Guest Editorial:

Challenges and opportunities of Neonatal Care in India

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According to the India Newborn Action Plan-2014, Govt. of India has committed to reduce the Neonatal Mortality Rate (NMR) from 28 to 9 by year 2030. Neonatologists in India face the following main challenges for achieving this objective.

1. Current variable NMR of 6 to 37 in different states of the country requires different approaches for action

2. Unaudited quality of neonatal survival is leading to increasing incidence of Retinopathy of Prematurity (ROP), multidrug resistant neonatal sepsis and brain damage causing Neuro-developmental delay.

3. 85% of the neonatal deaths are due to Birth Asphyxia, Sepsis or Low Birth Weight. These need focus.

4. 80% of newborn babies need only Level I (L-I) care, which is inexpensive.15% require Level II (L-II) care, which costs 5 times that of L-I care. Only 5% need Level- III (L-III) care, which is expensive and costs 5 – 10 times that of L-II care. Hence, intensive care should be built upon good basic care

5. 70% of the population is very poor, poor or low middle class, hence, exclusively dependent upon care at Govt. hospitals.

6. Govt. sector has poor availability of doctors and nurses with sub optimal training, poor maintenance of equipments, poor functioning of supporting services, irregular supplies and financial flow. There is lack of proper protocols for patient care, referral and transport. There is poor coordination between PHC's/CHC's and SNCU's without any community participation. There is also lack of audit for the quality and cost of care .

We need to handle the above mentioned challenges by creating the following opportunities

1. Do the local situational analysis, prioritization and micro planning for handling variable NMR in different areas. One may prioritize for L-I care if NMR is very high i.e. > 3 0, L-II care for NMR of 15 – 30 and L-III care if NMR is <15.

2. There is need for periodic accreditation of neonatal care facilities at different levels of care according to the NNF recommendations. These facilities include infrastructure, human resources, equipments, laboratory facilities, protocols, SOP's, neonatal resuscitation facilities, thermoregulation, nutrition, I.V fluids, drugs, infection control measures, neonatal monitoring and the quality of patient's records.

3. Create district level Neonatal-Perinatal Care Coordination Committees. It should comprise of CMO, Neonatologist I/C SNCU, district obstetrician, head nurse of SNCU, manager SNCU, local NGO representative and a local community leader. This committee should meet once a month. It should coordinate referrals from health centers, patient transport, outreach education for the referring centers and also audit coverage and quality of patient care in the district. Similar committees may be created at the block level.

4. The quality of neonatal care can be assessed by auditing the incidence of NEC, CLD, IVH, ROP, preventable deafness and Neuro developmental delay on follow up.

5. The cost of Neonatal Care can be reduced by

an improved obstetric care, fetal transfer, timely referral and effective transport of sick neonates, full utilization of patient care facilities, shifting the patient to lower level care as soon as possible, preventing avoidable prolonged assisted ventilation and by introducing health insurance for neonatal intensive care. Cost can also be reduced through reducing the duration of hospital stay by preventing hospital acquired infections, involving the mother in the care of her baby in the hospital and by early discharge of a growing high risk baby by providing supervised n care at home.

6. For carrying out all the above mentioned recommendations we need to develop effective leadership for neonatal care at the state health directorate, district hospital and community health center i.e. block level. For helping the district leader i.e. the neonatologist in-charge of SNCU, there is a need to have an administrative manager to help him. Such a manager will ensure functioning of various services including neonatal equipments, neonatal transport, district neonatal coordination committee meetings and periodic accreditation of various services and ensure audit of the quality of the patient care. Such administrative functions otherwise consume lot of working time of the neonatologist and is essential for the success of the programme.

These recommendations are also applicable to the private sector, especially for SNCU's in nursing homes and small hospitals. The corporate hospitals can adopt suggestions for cost reduction and better coordination with the referring units.