



CHALLENGES IN ACCESSING HEALTHCARE FOR SLUM CHILDREN IN VADODARA DISTRICT, GUJARAT

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Abstract

Children in the urban slums of Vadodara district, Gujarat, face continuous obstacles to receiving healthcare in an equitable manner, which leads to negative health outcomes and exacerbates existing inequalities. The research synthesises existing literature, primary qualitative interviews with carers and frontline health professionals, and secondary health-service data in order to determine the most significant difficulties that impact access to preventative and curative treatment for children who live in slums (aged 0–14 years). The following are some of the main obstacles to providing healthcare: (1) structural constraints, such as an insufficient number of public and private healthcare facilities, an uneven distribution of these facilities, overcrowded clinics, and poor transportation connections; (2) financial barriers, such as direct out-of-pocket expenses and the loss of daily wages that discourage individuals from seeking medical care in a timely manner; (3) informational and cultural factors, such as a lack of awareness. These obstacles combine with underlying socioeconomic determinants of health, like poverty, bad housing, and insufficient water and sanitation facilities, in order to increase risk. The recommendations put forward by the study include a multifaceted response to the problem: improve community health outreach, simplify the enrolment process for child health programs, increase capacity in public facilities and paediatric training, introduce demand-side financing or conditional cash transfers, and encourage community engagement in order to rebuild trust. It is imperative to implement decentralised interventions that target Vadodara's slums in order to enhance healthcare access and child health outcomes in these areas. These interventions must include a combination of service strengthening and social protection.

Keywords: Healthcare, Slum Children, Slum Children

Introduction

A large percentage of the people living in India's urban slums are children, and they face even greater obstacles when trying to get medical treatment than the rest of the population. One of Gujarat's fast-growing metropolitan districts, Vadodara, is rife with slum settlements where people face increased health risks due to poverty, overcrowding, and bad living conditions. Malnutrition, infectious infections, respiratory disorders, and other avoidable illnesses afflict children in these locations at disproportionate rates, despite the fact that these places lack effective and timely healthcare treatments. There are several social, economic, and infrastructure hurdles that make it difficult for children living in Vadodara's slums to get the healthcare they need. Lack of paperwork makes it hard for families living in informal settlements to access government health systems, and financial restrictions make it much more difficult for them to

get the treatment they need when they need it. Because state and local health systems are struggling to keep up with the demands of rapidly expanding cities, the urban poor are often left out of healthcare planning processes. Social and environmental variables of health compound the problem. Children are more likely to become sick or die as a result of environmental pollution, uncollected solid waste, poor sanitation, and a lack of access to safe drinking water. One of the most common health issues in slum areas is malnutrition, which makes people even more susceptible to infectious infections and weakens their immune systems. National initiatives like ICDS and RBSK, as well as routine immunisation drives, try to reach slum regions, but they aren't as successful because of implementation gaps and service delivery issues. Additionally, carer ignorance, cultural views, and health-seeking behaviour all have substantial impacts on access. Many families put off getting medical attention when they need it because they rely on outdated treatments, have misunderstandings about contemporary medicine, or are afraid to visit public facilities for fear of neglect or low-quality services. Furthermore, children have additional challenges while trying to visit healthcare facilities, especially during crises, due to transportation limitations and geographical accessibility. Research on the barriers that children living in slums in the Vadodara area face while trying to get medical treatment is, thus, urgently needed and warranted. Improving child health outcomes may be achieved by focused interventions and policy responses that are informed by an understanding of the structural, financial, social, and cultural barriers that restrict healthcare utilisation. This study aims to contribute to evidence-based initiatives that boost healthcare delivery, guarantee fairness in service access, and promote healthier futures for children in urban slums of Vadodara by shedding light on the ground realities of these marginalised populations.

Given Gujarat's demographic and developmental background, it is crucial to address healthcare concerns affecting slum children in Vadodara district. Disparities in health outcomes are still quite noticeable, despite the state's outstanding achievements in other areas, such economic growth, infrastructure, and education. Many migrant labourers dwell in informal slums in Vadodara because of the city's status as an economic and industrial powerhouse. Not only do these migrating families often lack permanent residences, formal documentation, and social support networks, but they also have difficulties in integrating into the metropolitan healthcare system, which compounds their socioeconomic vulnerabilities. The everyday battle for existence often takes precedence over the healthcare requirements of young children, making them especially susceptible. A major part of the problem with healthcare is that there isn't enough healthcare to meet the demand. The urban poor have access to government-run healthcare through programs including outreach initiatives, community health centres, and urban primary health centres (UPHCs). But these services can't keep up with the slums' fast expansion in Vadodara. Government healthcare institutions frequently face staffing shortages, inadequate paediatric services, unpredictable pharmaceutical supply, and lengthy wait times, all of which deter families from seeking treatment there. Misdiagnosis, improper treatment, and financial exploitation are consequences that people face when they seek healthcare from private providers, some of whom may lack the necessary qualifications. The high cost of medical treatment is another important obstacle. The reach of plans like the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PMJAY) in urban slums is uneven, despite their purpose of providing financial security. Because of a lack of knowledge or the necessary paperwork, many families are unable to enrol in these schemes. Everyday health requirements like fever, diarrhoea, or respiratory infections can force families to pay out of pocket. Many people put off getting medical help until their diseases have worsened because of the high expense of transportation, medications, and lost earnings. Children living in slums also face significant challenges in their psychological and social

environments. A lack of clean water, proper sanitation, and areas to play is common in many of Vadodara's slums. Poverty, food insecurity, and unpredictable living situations put them through chronic stress, which further hinders their mental and physical development. Lack of access to healthcare is a cause of malnutrition as well as an effect of it. Malnutrition makes a kid more susceptible to infections, and a vicious cycle of sickness ensues as subsequent illnesses exacerbate nutritional deficits.

Another level of intricacy is added by gender differences. Uneven access to food, healthcare, and education affects many slum households, particularly those whose children are girls. When parents are faced with tough financial choices, they may prioritise their boys. This leads to females putting off seeking medical attention, which in turn keeps gender-based health disparities alive.

The larger socioeconomic determinants of health must be considered in order to comprehend the problem of healthcare accessibility in the slums of Vadodara. When it comes to healthcare-seeking behaviour, parental education levels, particularly those of moms, are quite important. Slum women are less likely to be literate, which means they are less likely to know about children's nutrition needs, immunisation schedules, and accessible resources. In a similar vein, service accountability suffers when community members aren't included in making health decisions. These weaknesses were exacerbated and brought to light by the COVID-19 epidemic. Food shortages, delays in child immunisation, and disruptions to maternity healthcare services were some of the consequences of the lockdown, which impacted many slum households. People were less likely to use healthcare facilities due to concerns about infection and mobility limits. Many people, particularly those living in low-income metropolitan areas, still had doubts about the healthcare system even after regulations were relaxed.

In light of these complex issues, a holistic, equity-oriented strategy is necessary to improve healthcare access for children living in Vadodara's slums. Healthcare facility expansion is not enough; interventions must also tackle systemic hurdles like cost, cultural acceptance, and lack of knowledge. One way to address service shortages is by enhancing outreach programs with the use of Anganwadi workers, mobile health units, and Accredited Social Health Activists (ASHAs). Communities may be mobilised, awareness can be communicated, and trust can be built through partnerships between government, non-governmental organisations, and community-based organisations. Consequently, the purpose of this research is to investigate the difficulties encountered by children living in slums in the Vadodara area when trying to get medical treatment. A better understanding of the cultural dynamics, socioeconomic hurdles, and structural deficiencies that impact health outcomes is the ultimate goal. This research seeks to improve child health interventions in urban slum settings by determining the reasons why people in these areas have limited access to healthcare and then investigating possible solutions and policy suggestions to address these issues. Achieving sustainable development goals pertaining to children's survival, health, and welfare requires, first and foremost, that all children, even those living in slums, have equal access to healthcare.

Urban paradox and child health in slums

The "urban paradox," which refers to the fact that children living in the poorest urban informal settlements frequently have poorer outcomes than their rural counterparts in terms of mortality, nutrition, and service access, is emphasised in studies at both the national and global levels. Children who are members of disadvantaged urban communities are not receiving basic services and face greater risks of poor health

and restricted schooling, according to UNICEF's report. This defines children living in slums as an especially susceptible urban minority that requires specialised intervention.

Epidemiology and indicators — NFHS evidence (Gujarat)

Data from large-scale surveys offer a baseline for child health in both Gujarat and India as a whole. NFHS-5 (2019–21) provides data at the state and district level about immunisation, stunting, wasting, anaemia, and service utilisation. This information is often utilised to evaluate the outcomes of the urban poor and to identify inequities that exist within urban areas. Research that utilises National Family Health Survey (NFHS) data has consistently demonstrated that children who come from poorer, informal families have poorer nutrition and lower full-immunization coverage than children from wealthy urban households.

Determinants of service underutilization in slums

A wide range of research—including cross-sectional surveys, qualitative studies, and program evaluations—has found that there are recurring structural, financial, informational, and socio-cultural obstacles that decrease the utilisation of healthcare among households living in slums:

- **Structural and supply-side constraints:** Families are pushed towards informal providers due to the lack of primary health facilities in slum areas that are accessible and well-staffed, long waiting periods, unreliable medicine supply, and limited paediatric treatments. The supply deficits in these areas and the significance they play in care-seeking behaviours are documented by assessments of several cities and studies of single cities, including research on peri-urban Vadodara.
- **Financial barriers and coping strategies:** Even in cases when public services are available, out-of-pocket expenses (for example, for medications, diagnostics, and transportation) and salary losses discourage people from seeking immediate medical treatment. Qualitative research conducted in Vadodara has examined the coping mechanisms that households employ in order to deal with the costs of inpatient care, as well as the economic trade-offs that families must make.
- **Informational, cultural and gendered factors:** When mothers have poor literacy levels, have a limited understanding of immunisation schedules and danger indications, favour traditional medicines, and experience gender bias in the distribution of resources within the home, girls are more disadvantaged, which can result in delayed or uneven access to resources. The findings of this study are supported by research on breastfeeding and baby feeding as well as studies on community-level perceptions in urban slums.
- **Administrative and entitlement barriers:** The failure to possess identity papers, the temporary or migratory status of an individual, and the complicated enrolment processes for welfare or health programs serve to limit the extent to which benefits such as health insurance or conditional cash transfers are utilised. Program evaluations of national child health programs highlight implementation challenges that arise when trying to serve the most undocumented, impoverished urban residents who are mobile in nature.

Effectiveness and limits of national child-health programs (RBSK, ICDS, immunization)

The results of program evaluations and quick assessments indicate a variable level of success. Evaluations have revealed deficiencies in the availability of services at higher levels (DEICs), particularly in urban settings where migrant populations and fragmented service delivery complicate continuity of care, in spite

of the fact that Rashtriya Bal Swasthya Karyakram (RBSK) and other screening initiatives have expanded the policy architecture for early detection of child health problems and have improved referral linkages and follow-up. Despite the fact that Anganwadi and ICDS platforms are essential for early childhood interactions and nutrition, they are unable to meet the demands of dense slums due to limitations in the labour, infrastructure, and supplies.

Role and challenges of community health workers (ASHAs, AWWs) in slums

Community health workers are essential for outreach and trust-building, but studies have documented a number of hurdles to their efficacy in urban slums, including the increased mobility of people, imprecise catchment mapping, inadequate incentives and retention, safety concerns, and heavier opportunity-cost burdens for volunteers. In order to address the distinct requirements of populations that reside in slums, management and incentive systems that are used in urban ASHA programs are frequently need to differ from those that are utilised in rural settings.

Health-seeking behavior and the private/informal sector

The results of several studies conducted in Indian cities—including Mumbai and other metropolitan areas—indicate that inhabitants of slum areas have a significant dependence on private clinics and practitioners who are not certified. This is due to factors such as convenience, the perceived responsiveness of these practitioners, and flexible payment options. Private solutions improve access in a practical sense, but also bring up worries about quality, the improper use of antibiotics, and expenditures that are catastrophic in scale.

Mental health, environmental risks and non-communicable contributors

Recent qualitative and epidemiological research has shown that children who live in slums are exposed to chronic stressors, such as overcrowding, violence, and environmental pollution (for example, polluted rivers and floods in Vadodara). These stressors lead to mental health problems and broader developmental hazards. In metropolitan areas, inadequate sanitation and polluted waterways, which are environmental variables, combine with healthcare access to exacerbate negative health outcomes for children. When it comes to Vadodara in particular, current research and local reporting indicate that environmental dangers (e.g., Vishwamitri pollution) have an impact on the city's slum neighbourhoods.

COVID-19 and interruptions to child health services

The epidemic worsened pre-existing vulnerabilities. Routine immunisation sessions, anganwadi services, and outreach were all disrupted by lockdowns, and food insecurity rose as a result of economic shocks. There are a number of problems that are faced by communities living in slum conditions during the COVID-19 pandemic. These include an increase in vaccination reluctance in some contexts, difficulties in sustaining regular services, and the necessity of resilient outreach strategies in order to sustain vital child health treatments.

Economic evaluations and inequities in urban contexts

Reviews that examine the scope and system demonstrate that the urban poor are disproportionately burdened by the expense of health care. Coping methods are widespread among the urban poor, and they

include asset sales and borrowing, both of which can further entrench households in poverty. Demand-side safeguards, such as cash transfers and fee exemptions, stronger public primary care, and regulation of private providers to limit catastrophic expenditure are all advocated for in equity-focused studies.

Methods

In Anganwadi of one of the Talukas of Vadodara, Gujarat, India, a community-based cross-sectional study was carried out. In India, Anganwadis are preschools that are typically available in every 800 people. Children under the age of five are one of the people who benefit from the services that are provided by these institutions. The employees at Anganwadis are responsible for determining if children are malnourished; they often do this by taking anthropometric measurements, such as height and weight. Their height and weight are displayed on the growth chart that was designed by the World Health Organisation (WHO). As a result, any deviation as well as any instances of development retardation may be discovered at the community level. The study included all children and their mothers who attended the specified Anganwadi, with ages ranging from six months to sixty months, and who had moderate acute malnutrition (MAM), severe acute malnutrition (SAM), or normal nutritional status. Before being included in the trial, the mothers were given a written informed permission form and a pre-tested semi-structured questionnaire. Parents who did not give consent and children with congenital defects or admitted in NRC / CMTC at the time of visit were excluded. At the time of data collection, the chosen taluka had a total of 299 registered Anganwadis and 22,663 children. Anganwadi was selected by thirty-cluster sampling technique (a probability sampling technique). In thirty sampling technique, usually thirty cluster are selected based on the cluster interval. The present study treated Anganwadis as a single unit, or cluster, for the purposes of the research. The "cluster interval" is a term that refers to the gap between sample points that is utilised in order to choose clusters during the first round of sampling when utilising a systematic technique. According to the calculations, the spacing between clusters came to 755, which is equivalent to 22663 divided by 30. There were two SAM children available, on average, in each Anganwadi centre. As a result, two SAM children, two MAM children, and four children who are in good health were chosen using the basic random selection approach. As a result, eight children were chosen from each Anganwadi centre. The sample size was calculated to be 240 by using this method. The final sample size was 246 due to the fact that the authors received an additional three SAM and three MAM throughout the data collection process. After obtaining the approval of the Institutional Ethical Committee from the linked institute and receiving authorisation from the Integrated Child Development Services (ICDS) officer, data collection was initiated. A pre-tested, semi-structured questionnaire was used to collect data from a selection of Anganwadi. The mothers were interviewed on the sociodemographic profile, nutritional status, history of sickness, and health-seeking behaviour of their children. On the day of the visit, measurements of the patients' heights, weights, and mid-upper arm circumferences were taken. The data obtained was entered in Epi data and analyzed using Epi Info 7. Key output analysis summarized as mean (Standard deviation) or Median (Inter-quartile range) depending on the normalcy of data and in proportions and percentages. For the health seeking pathway, the organogram was drawn. Confidentiality and data security were also taken under careful attention during the process.

Operational Definition

Well-nourished children: Children with a weight for height or length z score that falls between plus or minus two standard deviations of the median.

Malnourished children: Children who were malnourished comprised both types of children, namely severely acute malnourished (SAM) and moderately acute malnourished (MAM).

MAM: Weight-for-length/height is ≤ -2 SD and > -3 SD, or mid-upper arm circumference is ≥ 115 mm and < 125 mm.

SAM: Weight-for-length or height measurements that are less than -3 SD or mid-upper arm circumference measurements that are less than 115 mm, or bilateral pitting oedema.

BG Prasad Classification for socio-economic class: The categorisation is determined by the consumer price index for the base year and the monthly per capita income. As per the scale, upper class, upper middle class, middle class, lower middle class, and lower class are the five primary groups.

Results

A total of 246 children and their mothers were enrolled in the research. Of these children, 120 were well-nourished and 126 were malnourished. The sociodemographic information of the children and their parents is included in Table 1 and Table 2. As opposed to newborns and children older than thirty-seven months, those who were between thirteen and thirty-six months old had a higher likelihood of suffering malnutrition, according to Table 1. Malnutrition was shown to be more likely to occur in breastfeeding mothers who were also employed (see Table 2).

Table 1: Comparison of socio-demographic details of the children (N = 246)

Variables	Malnourished N(%)	Well-nourished N(%)	Chi-Square	P value	OR(95% CI)
Age(in months)					
6-12	14(11.11)	47(39.17)	26.80	0.0001	1
13-36	54(42.96)	30(25.00)			6.04(2.86-12.73)
37-60	58(46.03)	43(35.83)			4.52(2.21-9.25)
Gender					
Male	60(47.62)	68(56.67)	1.67	0.19	0.69(0.42-1.14)
Female	66(52.69)	52(43.33)			
Siblings					
0	30(23.81)	34(28.33)	1.94	0.58	1
1	62(49.21)	57(47.50)			1.23(0.67-2.26)
2	27(21.43)	26(21.67)			1.17(0.56-2.43)
3ormore	07(05.56)	03(02.50)			2.64(0.62-11.14)
Birth order					
1	48(38.10)	55(45.83)	1.99	0.36	1
2	56(44.44)	50(41.67)			1.28(0.74-2.20)

3ormore	22(17.46)	15(12.50)			1.68(0.78-3.60)
Mother education					
Illiterate	13(10.32)	06(05.00)	3.65	0.18	2.18(0.80-5.95)
Literate	113(89.58)	114(95.00)			

Table 2: Comparison of socio-demographic details of the parents (N = 246)

Variable	Malnourished N(%)	Well-nourished N(%)	Chi-square/t-test	P value	OR(95% CI)
Mother education					
Illiterate	13(10.32)	06(05.00)	3.65	0.18	2.18(0.80-5.95)
Literate	113(89.58)	114(95.00)			
Mother occupation					
Non- working	110(87.30)	115(95.83)	4.68	0.03	3.34(1.18-9.44)
Working	16(12.70)	5(04.17)			
Father education					
Illiterate	16(12.69)	05(04.77)	4.68	0.03	3.34(1.18-9.44)
Literate	110(87.30)	115(95.23)			
Socio-economic status(BG Prasad classification)					
I	02(01.59)	06(05.00)	3.52	0.47	1
II	08(06.35)	11(09.17)			2.18(0.34-13.75)
III	24(19.05)	23(19.17)			3.14(0.57-17.12)
IV	69(54.76)	63(52.50)			3.28(0.63-16.87)
V	23(18.25)	17(14.17)			4.05(0.72-22.63)
Total	120	126			

The behaviour of youngsters who are well nourished and underweight in search of medical attention is illustrated in Figures 1 and 2. Of the 120 well-nourished children, 46 (or 38.33%) had been unwell in the previous six months. In contrast, 68 (or 53.96%) of the malnourished children had also been ill in the previous six months. Table 3 displays the median length of sickness for each of the two groups, as well as the frequency of illness among the members of each group.

Table 3: Comparison of frequency of illnesses among both the group (N=246)

Frequency of Illness during last six months	Mal-nourished (N = 126) N(%)	Well-nourished (N = 120) N(%)	Chi- square	P value	OR(95% CI)
0	58(46.03)	76(63.33)	8.25	0.04	1
1	28(22.22)	15(12.50)			2.44(1.19-4.99)
2	18(14.29)	15(12.50)			1.57(0.73-

					3.38)
3	22(17.46)	14(11.67)			2.05(0.97-4.36)
Me dianduration of illness(in days)	6(IQR-3to9)	7(IQR-4to11.5)	1346.50	0.37	

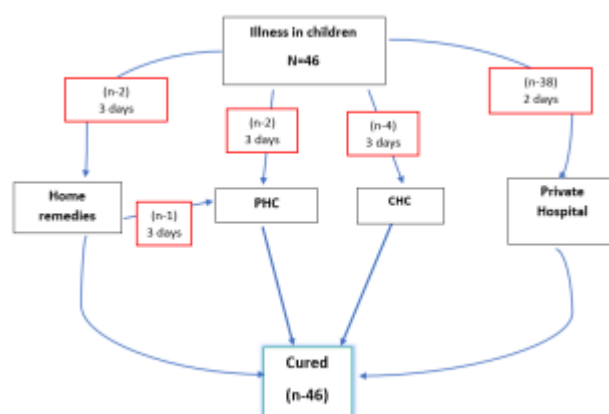


Figure 1: conduct of children who are well-nourished in seeking medical attention (N=46)

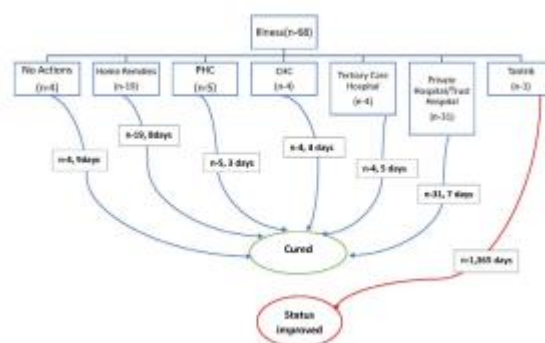


Figure 2: Health-seeking behaviours in children suffering from malnutrition (N = 68)

The health-seeking process of the total of 63 SAM children that were recruited is illustrated in Figure 3. Out of a total of 63 SAM children, 50 (79.63%) children were detected by Anganwadi staff during their routine screening. The parents recognised the remaining 14 (22%) children owing to growth standstill or loss of body weight. The AWW or parents failed to identify two (or three percent) of the youngsters as suffering from SAM or malnutrition. The Anganwadi worker failed to recognise that the children were suffering from severe acute malnutrition, yet they were still in that state.

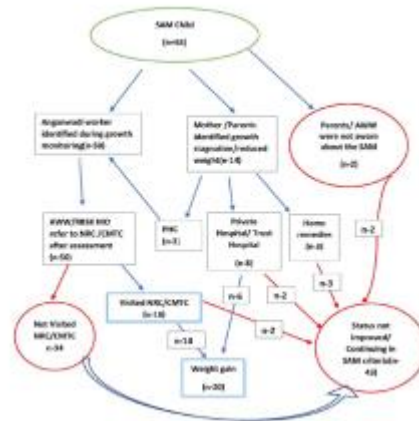


Figure 3: The conduct of children who are malnourished when it comes to seeking health care (N = 63)

Out of all the 50 children who were screened by Anganwadi personnel, referrals were made to the permitted facilities for all of them, however only sixteen children made it to the centre. The reasons for not visiting the referral centres included the fact that other family members were not available to take care of the other children (82 percent), the fact that there was no one to stay in the hospital with the child (67 percent), issues with transportation (26 percent), and other factors (10 percent), such as financial difficulties and disbelief in government institutions. The average length of stay at the referral facility was fourteen days. For the children who had visited the referral facilities, the median delay in reaching was found to be thirty-five days. Among the sixteen children who had been at the referral centre, fourteen (87.5%) saw weight increase by the conclusion of their stay. However, two children did not experience weight gain until fourteen days following their stay, and at the time of the visit, they were still in the severe acute malnutrition (SAM) category. Of the fourteen SAM children identified by parents, eight, or 57.14 percent, were admitted to private hospitals. Out of that group, two children continued to fall into the severely acute malnutrition (SAM) category, despite the fact that six of them had gained weight. Out of the fourteen, only three were recommended home cures such as nutrient-rich foods, increased frequency of meals, and greater diversity of foods. In all, only twenty children (29.41%) had weight increase; fourteen of these children were referred to the centre, while the other six were referred by private practitioners.

Discussion

If carers act in a timely and proper manner while seeking treatment, it can greatly affect survival rates. 6 Edem MA Tette et al. found that compared to well-nourished children (40%) and malnourished children (67%), the former had more episodes of diarrhoea (67%), and the latter had more sick days (55%) overall. 9 Malnutrition was linked to sudden bouts of diarrhoea, according to research by Murarkar S et al. 10 The current study found a strong correlation between a child's nutritional health and the frequency of sickness. Hence, it is safe to say that the nutritional state of the kid was substantially correlated with malnutrition. It would be unfair to say that one cause caused the other in the vicious circle of disease and starvation that is infections. 11 Mishra K et al. found that in the urban slums of Bhubaneswar, India, around 21.92% of the population provided primary care at home, whereas 33.46% went to a pharmacy, 33.08% went to a local health centre, and 22.71% did nothing. 6 Malnourished youngsters in this research received more

therapies, including home remedies, than their well-nourished counterparts, which contributed to their malnutrition in a roundabout way. In compared to children who were well-nourished, fewer children in the malnourished group were sent to the healthcare facility. More people are putting off getting medical treatment as a result of these measures. Among the youngsters in the well-nourished group, 45 (or 66%) had been sent to the hospital for sickness, whereas 42 (or 95%) had been transported there before. It follows that youngsters who were well-nourished exhibited healthy habits when it came to seeking medical attention. Lack of information, loss of income, lower socioeconomic status, having several children, and transportation issues are some of the reasons people may not use the healthcare system. It is also recognised that these variables contribute to the onset of malnutrition. Thus, the progression of both starvation and infection are interrelated. Minz A et al. discovered that 2.5 days (SD-0.75) elapsed between the start of sickness and seeking health care in a community-based cross-sectional research that sought to detect care seeking for paediatric pneumonia. 12 In our study median delay in well-nourished children was three days and in malnourished children it was seven days. Possible causes of the delay in getting to the healthcare facility include not knowing what to look for and not realising that something is wrong for a long time. 13 In this study, too, parents of undernourished children had lower levels of education than those of adequately fed children. In an effort to better the nutritional quality of SAM, the government has set up referral facilities. Gaining insight into the viewpoints of the parents or health seekers is crucial for this objective. Within this framework, fresh investigations into the reasons people visit referral clinics for medical care were launched. Parents' treatment seeking conduct and the various tactics they used after discovering their children's malnutrition were documented in this research. Fifty children out of 63 were recommended, however only sixteen (32% of the total) actually made it to the referral facility. The lack of a reliable government system, problems with transportation, a lack of funds, and an absence of home carers or referral centres are among the most important factors. Lyimo EJ et al. found that parents' ignorance of the symptoms of malnutrition, the character of their economic activity, poverty, and neglect were among the reasons their malnourished children did not seek healthcare until later in life.

Conclusion

Healthcare disparities in urban poor contexts are multi-faceted, as reviewed below with reference to the difficulties slum children in the Vadodara district of Gujarat face while trying to get medical treatment. Children living in slums still confront systematic disadvantages that undermine their right to health, even though Gujarat has made general gains in health indicators and national programs like ICDS, RBSK, and Ayushman Bharat are available to them. Poor child health outcomes are perpetuated by a cycle of vulnerability caused by the interconnectedness of the identified obstacles. High rates of avoidable illness and malnutrition, treatment delays, and dependence on inexperienced private practitioners are all evident outcomes. Overcrowding, environmental pollution, and inadequate sanitation all contribute to these problems by making it easier for diseases to spread. Slum health service delivery was already precarious before the COVID-19 pandemic hit, and the distrust between slum dwellers and official healthcare professionals was exacerbated. The epidemic heightened interruptions to normal child health treatments. A comprehensive and situationally aware strategy is necessary to overcome these obstacles. To close the service gap, it is necessary to strengthen community outreach through Anganwadi workers, mobile health units, and ASHAs. On the supply side, we need to improve the infrastructure of urban health centres, make sure the drugs are always available, and make sure that facilities include services that are suitable for children. To increase demand, we may launch health education programs that specifically target certain

demographics, streamline the welfare enrolment process, and implement financial protection measures like transportation vouchers or conditional cash transfers to ensure that people really use them. To make a lasting difference, it is crucial to establish trust by providing care that is respectful of other cultures and genders. Last but not least, it is our moral and public health obligation to provide Vadodara slum children with equal access to healthcare. Neglecting the health of the most vulnerable endangers not just individual lives but also larger social and economic growth; after all, healthy children are the bedrock of every productive community. It takes long-term political will, creative neighbourhood solutions, and engaged citizens to close the gap between official policy goals and everyday life. Breaking the cycle of disadvantage and providing every kid, regardless of their location, with the opportunity to survive and grow requires an integrated approach that integrates improving health systems with social safety.

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