



Children's Health Care Needs And Homoeopathy

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ABSTRACT

In India, an estimated 26 millions of children are born every year. As per Census 2011, the share of children (0-6 years) accounts 13% of the total population in the Country.

Children are the future of any nation, and their health and well-being are paramount for the overall development of a country. In India, with a significant portion of the population comprising children, addressing their healthcare needs is of utmost importance. The **World Health Organization (WHO)** recognizes the critical healthcare requirements of children and emphasizes the significance of providing comprehensive healthcare services to this vulnerable demographic.

The specific healthcare needs of children in India .

Nutrition and Malnutrition:

Nutrition plays a crucial role in a child's growth and development. In India, malnutrition remains a significant public health concern, contributing to stunted growth, underweight children, and micronutrient deficiencies. The WHO advocates for improving maternal and child nutrition, promoting breastfeeding, and ensuring access to a balanced diet to combat malnutrition effectively.

Safe Water and Sanitation:

Access to safe drinking water and proper sanitation facilities is essential for children's health. Lack of clean water and sanitation can lead to waterborne diseases, which disproportionately affect children in India. The WHO stresses the need for improved water and sanitation infrastructure to reduce the burden of preventable illnesses and ensure a healthy living environment for children.

Preventive Healthcare:

Preventive healthcare measures, such as regular health check-ups, early detection of diseases, and health education, are crucial for children. The WHO emphasizes the need for comprehensive preventive healthcare programs to identify health issues early and provide appropriate interventions promptly.

Primary Healthcare Access:

Access to primary healthcare services is vital for children, especially in rural and underserved areas of India. The WHO advocates for strengthening primary healthcare facilities and ensuring that quality healthcare services are accessible to all children, regardless of their socioeconomic status.

Mental Health Support:

Mental health is an integral aspect of a child's overall well-being. Addressing mental health issues in children is crucial to ensure healthy psychological development. The WHO emphasizes the need for awareness, early identification, and support services for children facing mental health challenges.

Child Protection and Safety:

Ensuring a safe environment for children is essential to protect them from injuries and accidents. The WHO stresses the importance of child protection policies and safety measures to reduce child mortality and injuries.

The healthcare needs of children in India are diverse and complex. The World Health Organization recognizes the significance of addressing these needs to ensure a healthy and thriving generation.

Infant and child health status constitute sensitive indices of the socio-economic status of a country. In this regard India has made considerable progress.

The infant mortality rate (IMR) that was typically high (222/1000 live births) in 1911 has registered a steady decline through the years to rest currently at 79/1000 live births in 1998.

Though the overall IMR has come down to nearly a third of the 1911 figure, newborn and neonatal mortality continue to constitute 62% of IMR. Nearly 52.3% of births fall under the category of being “high risk” (Rajagopalan 2000) More than 60% of these deaths occur in Assam, Bihar, Madhya Pradesh, Uttar Pradesh, Orissa and Rajasthan. Wide intra- and inter-state differentials prevail with rural Madhya Pradesh registering an IMR of 109/1000 as opposed to urban Kerala, whose IMR is just 13/1000. Further, low birth weight (LBW) constitutes 33% of all newborns and 25% of these are premature. Although IMR has declined considerably the current figure of 79/1000 live births is still high.

Child or under fives mortality (UFM) is another important indicator not only of the socio-economic status but also nutrition security among children. Table 6 depicting the percentage distribution of deaths by age and

sex in India clearly suggests that mortality is highest among the 0–4 years across decades. Sex differentials further indicate that deaths in this age group consistently remain higher among female children compared to male children.

The UFMR which was 53/1000 children below five years of age in 1971 has declined to 35/1000 in 1987 (Reddy et al 1993) and 26.5/1000 in 1991 (CSSM, GOI 1994). Further, rural–urban differentials suggest wide variations, with the urban UFMR being substantially lower (20/1000) compared to the rural figure (36/1000). Major factors contributing to the present levels of IMR and UFMR include maternal malnutrition, poor intra-natal care (only 35% of deliveries are attended to by trained personnel), low birth weight, pre-maturity, energy and protein malnutrition, afflictions with vaccine preventable disease (total vaccine coverage for all doses is still only 45% as per NFHS 1997–98), poor socio-economic and environmental conditions accompanied by high levels of female illiteracy and poor personal hygiene.

An important indicator of the quality of health services and gender equity is maternal mortality rate (MMR). At the time of independence the MMR in India was very high (20.2/1000 live births). As of 1991 it has dropped to 1/5th of that level (4.6/1000) indicating that considerable improvements have been instituted with regard to health service delivery for pregnant women in the country. Various proportionate causes of maternal mortality are profiled in figure 5. Major factors contributing to the observed declines in MMR include strengthening of MCH services, the World Bank assisted India population project, the government of India's child survival and safe motherhood (CSSM) programmes in the country .

Every day 67,385 babies are born in India, that's one sixth of the world's child births. Every minute one of these newborns dies.

The day of birth is the riskiest day for both the mother and the newborn as nearly 40 per cent of newborn deaths and half of maternal deaths occur on the day of birth. Measures to ensure that every woman delivers in a health facility, assisted by a skilled birth attendant, are key to preventing these deaths as nearly five million newborns are delivered at home in India every year.

Concerted efforts have seen neonatal deaths, occurring within in the first 28 days of life, reduce significantly from one third of the global deaths to below a quarter of global newborn deaths.

Increases in the number of women delivering in a health facility, from six out of ten to eight of ten, has contributed in one million fewer newborn deaths and 10,000 fewer maternal deaths every month. Pre-maturity (39.5 per cent), neonatal infections (17 per cent), birth asphyxia (31 per cent) and congenital malformations (4 per cent) are among the major causes of new-born deaths. Ensuring access to quality care and delivery in a health facility has been key because nearly 46 per cent of all maternal deaths

and 40 percent of neonatal deaths happen during labour or the first 24 hours after birth.

India has shown significant progress in the reduction of child mortality and the focus now needs to be on newborns and reaching the most marginalized children, with special focus on the girl child. The gains in reducing neonatal deaths have not been as significant as those in reducing under-five deaths. India contributes to nearly one sixth of the global burden of under five deaths and around a quarter of the global burden of neonatal deaths.

India is the only large country in the world where more girl babies die than boy babies. The gender differential in child survival is currently 11 per cent. This discrimination begins even before birth with an adverse sex ratio for the female child, meaning more boys are born than girls, and continues across all stages of a child's life. Statistics reflect community attitudes with fewer hospital admissions for girls than boys, showing that parents sometimes give less attention to girl newborns. In 2017 alone 150,000 fewer girls were admitted to SNCUs than boys.

Most newborns die from things that we know how to prevent or treat: complications due to prematurity or during labour and birth, and infections like sepsis, pneumonia, tetanus and diarrhoea.

Newborn deaths can be prevented with simple and inexpensive interventions. Yet almost 62 percent of children who die under the age of five do so within the first month of life. (442,000 NMR out of 709,000 U5MR in 2022: UN IGME report) Preventing newborn deaths requires concerted action at all levels of society – from families and communities to health care workers and governments.

UNICEF is working in partnership with the Government of India in implementing its maternal, child and newborn health

programmes across the Country to make sure they reach every child and every parent.

Reaching every child

The need for equitable access to health care for every girl child warrants an intensification of our combined efforts to bridge this gap and ensure equitable access to health care for every girl child. Even in the states that have met the MDG targets there are persistent gender inequities.

Under-five mortality for girls in India remains 3.3 per cent higher than for boys. Globally this figure is 11 per cent. (Source: UNIGME child survival Report 2022) cent higher for boys.

Child health services are to ensure that:

- Every child receives adequate care and proper nourishment.
- Their growth and development is monitored and any deviation is identified and treated on time.
- Ailments are detected and treated without any delay to prevent it from getting worse.
- Trained persons render care.
- Mothers and family members are educated and trained to give proper care to their children to promote their health.

HOMOEOPATHY IN MOTHER AND CHILD CARE

Highly beneficial for many diseases related to women and children

Medicines can be safely administered for various ailments throughout pregnancy without

any adverse reaction/side effects

Can be used during childbirth to contain problems associated with labor and is effective

for post-delivery and lactation complaints

Effective for various diseases of children

Compliance is good especially in children as the medicines are sweet and palatable

Simple method of administration

No drug resistance, no drug dependency and no known side effects

Treatment is cost effective.

Shri Verghese Samuel, Joint Secretary (AYUSH) presented resolutions

Homoeopathic medicines are effective for certain common diseases and conditions relating to the mother and the child where no hospitalization or expensive investigation procedures are required and as such, there is a strong case for popularizing and utilizing the system at the primary and secondary health care delivery system level.

A focused and carefully targeted awareness program needs to be organized to inform and educate the public and practitioners of other systems of medicine about the strengths of Homoeopathy in the area of Mother and Child care.

Financial and technical support for the Information, Education & Communication (IEC) activities should be provided to the State Governments by the Government of India.

The State Governments must set up more Homoeopathic Indoor and Outdoor treatment facilities in existing allopathic hospitals under the NRHM. Alternatively, the State Governments could obtain funds from the Department of AYUSH under the Centrally Sponsored Scheme (Hospitals and Dispensaries) for the purpose.

The administrative set up for Homoeopathy in the State Governments requires to be strengthened.

The Homoeopathic Medical Colleges, NGOs working in the health sector and social service sector should be involved in the campaign.

There should be a National Task Force under the Department of AYUSH with representatives from the State Governments to plan and coordinate the campaign.

The Panchayati Raj institutions and Urban Self-government institutions should also be involved in the campaign.

Simple homoeopathic remedies for common ailments may be included in the School Health Programs.

A core group should be sent up consisting of experts of Allopathy and Homoeopathy to make recommendations regarding the specific conditions related to Mother and Child care which can safely and effectively be treated by Homeopathy. The core group will also make recommendations regarding

the manner in which PHCs and CHCs in the public health care system and CGHS units will provide homoeopathic treatment for mother and child care.

There is urgent necessity to improve the quality of obstetric care and gynecological training given in homoeopathic medical colleges. Attachments to allopathic medical colleges for such training may be considered where the number of labor and gynecological cases is low in homoeopathic medical colleges.

A CME program for practitioners exclusively on mother and child care should be evolved and implemented at district level.

A dialogue with the Medical Council of India should be initiated to provide for admission of Homoeopathic graduates in PG courses of Preventive & Social Medicine and Community Medicine.

To set up Resource centers at central and state level.

Orientation modules on Homoeopathy for allopathic doctors should be prepared.

a recent survey showed that less than 30% of Indian households use the traditional medical systems, quite higher than 14% usage as reported by an earlier National Sample Survey Organization survey a decade ago,⁸ and even much higher than the 8% reported usage by the National Council of Applied Economic Research survey during the early 1990s.⁹ The strong faith in AYUSH (Ayurveda, Yoga, Unani, Siddha, Homoeopathy, and last introduced Amchi/Sowa Rigpa/Tibetan Medicine) was the main reason for its usage. Average annual growth rate of 6.3% was realized in all AYUSH hospitals during 1980 to 2013 and 3.0% in the hospitals of homoeopathy.^{10–12} So, during the 12th plan period, the national policy on medical pluralism in India encouraged mainstreaming of AYUSH systems and the revitalization of local health traditions through the National Rural Health Mission to help overcome the shortage of health care professionals and to strengthen the service. It was envisaged that all primary, block, and community health centers would provide AYUSH treatment in one place.^{11,13,14} Eventually, the Department of AYUSH evolved into the Ministry of AYUSH.¹⁵ The AYUSH services began to be colocated within the existing dispensaries.^{14,16,17} To ensure

accessibility and availability of health care services to all, policymakers started implementing strategies to facilitate the mainstreaming of the AYUSH system with stringent monitoring.¹⁸ Different strategies are brought together in the recently adopted National AYUSH Mission,¹⁵ called as multidimensional mainstreaming, nurturing infrastructural facilities of teaching AYUSH institutions, increasing production of AYUSH medicines, improving standardization and quality control of drugs, propagation of the potential of AYUSH remedies in specific ailments, capacity building of professionals, building research and public health skills of practical utility, and initiating community-based AYUSH interventions for preventive and promotive health care.¹⁵

Incorporating public views in the development of integrated AYUSH models in India seems to be a pivotal and reasonable precedence in the formulation of future strategies. However, patients' preference for the integrated services remains underresearched in India. Earlier, PPIH-1 and PPIH-2 studies were undertaken in West Bengal assessing preference for integrated services of the patients already availing services from homoeopathy hospitals (PPIH-1)¹⁹ and evaluating satisfaction of patients from integrated services (PPIH-2).²⁰ The PPIH-1 survey revealed favorable attitude toward integrating homoeopathy into conventional health care settings among the patients attending the homoeopathic hospitals in West Bengal, India. In the northern districts of West Bengal, majority of the patients were found to be satisfied from availing integrated services and consultation with homoeopathic doctors in the PPIH-2 survey.

The present study (PPIH-3) is designed to examine the preference for integration where integrated homoeopathic services are still not available across India. Our objective is to examine the knowledge,

attitudes, and practice of patients toward homoeopathy and to assess their preference for its integration.

In acute pediatric illnesses, Haidvogel et al³¹ reported the findings of an international multicenter, comparative cohort study of 1577 children with acute respiratory and ear complaints across 57 primary care practices. They found homeopathic treatment noninferior to conventional treatment. However, they also demonstrated significantly faster onset of improvement in children and adults with homeopathy than with conventional treatment. Homeopathy had a significantly lower adverse event rate in adults, but a similarly low rate of adverse events in children (homeopathy: 2.0% vs conventional: 2.4%, ns).

The theme of earlier onset of symptom improvements with homeopathy has replicated itself across studies in multiple countries. In a prospective observational study of 131 German children with otitis media, Friese et al also noted complete recovery at an earlier point in time for the homeopathically-treated group vs the conventionally-treated group.^{120,121} Only 4.8% of the homeopathically-treated children ended up receiving a course of antibiotics. Frei and Thurneysen had evaluated rates of improvement and costs in 230 children with AOM, treated with homeopathy versus placebo. In the latter study, they found that 39% of the homeopathically-treated children achieved pain control within 6 hours of initiating treatment, followed by reduced pain in an additional 33% after 12 hours (72% experienced less ear pain within 12 hours). The rate of symptom improvement with homeopathy was 2.4 times faster than that in placebo controls.¹²²

Following a promising randomized, placebo-controlled pilot study of individualized homeopathy in 75 children aged 18 months to 6 years,¹²³ Taylor and Jacobs recently published a study of a commercial combination homeopathic eardrop medicine for

symptoms of otitis media in 120 children between the ages of 6 months and 11 years old.¹²⁴ Patients were randomized to standard therapy plus homeopathy vs standard therapy alone. They documented a faster early rate of improvement in the first few doses of treatment (directions suggest giving a dose every 4 hours until symptoms improve) in the homeopathically-treated group compared with the standard-therapy group. This finding has practical value for parents/caregivers who are unable to send their children back to day care or school until the symptoms of the infection are abated. Notably, as in earlier studies,¹²⁵ the homeopathically-treated children had significantly fewer diarrhea and “hyper” behavior adverse events than did those receiving standard care.

The homeopathic–ear drop group had antibiotic prescriptions filled only 7.1% of the time, whereas the standard therapy–alone group filled antibiotic prescriptions 36.5% of the time. The data in the Taylor and Jacobs study¹²⁴ were similar to the 4.8% antibiotic fill rate for homeopathy in the Friese et al study^{120,121} and other pilot studies¹²³ and previously published rates of antibiotic fill rates of 31% and 38% for watchful waiting prescriptions in standard therapy alone in previous studies.^{127,128}

Finally, Sinha et al¹²⁹ published a recent double-blind placebo-controlled trial of homeopathy vs conventional treatment in AOM (N = 81). Both treatment groups ended up with equivalent recovery rates by the end of the study. Again, however, the homeopathy group exhibited more rapid onset of symptom improvements and much lower rates of antibiotic prescriptions (0%) than the conventionally treated group (97.5%). This efficacy study is small and needs replication, but it is consistent with the much larger body of favorable evidence on speed of improvement and reduction in antibiotic fill rates from observational and comparative effectiveness trials.

In general, Appropriately designed early Homoeopathic interventions and disease management strategies can help to improve a child's ability to function, can slow the progression of illness, and often can decrease the long-term costs associated with the condition.

Homoeopathy has become an integral part of complementary and alternative medicine. In many parts of South East Asia, Homoeopathy has gained popularity among the wider population, apart from the other traditional systems of medicine.

As a Homoeopathic Practitioner we can recognise the importance of Pediatrics in the context of health care needs of the community and its adaptability in the practice of Homoeopathy.

Practicing Pediatrics ethically and in step with the principles of primary health care and the philosophy of Homoeopathy.

Need to identify social, economic, environmental, biological, emotional and miasmatic therapeutic, rehabilitative, preventive and promotive measures.

Need to plan and advise measures for the prevention and rehabilitation of children suffering from disease and disability

Empathy and human approach towards children and their family and exhibit interpersonal behaviour in accordance with the social norms and expectations.

Implementation of national health programmes, effectively and responsibly helps to reduce child mortality and morbidity and improve nutrition status, growth and early childhood development.

The status of Homoeopathy in the world is evident from the WHO report, which reveals that Homoeopathy is one of the most common forms of traditional & complementary medicine used by the member States of WHO

With the efforts of the Government of India, there is remarkable growth and development of Homoeopathy and other traditional systems of medicine including Ayurveda, Yoga, Naturopathy, Unani, Siddha and Sowa Rigpa (acronym as AYUSH). AYUSH services are now recognized as part of the health care system of the country at all levels of primary, secondary and tertiary health care.

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