Globally, the under-five mortality rate has dropped by 41%, from 87 deaths per 1000 live births in 1990 to 51 per 1000 live births in 2011. During this period, in the Member States of South-East Asia Region (SEAR), the under-five mortality rate reduced by about 50%, from 109 to 55/1000 live births.[1] In comparison to under-five mortality, the neonatal mortality has remained high. In SEAR, the neonatal mortality contributes to 52% under-five mortality, while, globally, it contributes to 40% of under-five mortality.

About one-third of newborn deaths worldwide are caused by pre-maturity; it is the second most common cause of child deaths, after pneumonia. About 1 million children die every year due to complications of pre-maturity. In addition, many survivors suffer a lifetime of disability, including learning disabilities and visual and hearing problems.

The World Health Organization (WHO) defines pre-maturity as birth before 37 weeks of gestation or fewer than 259 days since the first day of last menstrual period. The data and information on pre-term births in the SEAR remains a challenge. First of all, the birth registration rates are low in several countries. Second, assessing the gestational age is also a challenge as many women cannot recall the date of last menstrual period, birth weight is not recorded for all births, measurement of fundal height and neonatal examination for assessing maturity require skilled examiner and sonographic dating is not easily available.

The ‘Born Too Soon’ report provides global estimates for international comparisons. According to this report, 15 million babies are born before completing 37 weeks gestation every year, the prevalence being more than 10% of all live births. Over 60% of pre-term births occur in Africa and South Asia. In the underdeveloped countries, on an average, 12% of babies are born too soon as compared with 9% in developed countries. Within countries, poorer families are at higher risk. [2] In addition, the prevalence of low-birth weight continues to be significant in several of the SEAR member states, and the information on proportion of these on account of pre-term births is unknown.

Most pre-term births happen spontaneously and, in many cases, the exact cause of pre-term birth cannot be identified. Common causes include pregnancy among adolescents, pregnancies with narrow spacing, multiple pregnancies, maternal infections, chronic conditions like diabetes mellitus and pregnancy-induced hypertension, and exposure to tobacco, indoor air pollution and some environmental pollutants. Some pre-term births occur because of early induction of labour or caesarean section, owing to medical or non-medical reasons. It must be noted that births at 37-39 weeks still have suboptimal outcomes, and induction or caesarean birth should not be planned before 39 completed weeks, unless medically indicated.

The 'Born Too Soon' report has also highlighted several public health actions that are required to manage pre-term births. These have been considered in three broad areas: Preconception care, care during pregnancy and childbirth, and management of pre-term babies.

Pre-conception care
Early marriage of girls and early pregnancy in adolescence is common in Bangladesh, India, Indonesia and Nepal in the SEAR, which contributes to higher pre-term births. To reduce the pre-term birth rates, we need to focus on empowering adolescents to delay marriage and pregnancy, improve nutrition of girls and women and improve access to family planning and good quality of care during pregnancy. To address other causes, good control of gestational diabetes and prevention of use of and exposure to tobacco need to be ensured for all pregnancies.

Care during pregnancy and childbirth
Skilled care during pregnancy and childbirth would help in prevention and timely management of pre-term births. Health promotion during pregnancy to tackle maternal risk factors like intake of appropriate nutrition (including micronutrients), avoidance of exposure to smoke (tobacco and indoor air pollution) and alcohol, and gender-based violence would prevent pre-term births as well as intrauterine growth restriction. Use of antenatal steroids, tocolysis and prophylactic antibiotics for premature rupture of membranes in case of pre-term onset of labour improves neonatal outcomes.
Management of pre-term babies
Although neonatal intensive care may be required to save extremely pre-term babies, fortunately, deaths from pre-term birth complications can be reduced by over three quarters even without using high-tech care. About half the babies born at 32 weeks gestation could be saved with feasible, cost-effective, essential newborn care, such as provision of warmth (thermal care), breastfeeding support and basic care for infections and breathing difficulties.

Many of these interventions for prevention and management of pre-term births do not reach the populations that need them the most. Hence, efforts need to focus on high and equitable coverage of evidence-based life-saving interventions with good quality of services. Member states in SEAR are implementing adolescent health programmes, which include several pre-conception care interventions that need to be scaled-up. Fortunately, skilled care during pregnancy and at birth and the institutional deliveries are progressively increasing in these region, which would help improve prevention and management of pre-term labour and care of pre-term births. Countries in these region are strengthening home-based as well as facility-based newborn care to ensure essential care and timely referral of pre-term newborns. Investment in research is needed to understand the most efficient ways to reach people with preventive and curative interventions. Research is also needed to better understand the causes of pre-term births so that effective preventive interventions can be designed.

The recent commitments like the UN strategy for Women’s and Children’s Health and ‘Call for Survival-A Promise Renewed’ provide significant opportunities to expand efforts to address pre-term births towards overall neonatal and child survival.

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