Antenatal Malaria Parasitaemia And Haemoglobin Profile Of Pregnant Mothers In Awka, Anambra State, Southeast Nigeria

E Mbanefo, J Umeh, V Oguoma, C Eneanya

Abstract

Three hundred and two women comprising 242 pregnant women attending antenatal clinic and 60 non pregnant women that served as control group, were tested for malaria parasites using Giemsa stained thick films. The haemoglobin concentration of the mothers were also tested and matched with their infection status. The findings show that malaria parasitaemia and intensity are dependent on pregnancy and parity of pregnancy (p < 0.05). It demonstrated that anaemia is a common feature of malaria infection, more severe during pregnancy especially in the first pregnancy. There was a downward gradation in the prevalence of low haemoglobin levels from primiparous to the control group in both infected and uninfected populations. Over 70% of primigravid mothers, 45% of the multiparae and only 22% of the control group recorded haemoglobin levels lower than the World Health Organization benchmark (11.0g/dl). Anaemia was therefore dependent on infection status, pregnancy status and parity of pregnancy (p <0.05). The effects of malaria and its clinical features (especially anaemia) on the mother and foetus was again re-stressed with emphasis on availability, affordability and sustainability of malaria control efforts especially for the most vulnerable populations. The study will be of immense value as a public health tool for planning, delivery, monitoring and evaluation of interventions.

INTRODUCTION

Malaria remains one of the leading causes of morbidity and mortality worldwide, causing about 3000 deaths per day (1). Malaria caused by the protozoan parasite of the genus Plasmodium debilitates and kills more people than any other single infectious disease (2). Every year, 300 to 500 million clinical cases of malaria, accounting for over one million deaths are recorded globally (3). Over 90% of all cases of malaria occur in Africa, south of the Sahara (4, 5, 1).

Malaria infection during pregnancy is a major public health problem in the tropics and sub-tropics. In the endemic areas of the world, children under the age of five and women in their first pregnancy are most vulnerable to the disease (2). Each year, approximately 25 million African women get pregnant in malarious areas of Africa, most of who reside in areas of relatively stable malaria transmission (6). The burden of malaria in pregnancy is caused chiefly by Plasmodium falciparum, the most virulent of the Plasmodium parasites, especially in the sub-Saharan Africa (7).

Malaria infection during pregnancy can have adverse effects on both the mother and the foetus, including maternal anaemia, foetal loss, premature labour, intrauterine growth retardation, delivery of low birth weight babies (< 2.5 kg) and sometimes maternal death (8). In areas of stable (high and moderate) malaria transmission, women have gained a level of immunity to malaria that somewhat wanes during pregnancy. Here, malaria infection is more likely to result in severe maternal anaemia and delivery of low birth weight infants, which has been identified as a leading cause of poor infant survival and development in Africa.

In unstable (low) malaria transmission areas, women generally have developed no significant level of immunity and usually become ill when infected. The risk of developing severe disease is 2 to 3 times greater than their non-pregnant counterparts living in the same area (9). In these areas, malaria infection is more likely to result in spontaneous abortions, foetal loss and low birth weight (10). Also, death due to maternal anaemia may occur among pregnant women (11).

Anaemia in pregnancy is an important public health concern in developing countries (more pronounced in primigravidae
than in multigravidae) (12, 13, 14, 15). The aetiolo-
ogy of malaria in pregnancy is multifactorial; causes include poor
nutrition, malaria, haemoglobinopathies, advanced HIV
infection and infection with other parasites (mainly
hookworm), which together contribute to increases maternal
and neonatal morbidity and mortality (16, 17, 10). Though
most of the causes are preventable, the overall prevalence of
anaemia in pregnancy continues to be a common clinical
problem in the third world (18).

Anaemia has been reported to contribute significantly to
both maternal and foetal morbidity (19) and it is also found
to have a serious effect on neonatal birth weight (20).
Different studies have confirmed that majority of pregnant
women in developing countries are anaemic (21, 14).
Pregnant women especially the primigravidae, represent the
most important risk group of malaria among the adult
population. The objectives of this study is to determine the
antenatal malaria parasitaemia and the haemoglobin profile
of pregnant mothers attending antenatal clinic in the centre;
and to determine the relationship if any, between prevalence
of malaria and haemoglobin concentration in pregnant
women. The findings from the study will also serve as a tool
in evidence based health education on the need to intensify
efforts at malaria prevention during pregnancy through
prompt access to effective treatment, intermittent preventive
treatment and the consistent use of insecticide treated nets.

MATERIALS AND METHODS

STUDY AREA

Awka, the capital city of Anambra state is located at latitude
6.1oN and longitude 7.0oE in the rainforest belt, Southeast,
Nigeria. It has an annual rainfall of between 152cm and
203cm. The temperature ranges between 22oC and 33oC.
The study site Amaku General Hospital, is the major
government owned health care facility and serves as the
major reference point for the other public, mission and
private health centres in Awka metropolis.

STUDY POPULATION

The study population was drawn from both primigravid and
multigravid women, attending antenatal clinic at the general
hospital, including a group of non-pregnant women to serve
as the control. Prior to sample collection, advocacy was
sought from the Board of the Hospital and the research
endorsed by the ethical committee. Three hundred and two
(302) women comprising 98 primiparae, 144 multiparae and
60 non-pregnant control groups were enlisted after a non-
coercive informed consent.

PROCEDURE

Using a sterile syringe, 2ml of venous blood was collected
from each of the subjects and transferred into a sterile EDTA
container. A drop of blood was used in making thick blood
films. The thick films were stained using Giemsa stains as
described by (22) and examined microscopically using 100X
objective after applying a small drop of immersion oil. The
intensity of infection was also estimated based on the
number of parasites counted per high power field of the
microscope using the plus sign system. The remaining
venous blood was then used in the estimation of the
Haemoglobin level of each subject and the results matched
with the respective malaria infection status. Information on
the socio-demographic data, parity of pregnancy,
chemoprophylaxis and prophylactic practices of the women
were also obtained and recorded using a mini questionnaire.
The data was subjected to statistical analysis (chi-square) to
determine the significance of the observed differences in the
study sample.

RESULTS

Out of the 302 women examined, 118 (39.07%) were
positive for malaria parasites (Table 1). Prevalence was
highest in the primiparae (52.04%), followed by the
multiparae (40.28) and least in the control group (15.00%).
The primiparae also recorded the highest intensity of
infection (Table 2). There is a gradation of prevalence and
intensity from primiparae to the control group. Prevalence
and intensity of malaria among the study population were
found to be dependent on pregnancy and the parity of
pregnancy (p <0.05).

Figure 1

Table 1: Malaria parasitaemia by parity groups

<table>
<thead>
<tr>
<th>Parity</th>
<th>No Sampled</th>
<th>No Positive (%)</th>
<th>No Negative (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primiparae</td>
<td>98</td>
<td>51 (52.04)</td>
<td>47 (47.96)</td>
</tr>
<tr>
<td>Multiparae</td>
<td>144</td>
<td>58 (40.28)</td>
<td>86 (59.72)</td>
</tr>
<tr>
<td>Control</td>
<td>60</td>
<td>9 (15.00)</td>
<td>51 (85.00)</td>
</tr>
<tr>
<td>Total</td>
<td>302</td>
<td>118 (39.07)</td>
<td>184 (60.93)</td>
</tr>
</tbody>
</table>
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**Figure 2**

Table 2: Intensity of malaria by parity groups

<table>
<thead>
<tr>
<th>Intensity</th>
<th>Primipara (%)</th>
<th>Multipara (%)</th>
<th>Control (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-10/100Kf</td>
<td>20 (37.70)</td>
<td>37 (11.79)</td>
<td>7 (17.14)</td>
<td>64</td>
</tr>
<tr>
<td>11-100/100Kf</td>
<td>20 (34.90)</td>
<td>21 (26.21)</td>
<td>2 (23.23)</td>
<td>54</td>
</tr>
<tr>
<td>1-10/1Kf</td>
<td>3 (5.00)</td>
<td>0 (0.00)</td>
<td>0 (0.00)</td>
<td>3</td>
</tr>
<tr>
<td>11-10/1Kf</td>
<td>0 (0.00)</td>
<td>0 (0.00)</td>
<td>0 (0.00)</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>53 (32.04)</td>
<td>58 (34.21)</td>
<td>9 (15.00)</td>
<td>110</td>
</tr>
</tbody>
</table>

**DISCUSSION**

Pregnancy and the physiological changes associated with it, has been shown to be a predisposing factor of malaria, its associated maternal anaemia and the resultant reduction in Birth Weight. With increasing number of pregnancies, prevalence and parasite densities are declined and the effect of infection (LBW) is reduced (17).

The findings in this study have confirmed the high susceptibility of primiparae in malaria endemic regions. This could be due to the development of the new immunologically naive uteroplacental vasculature during the first pregnancy. It agrees with results from similar studies in Nigeria, Zaire, Kenya, Tanzania, Papua New Guinea and India (20, 13, 15, 14, 17, 21).

The pregnant women especially the primiparae recorded relatively lower haemoglobin levels as opposed to the control group, thus confirming that anaemia is an intrinsic feature of malaria which is more intense amidst pregnancy especially in the first pregnancy. This observation is attributable to the increased susceptibility to malaria and other infections during pregnancy, due to the suppression of the immune system to ensure the establishment and non rejection of the foetus as a foreign allograft (22).

Anaemia, attributable to malaria during pregnancy is a leading cause of maternal morbidity and mortality, abortion, foetal morbidity, still birth, intrauterine growth retardation and has been shown to have a serious effect on the infant birth weight. Thus, there is an urgent need for an intensified effort against malaria in pregnancy. The only way out of the menace of malaria during pregnancy is to adopt, practice and sustain the simple prophylactic measures targeted at preventing malaria transmission, especially during this inevitable period of immune depression. Prompt attack on malaria by the provision of access to effective treatment; reduction of contact with the vector Anopheles by correct and consistent use of insecticide impregnated bed-nets; and the compulsory and monitored standard chemoprophylactic practice (IPT) when applied in conjunction with other control measures will surely ameliorate the burden of malaria.

Tables 3 and 4 show that the haemoglobin profile of the women is highly dependent on malaria infection status and the parity of pregnancy. Over 70% of malaria positive primigravid mothers have haemoglobin levels below the World Health Organization benchmark for pregnant women (11 g/dl) while only 22.22% of the control group fall below this point. Even among the uninfected group, the primiparae still recorded a greater prevalence of low haemoglobin levels.

A massive health education campaign is recommended to improve the level of awareness of malaria, most importantly, of the preventive steps against the infection. Efforts should
also be geared towards improving availability, affordability and adaptability of these measures especially in the resource constrained settings. Political will, increased investment in interventions and a more intensified research in this area is strongly advocated.

ACKNOWLEDGEMENT

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References

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