

Improving Child Health in India

I was interested to read the editorial by Reddy and van den Hombergh, "Synthesizing evidence for improving child health in India" in the March issue of *Indian Pediatrics* [1]. They mention that high neonatal mortality, diarrheal disorders and pneumonia still remain the chief causes of morbidity and mortality in children, especially those below the age of 5 years, and also that community based newborn care, oral rehydration therapy and early detection and adequate management of acute respiratory infections are not widely used. They emphasize the difficulty of bridging the gap between evidence and policy and that policymakers would "benefit from information that is relevant to decisions highlighted for them and having evidence contextualized to their settings". Whereas it is important to generate, synthesize and communicate relevant evidence, we must understand that the chief constraints in improving child health and welfare include adverse socioeconomic conditions, illiteracy and ignorance, poor sanitation and hygiene, lack of safe water, and vector control.

In most parts of India, rural communities are illiterate and poorly informed about basic health care. If parents understood the benefits of vaccinations and several other measures to prevent common diseases and obtain appropriate treatment for illness, they would make use of available facilities and demand better services. In recent years the Government has launched a number of initiatives, which if properly implemented would have prompt and far reaching benefits. The National Rural Health Mission (NRHM) includes several important components to tackle the existing problems. The appointment of accredited social health activist (ASHA)

in villages for health facilitation, and participation of village panchayats in various healthcare activities, improvement of sanitation and several other programs undertaken by the Ministries of Rural development and Panchayati Raj are crucial measures. However, education and empowerment of the underprivileged communities (rural as well as urban), and their participation is of utmost importance without which no program is likely to succeed.

There are wide variations in indices of health status in different States of the country, and between affluent segments and underprivileged urban and rural communities. Morbidity and mortality patterns among the latter are highest and need to be investigated and analyzed separately and addressed appropriately. Generating new, relevant information on child health is clearly necessary, but enough information is already available for application of effective control measures.

I have also noted that efforts at bridging the gap between evidence and policy for child health programs in India and the series of systematic reviews are a result of partnership between Public Health Foundation of India and UNICEF. The Indian Academy of Pediatrics (IAP) has vast experience over several decades in various fields of child health and child welfare. Their expertise would be very useful in making recommendations for intervention and action in these areas.

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REFERENCE

1. Reddy KS, van den Hombergh H. Synthesizing evidence for improving child health in India. *Indian Pediatr* 2011; 48: 181-2.

Growth of VLBW Infants

Few issues need clarification, with reference to the recent article by Saluja, *et al.* [1].

First, the authors have observed maternal hypertension in 52 subjects (54%). A subgroup analysis of growth in these infants would have made the study more interesting. Similarly, maternal characteristics like socioeconomic status, parity, level of antenatal care, maternal weight gain/nutrition etc did not find a place in the report. These