Serum Ferritin and Iron Status of Mothers and Newborns in Lubumbashi in the DRC

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Abstract

Introduction: Ferritin is the primary form of intracellular iron storage. The serum concentration generally gives a faithful reflection of the level of iron reserves in the body. Hypoferritinemia is an early and specific marker of iron deficiency.

Methodology: A descriptive cross-sectional study with an analytical component was carried out in DR Congo in order to determine the reference values of serum ferritin for mother-newborn couples and to establish the link between these values in mothers and their newborns. Were included in the study mothers who delivered at term after a singleton pregnancy with no history of breakthrough bleeding or blood transfusion and eutrophic newborns with good APGAR showing no pathology, neither malformation. A blood sample was taken from the mother and the newborn for the determination of ferritin and CRP (C-reactive protein) and certain elements of the hemogram according to the methods recommended by the IFCC (International Federation of Clinical Chemistry) and ICSH (International Council for Standardization in Hematology). We have coupled the ferritin assay to CRP in order to eliminate cases of inflammatory syndrome that can influence ferritinemia. Iron supplementation and consumption of kaolin and tea during pregnancy, and some sociodemographic parameters of mothers and newborns were studied.

Results: A total of 103 mother-newborn couples were selected. For mothers: the average age was 27.68 ± 6.42 years and the average parity was 3.80 ± 2.52 [1-12]. About 98.06% lived as a couple 78.64% had a secondary education, 51.48% engaged in a revenue-generating activity and 20.40% had a poor nutritional status. Regarding the sex of the newborn, 56.3% was female. The mean serum ferritin level of the mothers is 59.21 ± 48.09 µg/l with a variability of 81.22; while it is 290.18 ± 212.69 µg/l with a variability of 73.29 in newborns. Reference values of serum ferritin ranged from 21.10 to 114.00 μg/l in mothers and 60.99 to 749.01 μg/l in newborns. There is a positive and significant correlation in the mothers between the hemoglobin level and the CCMH (0.216 and p=0.029) and between the reticulocytes and the CCMH (0.270 and p=0.006). In newborns, there is a positive and significant correlation between hemoglobin and ferritin (0.288; p=0.003) and between hemoglobin and TCCM (0.191 and p=0.037). We found a positive and significant correlation between maternal ferritin and the newborn VGM (0.191 and p=0.037). Iron Supplementation during pregnancy causes significant increase of hemoglobin in newborn (p=0.020). While the consumption of tea and Kaolin during pregnancy although statistically insignificant tends to decrease the values of hemoglobin, VGM, CCMH, reticulocytes and ferritin in newborns.

Conclusion: The mother-newborn Lubumbashi has a rate of ferritin serum in standards accepted. To better understand the origins-deficiency anemia of the newborn within 24 h of birth in our midst, we propose that we consider as reference values of ferritin in serum, those in the range (60.99 to 749.01 μg/l). Although small and not statistically significant, there is a relationship of negative correlation between ferritin maternal serum and the newborn.

Keywords: Ferritin serum; Iron status; Mother-newborn couple; Lubumbashi; DRC
Introduction

Ferritin is the primary form of intracellular iron storage. It is a hollow protein sphere of approximately 12 nm in diameter and with a molecular mass of 440,000 g/mol [1]. It occupies a primordial place in the evaluation of iron status since its serum concentration generally gives a faithful reflection of the level of iron reserves in the body. The hypoferritin is an early and specific marker of iron deficiency the dosage of serum iron is a poor indicator for assessing iron deficiency anemia because often influenced by the circadian rhythm where the use of ferritin assay [2-5]. From childhood, this parameter undergoes major pathophysiological changes related to a particular increase of iron requirements, to an intake deficiency sometimes relationship with socio-economic problems. This pediatric population therefore a significant risk of developing iron deficiency [5,6]. These iron deficiencies have significant hematological, but also extra hematological repercussions, in particular on cognitive functions and on immunity [7,8]. In Africa, the iron deficit remains the leading cause of anemia responsible for a high infant and child mortality risk [9]. In 2012, a WHO study reported that iron deficiency is a common form of nutritional deficiency in children; it results from a prolonged imbalance in the iron balance, which is due to an insufficient supply of iron, a problem of absorption or use of iron, increased needs for iron during the period of growth or losses of blood caused by parasitic infections (malaria, helminthiasis and schistosomiasis) [10]. In the DRC, Kalenga et al. [11] in 2002 reported 51.77% prevalence of anemia among children aged 1 to 2 years which they said was linked to malaria and nutritional deficiencies. Recently, the EDS-DRC II (2014) reported that in the DRC nearly one in two children aged 6 to 59 months (47%) has anemia: 20% in mild form, 25% with moderate form and 2% have severe anemia. From the point of view of age, it is between 6 and 17 months that children are most affected by anemia with a prevalence varying between 51% (minimum) at 12 to 17 months and 59% (maximum) at 6 to 8 months. Although anemia can also be caused by parasitic infections, hemorrhages, congenital conditions or chronic diseases, it is most often caused by a food deficiency, including iron deficiency [12]. The approaches previously discussed have clearly shown that anemia is related to a nutritional iron deficiency, but it can also be a consequence of a chronic deficiency since neonatal period due to antenatal behaviors of mothers. Assumani et al. [13] in 2018 in a study on the blood count of newborns of Lubumbashi, shows that erythrocyte markers values were weak in its African population compared to the European population. The hypothesis was to know if there is a link between iron deficiency and mothers' behaviors during pregnancy, with ethnic origin and/or to genetic factors. At birth, the reserve of iron is estimated by ferritin that is usually high to widely cover the needs of the hemosynthesis [14-17]. In this context, an assay of the ferritin serum is a major advantage to highlight the relationship between erythrocytes markers and the rate of iron serum. So therefore, this study was aimed to determine the reference value of serum ferritin mother and newborn in the first 24 h after birth, and to establish the link between these values.

Materials and Methods

Study framework

The study was carried out in 10 health facilities, namely: The University Clinics of Lubumbashi, the Jason Sendwe Hospital, the Health Center Maman WA Huruma, the Health Center Mery center, the Health Center Kenya 1, the Health Center Imani Bishop Nsoloreshi and the AENEF. The selection of structures for data collection was made by reasoned choice, taking into account the following:

- Welcome at least 300 new pregnant women per year for prenatal consultations and for prenatal care;
- Be accessible to all social strata of the population;
- Ensuring deliveries;
- Have a PMTCT service for the management of HIV infection

Type of study

We carried out a descriptive cross-sectional study with an analytical component, covering the period from April 10th to July 17th, 2019.

Study population and sampling

The population study was made by the mother and newborn couples. Our sample was exhaustive.

Inclusion criteria: Were included in our study; the mother and newborn couple, according to the following criteria:

- Mother who freely consented to participate in the study and who did not experience bleeding from the third trimester of pregnancy;
- Newborn with normal weighted futures, from a large singleton, no history of transfusion and having no pathology involving life-threatening.

Criteria for non-inclusion:

a) For the mother: Icteric, sickle cell or thalassemic mother, cesarized, multiple birth, positive TPM and anti-tuberculosis, recently transfused (less than 4 months), antimitotic, with large spleen and or large liver, febrile, CRP positive.

b) For the newborn: Icteric Newborn, polymarformed, or with infectious stigma (sepsis), fetomaternal ABO and/or Rh incompatibility, recently transfused newborn with depressed APGAR, with iron supplementation, sick at the time of selection, positive CRP.

Study parameters or variables

For mothers:

- Age (years)
- Marital status (living alone or living as a couple)
- Professional activity (activity generating revenue or not regenerating revenue)
- Parity: Nulliparous (P0), primiparous (P1), pauciparous (P2-3) and multiparous (P ≥ 4) [18]
- Nutritional status: appreciation indicator: Brachial Perimeter (BP): poor nutritional status: BP <24 cm, good nutritional status: BP ≥ 24 cm [19-21];
- Level of study: Low, if it is less than or equal to 8 years of study (2nd of secondary school); Acceptable if more than 8 years of study [22]
- Iron supplementation during pregnancy: Yes or no
- Tea consumption during pregnancy: Yes or no
• Kaolin consumption during pregnancy: Yes or no

For newborns:
• Gestational age (SA)
• Weight (grams)
• Gender: Female and Male
• Size (cm)
• Head circumference (cm)
• Thorax perimeter (cm)

Erythrocyte and biochemical parameters (mothers and newborns)
• Hemoglobin (Hb) level: g/dl
• Reticulocyte rate: %
• Average Globular Volume (VGM)
• Average Corpuscular Hemoglobin Concentration (CCMH): g/dl
• Serum ferritin: µg/l
• Reactive Protein C (CRP): Assay carried out by the qualitative and semi-quantitative method. CRP considered positive if greater than or equal to 6 mg/l

The blood sample was taken on an empty stomach at the crease of the elbow, the tourniquet being poorly verified. The assay was carried out according to the methods recommended by the International Federation of Clinical Chemistry (IFCC) and by the International Council by Standardization in Hematology (ICSH). We used the chemical PLC AU480 Beckman coulter for assaying ferritin and CRP. And the SYSMEX KX21N hematology machine for the determination of erythrocyte markers. The serum ferritin assay was coupled with CRP in order to eliminate cases of acute inflammatory syndrome which could influence ferritinemia.

Data analysis
The data processing was carried out using Epi Info 7.2.2.6 and SPSS version 23.0 software. The hemogram and ferritin values found were transformed to standard values using Z-Score to allow the values not included in the range of -2 DS and +2 DS to be located and the reference values are defined in this study as values between the 2.5th and 97.5th percentile. Descriptive statistics made it easier for us to calculate frequencies, averages and standard deviations. The Mann-Whitney test was used to compare the means of two groups and the Rho Spearman correlation coefficient for the relationships between the parameters of the mother and those of the newborn. p<0.05 was significative threshold is statistical. The study had respected the rules of confidentiality, justice and beneficence of mother-newborn couples. The protocol for this research study was submitted and approved by the Department of Pediatrics and the Ethics Committee with the approval number: UNILU/CEM/094/2018.

Limitations of the study
Although we have coupled the serum ferritin assay to CRP to eliminate cases of inflammatory syndrome that can influence ferritinemia, the intra-individual biological variability linked to very low serum ferritin levels can generate a bias. Hence the need, firstly, the soluble receptor assay of transferring that we have not been able to achieve for lack of reagents and their high costs and, on the other hand, the dosage of the spinal cord ferritin, on the other hand, is an invasive method.

Results
The variables sociodemographic taken are in Table 1 reported that 76 mothers or 73.79% were aged from 20 to 35 years. The average age is 27.68 ± 6.42 years with such extreme 16 and 42 years. Regarding marital status, 101 mothers or 98.06% lived in a couple against only 2 or 1.94% who lived alone. In connection with the profession of a woman two had a profession regenerative recipe (Table 2). Furthermore, the level of education was acceptable (78.64%). As for parity, 49.50% of pregnant women were multiparous with an intergenic space beyond 24 months in 44.70% of cases. Iron supplementation was made in 19.40% of cases, the consumption of tea and Kaolin were respectively observed in 85.40 and 84.50% of cases. The majority of mothers had

Table 1: Socio demographic characteristics of the mother.

| Age (years) | Workforce (n = 103) | Percentage | M ± SD |
|-------------|---------------------|------------|--------|
| <20         | 10                  | 9.71       | 27.68 ± 6.42 |
| 20-35       | 76                  | 73.79      |        |
| >35         | 17                  | 16.5       |        |
| Marital status |                   |            |        |
| Living alone| 2                   | 1.94       |        |
| Living as a couple | 101     | 98.06      |        |
| Profession   |                     |            |        |
| Recipe regenerator | 53      | 51.46      |        |
| Non-regenerative of recipes | 50     | 48.57      |        |
| Study level  |                     |            |        |
| Low         | 22                  | 21.36      |        |
| Acceptable  | 81                  | 78.64      |        |
| Parity      |                     |            |        |
| Primiparous (p = 1) | 21    | 20.40      |        |
| Pauciparous (p2-3) | 31     | 30.10      |        |
| Multipar (p ≥ 4) | 51     | 49.5       |        |
| Inter generational space (months) |        |            |        |
| <12         | 18                  | 17.50      |        |
| Dec-24      | 31                  | 30.10      |        |
| >24         | 46                  | 44.7       |        |
| Not precise | 8                   | 7.8        |        |
| Nutritional status |         |            |        |
| Bad         | 21                  | 20.39      |        |
| Well        | 82                  | 79.61      |        |
| Iron supplementation |       |            |        |
| No          | 83                  | 80.6       |        |
| Yes         | 20                  | 19.4       |        |
| Kaolin consumption | 15    | 14.6       |        |
| Yes         | 88                  | 85.40      |        |
| Tea consumption |               |            |        |
| No          | 18                  | 15.5       |        |
| Yes         | 87                  | 84.5       |        |
and maternal ferritin shows a correlation positive and significant (0.191, p=0.037) between the baby MCV and ferritin maternal serum (Table 8). P-value is significantly less than 0.05. Iron supplementation in mothers in the third quarter brought a slight Amelio ration red cell parameters of the new-born but not significant for most except for hemoglobin for which the difference is statistically significant (p=0.020). The consumption of tea in the mother, although not statistically significant, a tendency to decrease the value s erythrocyte newborn (Table 9). Kaolin consumption in the mother, although not statistically significant, a tendency to decrease the biological values of the new-born (Table 10).

### Discussion

#### Sociodemographic features of mothers

The sociodemographic profile in Table 1 reported that 76 mothers or 73.79% were aged from 20 to 35 years. The average age was 27.68 ± 6.42 years with 16 and 42 as the extreme. A study in France reported that out of 57 patients in the study, the average age was 27.6 ± 0.7 years [23]. These results are slightly lower than those of Assumani et al. [13] in Lubumbashi, which have found a mean age of 29.9 ± 5.7 ans.

Regarding marital status, in our series the majority of mothers lived in a couple (98.06%), one in two mothers had profession generating revenue. The most was the level of study acceptable (64%). These results are major part super imposable to those of Assumani et al. [13]. In relation to parity, 49.50% of cases, our pregnant women were multiparous; this result is similar to Assumani et al. [13] who reported more multiparous. Since, the profile of the mother in Lubumbashi has not changed as found in our study. Audrey Camiuzi in France reported a significant proportion of primiparous patients (45.6%) [23].

#### Gestational age and anthropometric parameters of the newborn

In our series, the average gestational age was 39.67 ± 1.26 S A and the anthropometric parameters of the newborn varied as follows: weight 3065.58 ± 433.83 g, size 48.17 ± 1.91 cm, the cranial perimeter 34.80 ± 1.14 cm, the thoracic perimeter 33.19 ± 1.62 cm, the brachial perimeter 10.84 ± 1.05 cm. It was observed that only the weight exhibited quite significant variability. The parameters remained super

### Table 2: Gestational age and anthropometric parameters of newborns.

| Parameters                  | N   | Average   | Coefficient of variation |
|-----------------------------|-----|-----------|--------------------------|
| Gestational age (SA)        | 103 | 39.67 ± 1.26 | 3.17                     |
| Weight (g)                  | 103 | 3065.58 ± 433.83 | 14.15                    |
| Height (cm)                 | 103 | 48.17 ± 1.91  | 3.97                     |
| Head circumference (cm)     | 103 | 34.80 ± 1.14  | 3.28                     |
| Thoracic perimeter (cm)     | 103 | 33.19 ± 1.62  | 4.88                     |
| Brachial perimeter (cm)     | 103 | 10.84 ± 1.05  | 9.69                     |

### Table 3: Mean and standard deviation of erythrocyte parameters and organic chemicals from the mother and newborn.

| Parameters                  | N   | Mother | Coefficient of the variation | Newborn | Coefficient of variation |
|-----------------------------|-----|--------|-------------------------------|---------|--------------------------|
| Hemoglobin level (g/dl)     | 103 | 10.16 ± 1.47 | 14.47                        | 17.28 ± 2.27 | 13.14                    |
| VGM (fl)                    | 103 | 84.70 ± 8.35 | 9.86                         | 96.28 ± 21.98 | 22.83                    |
| CCMH (g/dl)                 | 103 | 28.82 ± 2.18 | 7.56                         | 30.2 ± 2.40  | 7.82                     |
| Reticulocytes (%)           | 103 | 0.86 ± 0.29  | 33.72                        | 1.11 ± 0.39  | 7.82                     |
| Serum ferritin (µg /l)      | 103 | 59.21 ± 48.09 | 81.22                        | 290.18 ± 212.69 | 73.29                    |
imposable on those of Assumani et al. [13] and within the limits of evolution as described by the Alexander scales [24].

**Average and range of reference values of erythrocytes in mother and newborn**

The mean serum ferritin in mothers is $59.21 \pm 48.09$ mg/l with high variability (81.22) compared to newborn which is $290.18 \pm 212.69$ mcg/l with fairly low variability (73.29). Ferritin crumb undergoes important variations during the first-year service life. Our results can be superimposed on those of Morel et al. [25] that in turn the first months have observed an average 254.4 mg/l. Unlike the study by Sankande et al. [26] in Ivory Coast who reported a low ferritin level of from 50 to 600 µg/l the serum ferritin concentration in the newborn. However, through various studies on the iron status of the newborn, the authors observed averages ranging from 81 to 677 mg/l for ferritin from birth, most of which are in the normal range compared to newborn which is $290.18 \pm 212.69$ mg/l with fairly low variability (73.29). Ferritin crumb undergoes important variations during the first-year service life. Our results can be superimposed on those of Morel et al. [25] that in turn the first months have observed an average 254.4 mg/l. Unlike the study by Sankande et al. [26] in Ivory Coast who reported a low ferritin level of from 50 to 600 µg/l the serum ferritin concentration in the newborn.

Table 5: Correlation parameters erythrocyte and organic chemicals from mother.

|                     | Rate of hemoglobin (g/dl) | VGM (fl) | CCMH (g/dl) | Reticulocytes (%) | Serum ferritin |
|---------------------|---------------------------|----------|------------|------------------|--------------|
| Hemoglobin level (g/dl) | 0.132 | 0.316 | 0.039 | 0.270 | 0.531 | 0.156 |
| VGM (fl) | 0.216 | 0.045 | 0.006 | 0.115 |
| CCMH (g/dl) | 0.131 | 0.037 | 0.042 | 0.071 |
| Reticulocytes (%) | 0.079 | 0.071 | 0.156 | 0.426 |
| Serum ferritin (µg/l) | 0.031 | 0.039 | 0.042 | 0.071 |

*: The correlation is significant at the 0.01 level (bilateral); **: The correlation is significant at the 0.05 level (bilateral)

Table 6: Correlation parameters erythrocyte and organic chemicals in the newborn.

|                     | Serum ferritin | Rate of hemoglobin (g/dl) | VGM (fl) | CCMH (g/dl) | Reticulocytes (%) |
|---------------------|---------------|---------------------------|----------|------------|------------------|
| Serum ferritin      | 0.003         | 0.753                     | 0.106    | 0.929      |
| Hemoglobin level (g/dl) | 0.288** | 0.699                     | 0.037    | 0.686      |
| VGM (fl) | 0.031 | 0.039 | 0.871 | 0.375 |
| CCMH (g/dl) | 0.160 | 0.205* | -0.016 | 0.800 |
| Reticulocytes (%) | 0.009 | -0.040 | 0.088 | 0.025 |

Table 7: Correlation parameters erythrocyte and organic chemical in infants (n-born) and ferritin mother.

|                     | Maternal ferritin | Ferritin newborn | N-born hemoglobin | VGM newborn | CCMH newborn | Reticulocytes & No baby |
|---------------------|-------------------|------------------|------------------|------------|-------------|------------------------|
| Maternal ferritin   | 0.917             | 0.808            | 0.037            | 0.707      | 0.823       |
| Ferritin newborn    | -0.01             | 0.011            | 0.538            | 0.316      | 0.876       |
| N-born hemoglobin   | 0.022             | 0.231*           | 0.86             | 0.020      | 0.552       |
| VGM born            | 0.191             | 0.057            | 0.016            | 0.531      | 0.574       |
| CCMH newborn        | -0.035            | 0.092            | 0.212*           | -0.058     | 0.349       |
| Baby reticulocytes  | -0.021            | -0.014           | -0.055           | 0.052      | 0.086       |

Table 8: Iron supplementation in the mother and in erythrocyte a meters of the newborn.

| Parameters | Yes (n=20) | No (n=83) | p-value |
|-----------|-----------|-----------|---------|
| Hemoglobin level (g/dl) | 18.23 ± 1.87 | 16.86 ± 2.29 | 0.020 * |
| VGM (fl) | 82.91 ± 29.51 | 94.26 ± 19.75 | 0.21 |
| CCMH (g/dl) | 30.48 ± 2.88 | 30.64 ± 2.29 | 0.854 |
| Reticulocytes (%) | 1.05 ± 0.35 | 1.04 ± 0.40 | 0.954 |
| Ferritin (µg/l) | 2.85 ± 197.29 | 205.85 ± 215.69 | 0.253 |

low values. By comparing the mother to the newborn; all markers were in increased in the normal range in the newborn. These results are in agreement with those of the literature [31].

**Correlation matrix parameters erythrocyte in the mother and in the newborn**

The correlation matrix parameters erythrocyte mother shows a positive and significant correlation (0.216; p=0.029) between the hemoglobin and the rate of MCHC. A positive and very significant correlation (0.270; p=0.006) between reticulocytes and CCMH. Furthermore, the non-significant negative correlation (-0.131; p=0.186) between the hemoglobin level and the reticulocytes and a non-significant positive correlation (0.156; p=0.426) between the reticulocytes and the serum ferritin. The newborn’s biological correlation matrix parameter reported a positive correlation and very significant (0.288, p=0.003) between the hemoglobin and ferritin. A positive and significant correlation (0.205; p=0.037) between the hemoglobin level and the CCMH. We observed a non-significant positive correlation (0.160; p=0.106) between serum ferritin and...
Table 9: Consumption of tea at the mother, erythrocyte ferritin parameters and newborn.

| Parameters       | Yes (n=21) | No (n=82) | p-value |
|------------------|------------|-----------|---------|
| Hemoglobin (g/dl)| 17.29 ± 2.34 | 17.22 ± 1.91 | 0.916   |
| VGM (fl)         | 97.00 ± 22.36 | 96.62 ± 20.50 | 0.949   |
| CCMH (g/dl)      | 30.80 ± 2.34 | 30.23 ± 2.74 | 0.391   |
| Reticulocytes (%)| 1.12 ± 0.41 | 1.07 ± 0.24 | 0.662   |
| Ferritin (µg/l)  | 298.64 ± 215.60 | 244.20 ± 196.00 | 0.885   |

Table 10: Consumption of Kaolin during pregnancy in the mother, erythrocyte parameters and ferritin in the newborn.

| Settings | Kaolin |
|----------|--------|
|          | No (n=15) | Yes (n=88) | p-value |
| Hemoglobin (g/dl) | 17.00 ± 1.54 | 17.32 ± 2.37 | 0.607   |
| VGM (fl) | 101.86 ± 6.19 | 96.11 ± 23.57 | 0.352   |
| CCMH (g/dl) | 30.10 ± 2.59 | 30.81 ± 2.37 | 0.292   |
| Reticulocytes (%) | 1.02 ± 0.35 | 1.12 ± 2.37 | 0.348   |
| Ferritin (µg/l) | 297.54 ± 251.93 | 288.93 ± 206.90 | 0.886   |

CCMH. The two-matrix show that maternal serum concentration of ferritin is not bound to any parameters of iron status. In the newborn the ferritin is closely related to hemoglobin. These results corroborate with this stream of Dop et al. [32] and Sakande et al. [26] in Ivory Coast. The authors thought that the lack of correlation between the hemoglobin level of mothers and newborns testifies to the active transfer of iron to the fetus. However, when the maternal serum iron is low, it no longer allows sufficient supplies to the fetus whose serum iron is then reduced.

Iron supplementation in the mother and erythrocyte parameters in the newborn

In our series, iron supplementation in the mother in the third trimester brings a slight improvement in erythrocyte parameters of the newborn but not significant for most, except the hemoglobin level for which the difference is statistically significant (p=0.020). The intake of iron during pregnancy has been shown as an effective way to fight against iron deficiency. The authors: Assumani et al. [13] and Dop et al. [32] have also dince showed.

Consumption of tea, Kaolin in the mother and biological parameters of the newborn

The consumption of tea and the kaolin in the mother, although statistically insignificant, has the negative influence on the future of ferritin and markers erythrocyte newborn. These results corroborate those of a study carried out by WHO in 2012 and by Assumani et al. [13] who made the same observation.

Conclusion

The mother-newborn Lubumbashi has a rate of ferritin in serum within accepted standards. To better understand the origins of deficient anemia of the newborn within 24 h of birth in our environment, we suggest that we consider as reference values of serum ferritin, those in the interval (60.99 to 749.01 µg/l). Although weak and not statistically significant, there is a negative correlation between maternal serum ferritin and that of the newborn.

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