk of prematurity by around 24%.

Preventing deaths and complications from preterm birth starts with a healthy pregnancy. Quality care before, between and during pregnancies will ensure all women have a positive pregnancy experience. WHO's antenatal care guidelines include key interventions to help prevent preterm birth, such as counselling on healthy diet and optimal nutrition, and tobacco and substance use;

fetal measurements including use of ultrasound to help determine gestational age and detect multiple pregnancies; and a minimum of 8 contacts with health professionals throughout pregnancy to identify and manage other risk factors, such as infections. Better access to contraceptives and increased empowerment could also help reduce preterm births.

Preterm birth occurs for a variety of reasons. Most happen spontaneously, but some are due to early induction of labour or planned caesarean birth, whether for medical or non-medical reasons.

Common causes of preterm birth include multiple pregnancies, infections and chronic conditions such as diabetes and high blood pressure; however, often no cause is identified. Better understanding of the causes and mechanisms will advance the development of solutions to prevent preterm birth.

In 2012, WHO and partners published a report *Born too soon: the global action report on preterm birth* that included the first-ever estimates of preterm birth by country.

WHO is committed to reducing the health problems and lives lost as a result of preterm birth:

- Working with Member States and partners to implement *Every newborn: An action plan to end preventable deaths* adopted in May 2014 in the framework of the UN Secretary-General's *Global strategy for women's and children's health*;
- Working with Member States to strengthen the availability and quality of data on preterm births;
- Providing updated analyses of global preterm birth levels and trends every 3 to 5 years;
- Working with partners around the world to conduct research into the causes of preterm birth, and test effectiveness and delivery approaches for interventions to prevent preterm birth and treat babies that are born preterm;
- Regularly updating clinical guidelines for the management of pregnancy and mothers with preterm labour or at risk of preterm birth, and guidelines on the care of preterm babies, including kangaroo mother care, feeding babies with low birth weight, treating infections and respiratory problems, and home-based follow-up care (see WHO 2015 recommendations on interventions to improve preterm outcomes);
- Developing tools to improve health workers' skills and assess the quality of care provided to mothers at risk of preterm delivery and preterm babies; and
- Supporting countries to implement WHO's antenatal care guidelines, aimed at reducing the risk of negative pregnancy outcomes, including preterm births, and ensuring a positive pregnancy experience for all women.

WHO has developed new guidelines with recommendations for improving outcomes of preterm births. This set of key interventions can improve the chances of survival and health outcomes for preterm infants. The guidelines include interventions provided to the mother – for example steroid injections before birth, antibiotics when her water breaks before the onset of labour, and magnesium sulfate to prevent future neurological impairment of the child – as well as interventions for the newborn baby – for example thermal care, feeding support, kangaroo mother care, safe oxygen use, and other treatments to help babies breathe more easily.

http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/preterm-birth-guideline/en/

The burden of group B streptococcus in maternity worldwide

A team of authors from Bangladesh, China, Ethiopia, South Africa, Spain, UK, USA and the WHO has published a review aimed to be the

first comprehensive estimates of 'the burden of group B Streptococcus (GBS), including invasive disease in pregnant and postpartum women, fetal infection/stillbirth, and infants'.

While the number of worldwide child deaths has recently declined, there has been less progress in reducing neonatal mortality and stillbirths, with 2.7 million neonatal deaths and 2.6 million stillbirths in 2015. Most of this burden is in low-income settings, particularly in sub-Saharan Africa and South Asia, and infection is an important cause of both mortality and short- and long-term morbidity. Understanding of specific aetiologies and quantifying the burden of individual aetiologies are necessary to inform public health interventions. Group B *Streptococcus* (GBS) is an important perinatal pathogen, yet to date no systematic estimates have been undertaken of its overall global burden.

Intrapartum antibiotic prophylaxis is the current mainstay of prevention, reducing early-onset infant disease in high-income contexts. Maternal GBS vaccines are in development.

Worldwide in 2015, we estimated 205,000 infants with early-onset disease and 114,000 with late-onset disease, of whom a minimum of 7000 presented with neonatal encephalopathy. There were 90,000 deaths in infants < 3 months age, and, at least 10,000 children with disability each year. There were 33,000 cases of invasive GBS disease in pregnant or postpartum women, and 57,000 fetal infections/stillbirths. Up to 3.5 million preterm births may be attributable to GBS. Africa accounted for 54% of estimated cases and 65% of all fetal/infant deaths. A maternal vaccine with 80% efficacy and 90% coverage could prevent 107,000 stillbirths and infant deaths.

The authors conclude that 'conservative estimates suggest that GBS is a leading contributor to adverse maternal and newborn outcomes, with at least 409,000 maternal/fetal/infant cases and 147,000 stillbirths and infant deaths annually. An effective GBS vaccine could reduce disease in the mother, the fetus, and the infant'.

Seale AC et al. *Estimates of the Burden of Group B Streptococcal Disease Worldwide for Pregnant Women, Stillbirths, and Children.*

Clinical Infectious Diseases, Volume 65, Issue suppl_2, 6 November 2017, Pages S200–S219, <https://doi.org/10.1093/cid/cix664>

Respectful maternity care

A recent review has presented an evidence-based typology of respectful maternity care (RMC) in health facilities globally, and demonstrates that the concept is broader than a reduction of disrespectful care or mistreatment of women during childbirth. Innovative approaches should be developed and tested to integrate RMC as a routine component of quality maternal and newborn care programs.

Authors from the Department of Reproductive Health and Research at WHO and others from Australia, Brazil, Egypt and Iran explored 67 studies from 32 countries to meet rigorous inclusion criteria. Twelve domains of RMC were synthesized:

- being free from harm and mistreatment
- maintaining privacy and confidentiality
- preserving women's dignity
- prospective provision of information and seeking of informed consent
- ensuring continuous access to family and community support
- enhancing quality of physical environment and resources
- providing equitable maternity care
- engaging with effective communication
- respecting women's choices that strengthen their capabilities to give birth
- availability of competent and motivated human resources

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