

Regarding the co-trimoxazole or amoxy issue, I have no fixation for a particular antibiotic. With the time and evidence, the choice of antibiotic may change. However, the more important issues are

- 1) Neonates should receive antibiotics when needed.
- 2) In spite of the JSY, the mother and baby come back home on 2nd day. Sepsis usually manifests after that. If the family is willing to go back, great. But a large percent don't. In that case ASHA and ANM should be enabled to use antibiotic appropriately. This is not a rocket science. Most human beings can be trained. The simplified clinical criteria and choice of oral antibiotic permit doing this.
- 3) This will also be in line with the pro-people and empowerment philosophy of all of us in MFC.
- 4) The possibility that co-trimoxazole may increase neonatal jaundice seems purely a theoretical conjecture. Intravenous administration in much higher doses even in preterm & LBW neonates did not lead to bilirubin displacement or increased jaundice as suspected. (Springer C. et al. J. Pediatrics, 1982)
- 5) Co-trimoxazole is not absolutely contraindicated in neonates. Thus
 - i) The bible of neonatology –Schaffer and Avery - recommends the use of co-trimoxazole in neonates for shigellosis in the cases resistant to other antibiotic – even in developed countries.
 - ii) The WHO program on ARI in children recommends the OPD use of co-trimoxazole for pneumonia in neonates.
 - iii) The IMNCI program of WHO/UNICEF recommends it in neonates even for the less life threatening situations such as umbilical infections or skin infection or ear infection – with caution.
 - iv) It is used prophylactically in pregnant women with HIV infection (WHO guidelines) even though there is a risk of the drug reaching the foetus or neonate through placenta or breast milk.
- 6) There is not a single instance that co-trimoxazole used in more than 2000 sick neonates so far in the six field trials world over, (including the ICMR trial in 5 states) has led to increased cases of neonatal jaundice or kernicterus. On the other hand, there is definite evidence from meta-analysis and from the Ankur and ICMR trials that the NMR decreased by 27 to 51 percent. At the national level, this would mean a possibility of averting 250,000 to 500,000 neonatal deaths every year.
- 7) Should a public health policy decision be based on epidemiological ground and risk-benefit analysis or on a theoretical bogey of a possible rare side effect – not encountered in any of the world's six field trials and even on giving intravenous co-trimoxazole to neonates less than 3 days old in an independent study ?
- 8) Our two recent studies clearly show that a) There is no increased prevalence of kernicterus in children and youth in our intervention area where we have been using co-trimoxazole in neonates since 1988. b) The home-based management model with

selective referral is 4 to 16 times cheaper than the entirely facility-based model of sick newborn care for a defined population.

9) Using his line of 'scare of the rare', will he ask for the ban on the use of paracetamol (hepatotoxic) or chloroquin by ASHAs and paramedics, and on the vaccines ?

10) There is no such field evidence on Amoxy so far.

- i) Amoxy also has the known side effect of diarrhea which can be dangerous to a neonate.
- ii) Most recommendations of the WHO on the use of amoxy in neonates are for the clinic/facility based use, and not by the CHWs.
- iii) The only field trial of oral amoxy (Zambia) did not show reduction in sepsis/pneumonia NMR. There are no other field trials.
- iv) Amoxy-clavulanate combination has risk of serious disease – Necrotising Enterocolitis

Where is the evidence that amoxy is more effective or safe in the hands of CHWs ?

Finally, Shyam's real target seems not the antibiotic, but the module 6 and 7. Why has he asked the Health Minister to suspend entire module 6 and 7, for a difference of opinion only on the four lines – about the use of co-trimoxazole, which he never raised in the past 20 years ever since we published its effective use (Lancet 1990, Arch Dis Child 1993, Lancet 1999, J Perinatology 2005) or when the 11th Five Year Plan incorporated it in 2007, or in the ASHA Mentoring Group during 2008-12 ?

I am afraid Shyam is motivated by reasons other than ethics, science or public interest.

It will be a pity if MFC members become a silent spectators to the shooting down of module 6 and 7 which really aim to empower ASHAs, increase the access to care for neonates and strengthen the people – all that MFC and you and I have stood for.

With regards

Abhay Bang

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