Research Article

Paediatric HealthCare In Urban India

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Abstract

The urbanization in India has been accompanied by a concentration of poverty and urban public healthcare has emerged as one of the most pressing priorities facing our country. Newborn mortality rates in urban settings are lower than rural areas, early neonatal deaths account for greater proportion than late neonatal deaths. The available evidence suggests that socio-economic inequalities and poor environment pose major challenges for newborn health. Moreover, fragmented and weak public health system, multiplicity of actors and limited capacity of public health planning further constrain the delivery of quality and affordable health care service. Though healthcare is concentrated in urban areas, delay in deciding to seek health care, reaching a source of it and receiving appropriate care affects the health outcomes disproportionately. However, a few city initiatives and innovations piloted in different states and cities have brought forth the evidence of effectiveness of different strategies. Recently launched National Urban Health Mission (NUHM) provides an opportunity for strategic thinking and actions to improve newborn health outcomes in India. There is also an opportunity for coalescence of activities around National Health Mission (NHM) and Reproductive, Maternal, Newborn and Child Health + Adolescent (RMNCH+A) strategy to develop feasible and workable models in different urban settings.

Keywords: National Urban Health Mission, Child health, Pediatric health Care, Newborn Babies.

1. Introduction:

Paediatric healthcare in urban India faces challenges like access to quality care, disparities in service delivery, and the need for improved urban planning that prioritizes children's needs. Many urban children, particularly those from low-income families, rely on unlicensed and untrained private providers due to limited access and overcrowding in government hospitals. Effective urban planning and governance, including initiatives like Smart Cities, AMRUT, and Housing for All, can improve access to healthcare and other essential services for children. According to the Population Census of India, 2011, urban India is the home of 135.5 million (36% of the urban population) children and adolescents within the age group of 0-19 years. Several child-specific programmes were launched during the Five-year Plans to address the growing challenges faced by this age-cohort, which were compounded in their implementation by the growing population and lack of adequate investment. A review of policies and programmes reveals that the progress in the holistic development of cities has been far from satisfactory, especially with regard to children from the poor and marginalised communities. In particular, children and adolescents in slums are forced to live in filthy environments without proper basic services such as drinking water, improved sanitation, a well-developed drainage system, adequate street lighting, quality schools and health centres with proper healthcare

facilities. These areas also lack safety and security and are more prone to crime and violence against children.

City dwellers are often oversupplied with healthcare choices. State government hospitals and municipal facilities at primary, secondary and tertiary levels are accompanied by private sector providers from Allopathic, Ayurvedic, Unani, Siddha and Homoeopathic traditions (AYUSH). From single-handed practitioners to super-specialty hospitals, the market provides something for everyone from the richest to the poorest—and this raises the fundamental challenges of quality more than quantity or availability of services. However, in rapidly growing smaller towns, the healthcare systems are more vulnerable with less prepared governmental bodies, less available health care options and thus more fragile and fragmented health services.

2. Objective:

1. The aim of the baseline study is to look at children's needs in a comprehensive manner through the lens of urban planning design and the idea is to examine and analyze existing information on children in urban India.

3. Methodology:

The evolution of the indigenous people's response to the colonial circumstances produced by White people is a significant issue that one cannot overlook in the novels examined here. The indigenous people initially view education with suspicion, but they eventually come to appreciate its power—which they refer to as "the white man's magic." They strive to obtain it and put it to use for their own empowerment and self-preservation. In Achebe's Arrow of God, Ezeulu warns his son about the drawbacks of mission education before sending him to the mission school. Ezeulu's strategy of gaining a new power without sacrificing anything else does not work. Chege's attempt in Ngugi's The River Between, however, is only partially effective. Later, Waiyaki establishes separate schools that honour the customs and values of the populace while making every effort to promote their well-being. Even when many aboriginal people eventually come to accept Christianity as a new reality, they would not accept it as an instrument of subjugation. The Bible serves as a motivation for Kihika and other freedom fighters in A Grain of Wheat as they fight for their lands and freedom. In The River Between and A Grain of Wheat, Ngugi uses the characters of Joshua and Kihika to show how his people's reaction has improved over time. Kihika uses the Bible in an innovative way for the benefit of his people, in contrast to Joshua's unthinking and obedient attitude. To better the situation for the local people, the converts who were once despised for violating and dishonouring their customs are now trusted with their knowledge and skills regarding the white man. Arrow of God's Unachukwu is a prime illustration of this kind of progression.

Mohanty's Balidatta aspires to be simultaneously Hitler, Napoleon, and Alexander. It implies that there might have been a great deal less suffering for the aboriginal people and a less bloody transition if Khond's moral qualities had served as the foundation for the Paraja tribe's prosperity. On the other hand, Mohanty thinks that no one has the authority to dictate to others what kind of lifestyle they ought to lead.

Achebe has proudly discussed the dualism and tolerant spirit of Igbo society on numerous occasions, pointing out how these qualities are mirrored in many of their proverbs and daily lives. In addition to illustrating how these ideas frequently inform how Igbo society responds to missionary encounters, Achebe's two novels also demonstrate how he embraces and adheres to these ideas. Because of his inflexible mindset, Okonkwo commits suicide, which is against the teachings of the traditional faith. Therefore, Okonkwo's response does not receive Achebe's authorial approval. However, Ezeulu's adaptability in handling it is portrayed as a typical Igbo strategy. Ezeulu is praised by Achebe as a cunning politician who seeks to fit in and make use of the tools at his disposal to preserve his people and their customs.

In The River Between, Ngugi reveals the extreme viewpoints of both sides as well as the bloodshed and devastation these viewpoints cause. Kabonyi and Joshua both stand for two extremes that are incompatible with one another. The syncretism and moderation of Waiyaki's approach is portrayed as the most sensible course of action.

The three novelists employ various techniques and approaches in their attempts to decipher the pictures of the colonial and missionary representation and reinterpret new images of the self. When Achebe's novels are examined closely, it becomes clear that he has taken a lot of inspiration from the native Igbo culture. This helps him convey his ideas—particularly those related to cultural assertion—in a more impactful way and sheds a great deal of light on the fact that the Igbo society had a robust spiritual system and rich cultural heritage that was beneficial to them. His works, which are replete with Igbo proverbs, vocabulary, images, and stories, evoke a certain feeling in the reader. They provide a tangible illustration of how a culture, no matter how fictitious, may establish itself by giving the stories a structure and by using its own resources to protect itself. Even with his Christian upbringing and missionary schooling, Achebe manages to fully disassociate himself from the impact of missionary education and exhibit his immersion in the local way of life. Despite having a similar upbringing, Ngugi cannot resist the impact of the missionaries. His attempts to produce works of cultural assertion are severely undermined and his cultural alienation is revealed by his use of Christian imagery, narratives, analogies, and notions.

The three novels vary in how they enter the colonial-missionary discourse, despite having comparable depictions of the missionary character and the effects of missionary work. Nonetheless, Achebe uses conventional methods to portray his traditional culture as having many virtues and some flaws, much like the cultures of all other people. Ngugi makes extensive use of his understanding of Christianity to highlight the virtues of his people and their culture while refuting the missionary narrative and the harmful actions of the missionaries.

The novels discussed here provide an alternative history written from an insider's point of view and stand out as a rich and authentic archive of African history. African history, including the history of the missionaries and their activities in Africa, is a record of "facts" and events as perceived by historians. This interpretation of history doesn't ignore the suffering; instead, it emphasizes the human aspect of the events and the actual experiences of actual individuals.

This comparative study, which pays particular attention to the three novelists, surely provides an insight into the missionary endeavours in Africa and India as a whole. It demonstrates the variety of missionary endeavours and the range of African writers' reactions. It opens new avenues for research into this complex issue in other African writers. It provides an understanding into the complex ways that Africans perceive missionaries, the positive evolution of their responses to their activities, the actual daily encounters that missionaries have with the natives, and the powerful interventions made by African writers.

Things Fall Apart, The River Between, and The Ancestor have a few aspects in common. To distinguish their past in terms of its myths, customs, and rituals, the three novels aim to retrace the historical development of their unique communities. Okonkwo, Waiyaki, and Thenga, the main characters, fit a tragic stereotype. The early missionaries' arrival and the ensuing cultural struggle are the focus of the novels.

Thenga, Okonkwo, and Waiyaki appear to support the idea that a person's religious faith must develop naturally from inside. The underlying theme of The Ancestor, Things Fall Apart, and The River Between is that a people's faith and way of life must coexist and develop from one another. Each one is insufficient on its own. In the end, Nyambura and Muthoni both come to the realization that the type of Christian faith they are exposed to is insufficient to support them.

Nyambura completely gives up her Christian faith to attain "peace," while Muthoni tries to incorporate it into her pagan circumcision process.

The three pieces, Things Fall Apart, The River Between, and The Ancestor, all aim to retrace the origins of their respective cultures to shed light on the myths, customs, and rituals. These are just a few of the commonalities across the three works. This might be imagined in the way that Mohanty laments the devastation of nature, revealing the existence of a spirit that is beyond human comprehension. Soon after, a few axes struck the tree. It was trimmed to human height. Dadi Buddha has now sprung from the stem of the date palm tree (The Ancestor, p.6).

In a similar vein, Ngugi uses human folly in The River Between to emphasize the unbreakable nature of faith. "The ridges are arranged side by side, akin to two adversaries poised to engage in a combative struggle for supremacy over this venerated faith" (The River Between p.1).

But Achebe's wisdom is evident when he points out that any violent aspect of human nature ultimately results in death!"We have fallen apart because he cut the things that held us together" (Things Fall Apart, p. 160).

4. Health Service Delivery In Urban Areas:

The process of developing a healthcare delivery system in urban areas has not as yet received the desired attention. Unlike the rural health services, there have been no efforts to provide well-planned and an organised primary, secondary and tertiary care services in geographically delineated urban areas. As a result, in many areas primary health facilities are not available; the limited but the existing primary care services remain underutilised while there is over-crowding in most of the secondary and tertiary 15 centres. The Constitution of India mandates that primary healthcare in urban areas is the responsibility of the Urban Local Bodies (ULBs). As of now, the country has four types of urban health posts, A, B, C and D. The Urban Family Welfare Centres are also of three types, I, II and III. They differ mainly in staffing patterns and, accordingly, in the services provided. They are supposed to mainly provide integrated Reproductive and Child Health (RCH) care. According to the Report and Recommendations of the Technical Resource Group, National Urban Health Mission (TRG, NUHM), Ministry of Health and Family 16 Welfare, 2014), it identifies three broad institutional patterns from the perspective of which government 17 takes primary responsibility for organising healthcare in the city. In the first pattern, healthcare facilities are entirely provided by the state departments of health, with no involvement of the Urban Local Body (ULB). There is usually a Municipal Health Officer who is in charge of a number of non-medical services relating to public health, but even this post is often vacant or lacks the necessary support staff and importance. This is the pattern in all urban areas of states such as Himachal Pradesh and Bihar, and in small towns (typically less than 2 lakh population) in almost all the states. In the second pattern, a minority of care provision is by healthcare facilities under the ULB and this role is receding. Typically, it is usually a maternity hospital and a few UHPs/ dispensaries and sometimes a cadre of health volunteers who are under the ULB. For the main part, it is the district hospital or medical college hospital that provides the healthcare services and there may be some UHCs under the state government as well.

5. Evidence on urban health initiatives

A recent commission on healthy cities recommended the option of trying a range of approaches for improving urban health and choosing successful features from among them. A few city initiatives and innovations in Uttar Pradesh, Maharashtra and Gujarat have provided evidence of effectiveness of some innovative strategies. However, by and large, the service delivery structure and mechanisms in the urban areas continue to be rudderless with complete lack of clarity on roles and responsibilities as compared with rural areas, where the district administration is structured and responsible for service provision. In addition, lack of

demonstrated political will to assume responsibility and accountability for urban services as well as absence of interdepartmental coordination between the Departments of Public Health, Urban Development, Medical Education, the Municipal Corporations and the local bodies have compounded the problem further.

6. Policy initiatives

Urban Family Welfare Centres (UFWCs) have been functioning in India since the first family planning program launched in 1952. In the 1980s, as a result of the recommendations of the Krishnan Committee Report, 1982, Urban Health Posts (UHPs) were opened to provide primary healthcare for the urban slums and the urban poor. Over the years, various committees such as the Bhore Committee 1946, Jungalwalla Committee 1967, Bajaj Committee 1996, Mashelkar Committee 2003 and the National Commission on Macroeconomics and Health 2005 have suggested ways to strengthen the health sector. Subsequently, the Ministry of Health and Family Welfare in 2013 has launched a National Urban Health Mission (NUHM) besides NRHM launched in 2005.

Since urban health involves the convergence of the domains, a number of programs and policies implemented by other sectors such as the Ministry of Housing and Urban Poverty Alleviation are also very important. Jawaharlal Nehru National Urban Renewal Mission (JNNURM-2009) covers the provision of the basic services for the urban poor (BSUP). The Swarna Jayanti Shahari Rozgar Yojana (SJSRY, revised 2009) targets skill development for livelihoods. Other relevant schemes include Affordable Housing in Partnership (AHIP), the Interest Subsidy Scheme for Housing the Urban Poor (ISHUP) and the Integrated Low-Cost Sanitation Scheme (ILCS). Launched by the Prime Minister in 2009, the Rajiv Awas Yojana (RAY) envisages a slum-free India and proposes affordable housing by merging the AHIP and ISHUP.

7. Urban health structures and mechanisms: Key aspects

1. The ultimate responsibility of providing health services in urban areas is not clear as it is in rural areas where the district administration is in charge of public health.
2. All resources invested in urban healthcare deal primarily with curative services.
3. Urban health posts mainly provide three types of services: Regular (including preventive, curative, IEC activities and training), seasonal (pre-monsoon and monsoon-related activities) and disaster management.
4. The urban healthcare system is focused on secondary and tertiary care, and not on primary level services

8. Service provision: Key aspects

1. Health services vary from city to city. Some cities have a well-established ICDS in place. A few large cities like Mumbai, Kolkata and Chennai have focused on the health infrastructure establishment in urban slums.
2. Only a few large municipal Corporations with good revenue resources have demarcated special resources to provide urban health services.
3. Referral services are available in corporation hospitals/district hospitals/medical college hospitals as well as several private hospitals.
4. There is no mechanism for a health worker to make community or home visits and thus no outreach and follow-up services are available.
5. There is no definite system of referral; no linkages between domiciliary, health centre, and hospital; and no protocols for admissions to primary, secondary, and tertiary levels.
6. A link worker or community health volunteer has been appointed in a few cities that are effectively implementing the NRHM (Urban Component) and RCH II project. The main role of the link worker is family welfare, maternal and child health, immunization, health education and demand generation.

9. Environmental challenges and the need for Convergence

Communities residing in slums often suffer deficiencies in water supply and sanitation. Poor housing fabric, poor ventilation and indoor pollution, and the density of homes contribute to the spread of infectious diseases and the burden of respiratory illness. Many homes are close to sources of industrial smoke and toxins, contaminated areas such as garbage dumps and water bodies, or hazards such as railway lines. The mandate for provision of municipal services is unclear when settlements are not legally notified and their residents do not have tenure with implications for water supply and collection of waste. There is a lack of coordination between the relevant departments and absence of convergence between infrastructural (water and sanitation, housing, transport) and health domains.

10. Public Sector Healthcare Concerns

There are two general concerns for newborn healthcare: quantity and quality. In terms of quantity, available health services in medium-sized cities where slums are present without municipal corporations is a critical gap. Also, the social exclusion experienced by residents of unlisted slum areas extends to provision of healthcare facilities and outreach. The varying quality of public healthcare is the product of a matrix of infrastructural weakness, efficiencies in equipment and consumables, human resource shortfalls, and limited provider competencies. For maternal and newborn care, there is a lack of norms for service provision at different levels of healthcare facilities. No protocols exist for identifying women at risk and referring them for specialized care. Referral chains have been undefined and based more on a hospital's reputation and bed availability than on a regional plan, and referrals themselves have been unsystematic. Clients are sent to hospitals that have not been warned and may not have beds, the paper trail is sketchy, accountability is minimal and transport is often the responsibility of the family.

11. Private Sector Healthcare Concerns

A central issue is the multiplicity of providers, with limited accreditation and quality assurance. Despite the policy emphasis on state and municipal healthcare provision, majority of outpatient consultations in India are with private providers. This is illustrated by the predominant use of non-government services in both slum and non-slum areas. Private healthcare clusters in towns and cities, and through a self-organizing complex system that takes into account ability to pay serve both the poor and the wealthy. Many hospitals are understaffed particularly in terms of qualified healthcare workers more than half did not have a single qualified nurse at the time of the study and accreditation was limited. Countrywide, majority of the healthcare expenditure is out-of-pocket. Reports of malpractice, over-medication, inappropriate prescription practices and treatments, and excessive use of diagnostic tests are common. Payments for healthcare delivery at a private health centre are about three times those for a public facility. Out-of-pocket payments can be impoverishing. Expenditure on maternity often requires borrowing and can be catastrophic for poor households.

12. Health-Seeking Behaviours of the Urban Poor

Studying systems alone may not give us the required answer. A study on health-seeking behaviour with regard to newborn care in urban slums and villages of Anand, Gujarat, revealed wide socio-economic gaps between slums and villages. It revealed that the proximity of the slums to two multi-specialty hospitals and smaller private hospitals did not improve utilization of services. Urban slum dwellers are ignorant about their health needs and also lack a positive attitude for seeking healthcare. Acceptability of existing public health infrastructure in both the areas was poor in contrast to the studies undertaken earlier. Neonatal follow-up, and care for infants that required medical advice, was largely provided by unqualified professionals as high as 72% in the slum areas. Similarly, a multi-centric study also found that education of immediate healthcare providers and mothers in basic newborn care is a must in urban slums, as similar provisions exist in villages under various government efforts. The study also describes a

wide gap in newborn practices in slums of a smaller town as compared to the surrounding villages, which had better practices than slums. Urban slum dwellers were 6 times less likely to seek care. Not seeking ANC and illiteracy were also associated with more home deliveries. Though, a single district study did pose its limitations, similar gaps between rural and urban health settings undoubtedly exist not only in the rest of the state Gujarat but in most other states of India.

13. National Urban Health Mission

The Government of India's Twelfth Plan builds on the National Rural Health Mission (NHRM) and converts it into a National Health Mission for the whole country. In doing so, it incorporates the developing National Urban Health Mission (NUHM) as a sub-mission. NUHM endeavours to achieve its goal specifically through a need-based city-specific urban healthcare system that will meet the diverse healthcare needs of the urban poor and other vulnerable sections and through public health management systems to meet the health-related challenges of a rapidly growing urban population. Focusing on the primary healthcare needs of the urban poor, the NUHM is being implemented in 779 cities and towns having populations of more than 50,000 each. The NUHM framework for the implementation provides one U-PHC for every 50,000 population. This would be achieved by both adapting and upgrading existing facilities and adding new ones. In response to the needs for convergence and public health management, the NUHM plans that every Municipal Corporation, municipality, Notified Area Committee and town Panchayat will be a planning unit in its own right with its own approved norms for setting up healthcare facilities. These local bodies will prioritize services for the urban poor and for vulnerable groups such as the homeless, rag pickers, street children, rickshaw pullers, construction and brick and lime kiln workers, and sex workers. Sanitation, clean drinking water, and vector control will be central to the public health remit.

14. Governance Mechanisms in Urban Health

The urban local bodies, state health departments and other social welfare departments are at the core of governance systems in the city. Although as a policy, management of MNH care needs to be paid attention to, so as to reduce the proportion of maternal and newborn deaths, it is an irony that the Municipal Corporation, (the basic unit of local governance in cities) is presently playing a minimal role as far as providing of MNH care is concerned. A perusal of the city visits reports by the NHSRC experts conducted across 31 cities, suggests that most of the Municipal Corporations have been restricting themselves to public health engineering. One of the reports clearly says: "They mainly have the responsibility regarding water and sanitation. Only a single person, who is designated as a Health Officer in the Municipal Corporation, has the responsibility with regards to health. His responsibility is looking after the cleanliness of the drains, dealing with dog bite cases/rabies prevention. There is some fund allocation for insecticide sprayed. mosquito nets and people are provided with the same".

15. Conclusion

India is urbanizing rapidly with an expectation that the urban population will be almost 600 million by 2030. National health survey data demonstrate that overall neonatal mortality rates are lower in urban areas but the figures mask substantial urban inequalities. Recent data also suggest a relative lack of progress in reducing early neonatal mortality. Socioeconomic inequalities and environmental concerns pose major challenges for newborn health. Healthcare is concentrated in urban areas but health outcomes are subject to variation in pluralistic provision and a lack of clarity in protocols, communication, referral and transport between institutions. Fragmented and weak public healthcare systems, a multiplicity of actors, and limited public health planning capacity compromise the delivery of affordable quality healthcare. However, a number of pilot initiatives have begun, including private-public partnerships, community action models, demand side financing and insurance, but evaluation

has been limited. Within the NHM, the NUHM provides an opportunity for strategic thinking and actions to improve urban newborn health. RMNCH+A initiative adds to this an opportunity to integrate healthcare over the life cycle.

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