President's Page

Improving Status of Neonatal Health in India

Reduction in infant and child mortality is a major goal of the strategy to achieve health for all. During the last quarter of the century emphasis has been placed on reducing under-five childhood mortality largely through immunization, ORS and control of acute respiratory infections. Consequently, deaths among children over one month of age have sharply declined in the last three decades. These changes, however, did not have a marked impact among neonates, leading to the shifting of infant mortality at early age. Neonatal deaths now account for up to two-thirds of all infant deaths and half of under-five child mortality in developing countries. This means that interventions to reduce neonatal mortality are at the cutting edge of child survival programs.

Current scenario

The current state of neonatal health in India is indeed dismal to state the least. Three neonates are dying every minute in India and every 4th baby born is low birth weight! Out of 3.9 million neonatal deaths worldwide, India is accounting to 1.2 million or nearly 30% of global neonatal mortality! The present figure of 40 per 1,000 live births is too high. Furthermore, there is great diversity of NMR in different states and BIMARU states together constitute over half of all newborn deaths in India. Most neonatal deaths are caused by preventable and/ or treatable diseases. Infections, birth asphyxia, and prematurity are the leading causes of neonatal deaths in India.

Why the scene is so dismal?

A majority of newborn problems are specific to perinatal period, and are the results of poor maternal health, inadequate care during pregnancy, inappropriate management, and poor hygiene during the delivery, lack of newborn care and discriminatory care. Almost two-thirds of births in developing countries occur at home and only half are attended by a trained birth attendant. Only 25% of all births in India occur in health institutions like hospitals and primary health centers. The rest three-fourths of births occur at home. Trained personnel are in attendance in only 34% of the 25 million births that occur annually in the country.

Though GOI with the initiative of WHO, UNICEF and other international agencies has now recognized the significance of newborn, who is still not accepted as a person in the society, and given the highest priority in its next 5 year plan- RCH II (2005-10). The government has incorporated letter 'N' denoting newborn into existing IMCI.

Lack of proper infrastructure and training in newborn care were missing at the peripheral level. There was a paucity of trained health personnel to deal adequately many neonatal emergencies where time and speed of interventions not only decide the immediate outcome but also affects the long term intact survival of the neonate.

Current status of neonatal health services in India

The current status of neonatal health services in the country is quite slapdash and disorganized. Till quite recently, only 20 of the 125 medical colleges in the country had special care neonatal units. A series of surveys of neonatal centers conducted in the country revealed that out of 28 units only 50% had satisfactory resuscitation facilities while 33% had inadequate space. The numbers of neonatal beds in relation to high-risk deliveries were inadequate in 25% of the teaching hospitals. Only 12% of the units had optimum number of nurses for the available beds. Adequate monitoring facilities for sick newborns existed in only 19% of the centers. This was the state of neonatal health services in premier teaching hospitals and institutions of the country. No doubt, the situation has improved quite drastically in last 10 years but still considering our large population, we need at least 2000 special care neonatal units (*i.e.*, 4 units per district) all over the country.

As far as private sector is concerned, of late, there is mushrooming of many level II and level III neonatal centers especially in urban areas. They lack the objectivity of providing cost effective services affordable to the section of the society needing them the most. There is utter lack of facility of providing even the bare minimum newborn care at the primary health centers.

How to move forward?

Growing interest of our academicians for advanced neonatal care needs to be matched by their concern for the primary care of the newborn. Although it is well accepted that level II care is more cost effective than level III care, it must be realized that level I care is even more so. Hence, the primary care of the newborn amongst the deprived communities in rural areas and urban slums needs to be reinforced. But it is perhaps the most cost-effective among all the other intensive care services because saving a newborn is associated with survival and productivity for more than 5 decades! We can achieve the target without solely resorting to level II/ III grades of neonatal intensive care as quite amply shown by the Sri Lankan example. The tiny island could bring down NMR below 20 without having a single NICU in the country. With simple, innovative, community targeted measures, the same can be achieved here.

Neonatal deaths can not be substantially reduced without efforts to reduce maternal mortality and improving maternal health. We need to have a massive health initiative to train medical and paramedical personnel particularly trained birth attendants, ASHA, AWW, FMPW and primary care physicians in antenatal care, safe delivery, neonatal resuscitation, provision of asepsis, warmth and adequate feeding. The main components of essential newborn care like prevention of hypothermia and sepsis, neonatal resuscitation, exclusive breast-feeding, kangaroo mother care, and vaccination should not only form the cornerstone of training of health workers at grass root level but also needs to popularize at the community level through innovative schemes.

We also need to prioritize interventions based on the NMRs of different states. States having high NMR (MP, Orissa, UP) should give more priority to establish level I care units while states having low NMR (Kerala, Punjab, Maharashtra) should invest in level II and III care units.

Role of IAP and other professional bodies

The need of the hour is to launch a massive collaborative effort involving not only IAP and NNF-the two major academic bodies involved in carrying out the agenda of child and neonatal survival in the country but to include other organizations like FOGSI and IMA to provide a comprehensive program all over the country. IAP is now actively collaborating not only with GOI, ICMR, Unicef, WHO and other national health agencies on the project of child survival but it has now gone a step further and is going to establish a strategic partnership with AAP to start a nationwide Neonatal Resuscitation Program (NRP), a very popular and significant community oriented initiative of AAP in our country as well. This ambitious venture of IAP-AAP will go a long way to train pediatricians and other health personals in the art of neonatal resuscitation and have a positive impact on NMR and IMR.

Naveen Thacker,
President, IAP 2007,
Deep children Hospital, 208, Sector 1-A,
Gandhidham, Kutch 370201,
Gujarat, India.
E-mail:drnaveenthacker@gmail.com