Newborn care in India: a crying need of the hour

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“We are guilty of many errors and many faults, but our worst crime is abandoning the children, neglecting the foundation of life. Many of the things we need can wait. The child cannot. Right now is the time his bones are being formed, his blood is being made and his senses are being developed. To him we cannot answer ‘Tomorrow’. His name is ‘Today’.”

Gabriela Mistral, 1948

Newborn babies have a right to survive and grow into childhood, and to experience life to their full potential. Their healthy start in life is a shared responsibility of the family, community, and government. Across the lifespan, a human being faces the greatest risk of mortality during birth and the first 28 days of life—the neonatal period. Three quarters of neonatal deaths take place in the first seven days, the early neonatal period. Ironically enough, most of these are preventable.¹

Globally, neonatal deaths, about four million annually, constitute a much higher proportion of under-five deaths than in previous years. Deaths in the first month (neonatal mortality: 24/1000 live births) of life have now risen to 40% of under-five deaths (60/1000 live births).² Every year about 70% of neonatal deaths (almost three million) happen because effective yet simple interventions do not reach those most in need. Coverage of interventions is low, progress in scaling up is slow, and inequity is high, especially for skilled clinical interventions.³ A child born in a poor country is almost 14 times more likely to die during the first 28 days of life than one born in an industrialised country. A vast majority of newborn deaths in the world are the direct result of three main causes: severe infections, asphyxia and pre-term births. Low birth weight, which is caused by preterm birth or intrauterine growth restriction, is an underlying factor in 60–80% of neonatal deaths. Most of these deaths occur at home, are unrecorded, and remain invisible to all but their families. Deaths of newborns in developing countries have received far too little attention.⁴ Neonatal mortality is among the most neglected public health issues. A major barrier has been the erroneous perception that only expensive, high-level technology and health facility-based care can reduce neonatal mortality.

As per 2009 State of the World Children Report, in India, the under-five mortality has shown a decline from 117 in 1990 to 72 in 2007, infant mortality stands at 54 (2007) and neonatal

mortality rate at 39 (2004). India has the highest number of births (20%) and neonatal deaths (30%) in the world.⁵ Neonatal mortality constitutes 60% of infant mortality and over 50% of under-five child mortality. MDG 4 aims to reduce child mortality as the Target 4A aims to reduce the under-five mortality rate by two-thirds, between 1990 and 2015. Eleventh five-year plan (2007–2012) set out a goal to reduce Infant Mortality Rate (IMR) to 28/1000 live births.⁶ The foremost goal of the National Population Policy (2000), the National Health Policy (2002) and the National Rural Health Mission (2005) is to reduce infant mortality rate (IMR) to less than 30/1000 live births. With neonatal mortality constituting over two-thirds of infant mortality, this would require attaining neonatal mortality rate (NMR) of less than 20/1000 live births. The present neonatal mortality rate (NMR) of 36 (2007) is almost twice the avowed target. Improving neonatal survival is at the very heart of meeting the challenge of unacceptably high infant and child mortality; our efforts to address it continue to be half-hearted and ineffective.⁷

Prevention of newborn deaths requires skilled care more than technology, and demands flexible and responsive systems of intervention. Neonatal health can be improved, for instance, by practices that do not have high costs attached, such as clean delivery conditions and the promotion of early and exclusive breastfeeding, and by ensuring that the mother is healthy when she gives birth. In a resource-poor area of rural India, a simple, low-cost package of essential newborn care delivered through a culturally sensitive community mobilisation and behaviour change communication programme by community-based health workers and volunteers improved key newborn care practices and reduced neonatal mortality to half within one year.⁸ These include but not restricted to, promotion of warmth, early and exclusive breastfeeding, cord care and hygiene; avoiding harmful practices like early bathing, colostrum discarding, pre-lacteals and cord applications.

In India, though national average for institutional deliveries is about 50%, some EAG states record less than 25% institutional deliveries. (NFHS-3) The socio-cultural constraints coupled with lack of inadequate services both in terms of coverage and quality are responsible for this. In view of this, there is a need to improve neonatal survival by skilled birth attendance and essential newborn care which can be provided effectively at the community level as well, as shown by Bang et al.⁹

Several initiatives for neonatal survival have been taken in India. Key strategies under RCH II for newborn & child health include increased coverage of skilled care at birth for newborns in conjunction with maternal care. IMNCI is being currently implemented across the country. ‘Janani Suraksha Yojana’ launched in 2005 has the dual objectives of reducing maternal and infant

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mortality by promoting institutional delivery among the poor women. The actions at community level include Kangaroo mother care (KMC) for low birth weight babies, promoting early recognition of neonatal and childhood illness, educating families regarding 'danger signs' among neonates and children, enable families to seek care early and from trained providers.

All health professionals who attend the mother at birth must be skilled at resuscitation and know how to recognise babies at risk. They must anticipate the need for resuscitation in each delivery, be prepared with the necessary equipments that need to be checked prior to the birth of the baby and know what to do in what order. Under NRHM it is envisaged to include courses for multiple skills for serving Medical Officers, especially for anaesthesia, emergency obstetrics, emergency paediatrics particularly newborn care. 'Navjaat Shishu Suraksha Karyakram' (NSSK) has been launched to address care at birth issues i.e. prevention of hypothermia by KMC, prevention of infection, early initiation of breastfeeding and basic newborn resuscitation. The objective of this new initiative is to have one person trained in basic newborn care and resuscitation at every delivery. This training is being imparted to Medical officers, Staff nurses and ANMs at CHC/FRUs and 24×7 PHCs where deliveries are taking place. The training package is based on the latest available scientific evidence; training duration is only two days and will be immensely useful in decreasing neonatal mortality.

The health needs of women, newborns and children require integrated solutions. Essential services must be provided at key points in the life cycle through dynamic health systems that integrate a continuum of home, community, outreach and facility-based care. Continuum of Care is a model of primary health care services for mothers, newborns and children, embraces every stage of maternal, newborn and child health, and is most effective when delivered in a timely fashion at critical points in the life cycle of mothers and children: adolescence, pre-pregnancy, pregnancy, birth, post-partum, neonatal, infancy and childhood. The government has identified this fact and taken steps to rectify the shortcomings by promoting institutional deliveries, training of human resources, developing health infrastructure and placing these issue as social priority. Guiding principles for newborn and child health strategies under XI Five-Year Plan include evidence-based interventions, integrated approach in sync with family planning and maternal health components of the programme, equity-driven implementation and monitoring, rational mix of family-centred (home level), population-centred (outreach) and individual-centred (clinical) interventions. A new cadre of Community Skilled Birth Attendants (C-SBAs) is proposed to be introduced. After a training of one-year, a C-SBA would provide midwifery care as a 'practitioner' in the community.¹⁰

The professional bodies like IAP and NNF have also come forward in advocating issue of neonatal survival and contributed in training initiatives. The Comprehensive Newborn Care Programme was launched under the aegis of IAP vision 2007 along with several other programmes intended to impact the knowledge and practices of paediatricians all over the country. National

Neonatal Forum has worked as missionary for improving newborn health at all levels in the country, advancing science and technology, defining standard of care, improving education and training and partnering with other stakeholders for healthy future of newborn.¹¹

Since 1980, the Armed Forces neonatology speciality has grown to its present state. Now we have a sound health care system with provision for neonatal care in the form of NICUs, updated protocols for neonatal care, elaborate community outreach programme, common perinatal database and regular training programme to ensure standardised and high quality neonatal care.¹²

The country needs to recognise neonatal survival as a national priority and ensure sustained commitment for their priorities with financing, managerial and political support if we wish to meet our MDG goals. There is a need to increase access to effective maternal and child care, particularly for the rural and poor, by removing physical, social and financial barriers and fostering the involvement of the community and improving utilisation of available maternity and child health service facilities.

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