

COMMENTARY

Making every baby count – An urgent reproductive health priority as sub-Saharan Africa continues to witness a high incidence of stillbirths

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Abstract

The expected culmination of a positive pregnancy experience is a healthy mother and a bouncing live baby. Unfortunately, globally an estimated 2 million babies are still born every year, with the largest incidence of stillbirths of about 50% of the global burden occurring in sub-Saharan Africa (SSA). Significant gaps in access to quality antenatal care (ANC) and labour and delivery remain in SSA. It is estimated that only 24% of women receive at least four ANC visits in SSA. Women are prepared for labour and delivery during this period, and risk factors are identified, and potential complications can be averted. Access to labour and delivery services is critical for picking up foetal compromise. Women must deliver in facilities that can offer assisted delivery and offer foetal and neonatal resuscitation, to prevent stillbirths and early neonatal deaths. In SSA, many primary healthcare facilities are unable to offer these services, whilst higher level facilities that can offer these may be difficult to access. The majority of stillbirths are preventable if women access quality ANC and can access modern facilities for labour and delivery. Therefore, stakeholders in reproductive health must ensure access to ANC for a positive pregnancy experience. (*Afr J Reprod Health 2023; 27 [11]: 15-17*).

Keywords: Stillbirths, neonatal deaths, maternal care, barriers, interventions

Résumé

Le point culminant attendu d'une expérience de grossesse positive est une mère en bonne santé et un bébé vivant et rebondissant. Malheureusement, on estime que 2 millions de bébés naissent encore chaque année dans le monde, la plus grande incidence de mortinatalité, représentant environ 50 % du fardeau mondial, se produisant en Afrique subsaharienne (ASS). Des lacunes importantes subsistent en matière d'accès à des soins prénatals (CPN) de qualité, au travail et à l'accouchement en ASS. On estime que seulement 24 % des femmes reçoivent au moins quatre visites prénatales en ASS. Les femmes sont préparées au travail et à l'accouchement pendant cette période, les facteurs de risque sont identifiés et les complications potentielles peuvent être évitées. L'accès aux services de travail et d'accouchement est essentiel pour détecter une atteinte fœtale. Les femmes doivent accoucher dans des établissements capables de proposer un accouchement assisté et de proposer une réanimation fœtale et néonatale, afin de prévenir les mortinaissances et les décès néonataux précoces. En ASS, de nombreux établissements de soins de santé primaires ne sont pas en mesure d'offrir ces services, tandis que les établissements de niveau supérieur qui peuvent les offrir peuvent être difficiles d'accès. La majorité des mortinaissances sont évitables si les femmes accèdent à des soins prénatals de qualité et peuvent accéder à des installations modernes pour le travail et l'accouchement. Par conséquent, les acteurs de la santé reproductive doivent garantir l'accès aux soins prénatals pour une expérience de grossesse positive. (*Afr J Reprod Health 2023; 27 [11]: 15-17*).

Mots-clés: Mortinaissances, décès néonataux, soins maternels, obstacles, interventions

Dear Editor

The expected culmination of a positive pregnancy experience is a healthy mother and a bouncing live baby. Unfortunately, globally an estimated 2 million babies are still born every year, with the largest incidence of stillbirths of about 50% of the global burden occurring in sub-Saharan Africa (SSA)¹. This is also the region with the highest maternal mortality ratios globally, with a number of countries

struggling to attain Sustainable Development Goal 3 (SDG-3). Stakeholders in reproductive health in SSA must work towards a positive pregnancy experience for all mothers, and to make every baby count by working to significantly reduce the burden of preventable stillbirths.

Significant gaps in access to quality antenatal care (ANC) and labour and delivery remain in SSA^{2,3}. It is estimated that only 24% of women receive at least four ANC visits in SSA⁴.

ANC is a preventive service and a gateway to good pregnancy outcomes. Women are prepared for labour and delivery during this period, and risk factors are identified, and potential complications can be averted. Problems such as hypertensive disorders, maternal anaemia, maternal undernutrition, gestational diabetes, maternal infections, HIV infection and others are identified during this period, and life-saving interventions instituted, including those that can prevent vertical transmission of infections to the foetus, preventing congenital infections and syndromes, some of which result in congenital malformation, intrauterine foetal demises and stillbirths. An example is the administration of antibiotics to syphilis-positive mothers to prevent congenital syphilis, and administration of antiretroviral drugs to prevent vertical transmission of HIV. Antenatal ultrasound scans are critical for picking up foetal anomalies, foetal growth restriction and placental compromise all of which contribute significantly to stillbirths.

Access to labour and delivery services in a modern health facility is critical for picking up foetal compromise and early intervention. Women must deliver or be referred early to facilities that can offer assisted vaginal delivery and caesarean sections, and offer foetal and neonatal resuscitation, to prevent stillbirths and early neonatal deaths. Women in SSA may not utilize maternal healthcare services due to several cultural beliefs such as believing that giving birth is a natural process that does not require prior preparations⁵. In SSA, many primary healthcare facilities may not be able to offer these services, whilst higher level facilities that can offer these may be a long way, the road networks may be a challenge, and ambulance services or transport facilities may not be readily available³. Health system barriers to maternal healthcare utilization include long waiting times and disrespect and abuse by healthcare providers⁵. In addition, experienced nurses, midwives, and medical practitioners to identify maternal complications may not be readily available. The human resource-challenges which are a perennial challenge in SSA have been worsened by the COVID-19 pandemic, which has resulted in massive migration of skilled healthcare personnel to developed countries that offer higher remuneration and other packages⁶. A shortage of critical labour equipment such as cardiotocograms, foetal stethoscopes and labour ward ultrasound scan

machines is highly prevalent, and so is the shortage of life-saving medicines in the labour ward. Besides, experienced personnel to operate these pieces of equipment may also be missing. At some hospitals, equipment for doing life-saving vacuum deliveries is missing, there is no experienced staff to conduct breech deliveries, and there is a shortage of theatres, theatre staff and theatre equipment. These problems result in avoidable third delays, which can result in loss of mother, baby or both.

The majority of stillbirths are preventable if women access quality ANC and can access modern facilities for labour and delivery. Therefore, governments and stakeholders in reproductive health must ensure access to ANC for a positive pregnancy experience as recommended by the World Health Organisation (WHO) by removing barriers to care⁷. These include long distances to healthcare facilities, shortage of equipment, and long waiting times at ANC clinics. Adequate staffing of maternity facilities with appropriately skilled manpower is critical, and governments must continue looking for ways to improve remuneration and retain currently available manpower, as well as to accelerate training. Providing effective transport mechanisms from lower to higher level facilities, and adequately equipping these facilities is critical for effectively reducing Thaddeus and Maine's second and third delays. Reducing stillbirths is an urgent public health priority. All involved stakeholders must urgently converge and define effective interventions to make sure every baby counts in SSA.

Contribution of authors

Grant Murewanhema – Writing original draft

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