

Can India prevent 200 children dying every hour?

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It is estimated that India lost 1.8 million children under five years age in 2008. That is more than 200 child deaths every hour each day, or more than three deaths every minute. Out of about 25 million babies born every year in India, one million newborns die. A large proportion of children who survive do not get to grow up and develop well. About 48% of children are stunted (sub-normal height) and 43% are under-weight. Additionally, about one third of babies are born with low birth weight of less than 2500 grammes.

Some countries in South-East Asia such as Maldives, Sri Lanka and Thailand have reduced newborn and childhood mortality significantly. India has also demonstrated steady progress. Under-five mortality decreased from about 150 per 1000 live births in 1990 to 74 per thousand live births in 2005-06. But at this rate of decline India would not be able to achieve Millenium Development Goal 4 (MDG) target of 50 under-five deaths per 1000 live births by 2015. Moreover, the progress has been uneven among various states in the country.

The causes of death among children are well understood in India. Newborn mortality (death within the first 28 days of life) contributes more than half of under-five mortality. The major causes of death for newborns are asphyxia (inability to breathe at the time of delivery), infections and prematurity. The major causes after 28 days of life are acute respiratory infections (pneumonia) and diarrhoea. Undernutrition contributes to 35% of

deaths in children. In addition to these immediate causes of childhood deaths, there are several sociocultural factors including poverty, poor water and sanitation facilities, illiteracy (especially among women), the inferior status of women in the society, and pregnancy during adolescence (attributable to early marriage). The child mortality rates are also higher among rural populations as compared to urban counterparts.

We know what needs to be done to save the precious lives of newborns and children. Newborn deaths could be prevented by ensuring nutrition of adolescent girls; delaying pregnancy beyond 20 years of age and ensuring a gap of 3-5 years between pregnancies; skilled care during pregnancy, childbirth and postnatal care; and improved newborn care practices that include early (within first hour of birth) and exclusive breastfeeding; preventing low body temperature and infections; and early detection of sickness and timely treatment-seeking. Childhood deaths could be prevented by exclusive breastfeeding for 6 months and complementary feeding from 6 months of age with continued breastfeeding for 2 years; immunization; and early treatment of pneumonia, diarrhoea and malaria. In addition, it is important to invest in appropriate child caring practices by mother and other caretakers at home, right from birth to support early childhood development and lay a foundation to maximize human potential.

India needs to provide these interventions to most, if not all, newborn and children who need them. However, the coverage of these life-saving interventions has been quite low. For example, in 2005-06 (NFHS 3 Report), the rate of initiation of breastfeeding within one hour of birth was only 26% and exclusive breastfeeding at 6 months was just 46%.

Yet these two interventions have the potential to prevent 19% of deaths. The use of oral rehydration salts in cases of diarrhoea, the most recommended treatment, was just 43% and only 13% cases of suspected pneumonia received antibiotics. Immunization coverage has been relatively better, suggesting that high coverage is achievable.

The main causes of poor coverage of interventions include ineffective planning and implementation, mainly due to weaknesses in the health system. To address the systemic challenges, India launched a flagship programme, the National Rural Health Mission in 2005-06, to strengthen the health system in rural areas. Commendable initiatives have been put in place such as training about 800 000 village level health volunteers (Accredited Social Health Activist, or ASHA), hiring additional staff, strengthening the infrastructure of health facilities, augmenting programme management capacity at state and district levels, and enhancing community participation. However, much more needs to be done to minimize health inequities that exist among different subpopulations in the country.

Public health expenditure in India has remained at low a level of about 1% of GDP for quite some time. This needs to be scaled up. Considering that about 70% of health care is accessed from the private sector in the country, better regulation and participation of private health service providers must be ensured. Synergy between the health and nutrition sectors must be fostered through better coordination between the Ministry of Health and the Ministry of Women and Child Development, which are responsible for the ICDS (Integrated Child Development Services) programme.

To reach the unreached newborns and children, there is a strong case for providing home-based newborn care as well as community-based management of non-severe pneumonia and diarrhoea in children by trained ASHAs and other community health workers. This initiative would need to be supported by provision of incentives, necessary drug supplies, close supervision and appropriate referral linkages. At the same time, the quality of health services at first-level health facilities and referral hospitals must continue to be strengthened.

Fortunately, there is renewed commitment at global and national level towards accelerating progress towards achievement of MDG 4. To save the precious lives of newborns and children, national governments, development agencies, civil society and other stakeholders must work in close collaboration.