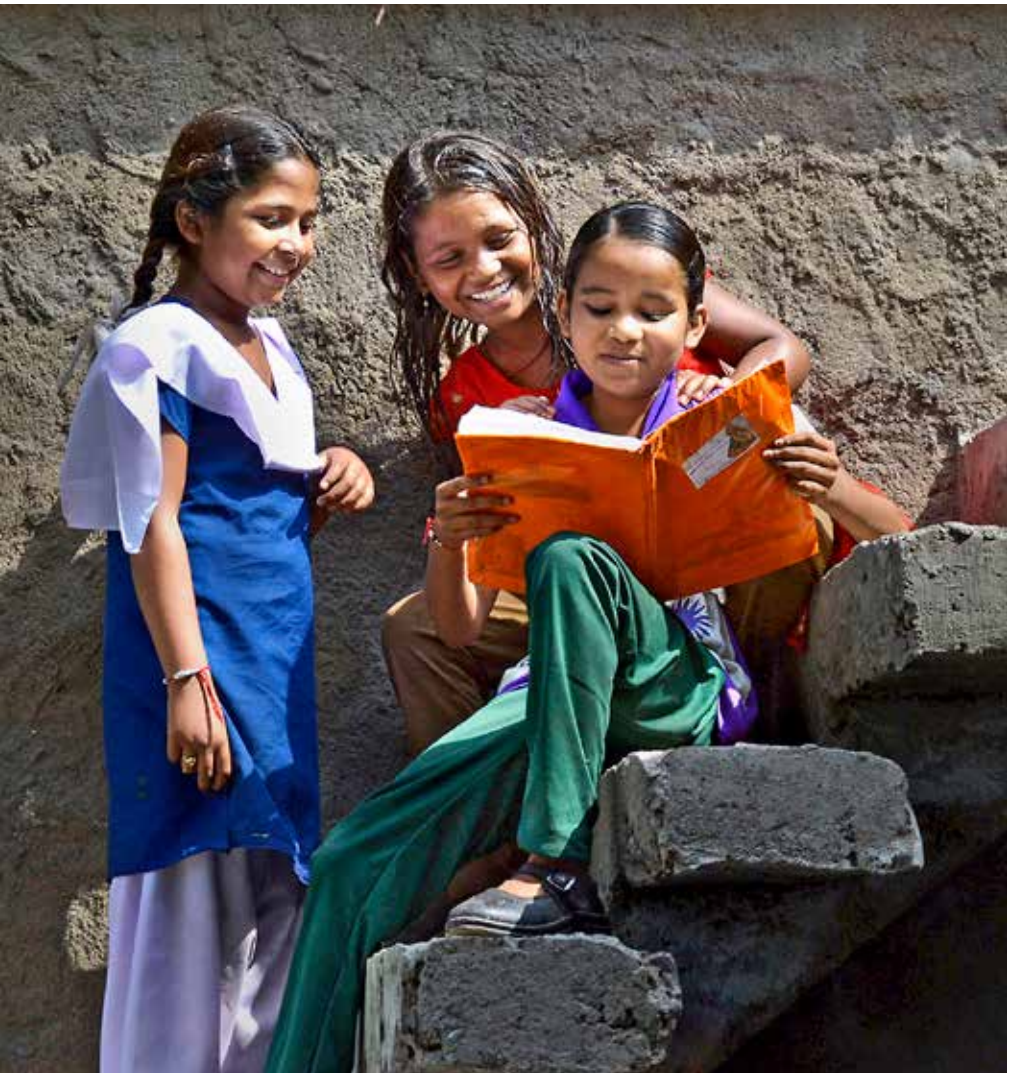
Save the Children®

Forgotten voices
The world of urban children in India



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Preface

"...in serving the best interests of children, we serve the best interests of all humanity."
- Carol Bellamy, Former Executive Director, UNICEF

In recent years, India has captured the attention of the global community for its promising and steady economic growth coupled with a high proportion of young population. Urbanisation holds key if the country has to emerge as the next superpower. With 37% of future adults in the country, of whom, 120 million will be living in urban spaces, mainly in slums, on and off the streets as well as in shelters, this number will only grow and is estimated to reach around 180 million by 2030.

For the urban deprived children, access to basic services such as clean water, toilets, decent education is a daily struggle. Lack of legal identity forces them to stay out of schools and deprives them of basic facilities such as health centres, proper nutrition and right to play among others. Insufficient protection measures make them vulnerable to all kinds of harassment and abuses, often inflicted by adults. Girls especially fall prey to archaic beliefs, forcing them to abandon their studies, stay restricted within the confines of their homes and subject themselves to physical exploitation, while spending their entire life fulfilling gender-specific duties. In all, for these children, one form of deprivation leads to another.

It is time that we hear their side of the story.

While looking at children as a demographic factor, we need to specifically strive to address the needs of millions of such children. We must protect them from physical as well as emotional threats and provide them with nourishment and good education so that they grow up as healthy citizens who contribute to the betterment of society.

It is with this thought that PwC and Save the Children came together to develop a cohesive and an in-depth report on issues important to children living in urban areas. In order to understand these wide-ranging themes and suggest possible solutions, we brought together a team of expert authors, guided by an advisory board consisting of representatives of academic as well as research institutions, NGOs and UN agencies. For our analysis, we have drawn from the best sources and proactively engaged with children in order to understand their perspective and have subsequently tried to capture that succinctly for you, our readers.

The report suggests practical solutions that government schemes such as the 'smart city' can implement for an inclusive, child-friendly and equitable urban development. It is heartening to witness that the new government has launched several urban development initiatives, thus, recognising the importance of cities in the country's overall growth and development.

Our endeavour, through this report, is to initiate a vigorous discussion on how these 'forgotten voices' can be heard. This can take place only when we have your support to sustain this debate and look at creative ways to implement some of the suggestions that this report highlights.

"I dream for a world which is free of child labour, a world in which every child goes to school. A world in which every child gets his rights."- Kailash Satyarthi, Nobel Peace Prize winner

Deepak Kapoor
Chairman
PwC India

Harpal Singh
Chairman
Save the Children India

Photo credit: Prasanth Vishwanathan/
Save the Children

Letter from the ministry

किरेन रीजीजू
KIREN RIJIJU

सत्यमेव जयते

MOS/Home/RJ/509756/2015/116
गृह राज्य मंत्री
भारत सरकार
MINISTER OF STATE FOR
HOME AFFAIRS
GOVERNMENT OF INDIA
12 MAY 2015

MESSAGE

I am glad that `Save the Children' and `PwC India' have made an in-depth study on the issues faced by urban children in India and come up with a report titled `**Urban Children in India**', offering solutions to the problem.

Though many child protection legislations have been brought by various Governments from time to time, incidents of child abuse both physical and mental, particularly against girl child, drug abuse, child trafficking, child labour, health and nutrition etc still pose serious questions before policy-makers. I am confident that suggestions brought forward in the Report on the basis of experience gained on the ground by `Save the Children' and `PwC India' will help both Central & State Governments in addressing these issues and other important concerns emphatically and decisively.

I convey my best wishes to all those who have worked on this subject and congratulate them for their initiative.

(Kiren Rijiju)

May 11, 2015
New Delhi.

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Contents

Photo credit: Anna Kari/Save the Children

Urban environment

According to the World Health Organisation's list of 30 most polluted cities in the world, 15 are in India with Delhi topping the list.

Population

The current population density of Mumbai is already 10 times than that of New York.

Nearly one in every six urban Indian residents lives in a slum.

Around 41.2 million children in the age group of 0 to 6 live in urban areas.

Every eighth urban child (0 to 6 years) in India lives in slums.

More than 8.1 million children live in slums.

There was a decline in birth of nearly 3 million girls as opposed to 2 million boys during 2001-11.

Around 47% of the children of the urban poor are malnourished.

Did you know

Poverty

The share of the urban poor in the total number of poor in India is growing and is now close to 27%.

Education and protection

Sixty-eight per cent of street children are illiterate and 40% work in the unorganised sector.

There are 13,21,424 child labourers in urban India (Census 2001 data).

Thirty-five per cent of India's street children are dealing with substance abuse.

The states of Uttar Pradesh and Delhi together accounted for 47.6% of the cases of kidnapping and abduction of children reported in the country.

In urban areas, out of 1,000 girls, only 14 reach Class 12.

Twenty-nine per cent of girls in urban areas are victims to child marriages and this trend is increasing.

In urban areas of India, only half of the girls between 15 and 17 years of age attend school.

Executive summary

Background

The urban century

By 2040-50, urban India will constitute a **50% share** in the total population of the country. Also, its share in India's **GDP will grow to 75%** by 2030.[1]

Though the share of the country's urban population to its total population is still at 31% (Census 2011), urban India has grown **five times** since 1961 in terms of population. India is going through a crucial phase of transition, from being a predominantly rural country to one where a majority of the people aspire to live in cities. For the first time in history, Census 2011 highlighted that the net decadal addition to the population during 2001-11[1] was more in urban than in the rural areas, thus marking the beginning of a **demographic shift**. This trend will be an ongoing process with **600 million people** expected to reside in urban areas by 2030 as compared to 377 million in 2011.[2]

While the number of people residing in urban India is on the rise, equally alarming is the rise in the number of the urban poor. Standing at no less than **76 million**, the burgeoning size of the urban poor cannot be ignored. As per Census 2011, there are **13.7 million slum households** in India that live amidst inadequate basic amenities, poor health outcomes, insecurity as well as unstable incomes. Today, slums are located across **urban areas** in the country, with **63% of statutory towns** in India being home to these dwellings. Our cities are overcrowded; over 53 million+ cities account for 13% of the population but occupy just 0.2% of the land. Around **half of the urban migrants** are among the **poorest** in terms of **consumption expenditure**.[3]

Over the last four decades, the total headcount of the poor in the share of urban poverty has gone up from 18.7 to 26.8%. While it may be a bit early to call it the 'urbanisation of poverty', there is a definite shift that must be acknowledged and addressed in a planned manner.[4]

Reaping the demographic dividend of urban India

Of the 377 million urban Indians, **32% (120 million)** are children below 18 years of age and around 10% (36.5 million) are children below six years.[5]

While the *demographic dividend* of India (over 65% of the population is below the age of 35 years, and 39% is 18 years or below)[6] is often hailed as the key to the future growth of the country, an inconvenient truth is that **more than 8 million children under six years live in slums**.

That is **more than** the combined population of the five north-eastern states: Sikkim, Arunachal Pradesh, Nagaland, Manipur and Mizoram.

UNICEF's State of the World's Children 2012 report states, "The children living in around **49,000 slums in India are *invisible***". Half of these slums are located across the five states of Maharashtra, Andhra Pradesh, West Bengal, Tamil Nadu and Gujarat.[7]

While tremendous progress has been made on the '*hardware*' front in terms of developing city infrastructure, not enough attention has been paid to the '*software*' of these cities, especially for its young citizens. Children in urban India, especially those from disadvantaged sections—slum as well as street children, orphans, and people with disabilities are susceptible to scenarios such as ill-health, poor access to water and sanitation, insufficient education, urban disasters and child protection and safety concerns.

The opportunity that urbanisation presents lies in designing the right governance structures, investing adequately to facilitate this growth and ensuring inclusive growth. A **child-friendly** city is one that has a system of local governance, and is committed to fulfilling children's rights, which include influencing decisions about the city, expressing their opinion, participating in social life, receiving basic services, walking and playing safely, living in an unpolluted environment and **being an equal citizen**.

Our report demonstrates that the major urban development schemes in India do not adequately take into account issues related to children's health, education, growth, safety and participation. The focus may need to be on smaller urban centres where most of the urban population is concentrated (68% of India's urban population lives not in metros but in towns with a population of less than 100,000[8]). We believe that any successful reaping of the demographic dividend will require focus on the following key areas:

- Urban governance
- Health
- Nutrition
- Water and sanitation
- Education
- Child protection
- Urban resilience

Urban governance

The year 1992 is a watershed period in the history of public administration in India[9] since the country realised the need for decentralised planning, plan implementation, development processes and authority to sub-national and local levels. In the subsequent year, the Constitution was amended with the enactment of the 74th Constitution Amendment Act that gave constitutional recognition to ULBs and envisioned the ushering of empowered and strengthened urban governance. However, the current lack of basic urban infrastructure in the country is an indication that this Act has not been implemented properly.

In recent years, the government has recognised the importance of urban areas and has implemented various programmes that address the systemic challenges of urban governance such as the need for municipal reforms and better financial health of urban local bodies along with the problems of poverty, livelihood and housing.

A review of these programmes reveal that it **does not include** specific needs of the **child**, especially the deprived one. In particular, lack of funds for basic services (water supply, solid waste management, and street lighting), civil works (parks and playgrounds, slum improvement and construction of primary schools) and prevention of food adulteration have a direct implication on their growth and development.

Thus, urban schemes need to ensure that a **sufficient budget** is allocated for **children**. There is also a need to replicate **child-friendly** programmes through child participation in the governance process, build their capacities, redesign long-term development plans through a child lens and prioritising budgeting and expenditure on issues identified by or which are important for children.

Health

In India, one primary healthcare facility located within an urban area caters to a much higher population when compared to the standard norm of one centre **per 50,000 persons**.[10] Also there is an imbalanced focus on curative care, and a near total neglect of preventive as well as promotive care.

> *"If I become a leader, I will start free medical facilities and build a hospital in the locality so that people don't have to go far for treatments."*
>
> - A boy of 14 near Govandi slum, Mumbai

Though we witnessed an improvement in the **mortality** rates from the previous decade, our research data indicates that all childhood mortality indicators among the urban poor are higher as compared to the overall urban averages- versus 51.9 for U5MR, 54.6 versus 41.7 for IMR, and 36.8 versus 28.7 for NNMR. Moreover, **infant mortality** rate is still an area of concern, varying widely across cities, ranging from 28 per 1,000 live births in Chennai to 63 per 1,000 live births in Meerut.[11]

Photo credit: CJ Clarke/Save the Children

Coverage of immunisation has improved and is at 67.4% in urban areas.[12] It is unfortunate that the birth order of the child still continues to affect the immunisation coverage. While 67.4% of birth order-1 children have received full immunisation, only 40.4% in the category of birth order-4 and above received full immunisation.[13] Child sex ratio continues to decline from 935 girls per 1,000 boys in 1991 to 905 girls per 1,000 boys in 2011.[14]

One of the key challenges facing urban poor is their limited capacity to spend on healthcare. Overcrowded government hospitals often force them to seek treatment from unlicenced and untrained, yet more affordable private providers.

Providing **healthcare** right from the pre-natal upto the adolescence stage is vital in order to ensure healthy growth and quality life of children. From the providers' perspective, service delivery in slums is an enormous challenge given the large and sometimes mobile population.

Nutrition

The problem of undernutrition in children is of a serious magnitude in urban India. In India, **32.7% of** urban children **under-five years of age are underweight** and **39.6% are stunted**.[15] The difference in prevalence rates is evident in the wealth index, **six out of 10** children under five years is stunted in the lowest wealth index as compared to 2.5 out of 10 children in the highest wealth index.[16] Also, **21.5% of** newborns in the country have LBW.[17]

The other emerging problem of urban India is the rising incidence of obesity, especially among middle and upper middle class urban children. Research by the Diabetes Foundation reports the prevalence of **overweight children** (14 to 18 years) in the private schools of Delhi is between **29 and 32%.**[18]

The long-term consequences of chronic malnutrition are far-reaching since the adverse impact in the first 24 months of life itself is largely irreversible. The impact of undernutrition on the girl child has serious inter-generational effects. A stunted young girl is likely to grow to be a stunted adolescent girl and subsequently a stunted woman with increased chances that her children will be born undernourished. The adverse effects of malnutrition are therefore not limited to children but can have serious implications throughout the life cycle, eventually resulting in adversely affecting the health, education, productivity as well as the economy of the state. In urban India, **51% of women** (15 to 49 years) and **17.7% of men** (15 to 49 years) are reported to be **anaemic** across all states and socio-economic groups.[19]

Physical development and proper **nutrition** of children are essential for the positive development of cities as they form the future workforce stimulating economic growth. India is still grappling with the problem of providing adequate nourishment to its young citizens.

Water and sanitation

According to the 2011 Census, around **one in five households** in urban areas do not have a household toilet and depend on shared facilities. Nearly 12% of urban households **defecate in the open** and another 8% use public or **shared toilets**. In terms of urban sanitation, while India has about 11% of the world's urban population, it accounts for nearly **half of the global population** defecating in open.[20]

> *"1,800 of us share only one toilet, which is dirty and we do not use it as boys tease us when we go there."*
>
> -A girl of 14 near Govandi slum, Mumbai

We find that though the urban population in India has better access to sanitation, however, the coverage is failing to keep up with the population growth. As a result, the number of **urban dwellers practising OD** has **increased from 140 million to 169 million** between 1990 and 2008,[21] though in relation to the **total urban population, the proportion fell from 64.3 to 49.7%.**[22] A study conducted by HUNGaAMA shows that **less than 15% mothers wash their hands** with soap and water after defecation.[23]

An estimated 1.8 million children die globally[24] before the age of five from **diarrhoea** and **half a million** occur in India.[25] It is reported that **16.3% children** suffer from diarrhoea in the two weeks that preceded the survey conducted in order to assess this occurence.[26] Children living in slums are **1.3 times more likely** to suffer from diarrhoea than in non-slum areas.[27] Another study from Tamil Nadu reports that a child living in an urban area suffers from about **12.5 illness episodes in a year.**[28]

Only **26.6% urban households** are reported to have access to **safe drinking water** within their dwelling premises.[29] Approximately **443 million school days** are lost as a result of water and sanitation related diseases.[30]

According to the Ministry of Health and Family Welfare, more than **12 billion INR** is spent every year on illnesses[31] resulting from poor sanitation. According to a 2010 World Bank report, **India loses 240 billion INR annually** due to the lack of toilets and hygienic facilities.[32]

> *"We never use school toilets as they are very dirty and so are the tanks that contain drinking water. We also carry our own lunch as the meals provided in schools have dust, and sometimes dead rats in it."*
>
> - A girl of 15 near Govandi area, Mumbai

WASH has a direct impact on the health and education of children. Stunting and underweight prevalence in 48% of malnourished children in India is linked to the absence of access and use of sanitation and hygiene facilities. Attendance and retention rates of girls studying in the middle and higher classes are affected the most by the absence of separate and functional sanitation facilities and their poor upkeep.

The physical environment in which the urban-deprived children live and their access to basic services such as **water and sanitation** has a direct impact on their health. Factors such as OD, lack of proper faecal disposal and management along with insufficient and poor quality water supply leads to the spread of diseases such as diarrhoea, typhoid, cholera and malaria.

Education

Schooling of children has to deal with the elusive triangle of access, equity and quality.[33] While approximately 27.4% of children in the age group of 7 to 18 years reside in urban areas, only 17% of schools are located in urban areas.[34] There are a total of 1.52 million schools in India out of which 14.9% are located in urban areas.[35]

The Census 2011 report shows that the child population (0 to 18 years) increased by 12.8% in urban areas during the preceding decade, but a closer look of the report reveals that neither the corresponding enrolment at the school stage nor the number of education facilities and teachers has increased proportionally.

A study of urban slums in Delhi indicated that the ratio of children who have never attended school (i.e. those may have enrolled but have never attended) to the total number of children is 31.5%. Reasons for 'never attended' a school range from being underage (46.5%), financial constraints (36.6%) and parents' negative perception of education per se (10%).[36]

Migrations of children with their families further add to the problem as language poses a major barrier to education. As schools only admit children for a brief period each year, parents face a tough time getting their children admitted. As a result, a large number of children remain out of the education system.

"I cannot join school as I need government documents such as an Aadhar card for registration. My parents could not get the card made as we do not have a ration card or any other government document that proves our citizenship."

- A boy of 15 near Sangam Vihar area, Delhi

The new millennium witnessed the onset of **landmark laws** such as the **RTE Act**. The Act has earmarked 25% seats for the underprivileged children, a provision particularly relevant for slum children.

How well India is able to harness the intellectual capital of its youth is dependent on the access and quality of **education** that it provides to its children.

Child protection

The growth of cities gives rise to several **child protection** issues. There was a **24% increase in crimes against children** between 2010 and 2011 and a further **52.5% increase** from 2012 to 2013.

The million+ cities are major contributors to urban crime. Major crimes against children include trafficking, kidnapping, rape and infanticide. The girl child is especially affected due to the proliferation of sex work in cities.[37] Highly urbanised states such as Delhi and Maharashtra are third and fourth in the list of states where most of these crimes take place.

> *"This boy who grew up with me tried to rape me while I was sleeping. He is a nice boy but was under the influence of alcohol, and the police took him and thrashed him so hard that he was unable to walk for a week."*
>
> - A girl of 17 near Patancheru, Hyderabad

Lack of protection for children on or off the streets was captured rather starkly by the 2007 study on child abuse undertaken by the MoWCD. The study covered 2,317 street children as respondents across 26 districts of 12 states from different zones of the country. Of these, 55.3% were boys. Taking both severe as well as other forms of sexual abuse together, **54.5% of street children confirmed experiences of sexual abuse**. Another Unicef report estimates that 27.1 million to **69 million children** are exposed to **domestic violence** in India.[38]

> *"We always keep some money to buy items such as Iodex and Corex. They give us much energy and are not bad for health either."*
>
> - A boy near Easamia Bazar, Hyderabad

In a country such as India, where it is lucrative for employers to employ child workers since it is cheap and labour laws are poorly implemented, **the number of urban child workers is huge,** though still less than that in rural areas. Small industrial workshops, small and medium-scale hazardous industries, service establishments, and informal businesses such as ragpicking, porter and vendor jobs are where child workers are concentrated. A large number of children work as domestic helps, suffering abuse and exploitation at the hands of their employers, which is usually away from the public eye. A study on children as **domestic workers** indicates that almost 70% of children reported physical abuse, slapping, kicking, burning, etc and **32.2% reported sexual abuse**. In addition, there are children involved in prostitution and bonded labour.[39]

A study[40] was carried out in 27 states and two union territories across 135 sites in cities and towns, with 4,024 child respondents in the age group of 5 to 18 years to understand substance abuse. It found that **83.2% respondents confirmed using tobacco on a daily basis.**

A higher-than-average crime rate clearly means that children in the cities are not only victims to such violence but are in the danger of becoming a part of organised crime rackets, especially when faced with circumstances such as disruption in schooling, dysfunctional family, lack of parental care and exposure to substance abuse.

Urban resilience and disaster management

Natural[41] disasters and extreme climatic conditions have a different impact on children than they have for adults and pose a serious threat to a child's survival and well-being.

According to a Save the Children 2008 report, **more than 50% of those affected by natural disasters worldwide are children,** including urban children as well. According to Unicef, every year, between 2000 and 2009, **8.45 million children under five years of age** were affected by disasters in India. Of these, **1.25 million** children are **malnourished**.[42]

Eighty-five per cent of the country's area is vulnerable to calamities[43] and 25 of the 53 million+ cities are located in coastal states.[44] Cities such as Kolkata, Mumbai and Delhi face serious threats related to climate change. Recently, the sudden floods in Jammu and Kashmir affected 250,000 children.

At the policy level, **the Disaster Management Act of India (2005) does not include** any references to **vulnerable groups**, such as children. District disaster management plans do not provide age-disaggregated data on children.

The government has not recognised heat or cold wave, a major killer of urban poor living on the streets during the severe conditions, as a calamity.

Disaster preparedness in India leaves a lot to be desired both at the policy level as well as its implementation.

What we need to do

As we compiled this report, some obvious areas of intervention for policymakers and NGOs emerged and are listed below:

Urban governance: For **inclusive cities**, a child-led planning process is essential since it allows children to provide solutions to the challenges that they encounter. Land-use planning is an important factor in creating a child-friendly city and it needs to be made more sensitive to the needs of vulnerable children through the use of various instruments such as social housing, master plans, land use conversion, discouragement of low or no occupancy, etc.

We also recommend that in defining schemes such as smart cities, the government should go beyond accommodating the aspirations of the new middle class comprising of professionals and investors by also addressing the priorities of the urban poor. Also, the proposed idea of '**citizen reference frameworks**' needs to be implemented in order to capture the concerns and opinions of children living in cities.

Health, nutrition and WASH: As the report explains, data on urban child health is both limited as well as difficult to use to provide useful information for planning purposes. Hence, there is a need to generate **evidence on indicators of child health**, specifically looking at poor versus non-poor and slum versus non-slum. There is also a need to **develop and implement models of child care** for urban populations, staffing norms for urban health facilities (in view of their tremendous workload) and convergence mechanisms of public, private, and third-sector institutions, since the private healthcare sector has a strong presence in cities.

We advocate the need for an explicit policy on **women's nutrition,** which is directly connected to health of newborns, community-based care of SAM children and tracking all urban pregnant women from conception to two years of age. Other recommendations include the mapping of urban poor clusters in order to identify high-risk populations, promoting home-based care practices, ensuring universal coverage with micronutrients. Also, building a system to reach newly-weds to counsel them and and improve their nutritional status prior to conception, monetary compensation to pregnant mothers during maternity leave, establishment of crèches attached to the ICDS centres must be considered.

We strongly recommend that the public policy on **water and sanitation** give first right on resources to children. Inhuman practices such as manual cleaning of septic tanks, sewage networks and drainage laden with faecal sludge need immediate attention of the public welfare system. The NUSP must **include children** as a **priority group**. Going beyond improving access to toilets, hygiene education needs to be proactively promoted since it comprehensively covers toilet use and the safe disposal of child faeces. The City Sanitation Ratings and Ranking led by the MoUD has to be scaled up and the database of the urban WASH requires further strengthening by way of establishing categories for children, poor and women.

Education: **Bridging and support classes** need to be **integrated** within the educational planning process so as to help bring back out-of-school children and retain them in school. Other recommendations include the need to establish public funded pre-schools in urban areas with a carefully designed age-appropriate learning curriculum and adequate trained teachers, the need for a **national-level mechanism for tracking the children in migration**, planning of vertical development of school space with proper security and, in view of the highly mobile nature of urban poor population, the need for a policy to ensure that identity of children and subsequent entitlement in term of educational right is protected.

Child protection: We recommend a **comprehensive national census of street children**. Other recommendations include making the elimination of child marriage in urban areas a time-bound goal, utilisation of gender resource centres as a medium to address violence against children in slums, training and sensitisation of law enforcement agencies such as the police force more intensively in order to ensure that they act in a child-friendly manner, setting-up of de-addiction facilities for children in cities and strengthening the system of tracking and rehabilitating missing children.

Urban resilience: In view of the increasing threat of natural disasters, this report recommends significant revision of urban planning practices across city and neighbourhood scales in order to integrate flood and climate change mitigation and adaptation measures into day-to-day urban development and service delivery. We specifically recommend **more** mayor-to-mayor**, city-level partnerships** as well as city-to-city **knowledge sharing practices**. Clearer role definitions of key stakeholders in the urban resilience planning process need to be laid down, **children made active participants in resilience building**, and **comprehensive school as well as day-care centre safety be prioritised**.

At an overall level for city development, **an inclusive and child-led planning** process is essential, to allow children to speak of the challenges that they experience and provide solutions and to facilitate the integration of child development with government schemes and policies.

Photo credit: Save the Children

Urbanisation and urban life in India: An overview

Urbanisation and urban poverty: India and the world

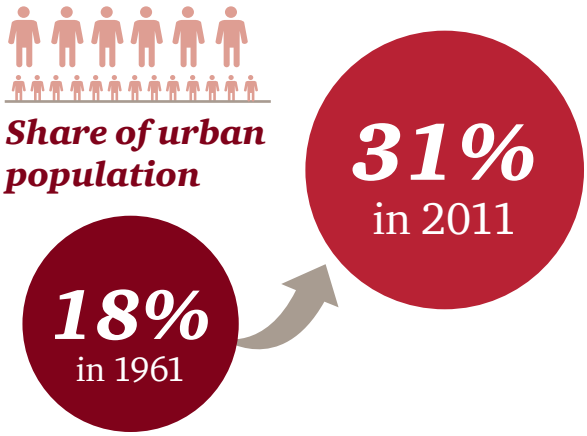
Today, globally, more people live in urban areas than in rural areas. The share of urban population in the total global population has grown from 30% in 1950 to 54% in 2014. By 2050, 66% of the world's population is projected to be urban. This means an addition of another 2.5 billion people to the urban population.

Today, the most urbanised regions include Northern America (82% living in urban areas in 2014), Latin America and the Caribbean (80%), and Europe (73%). In contrast, Africa and Asia remain mostly rural, with 40 and 48% of their respective populations living in urban areas. However, all regions are expected to urbanise further in the coming decades.

Africa and Asia are urbanising faster than the other regions and are projected to become 56 and 64% urban respectively by 2050. Close to 90% of the increase will be concentrated in Asia and Africa, according to a new United Nations report. In fact, the largest amount of urban growth is expected to take place in India, China and Nigeria[45] and in absolute numbers India will have the highest number of urban residents in the same period.

Increase in urbanisation comes with increase in urban poverty. Poverty is now growing faster in urban areas than in rural areas. Urban poverty is severe and largely camouflaged in urban average data. The increase in the number of people living in slum conditions is a reflection of the increasing urban poverty. As per current global estimates (UNFPA), one billion people live in urban slums, which are typically overcrowded, polluted, dangerous, and lack basic services such as clean water and sanitation. According to the latest Global Report on Human Settlements, 43% of the urban population in developing regions lives in slums. In the least developed countries, this percentage rises to about 78%. The poor living conditions in these slums are a major disadvantage for the children living in these vulnerable environs.

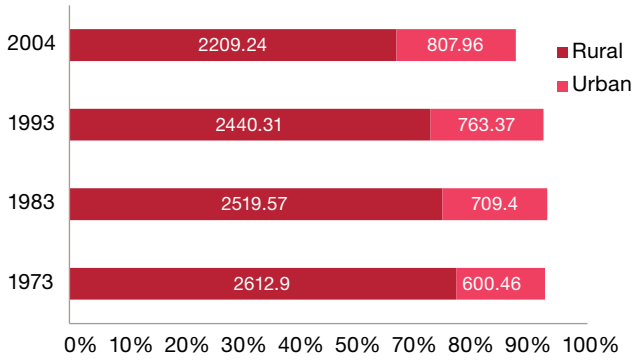
India accounts for around 11% of the global urban population (World Bank data).



India witnessed an important demographic milestone in 2011. For the first time since Independence, the absolute increase in population was higher in urban areas (91 million) as compared to rural areas (90.6 million).[46] This signifies that from this point onwards, the urban component of the country's population is going to see more growth than the rural component. As a result, by 2030, 600 million people are expected to reside in urban areas, a rise from the 377 million people residing in urban areas as per the 2011 Census. This shift towards urbanisation is a natural result of the growth of the Indian economy in recent years.

However, the increase in urban poverty worldwide is true for India as well. The NSSO's 61st round data reveals that about 81 million people in urban India lived below the poverty line in 2004-05. While the number of poor in the rural areas declined by about 231 lakh from 1993-94 and 2004-05, in urban areas, it increased by nearly 44 lakh. Over the last four decades, the total headcount of the poor in the share of urban poverty has gone up from 18.7 to 26.8%. While it may be a bit early to call it 'urbanisation of poverty', there is a definite shift that must be acknowledged and addressed in a planned manner.

Increase in the number of urban poor in India



Source: 11th Five Year Plan document, Planning Commission, chapter 4. Retrieved from http://www.planningcommission.nic.in

All numbers in Lakh

Original data: NSSO survey rounds in each of the last four decades

As per the press note of the Planning Commission on Poverty Estimates 2009-10 (released in March 2012), the number of urban poor in India now stands at 76 million.[47]

Slums: The underbelly in Indian cities

Slums have witnessed a substantial increase in urban population owing to the natural growth factor and the inability of migrants to find space in cities other than in slums. As per Census 2011, there are 13.7 million slum households in India, which constitute more than 17% of the urban households living in the country.[48] These slum settlements are characterised by poor housing conditions, social services, basic amenities, health outcomes, insecurity and unstable incomes and livelihoods. The residents of these slums and those living on the streets are forced to survive in vulnerable conditions and are deprived of their basic entitlements.

> *"In the kachcha colony, where I live, the condition is worse. There is no water connection, no parks to play, and the houses here are shanties. I feel discriminated against as people from JJ Colony also illtreat us".*
>
> - A boy of 17 from New Delhi

This is particularly true for the children living in slums. They are not only deprived of the most basic services but are also not recognised as an important segment by our urban planners and developers. This neglect comes even after studies show that children in the age group of 0 to 6 years form more than 11.5% of the total urban population and 12.3% of the slum population of India.[49]

In urban areas, approximately 32% of the population of 377 million comprises children. In rural areas, a larger proportion (41%) of the population consists of children.

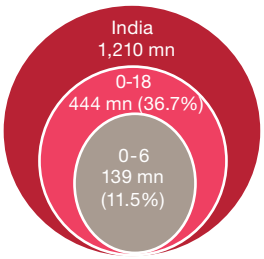
Child population in India[50]

	India	Urban	Slums[51]
Total	1210,854,977	377,106,125	65,494,604
Below six years	138,861,008	36,579,569	8,082,743
Below 18 years	444,153,330	120,078,346	-

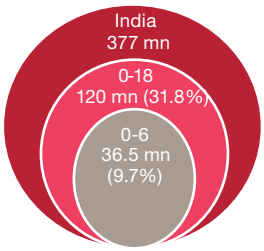
Note: Population of children below six years includes those in the age group of 0-59 months.


Photo credit: CJ Clarke/Save the Children

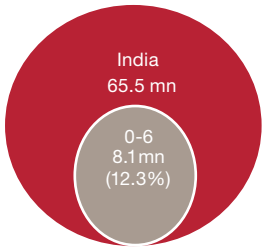
Breakdown of total population



Breakdown of urban population



Breakdown of slum population



The development indicators for urban and rural areas are constantly segregated and analysed. However, the inequality subsumed within the urban indicators is seldom analysed and much less acted upon.

Purpose of this report

As stated in Article 2 of the UNCRC, all children are entitled to certain basic rights. It also clearly states that no child should be treated unfairly and with any bias. With the increasing growth of urbanisation, the country needs to keep a check on how the deprived urban child is faring.

This report attempts to analyse the urban environment defined mainly by the changing urban demography.

The changing demography is marked by a rising number of the urban poor, in-migration and growth of slums. The report locates the urban deprived child in this environment, documents the progress of the urban deprived child over the past few decades and highlights their needs distinctly from the marginalized children living in rural areas

Concepts and definitions

Before discussing urbanisation trends and urban life in India in detail, it is useful to understand the key terms and concepts integral to the discussion.

The definitions of urban areas have not always stayed uniform across the country. However, from Census 1961 onwards, a uniform and rigid set of definitions were adopted to maintain the comparability and to study the trends of urbanisation. In the subsequent Censuses of 1971, 1981, 1991 and 2001, the same urban concepts were adopted with minor changes.

Following are the six town classes defined by the Census of India. As the population increases, a town progressively enters Classes V,VI , III, II and I.

Town classes in India

Size-class	Population	Usual status
I	1 lakh and above	City/Urban agglomeration (UA)
II	50,000 to 99,999	Municipality/nagar palika
III	20,000 to 49,999	Census town/nagar panchayat
IV	10,000 to 19,999	Census town
V	5,000 to 9,999	Census town
VI	Less than 5,000	New census town

Statutory town (ST): A statutory town is any habitation with an urban local body (municipal corporation, city municipal council, town municipal council, town panchayat, etc) defined by a state municipal act or a cantonment board or a NAC, etc notified under the law, irrespective of their demographic characteristics. A cantonment town can have a population as small as 2,500. A municipal corporation on the other hand, can administer an area consisting of a population of millions. A town in any of the above size classes will be a statutory town, if duly notified.

Census town (CT): All places other than statutory towns can be classified as a census town if it fulfils the following criteria:

- A minimum population of 5,000 inhabitants
- At least 75% of the male working population must be engaged in non-agricultural pursuits
- A density of at least 400 people per sq km (1,000 per sq mile)

Since these are non-notified areas and are not governed by a local self-government or a board, they are also called non-municipal census towns. This definition was adopted for classifying the towns in Census 2001.

Urban unit: All statutory towns are urban units. A district or taluka headquarter, which has not yet been notified as a statutory town and also fails to satisfy the demographic criteria defined for the census town, is classified as a rural unit. The list of all urban units in a state is known as the urban frame.

New census town: A census town with a population of at least 5,000 is placed in Class V, but there are also new census towns (Class VI) which have a population of less than 5,000 (though above 4,000) and yet in special situations, are recognised as census towns. An example of such a census town is the small township that developed around the Upper Sileru Dam Project Site Camp in Andhra Pradesh. Census 2001 recognised it as a census town with a population of 4,746. According to an estimate,[52] the share of new CTs in the total urban population growth between 2001 and 2011 has been really high in some of the major states such as Kerala (93.1%), West Bengal (66 %), Assam (56.7%), and Jharkhand (44.7%).

City: All towns with a population of 1 lakh or above (Class I) are called cities. In a process of natural growth, a city is formed when a town and its adjoining OGs or two or more physically contiguous towns together form a UA. These technical terms are explained below.

Outgrowths (OGs): It is a viable unit such as a village or hamlet or a CEB made up of such villages or hamlets and clearly identifiable in terms of its boundaries and locations. Examples are 'fairly large well-recognised' railway colonies, university campuses, port areas, military establishments, etc, which have come up near a statutory town outside its statutory limits but within the revenue limits of a village or villages contiguous to the town. While determining the outgrowth of a statutory town, it has to be ensured that it possesses the urban features in terms of infrastructure and amenities (such as *pucca* roads, electricity, taps, drainage system for disposal of waste water, etc), educational institutions, post offices, medical facilities, banks, etc. and is physically contiguous with the core statutory town.

The concept of outgrowth was introduced for the first time in Census 1971 with a view to have a true measure of the extent of urbanisation because such areas were already urbanised and it was unrealistic to treat them as rural just because they were outside the statutory limits of a town.

Urban agglomeration (UA): It is a continuous urban spread constituting a town and its adjoining OGs, or two or more physically contiguous towns together with or without outgrowths of such towns. It must consist of at least a statutory town and its total population (i.e. all the constituents put together) should not be less than 20,000 as per the 2001 Census.

Some of the largest urban agglomerations satisfying the basic condition of contiguity are Greater Mumbai UA, Delhi UA, etc. In the 2011 Census, 475 places with 981 OGs have been identified as urban agglomerations against the 384 UAs with 962 OGs recorded in the 2001 Census.

During 2001-11, there was an increase in the number of towns in all four major categories mentioned above (statutory towns, census towns, UAs and outgrowths), but most notably, in the category of census towns. This indicates that a large number of erstwhile rural areas have now assumed an urban character in terms of nature of occupation and population density[53].

Increase in the number of towns in each category: 2001-2011

Category of urban areas	2011 Census	2001 Census	Additions
Statutory towns	4, 041	3, 799	242
Census towns	3, 894	1, 362	2, 532
Urban agglomeration	475	384	91
Outgrowths	981	962	19

Cities are further classified according to their population and are as follows:

Million plus city: Out of 468 UAs or towns belonging to Class I category, 53 UAs or towns each has a population of one million each or above. Known as million+ UAs or cities, these are the major urban centres in the country.

Metropolitan area: A 'metropolitan area' is a special case of a million plus city or UA. It means an area with a population of 10 lakh or more, comprising one or more districts and consisting of two or more municipalities or panchayats or other contiguous areas specified by the governor of the state by public notification to be a metropolitan area.[54]

Mega city: The concept of 'mega city' is a recent phenomenon in urban sociology. It is defined as a metropolitan city characterised by large size, problems in managing civic amenities and capacity to absorb the relatively high growth of population.

Cities with a population of 10 million and above have been treated as mega cities in India. The three mega cities in India are Greater Mumbai UA (18.4 million), Delhi UA (16.3 million) and Kolkata UA (14.1 million).

Cantonment: The central government may, by notification in the Official Gazette, declare any place in which any part of the Forces is quartered, as a cantonment. This area is governed by the Cantonment Board. In terms of population size, there are four categories of cantonments:

- Category I in which the population exceeds 50,000
- Category II in which the population exceeds 10000 but not 50000
- Category III in which the population exceeds 2,500 but not 10,000
- Category IV, in which the population does not exceed 2500.[55]

Urban local bodies:

The 1991 Census of India classified the ULBs into four major categories:

- Municipal corporation
- Municipality (municipal council, municipal board, municipal committee)
- Town area committee
- Notified area committee

Photo credit: Raghu Rai/Magnum for Save the Children

On the basis of population size, different towns are administered by different types of municipal bodies.

Municipal corporation: It represents the topmost tier of urban LSG and is set up for a city UA with a population above 3 lakh. As an institution, it is more respectable and enjoys a greater measure of autonomy than other forms of LSG. It is set up under a special statute passed by the respective state's legislature, with the exception of Delhi, due to it being the National Capital Territory. Here the power to set up a municipal corporation lies with the Parliament.

The municipal corporations are in charge of wards (sub-division or district of a town or city) according to its population and representatives are elected from each ward. For example the MCGM—the civic body that governs Mumbai city—is divided into six zones each consisting of three to five wards. Individual wards or collections of wards within a corporation sometimes have their own administrative bodies known as ward committees.

In some cases, a municipal corporation may cut across two or more districts.

- Delhi Municipal Corporation (all nine districts)
- New Delhi Municipal Council (NDMC) (New Delhi, Central, South West and South districts) in Delhi
- Imphal Municipal Council (Imphal West and Imphal East districts) in Manipur
- Siliguri Municipal Corporation (Darjeeling and Jalpaiguri districts) in West Bengal
- Greater Mumbai Municipal Corporation (Mumbai Suburban and Mumbai districts) in Maharashtra
- Hyderabad Municipal Corporation (Hyderabad and Rangareddy districts) in Telangana

Notified area committee: In urban planning, a notified area is any land area earmarked by legal provision for future development. The term is used in the Hindi belt of north India.

The term also describes a village or settlement with a population between 10,000 and 20,000. A community of over 20,000 is considered a town under Indian law. Each notified area elects a notified area committee for its administration where all members as well as the chairman are nominated by the state government, which function like a municipality. The power of nomination helps centralise the process of governance in the hands of the state government. There have been various recommendations asking to stop such centralisation and place these areas under the PRIs.

Town area committee: It is a semi-municipal authority constituted for small towns and exists in several states of which Uttar Pradesh has the highest number. The members may be partly elected and partly nominated by the state government or wholly nominated or wholly elected. It is assigned a number of functions such as street lighting, drainage, roads, conservancy, etc. The district collectors in some states have been given powers of surveillance and control over the TAC.

Following the recommendations of the Rural Urban Relationship Committee, 1966, that smaller TACs be merged with Panchayati Raj bodies; Madhya Pradesh and Haryana have done so accordingly.

Thus, the municipal corporations and municipalities are fully representative bodies, while the NACs and TAC's are either fully or partially nominated bodies.

As per the 74th Amendment Act of 1992, the latter two categories of towns (NAC and TAC) are to be designated as municipalities or NPs with elected bodies. Until the amendments in state municipal legislations, mostly made in 1994, municipal authorities were organised on an *ultra vires* (beyond the authority) basis and the state governments were free to extend or control the functional sphere through executive decisions without an amendment to the legislative provisions. After the 74th Amendment was enacted, there have been only three categories of urban local bodies:

- Mahanagar nigam (municipal corporation)
- Nagar palika (municipality)
- Nagar panchayat (notified area council, city council)

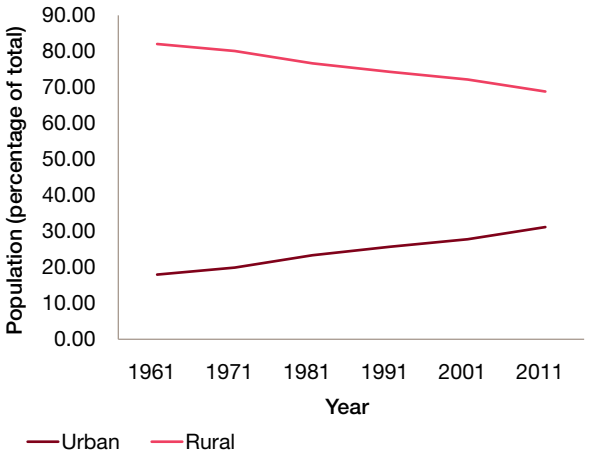
This Act designates a NP for transitional areas, i.e. an area in transition from rural to urban, a municipality for a smaller urban area and a municipal corporation for a larger urban area. Article 243Q of the 74th Amendment requires that municipal areas shall be declared on the basis of the population of the area; the density of population therein; the revenue generated for local administration; the percentage of employment in non-agricultural activities and the economic importance or other factors specified by the state government by public notification for this purpose.

Urbanisation trends in India: An analysis

Urban growth versus rural growth: A comparison

According to the 2011 Census, the total urban population stands at 377 million, which is way beyond what the various projections based on Census 2001 had said (viz. 357.9 to 362.3 million). The urban population reached the present level from 79 million in 1961. Though in absolute terms, this appears to be a huge increase, it must be noted that the proportion of India's urban population increased by a mere 14 percentage points from 17% of the total population in 1950 to 31% in 2011. For this reason, India has been labelled a 'reluctant urbaniser'.[56] However, at the same time, it must be noted that India has one of the strictest definitions of 'urban'.

Population in rural and urban India (percentage of total)



While the urban population growth rate has exceeded the rate of growth in rural areas in the past few decades, in absolute terms, it was for the first time in 2011 that the urban population grew more than the rural population.

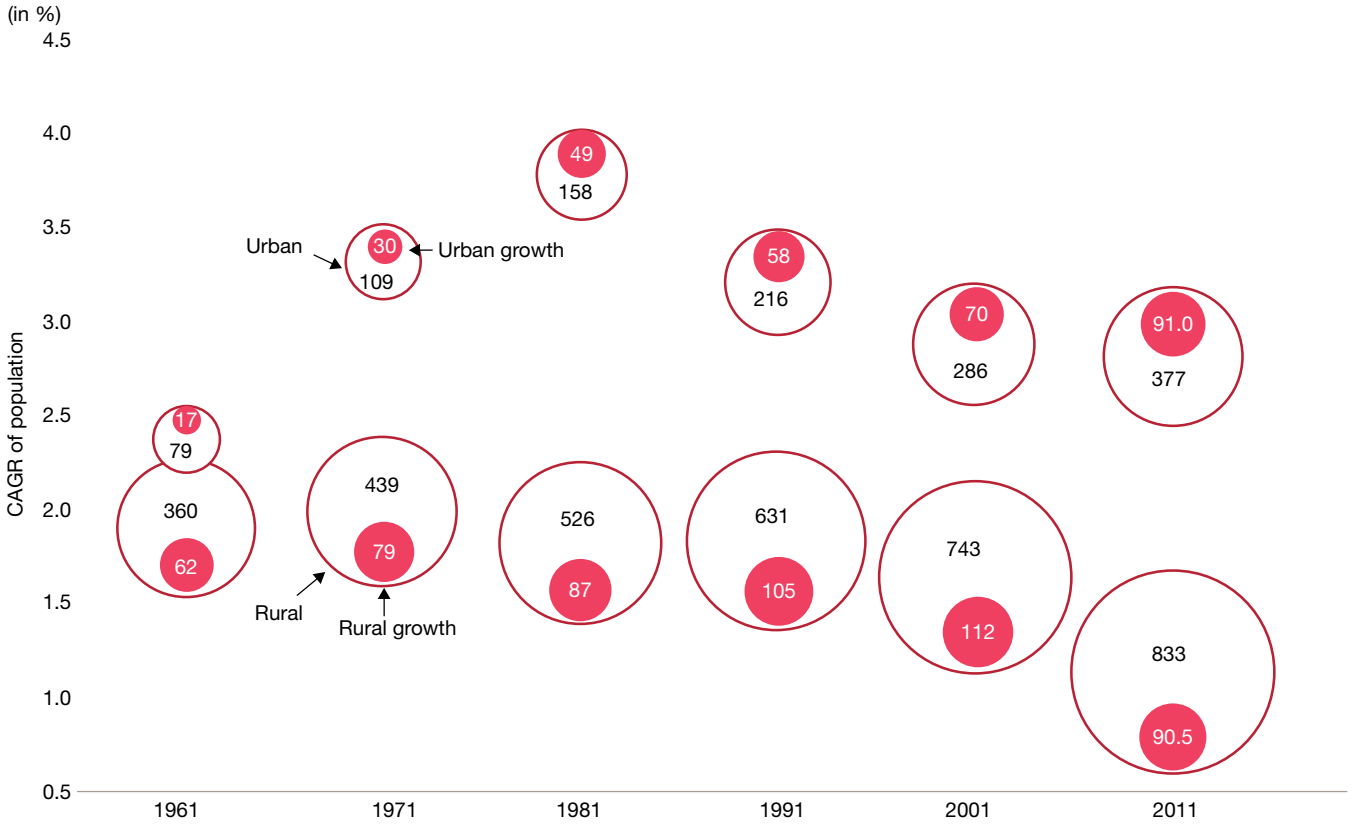

Photo credit: Prasanth Vishwanathan/Save the Children

Trends in urbanisation[57]

	Total population (in million)			% of urban population	Net population increase (in million)		% growth of population	
Period	Total	Rural	Urban		Rural	Urban	Rural	Urban
1961	439.2	360.3	78.9	17.96				
1971	548.2	439.1	109.1	19.90	78.8	30.2	21.87	38.28
1981	683.3	523.8	159.5	23.34	84.7	50.4	19.29	46.20
1991	846.3	628.7	217.6	25.71	104.9	58.1	20.03	36.43
2001	1028.6	742.5	286.1	27.81	113.8	68.5	18.10	31.48
2011	1210.2	833.1	377.1	31.16	90.6	91	12.20	31.81

The graph below presents the relative change in rural and urban populations of India along the timeline of 1961-2011. As the graph shows, the CAGR of urban population has been constantly higher than that of the rural population in every decade.

Rural and urban population growth (1961-2011) [58]

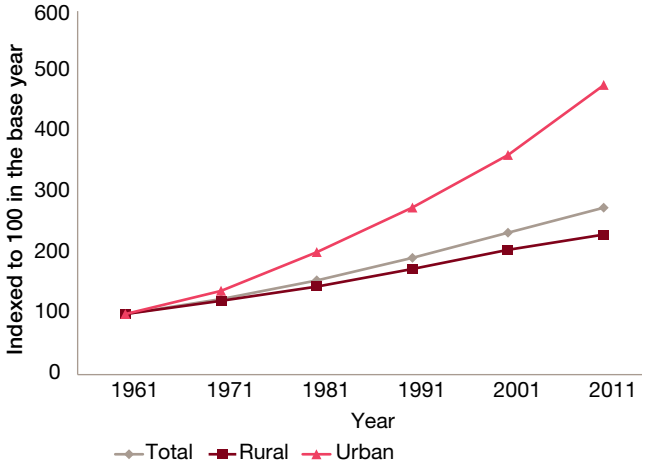


The outer bubble shows the total population (in million) and the inner bubble shows the increase in population (in million) with respect to the previous census . CAGR is the compound annual growth rate.

Source: Census 2011

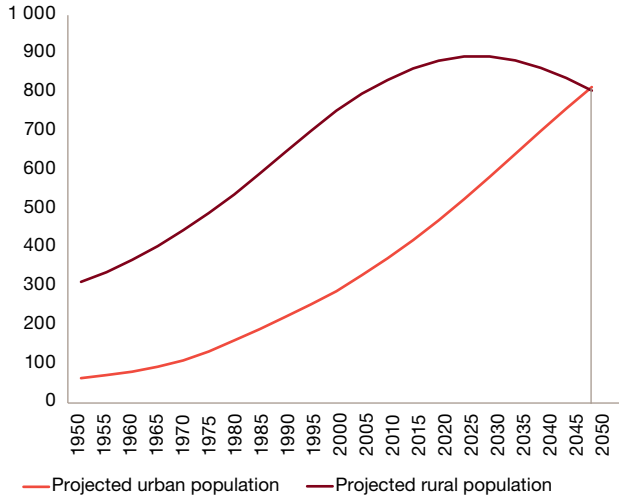
The constantly higher CAGR of the urban population vis-à-vis the rural population can be understood even more clearly with the help of indexation. The following graph shows that if we take the 1961 population level as equivalent to an index value of 100, in every decade, the urban index has risen more steeply than the rural index, though both have been on the rise. As a result, the rural index has barely crossed 200, whereas the urban index is close to the figure of 500.

Rural and urban population growth: indexed to 1961 values



If the urban growth continues at the current rate, it is predicted that by 2040-50, half of the country's population will live in urban areas.[59] At the global level, this has already taken place in 2008[60], which means that so far, India has been one of the slowest growing regions in terms of urbanisation.

Equalisation point of rural-urban population in India



Contribution of cities to the Indian economy

With the process of economic liberalisation unleashed in the early 1990s, the urban areas increasingly became important centres of growth. This is seen in the growing contribution of urban areas to India's GDP. While the share of urban population has been consistently growing over the past few decades, the contribution of urban areas to the GDP has grown much more dramatically. It grew from 29% (1950-51) to 37.7% (1970-71), 47% (1980-81) and 52% (1999-2000) before reaching the present level of 62 to 63% of India's GDP (according to the Mid-Term Appraisal Document of the 11th FYP) and has been its key growth engine in the past decade. The same document further projects that this share would rise to 75% by 2030.[61] With only 31% of India's population being urban, the process of urbanisation has the scope to significantly accelerate.

In urban areas, slum dwellers contribute significantly to the economy, as it is a major source of affordable labour supply for production in both the formal and informal sectors of the economy. Ironically, while the country as a whole welcomes the growth of the economy, it is, to a considerable extent due to the cheap labour supplied by children and young workers even in hazardous conditions.

Population in the cities has a different occupational profile than that in rural areas. Simultaneous to the growth in the urban sector, the share of agriculture and its allied services in the national economy has been consistently declining. In 1961-62, the share of agriculture and its allied services to the total GDP at constant (2004-05) prices was 46.25% which fell to 14.37% in 2011-12.[62] This indicates a shift towards urban occupations, in part caused by the non-remunerative nature of agriculture, uncertainty of monsoons (which continue to be the deciding factor for agricultural output even today), lack of public investment in agriculture and the emergence of lucrative options available to farmers living on the periphery of growing cities (subsequent to the real estate boom) to sell their lands to private developers in exchange of compensation.

Declining contribution of agriculture and allied services (at constant (2004-05) prices)

Period	Share of agriculture and its allied services to total GDP	Year	% of urban population to total population
1961-62	46.25	1961	18
1971-72	40.47	1971	20
1981-82	35.35	1981	23
1991-92	28.54	1991	26
2001-02	22.39	2001	28
2011-12	14.37	2011	31

Characteristics of urbanisation in India

The proportion of urban population in a state or area is an indicator of the nature of its economy and confirms the presence of factors that encourage urbanisation. In India, the percentage of population residing in urban areas varies significantly across different states. On the one hand, the coastal state of Goa—also an international tourist destination—has 62% of its population living in urban areas, the hilly state of Himachal Pradesh has 10% of its population in urban areas. Of the major states, Tamil Nadu, Kerala and Maharashtra are the three most urbanised states (45 to 48%), while Bihar, Assam and Odisha are the three least urbanised states (11 to 16%).

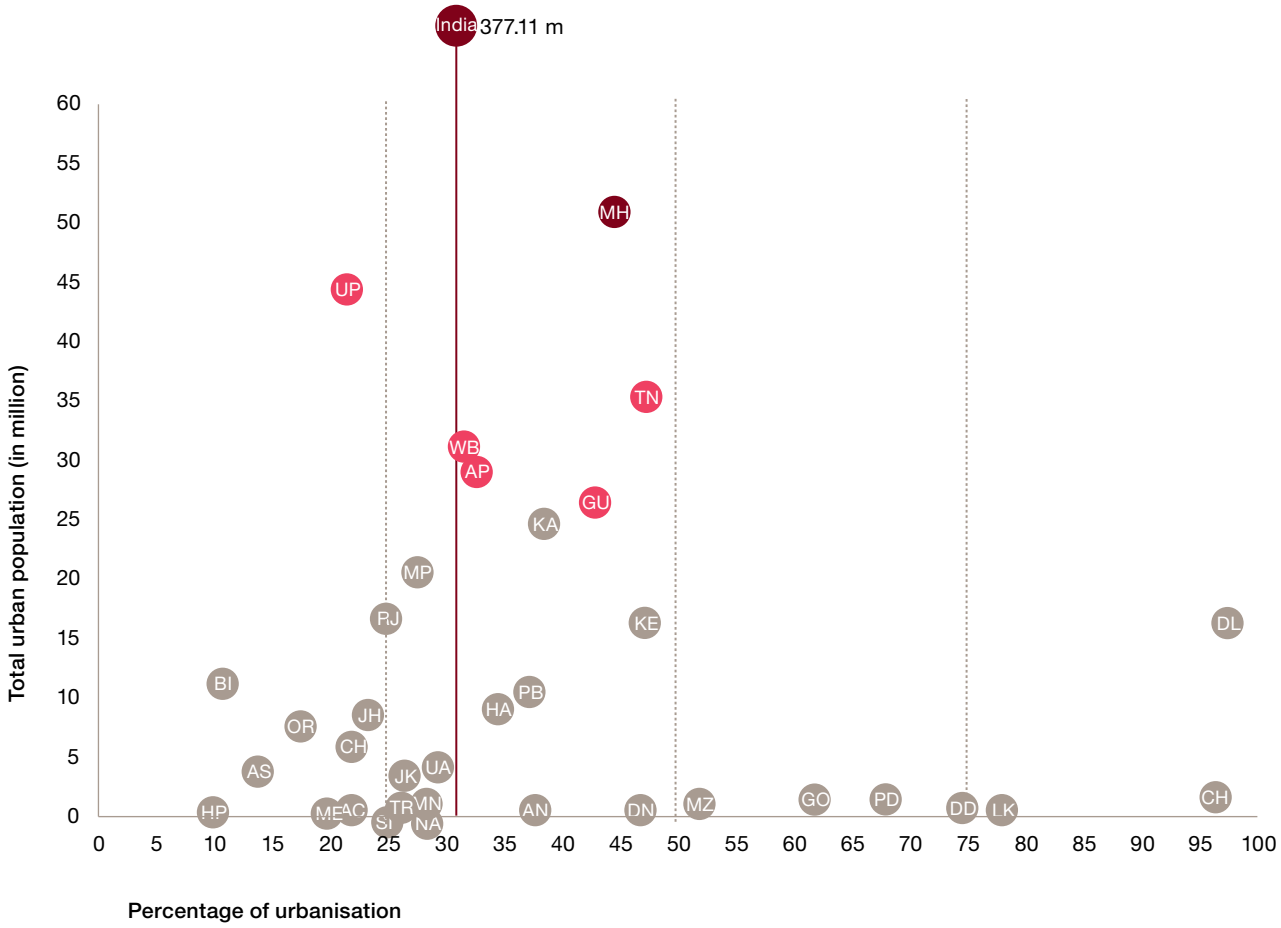
Between these two extremes, urbanisation rates are irregularly distributed. In terms of absolute numbers, Maharashtra, Uttar Pradesh, Tamil Nadu, West Bengal and Andhra Pradesh account for around 50% of the urban population. Uttar Pradesh has only 22% of its population living in urban areas, but being the most populous state in the country, it accounts for 12% of the total urban population of India.

On looking at cities instead of states, we find that the top 10 cities account for one-fourth of the total urban population (93 million out of 377 million). Eight states are still below the level of urbanisation attained by India in 1981. Thus, urbanisation in India is a highly concentrated phenomenon that has left large swathes of the country mostly untouched.

In India, Class I UAs and towns (population of more than 100,000 persons) grew from 394 in 2001 to 468 in 2011. Importantly, the total number of UAs and cities with a population of more than one million (million+ cities) is 53, which means an increase of 18 since 2001. With this increase, Kerala leads the pack; six out of the 18 new metros are located in Kerala. Overall, there are eight cities with a population of over five million each.

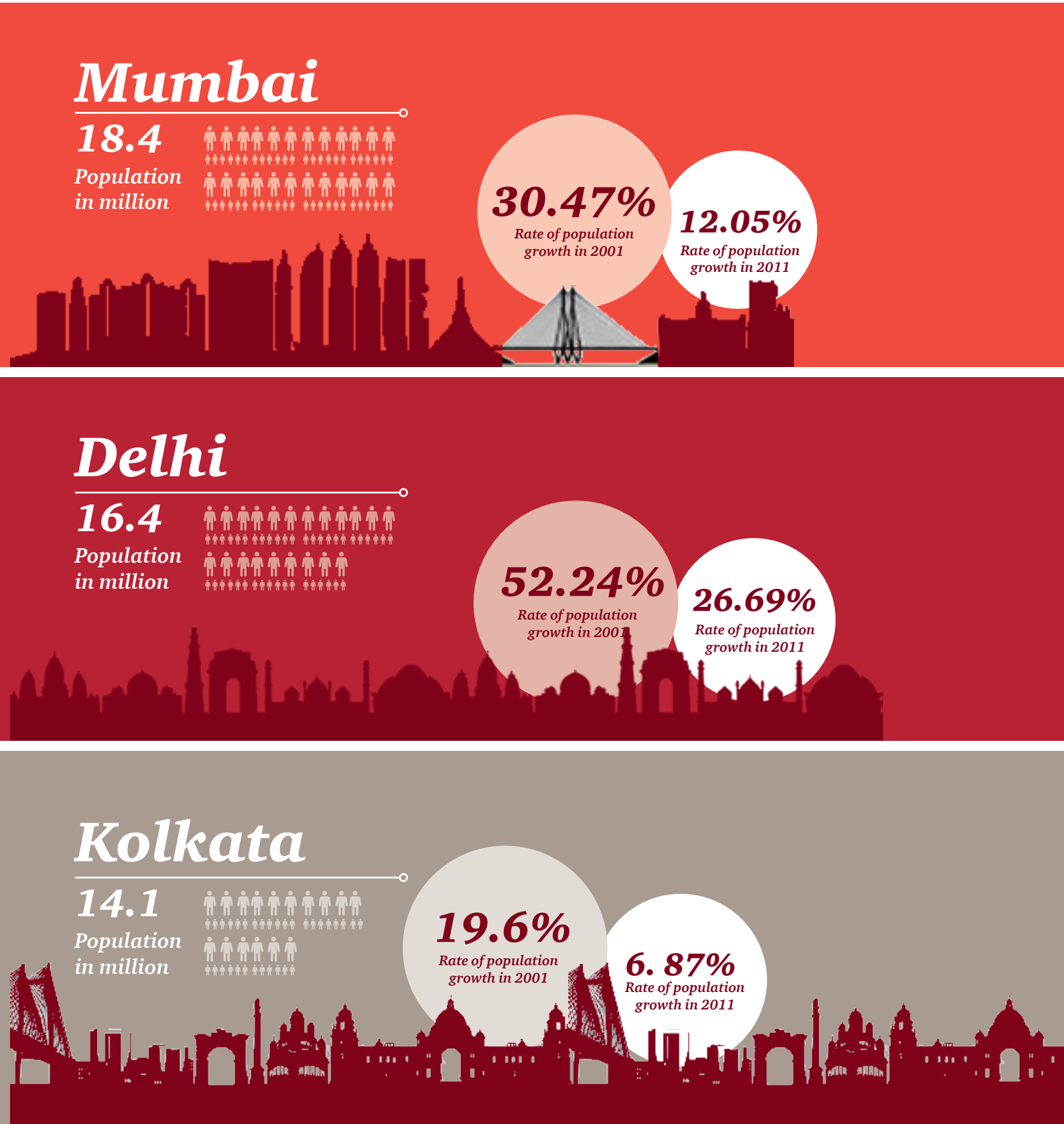
The million+ cities represent an interesting development in the story of India's urbanisation. More than 160 million people (or 42.6% of the urban population) live in these 53 million+ UAs and cities.[63] Twenty-two of the 53 million+ cities are located in the top five states which account for nearly one fourth of the urban population. These cities are important from the point of view of child population too as more than 27.3% of children in the 0-6 years age group in the million+ cities lived in slums (Census 2001).

Percentage of urbanisation and total urban population (Census 2011)



Distribution of the million+ UAs and cities is such that Uttar Pradesh and Kerala account for seven cities each. Maharashtra has six, Madhya Pradesh, Gujarat and Tamil Nadu have four each; Rajasthan, Jharkhand and Andhra Pradesh[64] have three each, Punjab, West Bengal and Chhattisgarh have two each and Jammu and Kashmir, Bihar, Haryana and Karnataka have only one city each. This clearly shows that except for the populous states such as Uttar Pradesh, the states that have either been major centres of in-migration (e.g. Maharashtra) or have been relatively more developed due to proximity to ports and commercial hubs (e.g. Gujarat, Maharashtra, Tamil Nadu and Andhra Pradesh), have more million+ cities whereas states with a more or less stagnant industrial development or unstable political climate such as West Bengal, Jammu and Kashmir and Bihar have not seen strong urban growth.

Significantly, while the million+ cities have grown in number, the pace of growth in the three mega cities—Delhi, Mumbai and Kolkata (UAs with more than 10 million people)—has actually fallen considerably during the last decade.



Mumbai

29,650

Population density (persons per sq km)

1

Global rank

Kolkata

23,900

Population density (persons per sq km)

2

Global rank

Chennai

14,350

Population density (persons per sq km)

8

Global rank

Delhi

11,050

Population density (persons per sq km)

13

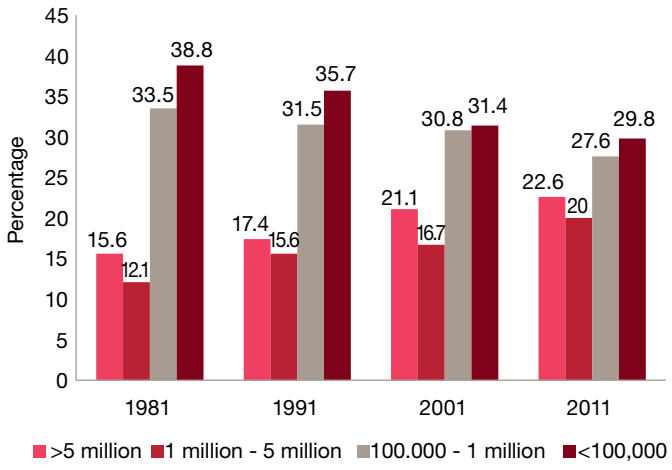
Global rank

Greater Mumbai UA, which had witnessed 30.47% growth in population during 1991-2001, recorded a 12.05% rise during 2001-2011. Similarly, Delhi UA (from 52.24 to 26.69%) and Kolkata UA (from 19.60 to 6.87%) have also slowed down considerably.

This sluggishness in the growth of mega cities is reflected in the share of the largest cities (population of more than 5 million) in India's total urban population. The graph alongside shows that while the share of the largest cities only grew from 21.1 to 22.6% during 2001-11, the share of the mid-sized cities (population of 1 million to 5 million) jumped from 16.7 to 20% during the same period.

> *"There are no open spaces in the neighbourhood and we play in the narrow gullies between our houses. The place stinks as the area is surrounded by the dumping ground and I don't feel like going out to play. To add to it, the older boys harass us. The houses facing the dumping ground have waste reaching up to their doorstep."*
>
> - A 12-year-old boy from Govandi in Mumbai

Share of various city classes in India's urban population: Change in the last four decades



As the share of the million+ cities as well as the large metros (5 million+ cities) in the urban population is increasing—the latter although at a slower pace than the former—it means the large urban areas in India are getting further crowded, leading to a high population density. *"According to Census of India 2011, as well as calculations by the IIHS geospatial lab, the top 10 cities of India account for almost 8% of India's population and produce 15% of the total economic output, but occupy only 0.1% of the total land area. Similarly, our 53 million+ cities are estimated to account for 13% of the population, produce a third of the economic output and occupy 0.2% of the land.*

The top 100 cities are estimated to account for 16% of the population, produce 43% of India's total output and occupy 0.26% of the land.[32]" From this, we see that our urban centres are home to a large chunk of the population living on a disproportionately small landmass. In fact, we see that four

of our mega cities figure in the list of cities with the highest densities of population globally, despite a decelerating pace of population growth.[66]

This increasing density of population and lack of planned response towards it has led to the mushrooming of slums and squatter colonies. The migrants, often from lower economic sections of society, initially build temporary shelters for themselves and later many use the vacant public space to build shanties and eventually settle down there. The civic authorities ignore them, usually at the behest of local politicians, and later there is no stopping the growth of other slum related problems in the cities such as crime, environmental degradation and excessive pressure on civic amenities.[67]

If this continues, the future will have to face further crowding of these spaces, as the urban population is all set to increase. Overcrowding leads to numerous problems ranging from unplanned growth of dwellings to pressure on basic services such as healthcare, educational facilities, etc.[68]

Overcrowding of cities and towns tends to push the slums into peripheral city areas, further limiting their access to basic facilities and adding to their numerous woes. Bengaluru is a prime example of this. Most of the slums in Bengaluru city are located on the fringe areas. Out of 585 slums, 579 slums fall in this category. Only six slums are located in the core city of which five are situated along a drain or *nullah*.[69]

Factors behind the increase in urban population

Contrary to the commonly held assumption that urban population increase is due to migration into urban areas, the key contributor to the growth in the urban areas of India is natural growth. According to an IIHS report, "For the last 30 years, migration has contributed about a fifth of population increase; natural population growth has contributed about 60% and the rest is evenly split between the formation of new towns due to reclassification and urban boundary expansion or sprawl.[70]" With regard to the third factor (classification of population as urban), Professor Amitabh Kundu[71] has argued that it is proactively induced by policymakers, who have identified 2,744 new towns since the last census by issuing notifications.[72]

Growth of urban population: Contributing factors

Time period	Population increase due to migration	Population increase due to natural increase	Population reclassified as urban
1991-2001	21%	59%	20%
2001-2011*	24%	44%	32%

As the table shows, in the last decade, 24% of the population growth has been due to migration, against the 44% caused by natural increase and 32% caused by reclassification of areas. In absolute terms, however, the population increase due to migration is a substantial 21.8 million.

Therefore, even though migration is a relatively less important contributor to urban population than natural growth and notification of new towns, it is important to understand the dynamics of migration since it has vital implications for children.

A comparison of data over a period of time (1999-00 to 2007-08) highlights the following facts.[73]

- Migration directed at urban areas increased in the last decade. Rural to urban migration increased from 18.8% of total migrants to 19.5% during this period. In the same cycle, urban to urban migration rose from 12.9 to 13.1%. At the same time, urban to rural migration saw a decline.
- Nearly half of the urban migrants fall in the bottom six consumption deciles (i.e. they are among the poorest) and work mainly as casual wage earners or are self-employed in the informal sector. These migrants have little access to housing and basic amenities, poorer entitlements, and suffer from poor working conditions and labour market discrimination. Poorer migrant workers who enter the urban job markets face large uncertainties in the potential job market. To begin with, they have very little knowledge about the markets and incur risks of high job-search costs, urging them to seek the help of middlemen. As the informal sector jobs lack financial security and regularity, the household remains financially vulnerable and often tries to mitigate the risks of job loss of the chief wage earner by employing children in petty jobs.
- Even though migration to urban areas has increased and migrants are mainly from the poorest backgrounds, the poor are finding it even more difficult to get a toehold in urban areas, as the urban environment policies have raised the costs of urban migration.
- Long-distance (inter-state) migration increased in recent years. In both streams (rural to urban and urban to urban), there was an increase in inter-state migration.
- Among all migrants (male and female), marriage-related migration of women alone constitutes 68.5% of all migration and marriage predominates as the reason for both rural and urban migrants.
- For males, the most important reason for migration is economic prospects. In 2007–08, 55.7% of urban male migrants gave economic reasons for migration. In 2007-08, more than 14.3% of the urban population consisted of people migrating to and within urban areas for economic reasons and this proportion has been increasing since 1993. This confirms the position of urban centres as magnets for employment-seekers.
- In general, gross in-migration rates are higher in high-income states such as Haryana (10.24%), Punjab (7.79%), Maharashtra (5.97%), Gujarat (4.20%) and Karnataka (4.11%). The general trend is towards higher out-migration from low-income states and in-migration to developed states.

Impact of migration on children

In the process of migration, families, including children, are not only uprooted from their homes year after year, but also end up getting disenfranchised. Families lose the benefits of state welfare—they forgo the facilities of the public distribution system in the villages and cannot access the public health systems and immunisation drives for young children that take place during the migration season. A large proportion of migrant labourers do not have their entitlement papers like caste certificates, election cards, BPL cards, old age pension cards, etc. In this entire process, the lives of children are adversely affected. They are forced to drop out of school or never get to enroll in one. A child out of school is an important indicator of child labour in the country. Seasonal migrants migrate alone (male, female or child only) or often in family units (husband, wife, children). When migration takes place as a family unit, each part of the family unit (excluding infants), contributes to the family subsistence in one way or another–in work or as part of the household 'care' economy. For children, the work environment means hardship and deprivation.

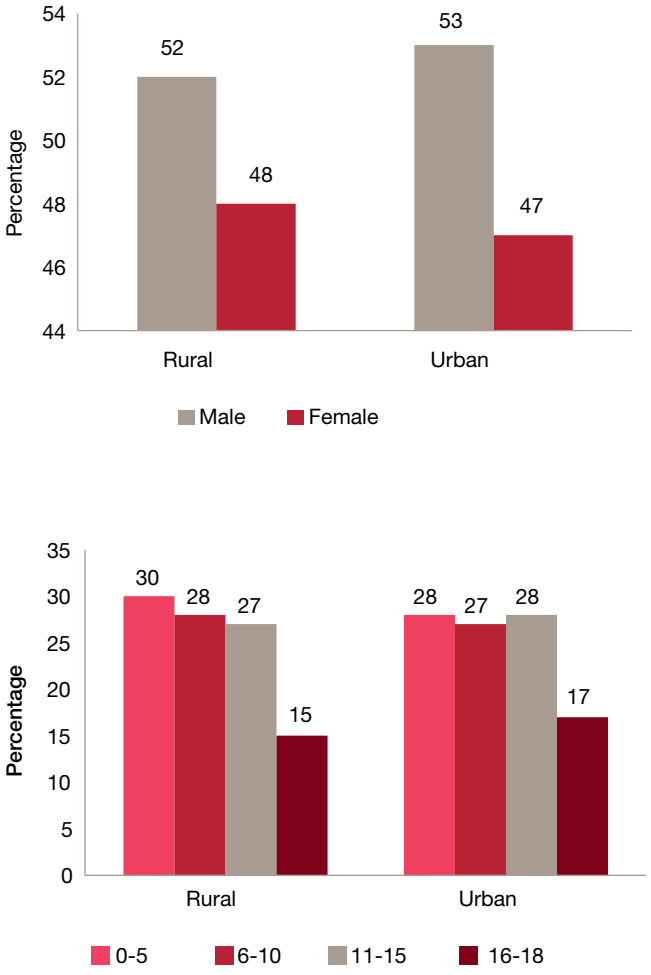
Studies show that seasonal migrants are in prime working age groups (15–45 years). Since these migrants come from the poorest and most economically vulnerable sections of the working population, their educational attainment is nil or negligible. A majority of them, who are married in this age group, have young children. Migration, of either one or both parents, has the potential of reducing the child's probability of being educated. Whenever both men and women migrate, more often than not, migration also takes place as a family unit involving children.

Child population in urban India

Statistics and emerging issues

From the data viewed early on, it is clear that there are more than 8 million children in the age group of 0-6 years living in India's slums and children who are on the threshold of entering the education system. At this time, they are at an important stage of physical and mental development where they need the best nutrition and care. Also, if the provisional totals are to be believed, more than two-thirds of the child population lives in the 53 million+ cities of India. These children face a peculiar set of challenges due to the fast growth of population in recent decades. Socio-economic or physical planning in these UAs continues to be rudimentary in nature. Efforts to undertake any kind of age-sensitive planning or analysis are few and far between, and there has been little effort to focus attention on children and adolescents in development planning. The neglect of age-specific needs results in the accumulation of underlying risks which reveal their presence during various cycles of stresses and shocks for poor families. In such cases, children emerge as the most vulnerable. As the graphs show,[74] the population of boys (52.7%) in urban areas is higher than that of girls (47.3%). This shows a slight skew against the girl child in urban areas vis-à-vis the rural areas. Over 55% of children in urban areas are not less than 10 years of age, highlighting the high vulnerability of these children.

Distribution of child population by sex and age



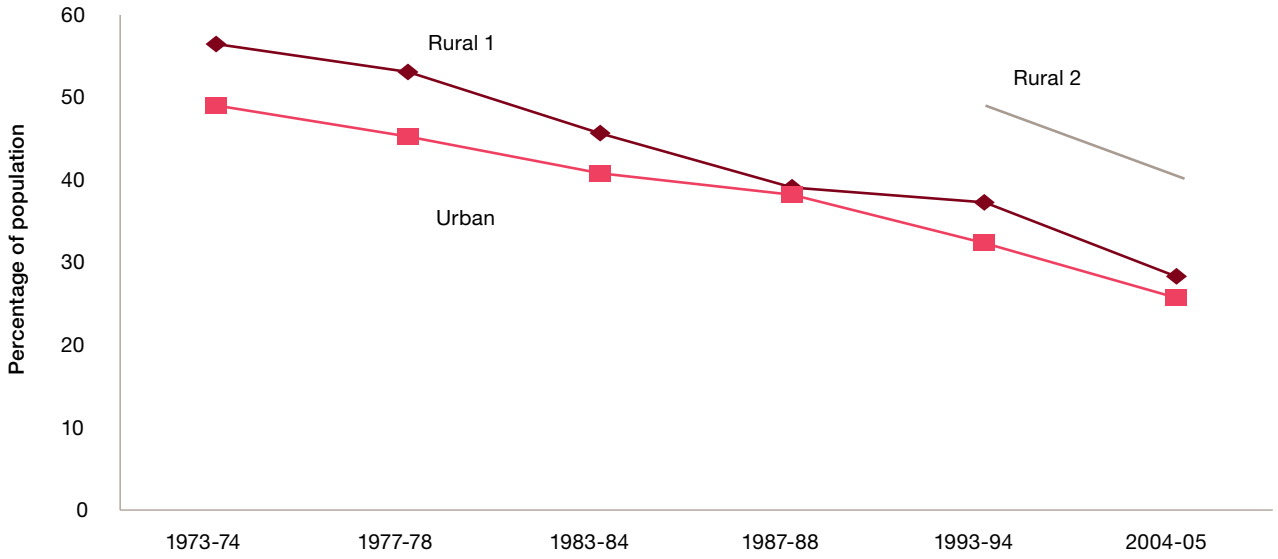
Urban poverty

Urban poverty: The numbers

Worldwide, poverty is growing faster in urban areas than in rural areas. One billion people now live in urban slums, which are typically overcrowded, polluted, dangerous, and lack basic services such as clean water and sanitation.[75]

For India, the HPEC estimates the levels of urban poverty on the basis of the Tendulkar Committee Report and data from the Planning Commission. It observes, "The incidence of urban income poverty declined significantly from 49% in 1973-74 to 32.4% in 1993-94 and 25.7% in 2004-05."

Rural and urban population below poverty line (in percentage)



Note: Rural 1 and Rural 2 depict the Planning Commission poverty estimates and the Tendulkar Group Rural Poverty estimates respectively. The two urban estimates are very close and converge in the chart.

Source: Planning Commission Poverty Estimates and Report of the Expert Group to Review the Methodology for Estimation of Poverty (2009)

However, the number of urban poor during this period has, in fact, increased. The HPEC states that while the proportion of the poor reduced significantly, there were still 80.8 million people in urban India in 2004-05 (out of an urban population of 309.5 million) who were below the poverty line (MPCE of less than 538.6 INR) and hence, were 'officially poor'. During 1973-2004, the absolute number of urban poor rose by 34.4% and the share of urban poor in total increased from 18.7 to 26.8%. In comparison, the number of rural poor has declined by 15.5%.

Poverty makes surviving in the city an everyday challenge. Eighty per cent of the meagre earnings of the urban poor go towards food and energy, leaving very little to meet the cost of living in an increasingly monetised urban society[76]. Besides this, as the HPEC notes, since the delivery of urban basic services is extremely poor, the level of environmental deprivation and individual poverty is much starker in cities, making it much harder for individuals to overcome urban poverty.

The definition of poverty has been debated extensively in the past few years and the data presented is dated. Researchers assert that the standard data collection and analysis fail to capture the full extent of poverty in cities. Often, studies overlook residents of a city whose homes and work are unofficial or unregistered– precisely those most likely to be poor. Moreover, official definitions of poverty seldom take into sufficient account the cost of non-food needs. Consequently, poverty thresholds applied to urban populations make inadequate allowance for the cost of transport, rent, water, sanitation, schooling and health services[77].

In order to get a proper sense of urban poverty, a possible option is to examine the number of people living in slums and on the streets. According to the 2011 Census, 17.3% of the urban population lives in slums. Out of a total of 65 million people residing in slums, Maharashtra alone accounts for 11 million, followed by Andhra Pradesh (10 million) and West Bengal and Uttar Pradesh (6 million).

Slum: The concept

Urban poverty is not limited to just certain pockets in cities and nowhere is it seen in a more hard-hitting and stark fashion than in our slums.

A slum, for the purpose of census, has been defined as a residential area where dwellings are unfit for human habitation owing to dilapidation, overcrowding, faulty arrangements and design of such buildings, narrowness or faulty arrangement of streets, lack of ventilation, light or sanitation facilities or any combination of these factors detrimental to safety and health.

Due to the visibly poor quality of housing and living conditions they offer, slums have come to signify what has been called 'shelter poverty'. A 2011 HPEC report states, "There is no doubt that 'shelter poverty' is much larger than income poverty. To a large extent, shelter poverty is the result of the heavily distorted land markets; a highly inadequate regulatory regime of protecting property rights and an absence of a well-crafted strategy for the inclusion of economically and socially weaker sections in urban planning. Slums and pavement dwellers are the most visible manifestation of shelter poverty in urban India. As cities expand and new cities develop, special care will have to be taken to ensure that there is room for the economically weaker sections alongside the higher income groups in urban areas[78]."

Slums go through a graded process of identification, recognition and notification before they become eligible for regular provisions of civic services. To begin with, a compact area of at least 300 people or about 60 to 70 households living in poorly built congested tenements and an unhygienic environment with inadequate infrastructure and improper sanitary and drinking water facilities is identified as a slum. Many or all of these identified slums, in due course of time, get recognised as a 'slum' by the administration or local government or housing and slum boards, and are subsequently notified as slums under an act, including the Slum Act.[79] The fight to get recognition and a notified status often involves negotiations with the local political system, bureaucracy and various lobbies.

It should be noted that this three-way categorisation of slums—identified, recognised and notified—one by the Registrar General of India, is not the only one that exists in the country. The NSSO used three different definitions in its surveys in 1976-77, 1993 and 2002. UN-Habitat has its own definition of looking at slums and the state governments of Andhra Pradesh, Madhya Pradesh, Haryana, Maharashtra and Uttar Pradesh have defined slums in their own way.[80] In addition to this, the Draft National Slum Policy, 2001, prepared by the Ministry of Housing and Poverty Alleviation defines a slum or informal settlement as 'all under-serviced settlements, be they situated on illegally occupied land, congested inner-city built-up areas, fringe area unauthorised developments, villages within or peripheral to urban areas, irrespective of tenure or ownership or land use'. The United Nations Human Settlements Programme, 2003, defined a slum as a community characterised by insecure residential status, poor structural quality of housing, overcrowding, and poor access to safe water, sanitation, and other infrastructure.[81]

Slums: The global scenario

A part of the MDG 7 adopted in 2000 (goal to ensure environmental sustainability) was to bring in a significant improvement in the lives of at least 100 million slum dwellers by 2020.[82] Globally, this target was met well in advance of the 2020 deadline. More than 200 million people in this section gained access to improved water sources, sanitation facilities or durable or less crowded housing, thereby exceeding the MDG target. Over 863 million people are estimated to be living in slums in 2012 as compared to 650 million in 1990 and 760 million in 2000. However, in countries like India, not much has changed and slum dwellers continue to live in challenging circumstances.

"Most houses are made of tin sheets that get very hot in summer and leaky during the monsoon. The tin sheet houses are assembled in rows and have a common toilet (8-10 families share this) whose cleanliness is taken care of by the users. The rent ranges between 1, 000 INR for a tin sheet home to 2,000 INR for one room made with concrete.

- A 13-year-old boy from Bibvewadi area in Pune

Indian slums: The story in numbers

Slums are widespread in India. They are present in 63% of the statutory towns. The states with the maximum proportion of slum households are Andhra Pradesh, Chhattisgarh, Madhya Pradesh, Odisha and West Bengal. When it comes to cities, Greater Mumbai has the largest proportion of households living in slums (41.3%), followed by Kolkata, Chennai, Delhi and Bengaluru.

Ironically, in spite of the slums having such a strong visible presence around us, it was only in 2001 that the Registrar General of India took up the enumeration of the slum population for the first time. But this was not completed exhaustively. The census left out the smaller states such as Himachal Pradesh and several north-eastern ones. In some states, the authorities did not report all the towns or enumeration blocks and in some places, the non-notified and non-recognised slums involved in land disputes were not considered.[83]

This makes the 2011 Census the first complete and systematic count of slum population in India. According to Census 2011, more than 17% of total households in urban areas lived in slums, with just 46 million+ cities accounting for 38% of total slum households.

Slums in India

Households	Number (in lakhs)	%	Million+ cities	%	Other cities	%
Slum	137	17.4	52	38.1	85	61.9
Non-slum	652	82.6				
Total (urban)	789	100				

A report by the Ministry of Housing and Urban Poverty Alleviation[84] presented the following findings:

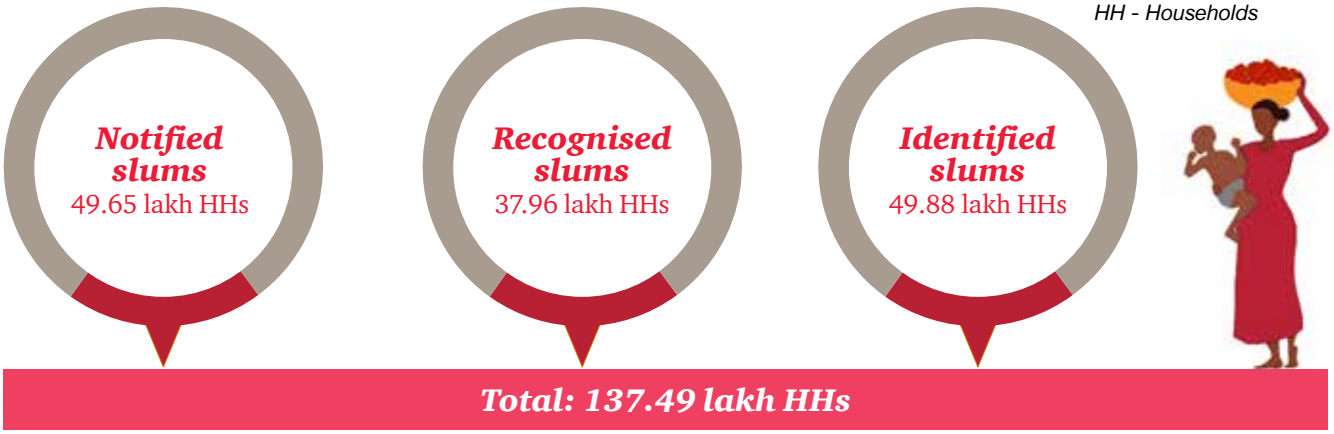
- Around 7.6 million children in the age group of 0 to 6 years live in the slums of India[85] and constitute 13.1% of the total child population of the urban areas.
- Maharashtra, which has the largest number of slum enumeration blocks (21,359)[86], also has the highest slum child population with around 1.7 million children (between 0 to 6 years) staying in slums.
  - Around 2.5 million children in the age group of 0 to 6 years lived in the slums of million+ cities in 2001, which constitutes 27.3% of the total child population of these cities. Half of these 2.5 million children lived in the three major metros—Mumbai, Delhi and Kolkata. While Mumbai had 0.86 million children, Delhi and Kolkata accounted for 0.3 million and 0.15 million children respectively.[87]

The Census 2011 categorised the households by type of slums. Only 34.3% of the slums enjoy the notified status and are home to just 36% households, implying that a vast majority is still waiting to live in notified settlements.[88]

Categorisation of slums in India

Note: 10 lakh=1 million

HH - Households



Life in Indian slums

Slum dwellers are increasingly grappling with the challenges arising from the polarisation of population in large cities, high-density slums and squatter settlements, acute shortage of housing and basic civic amenities, degradation of environment, traffic congestion, pollution, poverty, unemployment, crime and social unrest.

The quality of life in Indian slums is summed up by the following figures:

- Compared to urban areas, slums have fewer permanent shelters (77.7% against 84.3%).
- More households in slums live in single-room shelters (44.8% against 32.1%) and the household size is comparatively larger (46.8% households have five or more members as against the 44.5% in urban areas in general).
- Fewer households have access to a drinking water source within the premises (56.7% against 71.2%) a bathroom (66.6% as against 77.5%), closed drainage (36.9% against 44.5%), clean cooking fuel such as LPG (51.3% against 65%) or a latrine (66% as against 81.4%).

This means that the children living in slums experience poor sanitary conditions, live in congested spaces with adults, get unsafe water to drink, eat in smoky kitchens and lack privacy on a daily basis.

Population density in slums and squatter settlements ranges from 700 to 4,210 per acre, which creates a highly congested environment. **This poor housing and lifestyle causes a number of problems:**

- Indoor pollution
- Degradation of air quality with frequent slum fires
- Increase incidence of communicable diseases that may spread to city dwellers from the workplace
- Lack of water supply and sanitation facilities. As a result, both household waste and human generated waste go directly or indirectly into the low-lying lands, open spaces or water bodies of the city and cause a number of problems.
- Illiteracy and unemployment
- Slums as 'breeding grounds' for social problems such as drug abuse, alcoholism and high crime rate

Urban exclusion

Apart from poverty, an important aspect of urban life in India is exclusion. Exclusion is often reinforced by discrimination on the grounds of gender, ethnicity, race or disability. There is a high degree of exclusion in cities. Slum dwellers are excluded from many of the attributes of urban life critical to full citizenship that remain a monopoly of a privileged minority. They include having a political voice and participation in decision-making, secure and good quality housing, safety and the rule of law, good education, affordable health services, decent transport, adequate incomes, and access to economic activity and credit. Difficult urban living conditions reflect this and are exacerbated by such exclusion.

Urban homelessness

Homelessness is a result of an exclusionary environment. Exclusion from the government's housing schemes compels poor communities to illegally occupy available lands in and around cities. They live under constant threat of eviction as they cannot afford to rent or invest in the housing projects of private developers due to high prices and lack of credit. A status update[89] on the situation of the homeless and the shortage of housing in India shows that the number of homeless in urban areas has surpassed the number in villages.

"We live in makeshift houses often built on a platform with accumulated plastic material. During the monsoon, it gets pretty bad and we are forced to live in these poor conditions as we do not have pucca houses to go to."

- A 17-year-old street child from Mumbai

According to the 2011 Census, urban India now has 9.42 lakh homeless people—an increase of 1.64 lakh since 2001 and higher than the number of the rural homeless (8.35 lakh). As per the Census of 2001, the urban homeless population was 7.78 lakh as compared to the rural homeless population of 11.65 lakh. In spite of the increase, this figure is seen by organisations working with the homeless as a gross underestimation of the real extent of homelessness in India.[90] For children, homelessness in a city simply means more exposure to extremities of weather, health risks and lack of safety.

Unfortunately, the issues of the urban homeless have not been effectively addressed by the flagship schemes of the central government. The status report points out, "The current process of urbanisation being promoted by the government, including schemes such as the JNNURM[91], has extremely limited space and resources for the poor as it continues with a focus on large-scale infrastructure development." A recent CAG report[92] also highlights serious issues of diversion of JNNURM funds, incompletion of projects, and the risk of ineligible beneficiaries deriving benefits intended for the urban poor.

Forced eviction, unaccompanied by any offer of resettlement, is a major cause of urban homelessness. The snapshot of evictions in urban areas in 2013 are only some of the major incidents reported in the press and should not be seen as a representation of the problems of homelessness. But together, these do tell a story. A number of evictions have taken place to facilitate the building of private malls, apartments and star hotels in major cities.

Unsafe housing

In urban India, it is not just the lack of housing for the homeless which is a problem. Even those living in houses face the problem of poor quality of housing. The number of dilapidated houses in urban India is more than 2.27 million (2.9% of total occupied houses).[93] Such houses are unsafe, particularly for children, who cannot look after themselves. The collapse of dilapidated houses is a common occurrence in India, as is the collapse of buildings constructed without regard to standard, safe construction practices. In Mumbra, a suburb of Thane, Maharashtra, an illegal building completed up to five floors collapsed in April 2013 killing 74 people including 18 children[94] bringing back into focus the corruption in the municipal administration, especially with regard to inspection of building safety, issue of building permissions and occupancy certificates, etc.

What then is the solution to problems such as urban homelessness and unsafe housing? It needs to be understood that slums act as a housing market for the people at the bottom of the pyramid. For every rural poor migrant coming to the city, the only affordable form of shelter is a slum shanty. The economic model on which our cities are based is characterised by the occupation of large land banks by private developers, the influx of educated urban earners constituting the middle and upper middle class into bigger cities which are emerging as centres of commerce and service industries, easy availability of credit to this class and the emergence of real estate as an attractive investment avenue for its members. Taken together, all this has made housing simply unaffordable for the poorer sections of the society. Slums are sustained by this current socio-economic model. If urbanisation trends and cities are to become socially inclusive and sustainable, the economic model that sustains the cities must be wholly redefined.

Incidences of forced evictions in 2013

Sr no	Area and city	Month of eviction	Reason for eviction	Number of families evicted
1	Ejipura/Koramangala, Bengaluru	January	Construction of a mall and EWS apartments by private builders	1,200
2	Satellite, Ahmedabad	January	Site clearing	55
3	Sankalitnagar, Juhapura, Ahmedabad	January	Clearing of roadside	45
4	Gulby, Navrangpura, Ahmedabad	January, July and October	Road widening	187
5	Sonia Gandhi Camp, RK Puram, New Delhi	March-April	Road extension	50
6	Golibar, Mumbai	April	Construction of apartments by a private contractor	43
7	Gopi Talao, Surat	April	Lake development and bus rapid transit system corridor	1,412 (and 104 shops)
8	Ali Talao, Mumbai	May	Clearing of land for other projects	300
9	Kabo Leikai, Imphal	May	Construction of a five-star hotel	32
10	Gayakwad Nagar, Faridabad	June	Reclaiming of land by the Indian railways	1, 000
11	Ganpati Nagar and Adarsh Nagar, Mumbai	June	Extension of a sewage line	550

Crimes in cities

The million+ cities are major contributors to the incidence of urban crimes in India. In 2011, the million+ cities accounted for 41.9% of the total cases of auto thefts, 28.6% of cases of cheating, and 27.8% of counterfeiting cases. The NCRB observes, "Delhi, Mumbai, Bengaluru and Kolkata have accounted for more than 28% of the total crimes reported from 53 million+ cities. Coimbatore (Tamil Nadu) has reported a significant increase of 157% of IPC crimes during the year 2012 as compared to 2011 while in 21 cities, decline under IPC crimes has been observed.[95]" It further states, 'The average rate of crime (IPC crimes) in UAs at 294.7 was much higher than the national crime rate of 196.7**.** Kochi reported the highest crime rate[96] of 817.9 among the million+ cities followed by Indore (762.6), Gwalior (686.1) and Bhopal (623.0).' A higher-than-average crime rate clearly means that children in the cities are not only particularly vulnerable to crimes and violence but can also become part of organised crime rackets, especially when faced with circumstances such as disruption in schooling, a dysfunctional family, lack of parental care and exposure to substance abuse.

The slums, many of which are under unauthorised occupation, have difficult approach roads and narrow by-lanes and are mainly populated by people who lack regular, formal sector employment. They thus provide just the right setting for petty crimes to thrive.

Conclusion

We see that urban poor children are growing in an unstable and difficult environment which cities currently offer. They face difficulties of living in slums or on the streets where the crime rate is on the rise. Even if they have a roof over their heads, their access to basic services such as water, electricity, etc is poor. This situation will need urgent attention as the urban population, and the child population as its subset, is set to increase manifold in the years to come.

Rights...

[Supporting the rights of children and children is as easy as 1-2-3-4]

1. Non-discrimination: Treat everyone fairly and with respect.
2. Right to life, survival and development: Children and youth have a right to the basic things to live, survive and develop.
3. Best interests of children and youth: Always ask yourself, "Is the decision I am making good for kids?"
4. Respect the views of children and youth: Children and youth need to participate and have their views considered when decisions are being made that affect them.

Urban governance

Prof. Chetan Vaidya

Introduction

India is witnessing a rising trend in urbanisation in two ways. Firstly, the share of urban population within the country has seen a sharp rise and secondly, a major share of the country's GDP now comes from its cities. Since urban areas are the new centres of economic development, there is a need to realise that for the urban economy to operate with higher productivity and employment opportunities, urban infrastructure and governance needs to improve to attain an accelerated and sustained economic development. The urban governance system has a crucial and facilitative role to play in the economic development in general and the development of cities in particular.

While India in the post-liberalisation period has registered a healthy economic growth rate,[97] which is critical if the country aims to become an economic superpower, it is even more important to now achieve equitable and inclusive development that benefits the marginalised section of the society. One of these marginalised sections consists of the urban-deprived children.

For a country that has 36.5 million children (within the 0 to 6 years age group) living in urban areas, and at least 8.1 million of these children live in slums[98], it is important that cities build a conducive environment for children, and the fruits of urban development filters down to these children. Some of the questions that arise at this point are: What does a child-friendly city look like? Does the urban governance system of the country, and in particular, the ULBs that are responsible for delivery of public services in cities, have the necessary ingredients to make child-friendly cities a reality?

Child-friendly cities

We begin by presenting a conceptual framework that captures the essentials of a child-friendly city.[99] In a child-friendly city, children will be able to enjoy the following benefits:

- Influence decisions about their city
- Freedom to express their opinion
- Participation in family, community and social life
- The right to basic services such as healthcare, education and shelter
- Access to safe water and proper sanitation facilities
- Protection from exploitation, violence and abuse
- Safely walking the streets on their own
- Meet friends and play
- Accommodation for green spaces for plants and animals
- Live in an unpolluted environment
- Participation in cultural and social events
- To be an equal citizen of their city with access to all services, regardless of ethnic origin, religion, income, gender or disability.

A 'child-friendly city' is a multi-dimensional and comprehensive concept. A tripartite bond can only help to create a child-friendly environment. In a child-friendly city, children are active agents and their opinion influences the decision-making process.[100]

It is evident that this framework combines children's needs and rights of various kinds: (a) right to participation (influencing civic decisions, expressing opinion on matters concerning them, participation in cultural activities and in community life); (b) right to access quality infrastructure and services (healthcare, education, shelter, safe drinking water and sanitation); (c) right to safe environment (green spaces, freedom from pollution, etc) and (d) right to normal life and protection (including protection against exploitation, violence and abuse and safety in public spaces).

Clearly, there are elements in the above framework that can only materialise if urban governance in the country is child-sensitive, well-equipped and capable. For example, only a municipal corporation that is resourceful can ensure the presence of a strong physical infrastructure for basic services. Similarly, a feeling of protection will come mainly from having a sensitive, helpful, adequate and well-trained police force and judicial system within the city.

The analysis of where we are in terms of child-friendly cities needs to begin with a closer look at the current urban governance system in place, its strengths and weaknesses.

Urban governance system in India: An overview

History of urban governance

Municipal institutions in India have a history of over 300 years. The first municipal corporation in the country was set up in Madras (currently known as Chennai) in 1687 followed by the Calcutta Municipal Corporation and the Bombay Municipal Corporation in 1726. In 1850, the Improvements in Towns Act established a system of councillors and gave them administrative authority over the cities. Subsequently, Lord Mayo's Resolution of 1870 instituted the system of city municipalities and called for the introduction of an elected president to lead these authorities. In 1882, Lord Ripon's resolution of local self-government created the structure of municipal governance in India introducing a two-tier system to increase governance efficiency through decentralisation of functions. Based on the 1918 Montague-Chelmsford Report, the Government of India Act 1919 introduced the system of 'dyarchy', where power-sharing arrangements between the state and the local bodies differed, but conformed to the same organisational pattern. The District Municipalities Act of 1920 transformed municipal councils into elected bodies and granted them powers to flesh out their own budgets. The Government of India Act 1935 brought the local government within the purview of the state government and granted them enhanced powers.[101]

However, for many years even after independence, the Constitution did not make urban local self-government a clear-cut constitutional obligation and did not recognise the urban local self-government as decentralised autonomous entities. Researchers have linked this lack of recognition of need for autonomous and strong city management to the alleged anti-urban bias of independent India's early policymakers, the idea that 'real India was to be found in the country's villages'.

Indian government allocates to its urban citizens only one-sixth of the per capita spending allocated for rural citizens. The ratio is even more disproportionate when we consider spending on the urban poor which is one-tenth of that on the rural poor. An overview of India's Five Year Plans reinforces the pervasiveness of this attitude which has also prevented the upgradation of urban infrastructure within cities. This rural bias underscores the failure to create a comprehensive urban policy which encompasses issues such as migration and an urban agglomeration's relationship with its rural heartland.[102]

In the absence of adequate constitutional provisions as well as policy directions, democracy within the structure of municipal governance was unstable. The most drastic mechanism of control was applied by an act of supersession without reconstituting the municipal council through a fresh election for years together. Due to this, a large number of municipal councils came under prolonged suspension and many ULBs became weak and were unable to perform effectively.

Photo credit: Suzanne Lee/Save the Children

Over time, urban planning has evolved through a number of phases. The 2nd FYP (1956-61) provided for the creation of town and country planning laws and initiated planning institutions, after which master plans for a number of cities were rolled out. The state capitals of Gandhinagar (Gujarat) and Bhubaneswar (Odisha) were developed in the 3rd Plan (1961-66) and industrial towns such as Durgapur (West Bengal) were built. In all cases, emphasis was on building the infrastructure for the public sector. The need to limit the population growth within larger cities was emphasised in the 4th Plan (1969-74) and the idea of promoting smaller towns was pursued in the 5th Plan (1974-79). The prevailing socialist ethos often affected urban policy preferences, as in the case of the Rent Control Act (for e.g., in Delhi in 1958) and the Urban Land (Ceiling and Regulation) Act, 1976 enacted to prevent concentration of land holdings in urban areas. These laws caused serious distortions in ownership rights and land redevelopment. The 6th Plan (1980-85) set up the IDSMT scheme for towns with a population of less than 100,000 inhabitants for developing roads, pavements, minor civic works, bus stands, markets, shopping complexes, etc. The 1980s and 90s did not see many new government initiatives on the urban front since the attention shifted to opening up of the overall Indian economy. New urban centres were the result of investments by private developers. While construction quality improved with individual developments, the overall urban infrastructure suffered severe strain due to lack of public investment. There was renewed interest in the development of cities with the launch of the JNNURM in 2005.

The Seventy-Fourth Constitutional Amendment Act (CAA)

The year 1992 is remembered as a watershed year in the history of public administration in India[103]. This was when it was realised that planning, plan implementation, development processes and authority needed to be decentralised to sub-national and local levels. The Statement of Objects and Reasons appended to the Constitution (73rd Amendment) Bill, 1991, summarises the pre-amendment situation and the need for reform.[104]

In the light of this, the Constitution was amended in 1992 through the enactment of the 74th CAA, which came into force in June, 1993. It gave constitutional recognition to ULBs and envisaged the ushering in of a regime of empowered and strengthened urban governance in the country. Through this amendment, the ULBs were guaranteed constitutional right to operate, conduct regular elections, make reservations for women and weaker sections, and constitute the SFCs every five years.

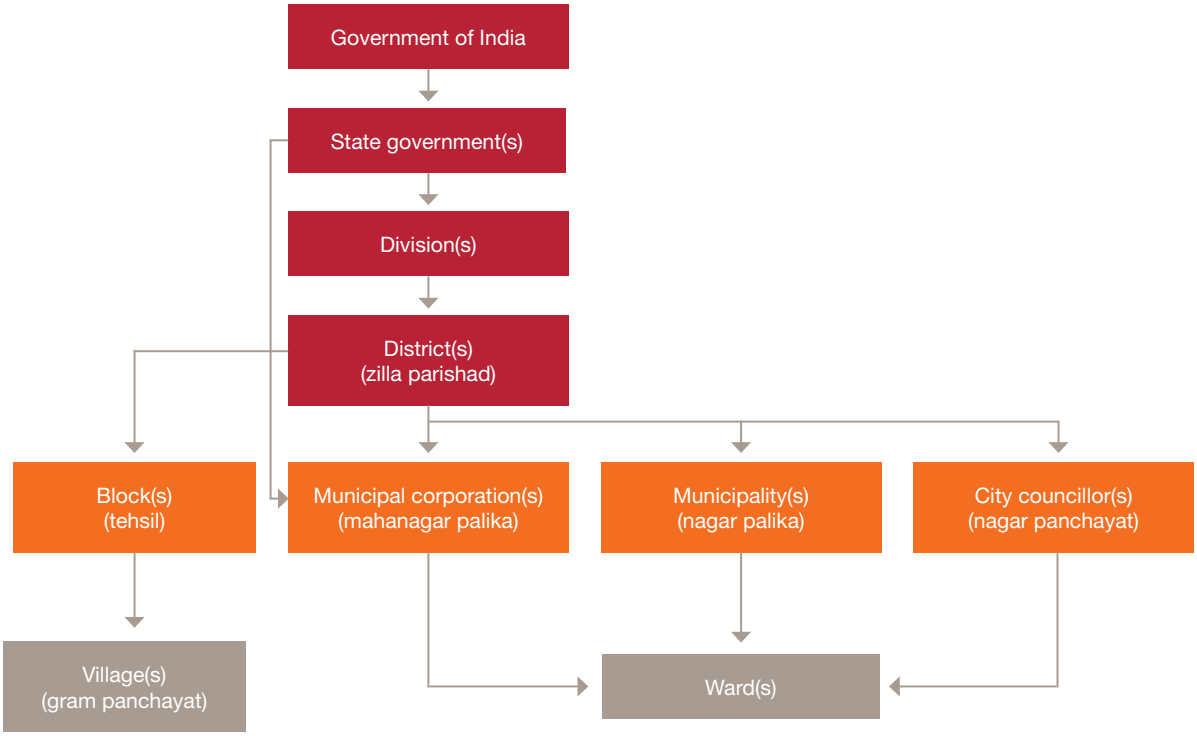
The main provisions include constitution of ward committees, reservation of seats, duration of municipalities, powers and functions, finances, constitution of a finance commission, elections, district and metropolitan planning committees, etc. The 74th CAA expects ULBs to assume responsibilities for urban planning, water supply, social and economic planning, slum upgradation, public health, etc.

The post-reform structure

India has a three-tier governance system: national, state and local governments. Local governments are further divided as urban and rural. In the post-reform local self-government system that exists today, there are three levels of municipal administration represented by the three ULBs—municipal corporation, municipality and nagar panchayat.

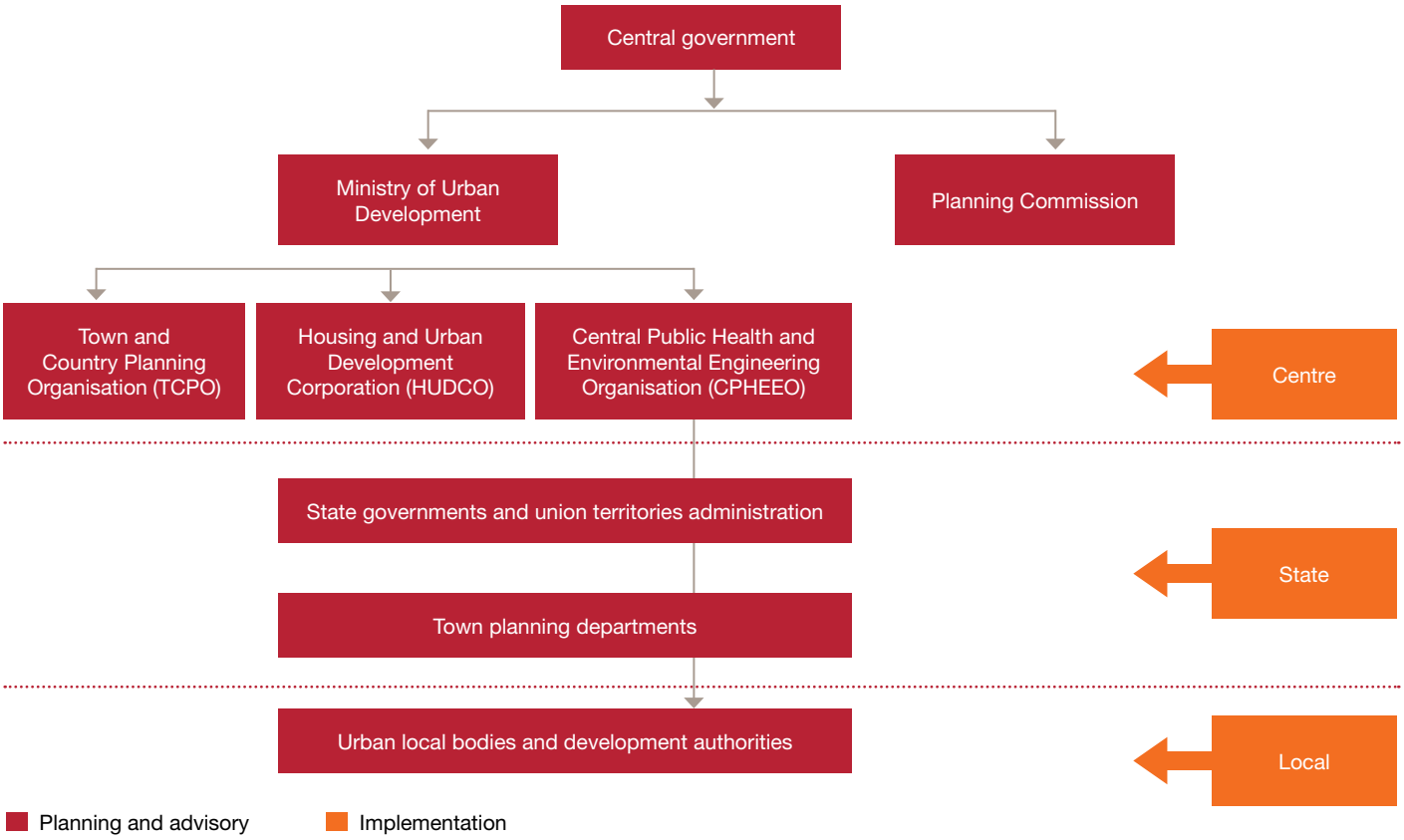
The rural local bodies are formed at the grassroots level (gram panchayat), the intermediate level (block panchayat) and at the district level (zilla parishad), whereas in the urban arm of local self-government, all the three bodies (corporations, municipalities and nagar panchayats) have wards as the basic unit. Though the municipal corporation is a body that operates at a sub-district level, this is not always the case, since some of the larger municipal corporations cater to the population of two or more districts and have a sizeable revenue base.

Administrative structure of India



Apart from the three levels of urban administration, it is also important to look at the other arm of governance—the urban planning system. The urban planning system in India is again a three-tier system which consists of the centre, state and local government. The central government only lays down policies and guidelines for urban planning and development. Urban planning is undertaken at all the three levels but is primarily a state subject. Constituent states and union territories enact their own urban and regional planning as well as development Acts. Within the framework of these Acts and the directives issued by the town planning department, these plans are implemented by the ULBs and development authorities.

Town planning system in India[105]



Other Factors

The institutional arrangement for urban governance and service delivery is not limited to the ULBs set up in the wake of the 74th CAA. This ecosystem also comprises of a large number of institutions at the state and city levels associated with governing cities and towns.

At the state level they include, departments of urban administration, housing, water supply, public health, environment, welfare, education, health, home, planning, etc. SFC and the State Election Commission are the other state-level institutions which have a role in the formation and financing of ULBs.

At the city level these institutions include ULBs, city police force, pollution control boards, fire stations, etc.

Parastatal agencies include institutions, such as *Jal Sansthans*, UDA, development authorities, housing boards, etc.[106] The parastatals are utility boards or development authorities set up by the state government. They are not under the purview of ULBs. These are statutory bodies set up in order to ensure the delivery of services and access to basic amenities and infrastructure within a city or state. For example, the Delhi Jal Board looks after the supply and treatment of water within the city of Delhi. In a typical case, the urban local body being the elected body has the greater onus and accountability to administer, plan and regulate the delivery of services and allocation of resources vis-à-vis a parastatal.

Legal environment

The laws governing the formation, functioning and legal status of parastatal bodies, SFCs and the CFC make up the legal environment of municipal governance. Within the overall legal environment, the MML has an important place.

Municipal laws in India are old and often do not enable ULBs to implement new reforms. Therefore, the government of India developed a MML in 2003 to guide states to enact their own municipal laws. The basic objectives of the MML are to implement the provisions of the 74th CAA in totality for the empowerment of ULBs and to provide the legislative framework for implementation of the Ministry of Urban Development reform agenda. This initiative was expected to not only enhance the capacities of ULBs to leverage public funds for the development of the urban sector but also to help create an environment in which ULBs can ensure better service delivery. Four states, namely Rajasthan, Bihar, Odisha and Sikkim have prepared their municipal laws on the lines of the MML and several other states are in process of amending their laws. The Rajasthan Municipalities Act, 2009, has introduced some innovative features that should help empower ULBs within the state.

Internal structure of ULBs and linkages with other agencies

The overall structure of ULBs varies across different states. In a typical municipal corporation, there is a ward committee or office dealing with the collection of taxes and fees, water supply and sewerage connections, solid waste collection and transfer, street lighting, minor repairs, preventative health, birth and death registration, etc. Ward committees or the zonal committee or office will deal with zonal issues. Both committees have an assigned budget. The general board, standing committee or the head office deals with planning and implementation of major projects, approval of building plans, primary education, major repairs, etc. Commissioners of the municipal corporation generally report to the Secretary of the Urban Development Department. Executive officers of municipalities report to the director of the municipal administration through the regional director. It needs to be noted that the district collector plays an important role in the administration of small and medium size ULBs.

Primary health and education is generally the responsibility of state governments. Several preventive health activities are a responsibility of ULBs, for example, spraying of disinfectants and anti-larval drugs. In some states, large ULBs as well as state governments provide primary health and education.

Functions of ULBs

The Twelfth Schedule under the 74th CAA has identified 18 functions for ULBs. However, it is not mandatory for the state government to transfer these functions to ULBs. Going by the various municipal legislations across different states, ULBs are devolved with a long list of functions. These include functions mainly related to development, public health, welfare, regulatory duties and public safety.

Services to be provided by the ULBs[107]

Sr no	Functional heads	Specific services
1	Development functions	Construction of roads and streets, development of parks and playgrounds, slum improvement, planning for socio-economic development, construction of primary schools (wherever primary education is devolved to ULBs)
2	Public health	Water supply, sewerage, drainage, conservancy and sanitation, eradication of communicable diseases, prevention of food adulteration, and ensuring hygienic slaughter of animals
3	Welfare functions	Provision of community facilities such as primary education, parks and gardens, swimming pools, markets, community centres, public conveniences, street lighting, etc.
4	Regulatory functions	Prescribing and enforcing building bye-laws, building and alignment of roads, checking weights and measures, regulation of advertisement and holdings, preventing encroachments on streets and public land, preventing food adulteration, enforcing zoning regulations and development control.
5	Public safety	Firefighting, demolition of dilapidated houses

The functions of municipal bodies are quite comprehensive. This is why, service provision by ULBs are said to affect the citizens from 'the cradle to the grave'. This includes several functions such as the development of parks and playgrounds, construction of primary schools, provision of basic services such as water supply and sanitation, prescribing and enforcing building bye-laws, public safety directly affecting children, though it may not be clearly mentioned within the context of municipal laws. It is a daunting task for the ULBs, especially those functioning in small and medium towns, to address the needs of the citizens, including children. Even several municipal corporations, the supposedly stronger form of urban local self-government, are not in a position to perform all of these functions effectively. This is evident from lack of basic civic amenities and infrastructure in cities.

Implementation of CAA: A critical review

Lack of basic urban infrastructure is indicative of the fact the 74th CAA has not been implemented properly. Looking back at the CAA and its efficacy in strengthening ULBs, it has been at most a qualified success. On an average, the progress on the implementation of the 74th CAA has been rather slow. Today, there are around 3,700 ULBs with 100 municipal corporations, 1,500 municipal councils and 2,100 nagar panchayats, besides 56 cantonment boards across the country. While these figures might be indicative

of a decentralised policy environment, a cursory survey of contemporary city-level institutions throws light on how much ground is yet to be covered. A study by a prominent research institute in Delhi assessed the impact of the 74th CAA across 27 states and one union territory in India. It concluded that *"…municipalities in India are confronted with a number of problems, such as inefficiency in the conduct of business, ineffective participation by the weaker sections of the population in local governance, weak financial condition, lack of transparency in the planning and implementation of projects, etc., which affect their performance adversely.*[108]"

***Unfinished compliance*:** In terms of compliance with the CAA provisions, there has been full compliance with respect to provisions such as constitution of the three types of ULBs, reservation of seats for certain sections (thus, paving the way for empowerment of women and other weaker sections) and constitution of the SFC which has helped in rationalisation of the fund transfer system. Also, prolonged supersession of ULBs has been prevented to a great extent and overall, there is a qualitatively change in the local political process. However, the same cannot be said for other provisions, namely the constitution of ward committees, district planning committees and metropolitan planning committees. The amendment has, however, not yet succeeded in putting in place the instrumentalities conceived in the CAA for institution building and thus, has not yet contributed to institutional capacity development of the ULBs. Even the mandatory provisions of the Indian Constitution are yet to be implemented primarily due to a lack of will on the part of state governments.

Lack of uniform leadership system and limited powers of the mayor: While ULBs have been constituted, there is no consistency of tenure, powers and method of election of the mayor, the topmost elected position in the ULB. In most states, commissioners and not mayors have the executive powers. In fact, municipal governments do not have the power to appoint their municipal commissioner, who is usually an IAS officer deputed by the state government. Since the local government has no role in the appointment, promotion, or transfer of the municipal commissioner, it is hardly surprising that he or she is in reality primarily accountable to the state government rather than to the elected local representatives. Recently, the Expert Committee on the Governance in Bangalore Metropolitan Region recommended that the Commissioner of the Greater Bangalore Municipal Corporation (BBMP) needs to be selected by a search committee constituted in consultation with the mayor and, more importantly, that the Commissioner's role needs to be redefined in order to make him or her clearly accountable to the mayor as well as the corporation. If India's larger cities are to have effective governance structures, similar steps need to be taken by all states in order to make municipal commissioners accountable to the respective ULBs. Of course, so long as the commissioner's career path remains essentially in the state bureaucracy, some problem of 'dual subordination' still remains, but at a minimum it is critical that the chief municipal officer needs to be primarily accountable to the municipality he or she serves rather than to the state, as is now the case.[109]

***Absence of specific revenue base*:** The CAA did not lay down the revenue base and revenue generating powers for ULBs. The revenue base refers to the major and regular sources of the gross revenue of any ULB. The power to determine the revenue base continues to remain with state governments.

***Formation of many parastatals*:** The presence of a large number of *parastatals* also creates a strange situation. Although *parastatals* are primarily responsible for the delivery of services and ensuring access to resources, they are not directly answerable to citizens, but only to the state government. Since, they are managed by the state government, ULBs have little say in the functioning of these bodies while the actions of the *parastatal* directly affect other stakeholders of the city.

Thus, paradoxically, on the one hand, ULBs are mandated by the Constitution to have adequate powers and mechanisms to perform all the functions parastatals are currently undertaking. On the other hand, the state has not devolved adequate powers to most of the large ULBs and manages the activities through the creation of parastatals, the result being that the responsibilities get divided among ULBs, state departments and various utility boards. In certain cities, with the dissolution of the elected body, the state government is wresting control over the same. Eventually, the government dilutes the provisions of the CAA that relate to institution building, ignores the setting up of required structures for effective urban governance and usurps the role of planning and governing the city. In such a situation, while the governance by the locally elected body is absent, the ULB continues to be primarily responsible to deliver basic amenities and ensure access to resources and infrastructure.[110]

Three broad models are discernible with regard to water supply and sewerage services. First, a scenario where the entire system is with a department or a parastatal of the state government, second, where the ULBs themselves handle the entire activity and, third, as in some large cities, where exclusive water supply and sewerage boards have been set up for the city. This diversity of arrangements is the consequence of the unfinished decentralisation agenda.

Institutional framework for delivery of services in selected cities[111]

City	Services provided by			
	ULB	Parastatal	Development authority	State agencies
Ahmedabad	All services	-	-	-
Hyderabad	SWM, roads, street lighting, drainage, etc.	Water supply and sewerage	Town planning	-
Bhubaneswar	SWM, roads, street lighting, drainage, etc.	-	Town planning	Water supply and sewerage

***Problems of SFCs*:** As per the provisions of the 74th CAA, state governments have set up SFCs. It is mandatory for state governments to accept the recommendations of the SFCs. The commissions have been reviewing the financial position of the rural as well as urban local bodies and suggesting ways and means to devolve finances by the state governments to ULBs. However, most SFCs have formulated the fiscal packages without access to a clear directive on the functional jurisdiction of municipalities. Absence of clarity in respect of the functional domain of municipalities is a serious gap in the functioning of the SFCs. Estimating the resource gap and putting in place the expenditure norms for various services are the important areas where SFCs need to work more while devolving funds to the ULBs.

Weak staff capacity: Most ULBs in India do not have the capacity to promote cities as 'engines of growth'. The local agencies have a weak capacity to plan spatial, social as well as economic development, have unstable revenue streams, and low capacity to plan, mobilise resources and implement urban infrastructure projects. Though the 74th CAA expects that major civic functions need to be transferred to ULBs, many small and medium-sized ULBs are not in a position to manage water supply, sanitation and town planning functions due to these limitations.

Lack of clear roles for MPC and DPC: The 74th CAA mandated the states to constitute MPCs and DPCs, which are responsible for the preparation of the metropolitan plan and district development plan. However, several states have expressed a lack of clarity on the need for formation of metropolitan planning committees. Many ULBs are not in a position to devolve all functions, for example, urban planning, including town planning. Hence, the state Town and Country Planning and the Development Authorities Acts have not been amended to incorporate the provisions for preparation of metropolitan plans and district development plans. Also, the MPCs and DPCs have no clear role in the preparation of these plans. As a result, ULBs are not in charge of planning for 'economic development and social justice' and implementation of city or town development plans. The 74th CAA has thus not brought out any significant change to the existing arrangements of metropolitan governance.[112]

***Lack of ward-level decentralisation*:** The 74th CAA envisaged the formation of ward and ward committees in order to decentralise urban governance within a city. As of 2011, wards committees existed across seven states only and enabling laws for establishing ward committees were passed across 10 states.[113]

To put it in a nutshell, several states have not transferred functions, funds and functionaries to the ULBs.

Urban finances: An overview

ULBs are expected to perform a wide range of functions related to development, public health, welfare, regulatory duties and public safety. However, the current state of urban finances constrains ULBs from executing this role effectively. The challenges in financing ULBs are as follows:

Undefined revenue base: The Constitution of India specifies taxes to be divided between the central and state governments, but it does not specify the revenue base for ULBs, which leaves their resource generation capacity uncertain and constrained. Often, there is a mismatch between the functional responsibilities and resource generation capacity of local governments. Therefore, the lower tiers of governance depend on the higher tier for actual devolution of funds.

Limited taxation options and sub-optimal non-tax rates: At one time, some states allowed urban local bodies to levy tax on the entry of goods into a local area for consumption, use or sale (octroi). This tax was distortionary and inefficient, but also provided a buoyant source of local revenues.[114] However, with the abolition of *octroi* (local tax) in all states, property tax has become the most important source of revenue for local governments. Several states have introduced the unit area method of property tax assessment. User charges are the most important sources of non-tax revenues for ULBs. There has been a tendency to charge for various services at rates that are much lower than the actual costs. This has led to poor cost recovery, poor maintenance and inadequate investments in the infrastructure.

Unpredictable state transfers: Revenues of municipalities are supplemented by state transfers. During the period of 1997-98 and 2001-02, state transfers to municipalities were characterised by a high degree of fluctuation. Transfers to municipalities have in the past been marked by unpredictability and instability. In addition, there is lack of distinction between capital account and revenue account transfers and further confusion that is caused by plan and non-plan transfers on many heads.

Rapidly increasing financing requirements: At present, the capital expenditure on urban infrastructure is low. Rapid urbanisation in India has led to tremendous pressure on urban service delivery systems such as water supply, sewerage and drainage, solid waste management, parks and open spaces, transport, etc. Over 2012 to 2031, the HPEC on urban infrastructure[115] estimated an investment requirement for urban services in the country at 39,200 billion INR (871.11 billion USD) at 2009-10 prices. The operation and maintenance of old as well as well as new assets will account for half of the total costs. Most of the investments are required in urban roads and water supply. To meet the HPEC projections, by 2021-22, the total urban infrastructure expenditure will be almost three times as much as that in 2011-12.

Investment estimates by the HPEC for the period 2012-2031 in million INR)[116]

Infrastructure head	Amount
Water supply	3,209,080
Sewerage	2,426,880
Solid waste management	4,85,820
Storm water drains	1,910,310
Urban roads	1,728,9410
Mass transit	4,494,260
Street lighting	1,85,800
Traffic support infrastructure	9,79,850
Renewal and redevelopment	4,089,550
Other sectors	3,09,8150
Total	39,186,700

Urban programmes and policies aimed at meeting these challenges

In recognition of the growing importance of urban areas, the government has implemented various programmes across various cities. These programmes, apart from addressing the systemic challenges of urban governance such as the need for municipal reforms and better financial health of ULBs, also deals with the problems of urban poverty, livelihood and housing.

The JNNURM

In the context of the growing problems of urban infrastructure and governance, the central government launched the JNNURM in December 2005. Its major objectives were to bring about urban renewal with a focus on inclusive development.[117]

At the launch of the JNNURM, former Prime Minister, Dr Manmohan Singh mentioned that it is a city-based programme expected to build capacity of our cities for management and to have financial and technical resources to rebuild themselves. The mission is the single largest initiative of the government for planned urban development that integrates two pressing needs of the country: (a) massive investments needed for infrastructure development, (b) reforms required in order to sustain investments.

The JNNURM was launched in a mission mode for a period of seven years (2005-12). With its two sub-missions, the UIG and the BSUP, the mission formulated reforms and projects, aimed at rendering ULBs empowered and financially sustainable in accordance with the spirit of the 74th CAA.[118] The states and ULBs accessing the JNNURM must complete a total of 22 mandatory and optional reforms, during the seven-year period. These include: (a) empowering ULBs, (b) enacting public disclosure and community participation laws, (c) integration of city planning and delivery function with ULBs, (d) municipal accounting reform, (e) property tax reform, increase in the collection of user charges, (f) introduction of administrative and structural reforms and (g) encouraging PPPs.

JNNURM has certainly focused attention on policymakers in all the three tiers of the government on the challenges faced by the cities. It has succeeded in getting the state and city governments on board to commit to reforms, though some of these commitments have not been met by concerned authorities. Based on the implementation of the reforms under the JNNURM, states which have reported a good performance include Karnataka, Andhra Pradesh (undivided), Himachal Pradesh, Maharashtra and Tamil Nadu[119]. Average performing states include Gujarat, Kerala, Rajasthan, Delhi, Uttar Pradesh, and Chhattisgarh. The north-east states, except for Assam and Tripura, have shown slow progress.

In order to implement this reform more effectively, long-term support will be required along with clarity in the roles of development authorities, parastatals and ULBs. Most ULBs do not have the capacity to take on city planning functions. Wherever there are parastatal agencies such as development authorities, there is lack of clarity on the roles of parastatal agencies and ULBs, thus giving rise to issues of coordination and accountability.

As far as the community participation law is concerned, area sabhas (community level committees) were to be formed. Area sabhas were the functional equivalent of the gram sabha with a small elected committee of representatives. As of now, though many states have enacted laws (public disclosure and community participation laws) only 10 states have implemented them.[120] The committees have not been created across most states and some have expressed the need for handholding for finalising the draft bill. In PDL, the place, form, content and interval of disclosure need to be made uniform across ULBs and there is a need for discussion with states to expedite the process of implementation.

Most states have expressed the lack of adequate baseline information to implement the reform on property title certification. In-depth understanding at the state level on operational issues is also required, and hence there is a need for handholding. It also needs to be understood that a move towards good governance or inclusive cities requires far more than just JNNURM reforms.[121]


Photo credit: Rachel Palmer/ Save the Children

The 13th CFC

The formation of this commission was an important development considering that urban financing has for long been a problem area. The 13th CFC divided the ULBs' grants into two components: general basic grant and general performance grant. The division is significant in terms of urban governance. The general basic grant can be accessed by all states as per the criteria laid down by the commission. However, the performance grant can be accessed only by those states which comply with the mandatory conditions laid down by the CFC. These conditions are in the nature of reforms. If states do not comply with these conditions, they will then forfeit the grant for that year. The nine conditions stipulated by the 13th CFC can be considered as reforms to improve the financial status and governance of ULBs. Conditions relate to improvements in audit and accounts system, accountability, improving municipal finances, addressing maladministration, quick transfer of 13th CFC grants to ULBs without delays, strengthening the organisation and working of SFCs, improvements in service delivery and putting in place a fire-hazard response system.

The RAY scheme

Launched in 2012, the RAY scheme envisaged a slum-free India. This called for multipronged approach focussing on bringing the existing slums within the formal system enabling them to avail basic amenities, readdressing the limitations of the formal system and tackling the shortage of urban land and housing. Security of tenure through entitlement is critical for promoting inclusive cities as part of the programme. Towards this, the state sanitation policy and city sanitation plans were prepared as part of the programme.

The NULM

The unemployed and underemployed urban poor have been the target of major livelihood programmes rolled out by the government for quite some time now. The MoHUPA is currently implementing an employment–oriented scheme, namely, the SJSRY. Started in 1997, it aims to provide gainful employment to this group. It has five components: (a) the Urban Self Employment Programme which targets individuals to set up micro-enterprises, (b) Urban women self-help groups, (c) skill training for employment promotion, (d) urban wage employment and (e) the urban community development network. It is implemented on a cost sharing basis with state governments in the ratio of 75: 25. It covers a small target. Lessons learned from the implementation of SJSRY include: uneven spread of self–help groups across the country, weak convergence with other social sector schemes (such as the Health Insurance Scheme, the Integrated Child Development Scheme, education, etc), poor targeting of benefits, lack of an integrated approach to training, top-down approach, and the lack of dedicated implement structure.[122]

In this context, the government proposed to set up the NULM based on the core belief that the poor have the ability to emerge as entrepreneurs. The challenge is to unleash these capacities to generate sustainable employment. Objectives of the mission are to: enhance livelihood options for the poor, skill enhancement, ensuring linkages to other programmes, etc. It recognises the need for dedicated support structures at the local, state and national levels. It will have the following components: social mobilisation and institutional development, capacity building and training, employment through skill training and placement and self-employment programmes.

Specific components of the mission include: formation of community structures, universal financial inclusion, revolving fund, community investment fund, capacity building, technical support at the local and state levels, employment through skill-training and placement, individual and group enterprises, credit card, marketing support, etc. It needs to be noted that unlike the Rural Employment Guarantee Scheme, there is no guarantee of employment in the urban scheme.

National Urban Housing and Habitat Policy 2007[123]

This policy has 'safe and affordable housing for all' as its motto. It has rightly centred its focus on the issue of affordability, given the fact that by the end of 10th FYP, 26.7% of the total poor population in the country lived in urban areas, which translates into 80.7 million people or around one-fourth of the country's total urban population. With a focus on the urban poor, the policy emphasised earmarking of land for the EWS or LIG groups in new housing projects.

While talking of the urban poor, the policy does provide for special provisions for the SC, ST, OBC, minorities, people with disabilities, slum dwellers, street vendors, other informal sector workers, vulnerable women (for example, women-headed households, single women, working women and women in difficult circumstances), etc. but as far as direct reference to children's issues is concerned, the policy only states that 'construction companies or public authorities will be directed to provide adequate support services such as crèches and temporary rest accommodation with appropriate toilet facilities at construction sites'.

Some of the other action points that will impact the urban deprived children positively, if implemented, include: upgrading of basic services and environment improvement of urban slums, provision of shelter to the urban poor at their present location or near their workplace, non-transferable shelter rights for a period of 10 to 15 years, development of a new scheme for meeting water, drainage, sanitation and sewerage concerns in slums located in smaller towns with a population of less than five lakh (half a million), special action plan for urban slum dwellers aimed at preventing geographical and social segregation, promotion of micro-finance institutions at the state level in order to expedite the flow of finance to urban poor, etc.

Gaps in urban governance: How is the urban child affected?

The less-than-perfect implementation of the CAA and flaws in the design of India's ambitious urban programmes has created several challenges for the urban governance in India. Many of these challenges directly affect well-being of the country's children, since the functions assigned to ULBs under the Twelfth Schedule and most municipal laws are often directly pertinent to the lives of children, viz public health, welfare, regulatory public safety, etc. However, a quick review of urban policies and programmes in India revealed little recognition to the specific needs of the child.

India's cities are large (53 of them with a population of over one million each), economically important, and growing in number. However, as the HPEC report points out, neither the urban infrastructure nor the level of urban public services is adequate to meet the current needs of the population, let alone meet the growing demands. Dealing with this problem is a formidable challenge and calls for adequate finances. However, investment in urban development lags far behind as compared to other competing sectors such as rural development, education and health. For example take the estimated plan investment allocation for the period between 2005 and 2011. The difference between investment in rural development and urban development was a staggering 2,58,000 crore INR(2580 billion).[124] At the ULB level, problems such as an unspecified revenue base, limited taxation options, poor cost recovery, unpredictable state transfers, and increasing funding requirements have meant that there is a lack of money available for urban infrastructure and service delivery, though the 13th CFC has moved towards improving the financial status of ULBs. In particular, the lack of funds for services (such as water supply, solid waste management, sewerage and street lighting), civil works (such as development of parks and playgrounds, slum improvement and construction of primary schools) and prevention of food adulteration have a direct implication on urban children, as these are related to the aspects of child safety, education, health, sanitation, opportunity to play and be physically active, etc. While various land-based financing tools such as development charge, external development charge, impact fee, betterment levy, etc (which are widely used in the US, Columbia as well as other countries) are being discussed in India as well, the fact remains that financing tools in the country use these names without following the principles underlying them.

While the steps taken up as part of the JNNURM reform package, such as property tax reforms and increase in collection of user charges have helped augment the resources available to cities, a larger question is that of distributing the available resources equitably such that the vulnerable sections, especially the urban-deprived children benefit from the budget. One way of ensuring that a sufficient budget is set aside for children is by applying what is called 'budget-for-children analysis'. Budget analysis requires engaging in dialogue with government representatives in order to identify programmes that benefit children, analysing the budget and feeding the key findings into an effective communication and advocacy strategy to ensure adequate resource allocation for children and better governance and budget management from the government. This tool has been used extensively by Save the Children in countries such as Bangladesh, Pakistan, Vietnam, Philippines, Zimbabwe, Uganda, Ethiopia and countries of South and Central America. In Fortaleza (Brazil), children come together each year to take part in a debate on their municipality's budget distribution.[125]

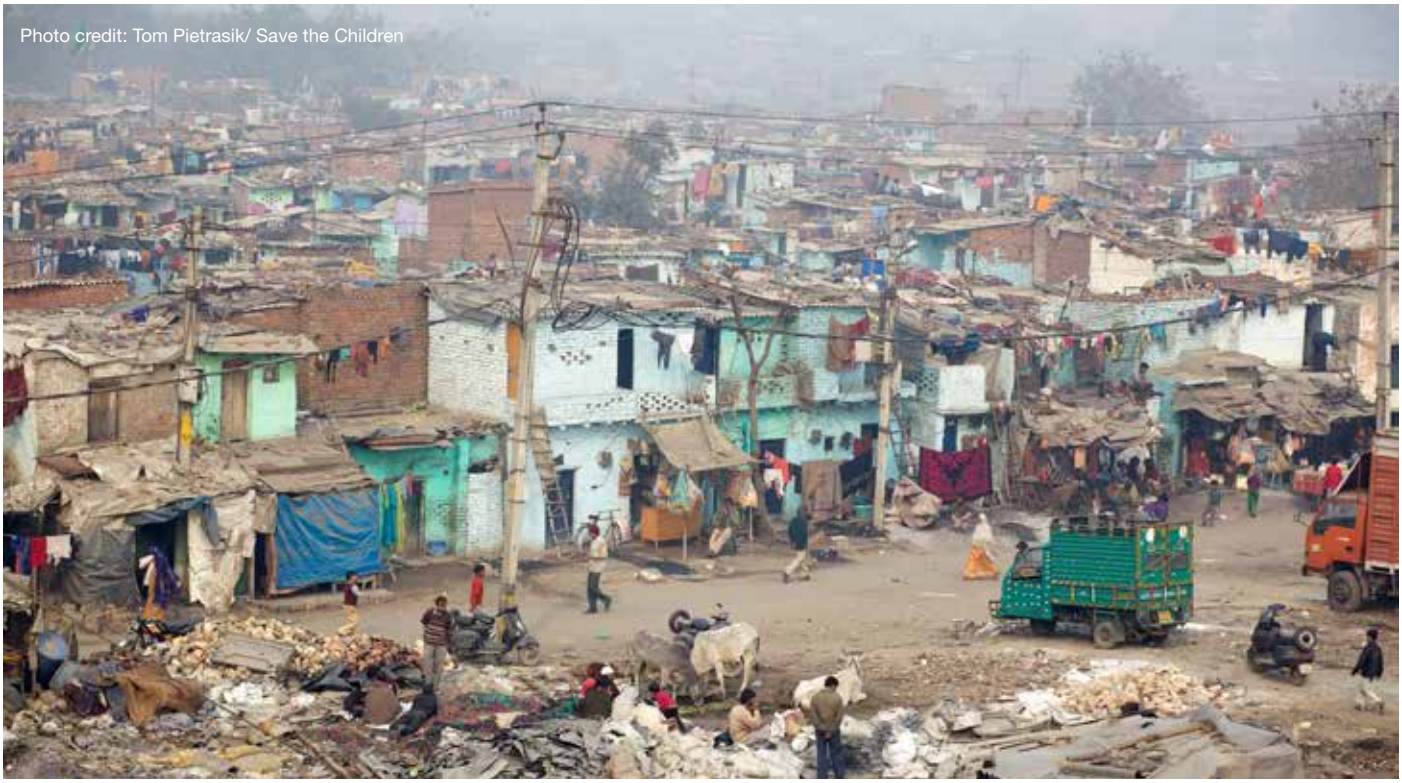


Photo credit: Tom Pietrasik/ Save the Children

Further, it is critical to ensure that the money spent results in the desired outputs and outcomes, especially the outcomes that favour the well-being of children. To do so, local governance structures need to be strong. However, there are glaring weaknesses in the governance structures at various levels: planning, implementation and public participation. The MPCs and DPCs do not have a well-defined role in planning, the capacity of existing staff to plan spatial, social and economic development and to implement the infrastructure projects is weak and ward-level decentralisation has not taken place in most states, thus limiting the community participation in governance and public accountability of implementers. With community participation being low, the aspiration of children to express their opinion on public platforms on matters concerning them seems even more remote.

The ambitious JNNURM programme has reached out to more than 60 Indian cities and over a period of seven years, aimed to bring about 22 key reforms. However, in the mission objectives, there was no mention of the specific needs of the children. Criticising this approach of JNNURM, the Humara Bachpan Campaign states:[126] "JNNURM… does not consider young children as an entity. The policymakers felt that providing a space for crèches and *anganwadis* was good enough. They did not consider that children have a say in planning their own city which will be dwelled by their own children when they grow up. The idea of community participation excludes child participation perhaps because the mission considers them too young to take decisions."


Photo credit: Lucia Zoro/Save the Children

However, the BSUP, a sub-mission of the JNNURM, which focuses on integrated development of slums, when reviewed from a child rights perspective, seems to uphold the principles enshrined in the UNCRC. Commitment to the security of tenure, improved housing, water supply and sanitation, education, health, employment near housing, civic amenities and utilities, converging social security services, etc as mandated in various articles of the UNCRC are built in the objectives of BSUP. This means that if the BSUP is to achieve its stated goals in slum development projects where all the above converge seamlessly then indeed the resultant projects will improve opportunities for survival and support healthy development of children in slums. If social security measures that protect children from all forms of abuse, neglect, exploitation and cruelty are converged with the BSUP, then the JNNURM will have mainstreamed critical protection concerns of children living in poverty in urban development.[127]

Besides the JNNURM, the RAY, NULM as well as other programmes should also have recognised the requirements of the child. This could have been in the form of adequate open spaces in low-income housing areas, design of water bathroom and toilets, safe roads for walking, appropriate building bye-laws so as to provide safe buildings, participation in identification of issues and planning, etc for children. However, there are many challenges in this effort, such as the following:

- Adequate data or information on the urban child and his or her specific needs is not available.
- Present state municipal and town planning do not have enabling provisions for child-friendly actions.
- A large number of ongoing urban programmes deal with different aspects of urban development. However, most government agencies typically act in silos and do not take coordinated steps in their area.
- Urban programmes provide broad guidelines but do not have specific guidelines for child-friendly planning and implementation.
- Isolated local initiatives or pilots are taking place. However, these cannot be replicated without adequate support.
- There is limited capacity at the local, state and national level where experts can provide technical assistance and training to mainstream child-friendly policies and programmes in the urban sector.

Good practices and possible solutions to the problems of urban governance

Innovative financing

Lack of financial resources in ULBs seems to be emerging as an important issue. Keeping the objective of improving the financial health of ULBs in mind, the GoI is encouraging cities and states in developing innovative financing mechanisms

such as mobilising market-based funds, land-based sources and PPPs. The Ahmedabad Municipal Corporation was the first ULB to access the capital market in January 1998. It collected 1,000 million INR by issuing bonds. Several ULBs and utility organisations have issued bonds thereafter in order to mobilise over 12,399 million INR of funds through taxable bonds, tax-free bonds and pooled financing.

Several land-based financing methods such as higher FSI[128], impact fee, area linked development charge, external development charge, betterment levy, etc have been used as tools for financing urban development in India. Land as a resource had a dominating role during 1960s and 70s. Infrastructure increases the land value, which in turn will lead to an increment tax. Examples are town planning schemes in Gujarat and Maharashtra. Another approach used to acquire land for creating urban infrastructure, including facilities for children, is to issue TDRs.[129]

As a response to the lack of access to finance and restrictions on recruiting new personnel, many ULBs have outsourced various tasks to private agencies. A number of PPP options have emerged. There are many examples of PPPs in solid waste management. In Hyderabad and Surat, private contractors are engaged to clean main roads and markets. As part of the World Bank-funded Karnataka Urban Water Supply Improvement Project, demonstration zones have been identified in the three cities (Belgaum, Gulbarga, and Hubli-Dharwad) and a private operator/ Consultant has been contracted for carrying out water supply improvements with the prime objective of demonstrating the provision of 24/7 water supply. It may be mentioned here that water supply tariffs in India are low and base data of existing water supply systems are missing. Unless these issues are taken care of, it will not be possible to undertake PPP projects in urban water supply and sanitation sector.

Innovative child-focussed programmes

Four child-friendly innovative programmes have been identified in Kerala, Karnataka, Ahmedabad and Nepal. These initiatives are made special by their focus on child participation in governance, capacity building of children, redesigning the long-term development plans through a child lens and priority budgeting and expenditure by the government on issues identified by or important for children.

a. Kerala's child-friendly initiative[130]

The state of Kerala has included the local self-governments in the planning, implementation and monitoring, of women and child-friendly programmes. As a part of the decentralisation process, funds are distributed to all the tiers of governance. Wards committees of municipalities have working groups, including poverty reduction, health, development of women and children, development of SC, education, culture, sports and youth. These operate by coordination between elected members, government appointed officials, expert practitioners and local volunteers. Apart from this, child development programmes have also benefitted by association with people involved in the Kudumbashree poverty alleviation programme. Local police although under the purview of the state government, actively support initiatives for child rights protection of local governing bodies. *Anganwadi* institutions created under the ICDS programme are primarily involved in child care development for children less than six years. These are important establishments and function on a community-based approach. They also provide important forums for interaction of women and children on issues related to nutrition, health and education. KILA, the autonomous body at the state level, has established the child resource centre (CRC-KILA), in association with the UNICEF, which seeks to provide support and training for effective child-centric governance throughout Kerala.

Apart from these functions, administration, infrastructure maintenance of schools, mainly the primary (classes 1 to 4) and upper primary (classes 5 to 7) schools are also the responsibility of municipalities. Monitoring is carried out by the LSG standing committee for health and education. These schools compulsorily implement the centrally sponsored schemes such as MDM and the SSA. Medical equipment, scholarships, pensions and stipend are provided for specially-abled persons under the SSA. Block level LSGs administer industrial training Institutes, while higher secondary and vocational schools are governed by the district level LSG. Kudumbashree also created *bala sabhas* (children's assemblies) which acts as a participatory space for children in the age group of 5 to15 years. A unique feature of this assembly is *adat bal sabhas*. These encourage children to save funds and invest to accrue interest. This gives them financial independence at an early age. Children are also motivated and involved through different trainings and summer programmes in the functioning of the police force.

Lessons to learn from Kerala are: coordination between local self-governing institutions and three panchayat tiers across various sectors such as health, education, etc special attention to disadvantaged groups and neglected gender and providing space to children for independent thinking and participation, one of the key ingredients of the child-friendly cities framework.

b. Karnataka's *baal sabha*[131]

Karnataka started the initiative of *bal sabha* through a circular in 2007. A few panchayats have implemented this initiative. It is a children's assembly on lines of the gram sabha. It brings out concerns of children and forwards them to the panchayat and state officials. The Concern for Working Children (CWC) has begun working to develop children's participation in governance in urban areas. In January 2012 CWC, Bruhat Bengaluru Mahanagara Palike (BBMP) and other organisations facilitated the first children's ward sabha India, in the Vigyan Nagar ward of Bengaluru. Ward sabhas are broadly the urban equivalents of gram sabhas, and enable local children to identify problems and present proposals to adult officials. This is a feature similar to the one observed in Kerala. The BBMP mayor extended his support in conducting such meetings for children across Bengaluru. Baal sabhas are not mandatory in the state panchayat raj or municipal acts.

c. Community initiative in Ahmedabad[132]

A network in Ahmedabad, aProCh, plans to make Ahmedabad into a child-friendly city through activities catering to children. It organises events for children called 'parents of the park'. Under this initiative, children from different backgrounds meet in a city park. Activities include story-telling, exercises and games, magic shows, etc. Moreover, Ahmedabad Municipal authorities and police close down a main thoroughfare six times a year for a child-orientated street party organised by aProCh.

d. Nepal

The Nepal government officially endorsed the national CFLG Strategy in 2011, developed jointly by the UNICEF and the Ministry of Federal Affairs and Local Development (MoFALD) and supported by various NGOs. The government has made it an integral part of its multipartite local governance and community development programme and its Three-Year Interim Plan. CFLG has been rolled out across 39 districts, 15 municipalities and 300 VDCs. Children are members of 13,291 active child clubs in over 52 districts, and 40,000 ward citizens' forums, as well as the village development committees, district development committees and municipal planning committees. With 27 sectoral and 12 institutional indicators centred on child rights, municipalities and VDCs implementing the CFLG are taking steps to ensure that their cities are child-friendly.

CFLG guides the government in marrying the rights of children related to their survival, development, protection and participation to the local government systems, structures, policies and processes and also facilitates the same at the higher levels. It is about planning jointly to achieve the results for children.

In terms of budgeting, the MoFALD ensures a mandatory provision of 10% for women, 10% for children and 15% for CFLG initiatives specified in the VDCs and DDC block grant guidelines endorsed by the Cabinet. The CFLG national framework also includes provision for 15% of the overall local body resources to be allocated for CFLG initiatives. Further, municipal authorities have committed 23 million NRs (3.1 million USD) for CFLG initiatives over the next five years.

Another set of institutions formed by the Government of Nepal comprises the central child welfare board and district child welfare boards in 75 districts in order to carry out massive programmes to sensitise children and the community on child rights, protect them from abuse and provide legal support. The Government of Nepal is also implementing a 10-year child development plan (2004-14).

A few cases of success have already emerged from Nepal. Municipalities have started looking at the process of development through the lens of a child wherein children's voices and their participation in decision-making bodies is encouraged. In Dang district for example, the municipality has made arrangements to allocate open spaces for parks. Child clubs in Biratnagar, which is the second largest city after Kathmandu have helped the municipality identify children missing out on education and immunisation. Child club members are also helped increase the enrolment of Muslim girls who had not been attending school due to the schools' restriction on school uniforms. As soon as the children managed to convince Biratnagar and the district education office to allow girls to wear *salwar kameez* instead of skirts, girls started going to school. The Biratnagar municipality in partnership with the Biratnagar child clubs ensured that their voices were reflected in key policy documents and interventions.

Recommendations

The Government of India is planning to roll out a large number of new urban programmes. These include the smart cities programme covering 100 cities, the National Urban Development Programme covering 500 urban centres, heritage cities and *Swachh Bharat* (Clean India) programmes and so on. There will be new programmes on low-income and affordable housing in addition to the NULM. In this scenario, this is the appropriate time to suggest ways and means of incorporating the needs of the children in the proposed programmes. Specific recommendations are as follows:

- **Data:** Analyse available data from different sources such as census, the NSSO, family health surveys, economic Census, etc to describe the status of urban child at city, state and national levels
- **Knowledge products**: Develop knowledge products such as case studies, policy notes, video films, PowerPoint presentations, design and planning options, etc that can be used for orientation, training and technical assistance of policymakers and experts to make cities child-friendly. Some of the case studies can be derived from the success stories of Nepal, Kerala, etc.
- **Capacity building**: Utilise the opportunities provided under various urban missions to orient and train policymakers, officials, NGOs and citizens on this issue.
- **Technical assistance**: Provide technical assistance to include child-friendly initiatives in various guidelines of governments and to make the city development plans and detailed project reports child-friendly.
- **Convergence:** Assist national, state and local governments to achieve the convergence of the various urban programmes and make them child-friendly.
- **Guide and support local initiatives**: Many local and community level initiatives can be guided and supported in order to create knowledge and demand for child-friendly cities.
- **Support student projects**: Students and research interns in the fields of architecture, urban planning, design, management, law, and social work needs to be encouraged to take up child-friendly projects that generate document good practices, suggest improvements in design of spaces and facilities, etc.

- **Initiate city awards:** Document good practices and initiate awards in order to recognise child-friendly cities and administrators who institutionalise good practices in cities under their jurisdiction.
- **Enabling legal environment**: Assist various levels of governments to amend municipal and town planning acts to include provisions for child-friendly urban governance.
- **M&E**: Develop tools for monitoring and evaluation of urban child-friendly policy and programmes. Support governments as well as civil society organisations in order to use them to generate evidence on the quality of policies and programme implementation.
- An important recommendation that we seek to make here is related to land use and urban planning, which is an important factor in creating a child-friendly city. Land is a limited resource and multiplicity of its competing uses—one of them being the use of land for children's facilities such as schools, AWCs, crèches and playgrounds—require careful planning. However, we notice that land use in urban India is extremely inefficient and poorly planned. Data shows that even as the demand for land increases in Indian cities due to population growth, ironically, large chunks of institutional land within big cities are lying vacant or underutilised (often as a result of weak property tax systems) or are concentrated in private hands, which makes them unavailable for urban development and prevents their optimum social use. It is important to plan a change in the land use patterns in favour of vulnerable children. Various instruments such as social housing, master plans, land use conversion, discouragement of low or no occupancy, etc. should be used judiciously to achieve this objective.[133]
- The Government of India has allocated 70.6 billion INR (1.2 billion USD) for smart cities in the Union Budget 2014-15. An amount of 83 million USD has been allocated for the Digital India initiative. A PPP model has been conceived to upgrade infrastructure in 500 urban areas. The Ministry of Urban Development plans to develop two smart cities in each of India's 29 states and the Delhi-Mumbai Industrial Corridor Development Corporation Ltd plans seven 'smart cities' along the 1500-km industrial corridor across six states with a total investment of 100 billion USD.[134]

While the spirit of creating smart cities sounds modern and resource allocation is impressive, the GoI in its conceptualisation seems to suggest that these smart cities are needed mainly to cater to the 'aspirations of the new middle class for better living standards'. It defines smart cities as "those that are able to attract investments and experts and professionals" by offering "smart housing, high level of healthcare, entertainment and quality education… comparable with any developed European city." The problems or priorities of the urban poor do not feature in this investor-focused definition. Secondly, while the government's concept note on this project speaks of 'citizen consultation and public scrutiny of services', it makes no mention of the participation of children or young citizens in civic affairs.[135] While it does speak of citizen reference frameworks (CRF) before the formulation of city development plans, it also categorically says that while capturing the citizens' aspirations and expectations through the CRF, the focus would remain on the main objectives of smart cities, namely, employment generation and creation of economic activities. We recommend that the concerns of children be made an essential part of such CRFs.

Photo credit: Rachel Palmer/Save the Children

Health, nutrition and WASH: The interconnections

The next three chapters in this report deal with three aspects of the well-being of urban children, namely, health, nutrition and WASH. The interconnections between the three are evident and have been detailed out by the respective authors.

Poor sanitary conditions, on the one hand, raise the morbidity and mortality rates by directly causing diarrheal illnesses and on the other, lead to stunting and malnutrition thus raising an entire segment of children with deficiencies which further reduce their immunity against childhood illnesses in a less direct way.

Health and nutrition[136]

Good nutrition—an adequate, well-balanced diet combined with regular physical activity—is the cornerstone of good health. Poor nutrition can lead to reduced immunity, increased susceptibility to disease, impaired physical and mental development, and reduced productivity.

- High sodium consumption (more than 2 grams/day, equivalent to 5 grams salt/day) through salt intake and insufficient potassium intake (less than 3.5 grams/day) contribute to high blood pressure and increase the risk of heart disease and stroke.
- IYCF practices such as exclusive breastfeeding help provide nutrition at an early age and may have longer-term benefits by reducing the risk of obesity in childhood and adolescence.
- Reducing the amount of total fat intake to less than 30% of total energy helps prevent unhealthy weight gain (and related non-communicable diseases) in adult population.

Nutrition and WASH

About the direct and indirect links between nutrition and WASH, WaterAid says the following:

Direct links

The WHO estimates that 50% of malnutrition is associated with repeated diarrhoea or intestinal worm infections as a result of unsafe water, inadequate sanitation or insufficient hygiene.[137]

- Diarrhoea, largely caused by lack of water, sanitation and hygiene, is a leading cause of death in children under five globally,[138] and its constant presence in low-income settings may contribute significantly to under-nutrition.
- Parasitic infections, such as soil-transmitted helminths (worms), caused by a lack of sanitation and hygiene, infect around 2 billion people globally,[139] while an estimated 4.5 billion people are at risk of infection.[140] Such infections can lead to anaemia and physical and cognitive impairment.[141]

Indirect links

According to a report—Undernutrition and water, sanitation and hygiene—a joint publication of WaterAid, London School of Hygieneand Tropical Medicine and Share, the lack of safe water close to home has many indirect effects on nutrition. People are often left with no choice but to drink unsafe water from unprotected sources. Where safe water is available to purchase from vendors, limited quantities leave little for good hygiene practices. The time wasted collecting water or suffering from water-related illnesses prevents young people from getting an education, which has a significant impact on their health, well-being and economic status.

Health and WASH

"Water and sanitation is one of the primary drivers of public health. I often refer to it as 'Health 101', which means that once we can secure access to clean water and adequate sanitation facilities for all, irrespective of the difference in their living conditions, a huge battle against all kinds of diseases will be won." – Dr Lee Jong-Wook, Director-General, World Health Organisation

In addition to diarrhoea, the other killer diseases caused by unsafe water and improper management of water resources used for irrigation include malaria, schistosomiasis, Japanese encephalitis, Hepatitis A, skin lesions caused by high arsenic content in drinking water, and dental fluorosis due to elevated fluoride in drinking water.[142]

These linkages are explained in the subsequent three chapters in the context of urban deprived children of India. The emphasis here is the need for a strong urban health system for the poor, improvement in sanitary conditions in the slum and a greater focus on ICDS in urban areas, which still have very few anganwadis vis-à-vis the eligible child population.

Photo credit: Lana Slezic/ Save the Children

Health of children in poor urban settings

Dr Benazir Patil and Dr Rajesh Khanna

Introduction

While India is grappling with the challenges of urbanisation, in most cases, urban population growth has outpaced the municipal's capacity to build essential infrastructure that is crucial in creating safe and healthy cities. Urbanisation, coupled with rising poverty, is becoming a severe, pervasive, and largely unacknowledged challenge of urban life. With regard to health of the children in urban locations of India, it is crucial that the two components—urban public health in general and urban child health in particular—be viewed separately.

Understanding healthcare and public health

Public health refers to all organised measures (whether public or private) adopted in order to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focusses on an entire population, not on individual patients or diseases. Thus, public health focusses on the entire system of curative as well as preventive healthcare and not only on the eradication of a particular disease. Child health on the other hand, is a state of physical, mental, intellectual, social and emotional well-being. Children in any part of the world cannot achieve optimal health alone. They are dependent on the adult members of their family as well as the community at large to provide them with an environment in which they can learn and grow successfully. With India contributing, more than any other country, to the global under-five and newborn deaths, it is important to understand that the survival of newborn babies as well as children till the age of five becomes the most crucial aspect that the country currently needs to tackle. Thus, the overall understanding of health of the children in our country begins with assessing their chances of survival first and then graduates to their overall well-being.

Similarly, health and healthcare need to be distinguished from each other for no better reason than that the former is often incorrectly seen as a direct function of the latter. Health is clearly not the mere absence of a disease. It is about achieving well-being and the ability to realise one's potential. The health of a population is a distinct issue in public policy discourse. The discourse includes a cultural understanding of ill-health and well-being, extent of socio-economic disparities, reach of health services and quality and cost of care as well as the current bio-medical understanding about health and illness.[143]

Health of urban population

Until recently, urban health was not the main focus of public health policy in most developing countries since majority of the population lived in rural areas. It was often assumed that heavy concentration of health facilities and personnel within urban areas, particularly in the private sector, will automatically take care of the increasing urban population and its health needs. However, rapid growth of cities within developing countries, coupled with the growth of the urban poor and inequities created within cities, made this position untenable.[144] A number of studies[145] concluded that the health of urban poor is significantly worse than the health of the rest of the urban population and is often comparable to health conditions in rural areas.

While India awakens to the challenges of urban health, the reality is that city dwellers are often oversupplied with healthcare choices. State government hospitals and municipal facilities at the primary, secondary, and tertiary levels are accompanied by private sector providers from sub-sectors such as allopathy and AYUSH. From single-handed practitioners to super-speciality hospitals, urban areas have a host of healthcare services to provide to its citizens across all income levels. This raises the possibility that the fundamental challenge may be more about quality than the quantity of healthcare services.[146]

Disaggregated data: An overall challenge

Traditionally, when the well-being of children are being assessed, a comparison is drawn between the indicators for children dwelling in rural areas and those within urban settings. As expected, urban results have reported better results, whether in terms of the proportion of children reaching their first or fifth birthday, going to school or gaining access to improved sanitation facilities. However, even within urban India, we witness a vast inequity of wealth and opportunity.

Studies that provide an eye-opening overview on urban health

- Researchers at Mumbai's City Initiative for Newborn Health published the disappointing results of their three-year effort to implement a community-based maternal and newborn health initiative within the city's slums. In Mumbai, it was found that while urban areas have the advantage of additional infrastructure and health services, there are also unexpected dynamics. The initiative set up 244 women's groups in order to discuss maternal and child health problems, counsel one another and work on solutions. While that worked in rural villages, in the city slums, mothers were hesitant to even depend on neighbours. The report 'Hidden Cities' by the WHO and UN-Habitat highlights the urban health inequities that are the result of the circumstances in which people grow, live, work and age, and the health systems they can access. The report demonstrates how aggregated data often masks substantial health inequities within urban populations. To reveal these inequities, we need to disaggregate the same information according to defining characteristics of city dwellers, for example, their socio-economic status or place of residence. Another study conducted in developing countries clarifies that the 'urban advantage' is, for some, a myth. The urban poor do not necessarily have better access to services than the rural poor, despite their proximity to services. There are two main patterns of urban inequality in developing countries: (1) massive exclusion, in which most of the population does not have access to services, and (2) marginalisation, in which only the poor are excluded.
- Results from a study in India reveal, in order of importance, poor economic status, parents' illiteracy and caste as major contributors to urban child health inequalities in the southern states in the country In contrast, parents' illiteracy, poor economic status, being Muslim and child birth in the order of three or more are major contributors to urban child health inequalities in the EAG states.

Source

- *Mumbai: Learning from Failure. Retrieved from http://pulitzercenter.org/reporting/urban-health-development-maternal-newborn-aid-development-india-research*
- *WHO, UN Habitat. Hidden cities: Unmasking and overcoming health inequities in urban settings.*
- *Matthews, Z., Channon, A., Neal, S., Osrin, D., Madise, N., Stones, W. (2010, September 14). Examining the Urban Advantage in Maternal Health Care in Developing Countries: PLoS Collection, 40-43-39. DOI: 10.1371/journal.pmed.1000327. Retrieved from http://www.newbornwhocc.org/SOIN_PRINTED%2014-9-2014.pdf*

Photo credit: Rachel Palmer/ Save the Children

According to the Suresh Tendulkar Committee report accepted in 2011, the estimated proportion of people living in poverty was 37%. However, poverty level differs widely across India: in Delhi, Goa, and Punjab, it is less than 10%, while in Bihar and Odisha, it is more than 40%. The fact that government health spending in India is around 1% of the overall GDP, while the total spending on health is around 5% of the GDP, indicates that India has one of the highest levels of out-of-pocket expenditure on healthcare in the world. Across the country, 86% of health expenditure is out-of-pocket. Thus, there is a huge financial burden on individuals as well as households, more so in the case of this poor segment of 37%. This is arguably one of the reasons for inequities in health observed across India.[147]

The urban versus rural comparison typically rests on aggregate figures, which hide the inequities that lie within the city.[148] The reality of urban-deprived children is obscured by the wealth distributed across other communities in the city. A few studies have tried to quantify this inequity.[149]

The urban advantage: Poor versus non-poor

The health of children is primarily determined by the socio-economic conditions of the environment in which they are born and nurtured, and these are shaped by the distribution of power and resources. On an average, children residing in urban areas are more likely to survive infancy and early childhood and enjoy better health and education opportunities than their rural counterparts. This effect is often referred to as the 'urban advantage'. However, when child health statistics are disaggregated, it becomes clear that even in a situation where services are located nearby, children growing up in poor urban settings face significantly higher health risks than those from non-poor households.

Understanding the universe of a child dwelling in a slum is critical in order to develop appropriate health interventions adapted to these conditions.[150] There have been studies focussing on child health, rather than urbanisation. These studies raise questions not about urbanisation, *per se*, but rather about the significance of urbanisation with respect to the health of the poorest children living in the poorest settlements within cities. The focus is on what is different about the health situations of these children (compared with the situation of 'average' urban or rural children) and to identify special opportunities as well as obstacles, related to their health, and on changes, in methods and programmes, if any, needed to reach out to these children more effectively.[151]

Moreover, situations in Indian cities have fuelled a debate on the impact of urban growth on socio-economic as well as regional inequalities in child health.[152] The two pertinent questions that emerge are: whether urbanisation drives average health improvement leading to child health inequalities and whether child health inequalities are the same across the least developed EAG states and the more developed south Indian states of urban India, given the socio-economic and cultural diversity of Indian cities.[153]

Public health conditions in Indian cities

Public health is concerned with disease prevention and control at the population level, through organised efforts and informed choices of society, organisations, public as well as private communities and individuals. However, the role of the government is crucial in addressing these challenges and achieving health equity. Towards this, the MoHFW plays a key role in guiding India's public health system.

Understanding the public health needs in urban areas requires a different conceptual framework. Traditionally, it is understood that alleviation of poverty is the most important precursor of improving the general health of the population. However, in urban areas, marginal increase in income for the poor, in itself, does not assure better living conditions due to wide disparities, which make decent accommodation, clean water and air unaffordable.[154] Operational challenges arising from the mobile nature of the population and high population density, growth of high-end private facilities, administrative issues related to human resources and overlap of functions of different agencies, imbalanced distribution of health facilities across the city, weak support system for the urban health infrastructure under the NRHM, etc are the typical features of the urban health scenario in India.

One primary healthcare facility in an urban area caters to a much higher population as compared to the government norm of one centre for every 50,000 population. From the providers' perspective, service delivery in slums is an enormous challenge given the large and sometimes mobile nature of the slum population. This leaves them with little scope for persuasion for appropriate behaviours with target families.

> *"The entire area of Shivajinagar or Indiranagar has only one local clinic and additional medical facilities are not available in the nearby areas. Hence, in case of an emergency, the locals have to rush to Chembur or Mankhurd for medical assistance."*
>
> - A girl of 14 from Shivajinagar, Mumbai

Also, there is an imbalanced focus on curative care, and a consequent near total neglect of preventive as well as promotive care. In cities, particularly in the large ones, there is an overemphasis on super speciality care centres within the private sector which are clearly out of the reach of the urban poor.

High staff turnover, absenteeism, inadequately skilled staff and lack of their supportive supervision are some of the human resource issues hindering effective implementation of services. A large number of positions of medical officers and paramedical staff are vacant at primary care facilities, which are supposed to cater to the slum clusters.

Health department, municipal bodies, ICDS as well as charitable organisations together provide services in urban areas with a constant overlap in few areas and lack of services in most part of the cities. The absence of a well-plotted updated city map indicating slums and facilities leads to the crowding of several primary care facilities within a small area, usually a central hub. Often, slums in the city's fringes are served by neither the rural nor urban health staff.[155]

In the NRHM (phase I), funding support was given for urban health and family welfare centres and urban health posts, national health programmes such as TB, immunisation, malaria, etc., and urban health component of the Reproductive and Child Health Programme, including support for *Janani Suraksha Yojana*. However, the norms for urban primary health infrastructure were not part of the NRHM proposal, which constrained the development of basic health infrastructure.

Primary healthcare units in urban areas are managed by municipal bodies. At this level, we do not see any overlap. However, at the secondary level, both facilities run by municipal and state governments are operational. At the tertiary level, the scenario is even more complex with different departments of the state government managing different facilities. For example, teaching college hospitals are typically administered by the Department of Medical Education, while the large municipal general hospitals continue to offer tertiary care.

Levels of public healthcare system:

Primary healthcare: Primary healthcare denotes the first level of contact between individuals and families within the health system. In India, primary healthcare is provided through a network of sub-centres and primary health centres located in rural areas, whereas in urban areas, it is provided through health posts and family welfare centres.

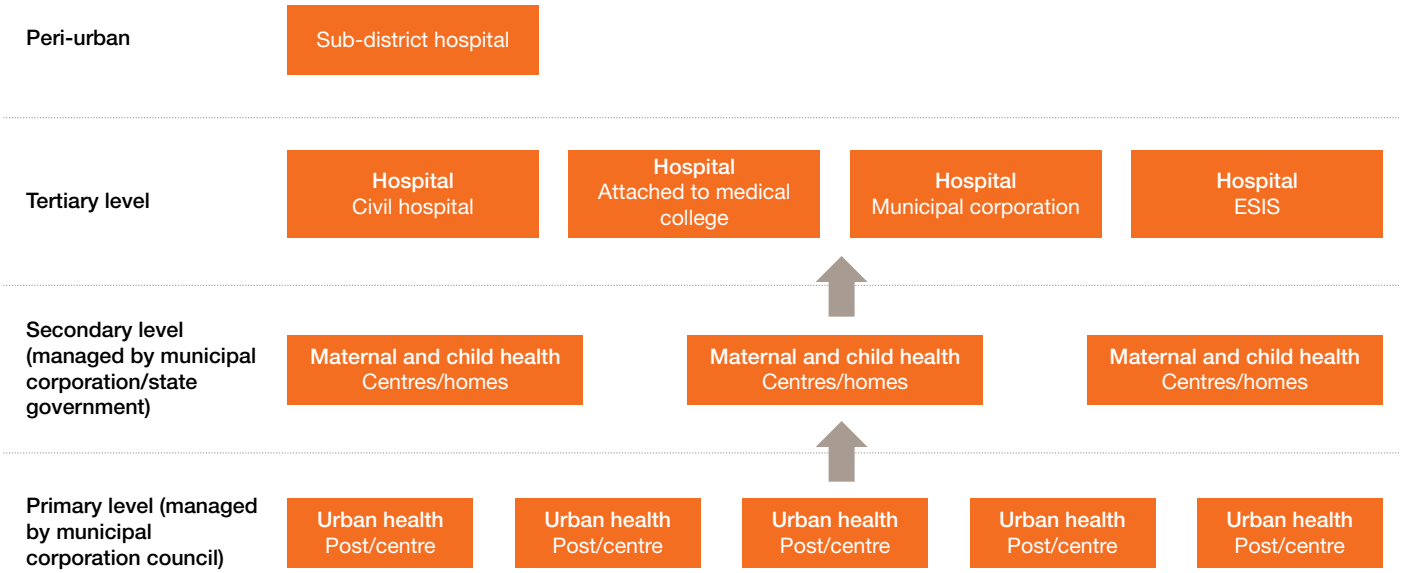
Secondary healthcare: Secondary healthcare refers to the second-tier of the health system, in which patients from primary healthcare are referred to specialists in higher hospitals for treatment. In India, health centres for secondary healthcare include district hospitals and community health centre at the block level.

Tertiary healthcare: Tertiary healthcare refers to a third-level of health system, in which specialised consultative care is provided usually on referral from primary and secondary medical care. Specialised intensive care units, advanced diagnostic support services and specialised medical personnel are the key features of tertiary healthcare. In India, under the public health system, tertiary care service is provided by medical colleges and advanced medical research institutes.

Source: http://www.arthapedia.in/index.php?title=Primary,_Secondary_and_Tertiary_HealthCare

Photo credit: Rachel Palmer/Save the Children

Urban public health structure



The following two boxes indicate the two different systems of urban healthcare present in India. The first talks about the system that operates in mega cities of India and the second is about the seven smaller cities. This gives an indication of the diversity of health delivery systems in urban India.

Three mega cities and four other metros with mandatory instructions in the NUHM: Key features

Seven metropolitan cities, viz Mumbai, New Delhi, Chennai, Kolkata, Hyderabad, Bengaluru and Ahmedabad will be treated differently. These cities are expected to manage the NUHM directly through their municipal corporations. Funds will be transferred to them through the state health society on the basis of their PIPs approved by the Government of India.

- Efforts were made in the metropolitan cities of Chennai, Bengaluru, Kolkata, Hyderabad, Delhi and Mumbai for improving the healthcare delivery through the World Bank supported IPP. Under the programme, 479 urban health posts, 85 maternity homes and 244 sub-centres were created, in Mumbai and Chennai as part of IPP-V and in Delhi, Bengaluru, Hyderabad and Kolkata as part of IPP-VIII.
- The ULBs, in line with the mandate of the 74th Amendment manages the primary healthcare services. However, in many cities such as Delhi, along with the urban local body, that is the Municipal Corporation of Delhi (MCD), the New Delhi Municipal Corporation (NDMC), Delhi Cantonment Board and other parastatal agencies along with the state government jointly provide primary healthcare services.
- The MCGM has a network of teaching hospitals, general hospitals and maternity homes across Mumbai.
- Two models of service delivery are seen to be prevalent in urban areas. In states such as Uttar Pradesh, Bihar and Madhya Pradesh healthcare programmes are being planned and managed by the state government. The involvement of the urban local bodies is limited to the provisioning of public health initiatives such as sanitation, conservancy provision of potable water and fogging for malaria. In other states such as Karnataka, West Bengal, Tamil Nadu and Gujarat healthcare programmes are being primarily planned and managed by the urban local bodies. In some of the bigger municipal bodies such as Ahmedabad, Chennai, Surat, Delhi and Mumbai the medical or health officers are employed by the local body whereas in smaller bodies, health officers are mostly on deputation from the state health department.
- In Kolkata, strong political ownership by elected representatives has played a positive role in the smooth implementation of the project and sustainability of the reforms introduced.
- Bengaluru and Kolkata have fully dedicated maternity homes in adequate numbers that facilitates better follow-up care. In Bengaluru, the management of health facilities has been handed over to NGOs.
- In several IPP VIII cities partnerships with profit or not-for-profit providers have helped in expanding services. Kolkata had the distinction of implementing the programme through establishment of an effective partnership with private medical officers and specialists on a part-time basis, fee-sharing basis in different health facilities resulting in ensuring community participation and enhancing the scope of fund generation.
- Andhra Pradesh has completely outsourced its service delivery in the newly created 191 urban health posts across 73 towns to NGOs. The experimentation, it appears, has been quite satisfactory with reduced cost.

Other Tier II or B level cities: Key features

Agra: In 2004, UHRC was designated by the Government of India as the coordinating agency for developing a sample health proposal for Agra city. The proposal was to guide the district health department as well as the municipal corporation to expand health services to the large urban poor population in the city. Based on the assessment, two approaches were followed, that clearly focussed on: involvement of NGOs to recruit and train community link volunteers (CLVs), formulation of Mahila Arogya Samitis (MAS), NGOs operating the urban health centres along with facilitation of linkages between community and service providers.

Coimbatore: There are nearly 750 hospitals in and around Coimbatore with a capacity of 5,000 beds. The first healthcare centre in the city was started in 1909. In 1969, it was upgraded to the Coimbatore Medical College Hospital (CMCH). It is a government hospital with bed strength of 1,020 and provides free healthcare. Including the CMCH, the corporation maintains 16 dispensaries and two maternity homes. The city also has many large multi-facility private hospitals. It remains the preferred healthcare destination for people from nearby districts and also from the neighbouring state of Kerala.

Indore: In partnership with the Department of Public Health, the Municipal Corporation of Indore, the district administration, NGO partners and local communities, the Indore Urban Health City demonstration programme was initiated in March 2003. The programme operates with the objective of improving maternal as well as child health and nutrition among the slum dwellers. Two programme strategies, the demand-supply and linkage approach and multi-stakeholder ward coordination approach were developed in order to improve the health of slum dwellers in a consultative manner.

Pune: The Pune Municipal Corporation provides public health services and has a robust health infrastructure comprising of 34 OPD units and two mobile healthcare units operated out of 11 urban health posts, 14 family welfare centres, one general hospital, two secondary hospitals, one special hospital for communicable diseases and one tertiary care hospital.

Lucknow: Health services in the city are provided by the public sector, the Department of Medical, Health and Family Welfare, the Lucknow Municipal Corporation and the private sector (hospitals, nursing homes, and clinics). In addition, there are several charitable hospitals, which provide subsidised health services to the poor. Also, there are central government health facilities, which include railways hospitals, ESI hospital and dispensaries and cantonment hospitals and dispensaries. Primary healthcare is provided through first-tier centres located in various parts of the city, which include UFWCs, urban RCH health, school health dispensary, medical care unit and urban RCH nodal unit. Due to substantial increase in the population over time, each health centre is now catering to a population ranging between 70,000 to 100,000, much higher than the norm of 50,000. Fifty-two ANMs are posted against an actual requirement of 100.

Navi Mumbai: Innovations in health infrastructure in 1992, led to the formation of a five-tier health system consisting of mobile clinics, 20 health posts, four maternity and child health hospitals (50-bedded), a general hospital and a proposed super speciality hospital. Earlier, 500-bedded hospitals for MCH used to be the norm. However, analysis of bed occupancy rates of these hospitals prompted a shift to 50-bedded MCH hospitals with the aid of PPPs. Twenty urban health posts (UHPs) with a total of 182 link workers were appointed by the NMMC under RCH-II. Parallel to the RCH, Navi Mumbai rolled out the Sure Start Project and developed excellent mechanisms since the project focussed on maternal and newborn healthcare. Most of the protocols for maternal and newborn care were developed through the Sure Start Project.

Surat: It has a four-tier system. The first tier comprises of a link worker who basically provides home-based care and support. The second tier includes trained ANMs, trained doctors and visiting paediatricians at the UHCs. The third tier comprises of maternity homes and the fourth tier consists of tertiary care centres, SMMIMER and civil hospital. Thus, most of the structure at the SMC is similar to the rural structure in Gujarat. The same administration and management pattern has been replicated in urban areas. Several state and central government schemes such as Sanjeevani, Bal Sakha, JSSK, NSSK and JSY are being implemented.

Child health in urban India: A historical backdrop

Child health: The influencing factors

Health outcomes are shaped not just by biological factors but also by the social, economic and cultural environment. Social hierarchies, living conditions, and inequitable distribution of power, money, and resources produce significant inequalities in the health and well-being of people. The journey in the life cycle of a child involves the critical components of child survival, development and protection. In the early 1980s, Mosley and Chen[156] suggested a framework of determinants for identifying proximate factors that affect child survival directly and underlying factors that are related to child mortality indirectly. WHO's conceptual model that was developed in 2008 for social determinants illustrates that structural factors lead to stratification in society on the basis of power, wealth, and position, which are the root causes of inequities in health.

Right to health

Child survival entails the basic right of children to be born in a safe and non-discriminatory environment and grow through their formative years of life in a healthy and dignified way. Adverse sex ratio at birth, high child mortality rates and the rapidly declining child sex ratio reflect the ensuing challenges.

It is important to note that the right to health is included in many national constitutions as a Directive Principle of State Policy. This is not itself legally enforceable but guides policy, and is a standard for measuring government performance and for advocacy. Directive principles can be used to argue for the recognition of an individual's rights through courts. For example, in Ghana, where the right to health is a directive principle, litigation has focussed on the right of the poor to user fee exemptions, which is covered in the legislation, rather than the right to health, which is not. Litigation has stimulated the Ghana Health Service to develop a set of patient rights. In many instances, laws exist but are not implemented, often because they are not known about. In some countries, laws related to reproductive, maternal and child health, are major barriers to reducing maternal and child deaths.

Evolution of health policy and programming for urban areas: An overview

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. More significant for policy formulation has been the share of urban population to the total population which has grown from 17.3% in 1951 to 31.2% in 2011.

On the recommendations of the Krishnan Committee, under the Revamping Scheme in 1983, the government established four types of UHPs across 10 states and union territories with a pre-condition of locating them inside or close to the slums. The main functions of the UHPs are to provide outreach, primary healthcare, and family welfare as well as MCH services. In reality however, limited outreach activities are being undertaken by the UHPs. Due to rapid growth of the urban population, efforts were made in the metropolitan cities of Chennai, Bengaluru, Kolkata, Hyderabad, Delhi and Mumbai for improving the healthcare delivery in the urban areas through the World Bank-supported IPP. It is only the India Population Project cities, which are conducting some outreach activities as community link workers are employed to strengthen demand and access. Limited outreach activities through the provision of link volunteers under the RCH are visible in Indore, Agra, Ahmedabad and Surat.

Post-1990 period

The post-1990 period saw the launch of several new projects by both multilateral and bilateral donors. This period saw the lead role of the World Bank in providing credit for numerous health, nutrition as well as reproductive health projects. The main features of the strategy were greater emphasis on outreach and priority in order to improve health services in urban slums and backward, high-fertility states not covered earlier. The IPPs, to some extent, resulted in enhanced service delivery and better capacity of urban local bodies to plan and manage health programmes in these cities.[157]

Apart from the IPPs, a new project called the Child Survival and Safe Motherhood (CSSM) project based on the above principles was launched in 1992 with IDA and World Bank support. The project provided direct budgetary support for the incremental costs to the MCH programmes. In particular, the CSSM supported two new programmes: the UIP Plus and Safe Motherhood, besides creating infrastructure across 90 backward districts for first referral units. This was followed by the RCH project launched in 1997 with IDA and World Bank credit of 248.3 million USD. The RCH dropped the target approach and encouraged the development of different implementation models in different situations.

Year 2000 onwards

The USAID in India launched a new Urban Health Programme activity in March 2002, introducing urban health into the USAID's portfolio in India for the first time. The four intermediate focus areas were: improved nutritional status for children under three years of age, improved health and survival of newborns, reduced morbidity and mortality from the major childhood illnesses in older infants and children under five, and improved child health and nutrition among the urban poor. Further, the USAID urban health EHP-UHRC programme aimed at 'improving child health and nutrition among the urban poor in selected cities by providing technical assistance to improve newborn care practices, coverage of immunisations and control of diarrheal diseases, prevention of malnutrition, and sanitation and hygiene practices.' The implementation results of this project influenced the GoI national programme in the following ways:

- The government's guidelines recommended that unlisted slums be identified and mapped, and urban health proposals for four cities were developed to target unlisted slums.
- It established the need to focus urban health activities on EAG states, and more importantly, on poor and underserved urban populations in those states.
- It directly applied the learnings from these activities to RCH-II
- It constituted an expert group on urban health.

Launch of the NRHM

The NRHM, the flagship programme of government in the health sector launched in 2005, aimed at inclusive health and improved access to quality healthcare for those residing in rural areas, particularly women, children and the poor by promoting integration, decentralisation and encouraging community participation in health programmes. The framework of its implementation was approved only in July 2006, and it therefore, became fully operational only in the financial year of 2007-08. This also coincided with the 11th Plan period (2007-2012).

From NRHM to NUHM

In order to effectively address the health concerns of the urban poor population, the Ministry proposed to launch the NUHM. The Mission Steering Group of the NRHM was expanded to work as the apex body for NUHM. Every municipal corporation, municipality, notified area committee, and town panchayat is to be a unit of planning with its own approved broad norms for setting up of health facilities. The separate plans for notified area committees, town panchayats and municipalities are a part of the district health action plan drawn up for the NUHM.

Structural and human resource propositions of the NUHM

Proposition		Serving
Urban primary health centre	U-PHC	50,000 to 60,000 population
Urban community health centre	U-CHC	250,000 to 360,000 population
		Five to six U-PHCs in larger cities
Auxiliary nurse midwife	ANM	10,000 population
Accredited social health activist	ASHA	200 - 500 households
Urban social health activist	(USHA)	1,000 – 3,000 population

Photo credit: Rachel Palmer/Save the Children

Access and use of health services: Poor and non-poor in cities

Results from a study looking at progress based on data from the three rounds of NFHS indicated that use of ANC services in the whole of India increased by 12 percentage points between 1992 and 2006 but that the increase among the poor was only 0.1 percentage points. The same study also showed that the use of skilled birth attendants had increased by 13 percentage points but that only 2 percentage points can be attributed to women belonging to the poorest quintile. This study also showed that the progress among the poor is substantially less than among the nonpoor in all states and that the use of skilled birth attendance among the poor remained low across an urban–rural spectrum.

A household survey from Chandigarh comparing coverage of maternal health care showed that among the women studied, only 32% of the women living in urban slums had an institutional delivery, compared to 93% of the nonslum urban women, and 79% of the women living in rural areas. A qualitative study on rural and urban areas of Maharashtra showed that financial constraints are important when understanding the user's perspective of barriers to maternal healthcare but that these are also closely linked to perceptions of healthcare. One of the findings from the study was that ANC and institutional delivery are both classified as preventative measures rather than curative and, due to financial constraints, are not prioritised.

Photo credit: Sanjit Das/ Panos for Save the Children

Post 2010: The launch of the NUHM

A pre-NUHM situational analysis clearly revealed that most of the existing primary health facilities, namely, the UHPs, UFWC or dispensaries are functioning sub-optimally due to problems of infrastructure, human resources, referrals, diagnostics, case load, spatial distribution, and inconvenient working hours. The NUHM, therefore, proposes to strengthen and revamp the existing facilities into an urban primary health centre with outreach and referral facilities, to be functional for every 50,000 population on an average.[158] The UPHC will provide preventive, promotive as well as non-domiciliary curative care (including consultation, basic lab diagnosis and dispensing). The treatment of seven metropolitan cities, viz, Mumbai, New Delhi, Chennai, Kolkata, Hyderabad, Bengaluru and Ahmedabad is to be different. These cities are expected to manage the NUHM through their municipal corporations directly.

Rural versus urban children

Urban Indians live across 7,935 towns and cities, of which 468 have populations of at least 100,000[159] and house 70% urban residents.

Of the 53 cities that have populations of over one million, three cities—Mumbai, Delhi, and Kolkata—are mega cities of over 10 million. Nearly 50% of the urban population of India lives in only five states, namely, Maharashtra, Uttar Pradesh, Tamil Nadu, West Bengal and Andhra Pradesh. Uttar Pradesh, which has just 22% of its population living in urban areas, accounts for almost one-fourth of the total urban population of these five states, purely due to its population size.

Although the idea of urban India conjures up images of these mega cities, the fact is that they have functional municipal corporations with a long history of grappling with urban concerns and at least to some degree, the health of their people. The most vulnerable healthcare systems are in rapidly growing smaller towns with less prepared governmental bodies and more fragile health services.

Child sex ratio

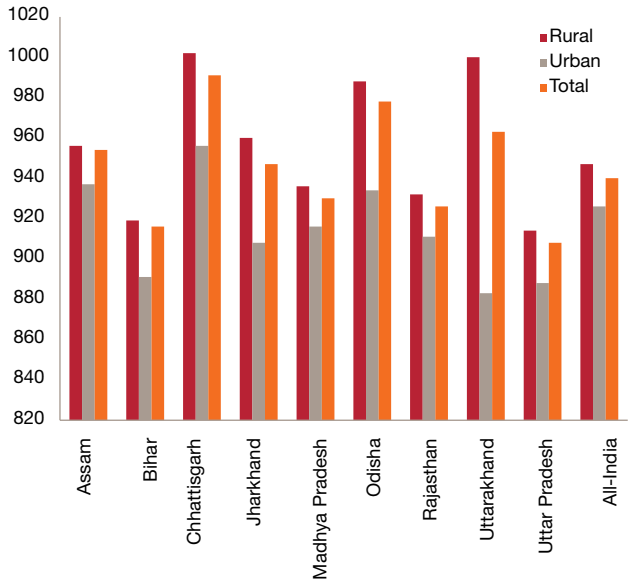
Gender disparities, reflected in preference for sons and the higher status of sons in the family, play a vital role in child survival and child health in India. Gender discrimination at each stage of the female life cycle contributes to gender-based health disparities, including sex selective abortions, neglect in care of the girl child, and poor access to healthcare for girls.[160]

From 1991 onwards, gender discrimination in India has manifested itself in the form of a continuous fall in CSR.[161] During 1991-2011, CSR declined in both rural and urban India. Though, the decline in CSR during 2001-2011 in rural areas is much sharper as compared to the drop in urban India still, a continuing fall in urban CSR is a matter of grave concern.

Child sex ratio (0-6 years) in India: 1981-2011[162]

	Total	Rural	Urban
1981	962	963	931
1991	945	948	935
2001	927	933	906
2011	919	923	905

Sex ratio in eight EAG states and Assam (Census 2011)



In the rural areas of 25 states and UTs, the CSR has declined in the 2011 Census over 2001, in nine states and UTs, CSR has improved in 2011 and there is no change in one state (Gujarat). The trend is slightly better in urban areas vis-à-vis rural areas, as in 21 states and UTs CSR has declined, in 13 states and UTs it has improved, and there is no change in one state (Kerala).

In the rural areas, CSR is higher as compared to urban areas in 26 states and UTs in the 2011 Census. In the urban areas of nine states and UTs (highly urbanised NCT Delhi, Chandigarh, Puducherry, Punjab, Maharashtra, Andhra Pradesh and Tamil Nadu, Mizoram and Manipur) CSR is higher when compared to their rural areas.

Child sex ratio: Distribution of districts in rural and urban India

Number of districts in each range of CSR (rural)			Number of districts in each range of CSR (urban)		
Range of CSR (0-6 years)	Census years		Range of CSR (0-6 years)	Census years	
	2001	2011		2001	2011
Total	640*	640	Total	640*	640
Nil (No rural)	9	9	Nil (no urban)	18	9
Up to 850	54	74	Upto 850	86	59
851-900	61	188	851-900	110	121
901-999	500	363	901-999	417	447
1000+	16	12	1000+	9	4

**O/o RGI generated 2001 results for the 640 districts of Census 2011*

In rural India, there were 74 districts with a CSR of less than 850 in 2011, a lot more than 54 found in 2001. Also in 2001, the CSR was greater than 900 in rural areas of 516 districts, a number that fell to 378 districts in 2011. On the positive side, in urban areas, the CSR has increased in 13 states, which is reflected in the increase in the number of urban districts in the category of CSR of more than 850.

Among the Annual Health Survey (AHS) states, sex ratio at birth was the highest in Chhattisgarh (951), and lowest in Uttarakhand (866). Across all the AHS states, except Rajasthan, Odisha and Assam, the sex ratio at birth was significantly higher in rural than in the urban areas. Uttar Pradesh, accounts for almost 12% of the total urban population of India and thus, is a major contributor to this phenomenon.

For the last 50 years, each successive census has found the number of young girls shrinking relative to boys. Interestingly, the deterioration in the child sex ratio has occurred in the face of rising living standards and improvements in every other indicator of demographic change and human development, average life expectancy, infant mortality, male and female literacy, fertility rate, and schooling enrolment of children. The problem is particularly severe at younger age groups. The child sex ratio has declined steadily from 964 in 1971 to 919 in 2011. The national PCPNDT Act of 1994, implemented in 1996, banned sex-selective abortions in the Indian states which hitherto had not formulated such a policy. Although demographers frequently mention the futility of the Act, there are studies that evaluate the law using a treatment-effect type analysis of the pre-ban and post-ban periods. Using village-level and town-level longitudinal data from the 1991 and 2001 censuses, one of the studies found a significantly positive impact of the PCPNDT Act on the female-to-male child sex ratio. In other words, in the absence of this Act, the child sex ratio would have declined further. Another interesting finding is the negative effect of female literacy rate on the child sex ratio. Two of the urban subsamples exhibit a weak negative association between female labour force participation rates and the child sex ratio. Again, this likely reflects the fact that women's participation in the formal workforce raises the opportunity cost of a child and lowers fertility. In the face of strong son preference, this induces couples to sex-select their children in favour of boys.[163]


Photo credit: CJ Clarke/Save the Children

In one of the studies undertaken in 2010, it was found that the implementation structures in most of the states have been constituted as per the Act. The identified gap, however, lies in their optimal functioning and effective delivery of operations as mandated. Despite broad awareness and knowledge about the Act, and their duties, an in-depth and accurate knowledge related to details of processes of filing complaints, collecting evidence, conducting decoy operations, conducting searches and maintaining records is a major gap which needs to be addressed. The Act is inadequately used while drafting court complaints and the full force of the law is often not brought to bear in prosecution. A total of 196 cases have been filed under the offence of non-registration of the Act, 153 under non-maintenance of records, 126 under communication of sex of the foetus and 37 under illegal advertisement at the time of the study.[164]

Another urban study in Navi Mumbai observed that although there was a high compliance with the PCPNDT Act, a significant percentage of doctors had only partially read the PCPNDT Act .The knowledge regarding the PCPNDT Act was imbibed mainly from whatever was instructed or informed by the appropriate authority and by their colleagues. Few doctors understood the motive behind the rules laid down by law. Most doctors were of the opinion that the PCPNDT Act needs to be continued although on its own it is not enough to curb female foeticide.[165]

Maternal and newborn health

In order to see the effects of the social determinants of health, one needs to view the urban data more closely. A special feature of NFHS-3 is the provision of separate estimates of population, health and nutrition indicators for eight cities (Chennai, Delhi, Hyderabad, Indore, Kolkata, Meerut, Mumbai and Nagpur) and for the slum and non-slum populations in each of these cities. Further, the Urban Health Resource Centre used an asset score to break NFHS-3 (2005-06) findings down into quartiles of socio-economic status. In urban areas in Delhi and six states, compared with wealthier groups, women in the poorest quartile were substantially less likely to make at least three antenatal care visits (54% compared with 83%) and to have a birth assisted by a health provider. Their children had higher under-five mortality rates, lower immunisation rates (40% compared with 65%) and higher proportions of stunting (54% compared with 33%).

The IMR varied widely across these cities, ranging from 28 per 1,000 live births in Chennai to 63 per 1,000 live births in Meerut. Differentials by slum/non-slum residence did not show a consistent pattern. In every city, at least 90% of children of age 12-23 months received some vaccinations. However, the proportion of children who received all basic vaccinations was not very high in any of the cities, ranging from 43% in Meerut to 78% in Chennai. In every city, except Chennai, vaccination coverage was higher for children in non-slum areas than in slum areas for almost every vaccination.

With regard to maternal and child care, although the utilisation of antenatal care services differs substantially among the cities and between their slum and non-slum areas, in almost all cases poor women are the least likely to receive antenatal care services. At least 60% of deliveries took place in health facilities, except in Meerut where only 46% of deliveries were conducted in health facilities. Institutional deliveries were nearly universal in Chennai, and were almost as high (92%) in Hyderabad.

Maternal and newborn health indicators in eight cities[166]

Cities	Area	NMR (per 1,000)	Antenatal care: 3 or more visits (%)	Skilled birth attendance (%)	Institutional delivery (%)	Caesarean section (%)	Postnatal check within 2 days (%)	Newborn put to breast within 1 hour (%)
Meerut	Slum	46	61	43	35	12	51	6
	Non-slum	36	61	60	56	15	67	7
Indore	Slum	42	84	80	76	17	76	32
	Non-slum	31	85	76	73	17	78	28
Delhi	Slum	36	58	42	33	7	44	18
	Non-slum	24	80	71	68	17	63	23
Nagpur	Slum	28	81	81	78	21	70	48
	Non-slum	33	94	87	85	35	74	50
Hyderabad	Slum	24	91	90	89	33	79	22
	Non-slum	26	91	95	93	37	84	29
Mumbai	Slum	24	90	82	83	13	62	50
	Non-slum	27	93	93	91	15	77	71
Chennai	Slum	23	99	99	98	23	96	62
	Non-slum	17	100	100	100	39	95	48
Kolkata	Slum	20	81	81	80	24	67	26
	Non-slum	34	90	93	92	41	76	22
India urban		43	44	37	29	6	25	22
India rural		46	61	43	35	12	51	6

The high neonatal mortality rates seen in Meerut and Indore slums underline concerns about health in rapidly growing cities. Even in the best circumstances (Chennai), rates of early breastfeeding were poor. A study involving about 300 mothers from 11 slums in Indore examined birth preparedness: 70% of mothers identified a birth attendant, 64% identified a health facility for an emergency, 30% arranged for transport and 77% saved money in advance. At a more micro level, a study in 48 areas in Mumbai demonstrated clear inequalities between socio-economic groups, even though all the participants lived in slums. There was a step-wise increase from the lowest to the highest quartile in the uptake of antenatal care, consumption of iron and folic acid supplements during pregnancy and institutional delivery, and a step-wise decrease in teenage pregnancy and low birth weight.

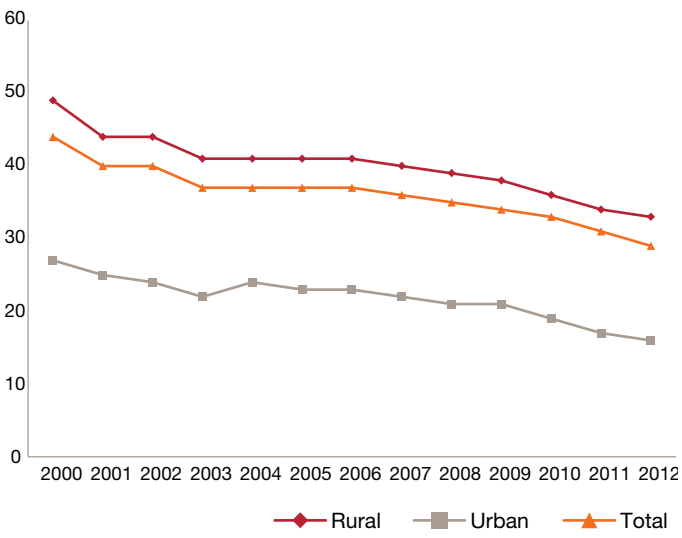
Neonatal mortality

Findings from the SRS and the Annual Health Survey, Office of the Registrar General of India (covering 284 districts of nine high-priority states), institutional records and isolated studies illustrate the steady fall in neonatal mortality rates over a decade, especially the fact that they are lower overall in urban than in rural areas, and reflect the relative lack of progress in reducing early neonatal mortality.

While the fall in NNMR is a positive development, the Annual Health Survey 2010-11 shows that in the EAG states and Assam, the NNMR continues to be high with NNMR highest in Uttar Pradesh (50) and lowest in Jharkhand (26). The rural-urban gap is also very significant in these states. However, the gap was found to be highest in Andhra Pradesh and Assam (23 points), followed by Rajasthan (22 points) and lowest in Kerala (3 points) followed by Tamil Nadu (6 points).

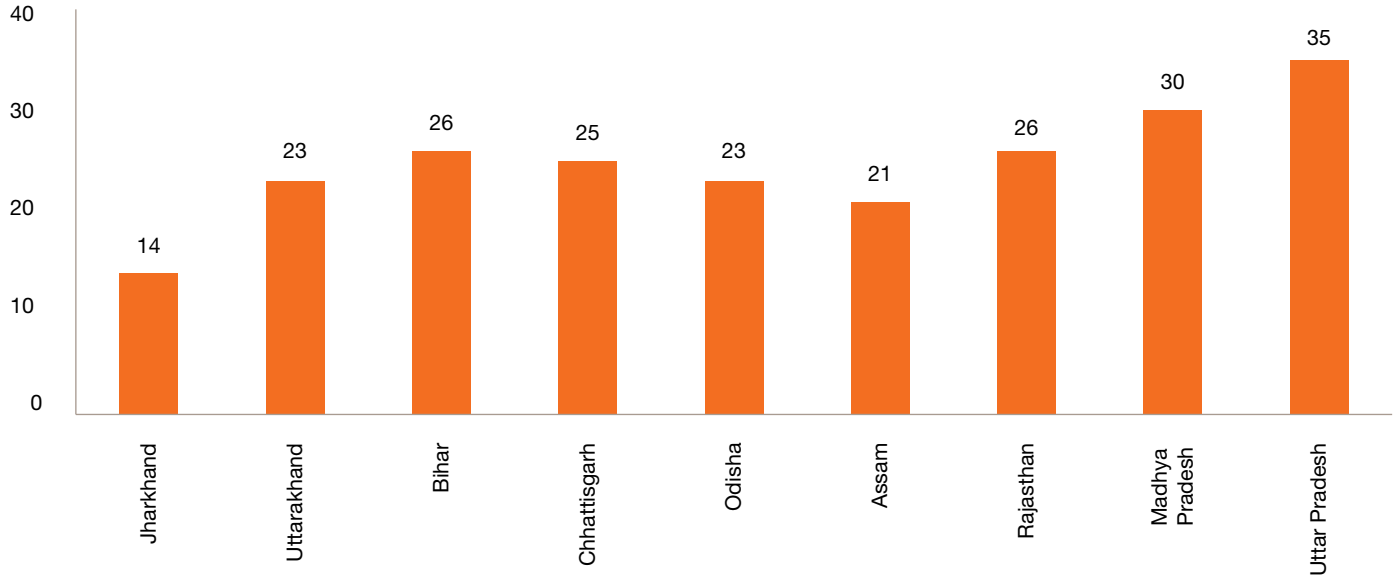
Reliable and disaggregated urban data or census data that include slums focussing on the most vulnerable city dwellers (often not counted), is completely absent.

Neonatal mortality rates by rural and urban residence



Source: SRS, RGI 2012

Urban neonatal mortality rates, per 1000 live births, in 9 EAG states



Source: AHS, 2010-11

Infant mortality

At the national level, the percentage share of infant deaths to total deaths in rural areas is 15.8%, whereas in urban areas, the figure is 9.7%. Kerala registered the lowest share of infant deaths (3% in rural and 2.3% in urban areas), followed by Tamil Nadu (5% each). The percentage share of infant deaths to total deaths is very high in Rajasthan (rural: 24.5%, urban: 11.9%), Uttar Pradesh (rural: 21.9%, urban: 17.1%) and Madhya Pradesh (rural: 21.6%, urban: 14.1%). Not only is the percentage share of infant deaths to total deaths much lower in other states but the rural-urban gap in the percentage is also lower as compared to that in Rajasthan, Uttar Pradesh and Madhya Pradesh.

The Annual Health Survey 2010-11 throws light on the current status of IMR in the states of EAG states and Assam. Among these states, the male-female gap in IMR is highest in Rajasthan, the female IMR is higher by 10 points than the male IMR, and this gap is mainly due to high mortality differential in the rural areas. In other EAG states and Assam, the difference between male and female IMR is less than 5 points (except Odisha).

Under-five mortality

Among children aged less than five years, the main causes of death are certain infectious and parasitic diseases (23.1%), diseases of respiratory system (16.1%) such as asthma, pneumonia, tuberculosis and malignant and other neo-plasm) diseases of nervous system (12.1%), diseases of circulatory system (7.9%), and injury,[167] poisoning and other major causes (33.9%).

U5MR at the national level has declined during the last decade. SRS-based U5MR in India for 2010, stands at 59 and varies from 66 in rural areas to 38 in urban areas. Within a span of last two years, U5MR has declined by 10 percentage points as against a drop of five points in the preceding three years. The U5MR is higher for females than males; in 2010, it stood at 64 for females and 55 for males. The male-female gap in U5MR was more in rural areas than in urban areas.

Under-five mortality rate in India (2010)

	Total	Male	Female
India	59	55	64
Rural	66	61	71
Urban	38	36	40

Source: SRS 2010

In 2010, among bigger states, U5MR varies from the lowest in Kerala (15) and Tamil Nadu (27) to alarmingly high level in Assam (83), Madhya Pradesh (82), Uttar Pradesh (79) and Odisha (78). In all the bigger states, U5MR is higher for the female child.

Death rates for children in age group of 5-14 years

The 5-14 years age group generally has lower mortality than the 0-4 years age group. The main leading causes of death in the 5-14 years age group are certain infectious and parasitic diseases (22.9%), injury, poisoning and certain other consequences of external causes (12.5%), diseases of the nervous system (11.5%), diseases of circulatory system (10.5%), diseases of respiratory system (8.5%), and other major groups (34.2%). Of total accidental deaths, 5.7% were reported as children (up to 14 years) during the year 2012 for the entire country.[168]

Literature clearly reflects that exposure to air pollution has been linked to poor child health outcomes in a range of studies that have looked at a variety of health measures.[169] For example, Frankenberg *et al* (2004) investigates the effect of outdoor air pollution due to forest fires in Indonesia in 1997 on infants and reports that there was a 1% decline in the Indonesian cohort size due to these fires. Smith (2000) on the other hand, looks at the impact of solid fuels used for cooking at home and suggests that as much as 4-5% of the national disease burden for India may be explained by indoor air pollution alone. Rise in ambient air pollution significantly increases the likelihood of a child suffering from cough and fever. However, the type of cooking fuel used at home is not significantly related to child morbidity after accounting for ambient air pollution and other child-level and household-level factors. Thus, while harmful air is bad for child health, we find that ambient air pollution is a more significant determinant of the child health outcomes. This suggests that controlling citywide air pollution could significantly lower child morbidity and should receive greater emphasis in urban planning and infrastructure development.[170]

As per the SRS report 2010, at the national level, the death rate (deaths per thousand) in the 5-14 years age group is estimated to be 0.9, with the urban areas registering significantly lower death rates (0.6) than rural areas (1.0). Among the bigger states, the lowest death rate in this age group is registered in Kerala (0.3) followed by Tamil Nadu, (0.5), Punjab (0.5) and Maharashtra (0.5) while the highest rate is observed in Jharkhand (1.4), Odisha (1.3) and Uttar Pradesh (1.3).

Immunisation status of children

The coverage evaluation survey published in 2009 by UNICEF and GoI, reveals the immunisation coverage rates[171] for each type of vaccine, according to either immunisation card or mother's recall. The analysis of vaccine-specific data indicates higher coverage for each type of vaccine in urban areas than in rural areas.

At the national level, 61% of the children aged 12-23 months have received full immunisation. The coverage of immunisation was higher in urban areas (67.4%) compared to that in the rural areas (58.5%), though in rural areas the 2009 level was a major improvement over the proportion of 47.4% recorded in 2005. It is a matter of concern that nearly 8% children did not receive even a single vaccine.

According to the Annual Health Survey, nearly 62% of the male children aged 12-23 months have received full immunisation, while among the females the figure was nearly 60%. It is shocking to note that the birth order of the child still continues to affect the immunisation coverage. While 67.4% of birth order-1 children are fortunate enough to receive full immunisation, only 40.4% received it in the category of birth order 4 and above are covered under full immunisation.

In comparison to 2005, measles immunisation in rural areas improved from 61.8% to 72.4%. In contrast, urban full immunisation remained unchanged at about 67.5%. Urban measles immunisation coverage in this period declined from 79.4% from 78.3%. Thus, rural-urban aggregation underplays the improvement in rural areas. Immunisation is an outreach programme in rural areas, whereas no such provisions are available in urban areas.

Healthcare burden

Evidence clearly indicates that all the childhood mortality indicators among urban poor are higher compared to the urban averages: 72.7 vs 51.9 for the U5MR, 54.6 vs 41.7 for the IMR, and 36.8 vs 28.7 for the NMR.[173] In these circumstances, healthcare expenses are significant for the urban poor as they seek medical intervention either from private providers or wait till the condition is critical, warranting tertiary level healthcare which is costly. The associated costs include missed work, travel costs, and costs of medicines, diagnostic tests and other medical procedures.

Percentage of children aged 12-23 months who received specific vaccination[172]

Antigens	Rural	Urban	Total
BCG	86.0	89.2	86.9
OPV0	63.3	73.2	66.0
OPV1	81.3	86.3	82.7
OPV2	76.1	82.4	77.9
OPV3	68.2	76.3	70.4
DPT1	81.3	85.8	82.6
DPT2	76.5	82.7	78.2
DPT3	69.1	77.6	71.5
Measles	72.4	78.3	74.1
Full immunisation	58.5	67.4	61.0
Received no vaccination	8.5	5.2	7.6
Vitamin A 1st dose	63.2	66.0	64.0

The prevalence of private healthcare facilities in urban areas may place the urban poor at a further disadvantage. Studies have shown that women are more likely to consult private providers than public healthcare providers. Lower socio-economic groups cannot afford expensive private care and often consult unlicensed and untrained, yet more affordable private healthcare providers.

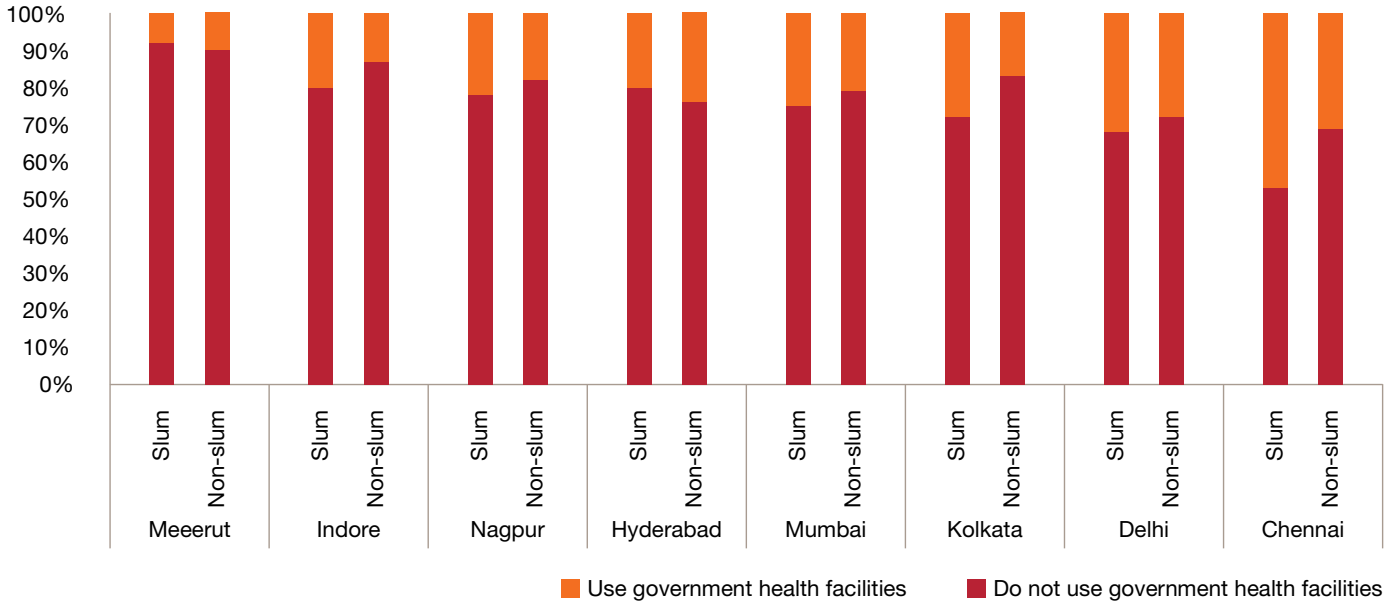
For the urban poor, public health is not a daily concern like food, shelter or recompense. It is more of a concern in the time of emergencies, when there are injuries caused by violence, or work, or infections brought on by the profusion of vectors—mosquitoes chiefly, but also viruses, helminths and dogs—that thrive in their vulnerable shanty areas. In Patna, for example, Kamala Nehru Slum is bifurcated by a drainage channel carrying untreated sewage; solid, liquid and gaseous effluents are attributable for the death of children due to diarrhoea and pneumonia, and of adults from tuberculosis.

> *"During rains, the small drains clog and people usually fall sick with malaria or typhoid."*
>
> - A girl of 15 from Mumbai

For maternal and newborn care, there is a lack of norms for service provision at different levels of health facility. No protocols exist for identifying women at risk and referring them for specialised 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 at best, accountability is minimal and transport is often the responsibility of the family. A central issue is the multiplicity of providers, with limited accreditation and quality assurance. Despite the policy emphasis on state and municipal healthcare provision, 80% of outpatient consultations in India are with private providers. This is illustrated by the preference for non-government health services in both slum and non-slum areas in cities.[174]


Photo credit: Valay Singh Rai/Save the Children

Preference for non-government health services in cities



Private healthcare clusters in towns and cities serve both the poor and the wealthy, through a self-organising complex system that takes into account the ability to pay.[175]

A study of 261 private hospitals in 10 districts of Maharashtra (India's second-most urbanised state) confirmed the rising use of private care. Many hospitals are understaffed—particularly in terms of qualified health workers: more than half did not have a single qualified nurse at the time of the study—and accreditation is limited.

Multiple service providers for maternal and newborn care in urban areas: Example of Delhi

Sector: Public

Providers
Central government
Delhi government
Municipal Corporation
New Delhi Municipal Corporation
Employees' State Insurance
Central Government Health Scheme
Railways
Cantonment

Sector: Private

Providers
Corporate hospitals
Large private hospitals
Small private hospitals
Nursing and maternity homes
Non-government organisations
Individual practices: Allopathic, AYUSH combination
Traditional birth attendants

Current situation: Key challenges

India's urban growth has been described as following a '2-3-4-5' pattern: annual population growth of 2%, urban population growth of 3%, mega city growth of 4% and slum population growth of 5%.[176] According to the 2011 Census, 63% of towns reported at least one slum block and 108,227 slums were included. Overall, about 17% of urban households live in slums, but the proportion varies across states.[177]

Nearly every city in the country has pockets of extreme deprivation together with extreme wealth. There are people who over-consume healthcare and people who forego the most basic and essential care for financial and other reasons. Certain city dwellers suffer disproportionately from poor health, and these inequities can be traced back to differences in their social and living conditions. No doubt, India's towns and cities enjoy a health advantage, but it has become increasingly obvious that the net benefits of urban living conceal substantial inequalities.

Inequity

There are clear inequalities between socio-economic groups in terms of access to ANC care, assisted births, immunisation, prevalence of malnutrition and early pregnancy, even where all mothers lived in slums. Though large disparities in health and living conditions between the poor and the non-poor children reflects an obvious need to improve living conditions and the health of children in slums, it is equally apparent that programmes that focus solely on slum areas will not be able to address the urgent needs of the large poor population not living in slums. Findings like these clearly point at the need for healthcare programmes designed specifically for the urban poor mothers and children with objectives such as promotion of IFA, institutional deliveries and immunisation.

Vulnerable groups reported the need for service that is better timed. This pertains to daily timings for check-ups. A UPHC in Bhubaneswar reportedly was open from 9am to noon and then from 3 to 5pm while in Delhi and Pimpri-Chinchwad (Pune), dispensary timings are from 8am to 2pm. This excludes all domestic workers and daily wage workers, even self-employed impoverished workers, indeed most of the populations. A visit to a morning OPD at UPHC would cost them a day's wages.

In Kochi, slum dwellers employed in waste collection reported not being able to access public health services because by the time they finish work and come to dispensaries, outpatient coupons are sold out.

In many cities, including Kolkata, Bhubaneswar, Guwahati, and Ahmedabad among others, vulnerable groups mentioned that public health facilities were simply too far away.

Environmental challenges

Communities suffer deficiencies in water supply and sanitation. Further, poor housing fabric, poor ventilation, and the density of homes contributes to the spread of infectious diseases and respiratory illness. Many homes are situated near sources of industrial smoke and toxins, contaminated areas such as garbage dumps and water bodies, or hazards such as railway lines. Increasing pollution levels has a direct impact on children's health. According to the WHO, India is ranked among the world's worst for its air pollution, with 13 out of 20 most polluted cities in India alone. Due to the increasing level of pollution in the country, the number of deaths due to pulmonary and respiratory diseases is also rising significantly. However, the air inside our homes can be up to 10 times more polluted than the outside air, according to US Environmental Protection Agency. As an average person spends around 90% of their time indoors, either at work or at home, indoor air quality plays a significant part in the general state of health. This is particularly true for children, elderly people and other vulnerable groups. While we pay attention to our health when considering our diet, most of us are indifferent to the quality of air we breathe.[178]

Access to water and sanitary facilities such as toilets and bathrooms is also a part of the environment in which the urban poor live. Most slum dwellers, including children either use shared toilets or defecate in the open, which exposes them to a risk of diarrheal diseases, infection of the skin and vagina, worm infestation, etc. This aspect has been discussed in more depth in the chapter on WASH.

Service delivery challenges

The mandate for provision of municipal services is unclear when settlements are not notified and their residents do not have tenure, with implications for water supply and collection of waste. There is a lack of coordination and convergence between the relevant departments dealing with water and sanitation, housing, transport and health.

The varying quality of public healthcare is the product of a matrix of infrastructural weakness, deficiencies in equipment and consumables, human resource shortfalls and limited provider competencies. Referral chains have been undefined and based more on a hospital's reputation and bed availability than on a regional plan. Thus, the paper trail is sketchy, accountability is minimal, and transport is often the responsibility of the family.

Lack of regulation and out-of-pocket expenditure

Reports of malpractice, over-medication, inappropriate prescription practices and treatments, and excessive use of diagnostic tests are common. Health payments for delivery at a private health centres are about three times higher than those at a public facility. Out-of-pocket payments can be impoverishing.

Incompleteness of data

Data on the vulnerable population in urban areas is grossly incomplete, missing out a sizable number of unlisted slums in any city. A need for targeting the most vulnerable as well as addressing the needs of the differentially vulnerable requires identification, mapping and assessment of all slums in order to locate the hitherto missed slums and also for focussing on the neediest. NFHS-4 data that may be released in 2015-16 would be able to provide the above mentioned information.

Identity factors

The BPL card system gets rather complicated due to slum notification issues. No uniform methodology has yet been evolved to identify BPL households in the urban areas. While the Ministry of Rural Development took the initiative to put in place a systematic approach for identification of BPL families in a uniform manner in the rural areas, for the urban areas there has not been any such mechanism except certain guidelines through which the states and UTs devised their own methodology or criteria on the basis of state-specific poverty lines for urban areas, as defined by the Planning Commission for poverty estimates from time to time.[179] A specific information problem relates to the lack of harmonisation between sources and the lack of accessibility to some of them. Bringing together the municipal data from a wide range of sources, including public and private hospitals and maternity homes, health posts, crematoria and local surveys poses challenges and, even if successful, may systematically exclude the most vulnerable. Most cities lack epidemiological data, information on the urban poor and illegal clusters, and information on private health facilities. India's cities also lack information management systems that can help with urban planning, particularly in for slum areas.

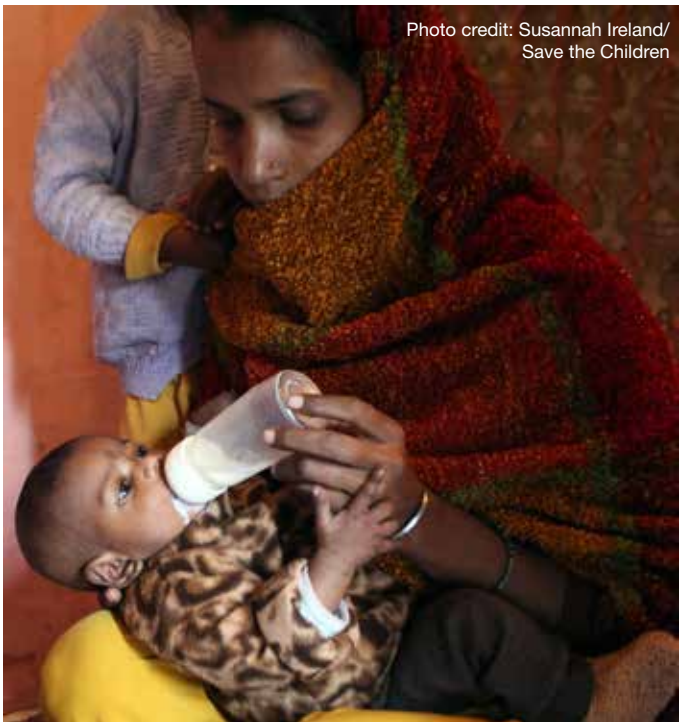


Photo credit: Susannah Ireland/ Save the Children

Efforts undertaken to deal with challenges

Governance and service delivery platforms

There seems to be, at first appearance, a wide and bewildering diversity of institutional arrangements for the attainment of better health outcomes and the delivery of healthcare services in urban India. But for ease of analysis these can be categorised into three broad institutional patterns from the perspective of which layer of government takes primary responsibility for organising healthcare.[180]

In the first pattern, healthcare facilities are entirely provided by the state departments of health, with no involvement of the 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 like Himachal Pradesh and Bihar and in small towns (typically less than 2 lakh) in almost all 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. Bhubaneswar is a typical example of this.

In the third pattern, most of the healthcare facilities are under the ULB which looks after medical and non-medical public health functions in an integrated manner. The state government may have a few facilities, usually medical college hospitals; but the rest of the functions are delivered effectively by the ULB. This is the pattern in all the major metros: Mumbai, Kolkata, Chennai, Bengaluru, Ahmedabad and Delhi, though in the last the state government too administers several facilities. Among non-metros, Pimpri, Visakhapatnam, Burdwan and Madurai show this pattern.

Re-organising the healthcare pyramid

The ideal organisation of healthcare services could be described as a healthcare pyramid. At the bottom of the pyramid are community and outreach processes where community health workers and frontline health workers like ANMs provide services. At the next level are the primary health centres that, together with the frontline health workers and community and outreach processes, constitute the primary care team. This is where the major part of the preventive and promotive action takes place, as well as the largest number of curative clinical encounters. Over 70% of health services occur at this level. At the next level are secondary hospitals that serve as the first referral site, offering hospitalisation and a larger range of diagnostics. This is an integral and essential part of the primary healthcare. The district hospital or medical college hospital at the apex is the hospital providing tertiary healthcare. Only 5% of care and illness requires


Photo credit: CJ Clarke/Save the Children

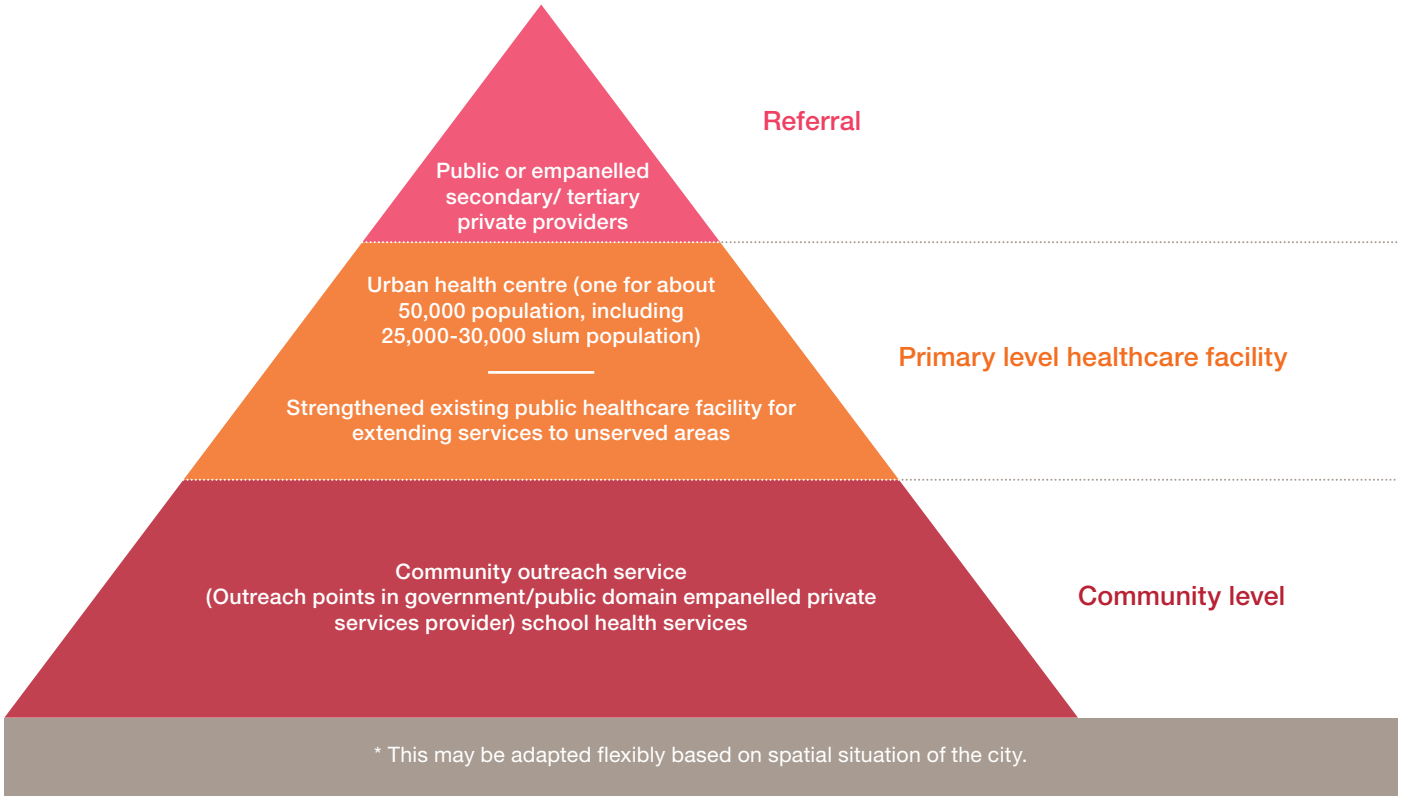
tertiary levels of care, with a majority of this being for complex illnesses requiring medical professionals, who have specialised skill sets or who are needed to make informed judgments, or where high levels of technology support are required.

Primary care is being accessed at all five levels: medical college hospitals, secondary care hospitals (two levels), primary care facilities and outreach services. In terms of the frequency of use, an inverse pyramid phenomenon works. The major proportion of curative primary care provision may be occurring at the medical college and the district hospitals, with the urban health centres and maternity homes catering to a much smaller proportion and almost no care occurring at the outreach of community level for a major part of the population. This does not happen to such an extent in a rural setting, because of the distances. However, in urban areas, geographical distance is not a major barrier, and since services are more assured at a higher level, the poor prefer to go there.

Addressing the structural determinants and building all the pillars of primary healthcare that impact child morbidity and mortality will help in changing the current scenario of healthcare available for the children.

In response to the needs for convergence and public health management, the NUHM envisions 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 health facilities. These urban local bodies will prioritise services for the urban poor (in both listed and unlisted slums) and for vulnerable groups such as the homeless, rag-pickers, street children, rickshaw pullers, construction and brick and lime kiln workers and sex workers.

Proposed national urban health service delivery model



Source: NUHM Framework, Ministry of Health and Family Welfare, 2013 [28]

Dealing with challenges related to health-seeking behaviour

Reasons for this inverse pyramid in urban areas have been attributed to different reasons across stakeholders. Preference for a bigger hospital and the specialist is considered to be an inherent health-seeking behaviour in urban areas. Poor quality of care and lack of service provision are perceived as few more reasons. However, a mismatch between the services available and the services needed and that service packages at each level are not responsive to needs is also a crucial factor. In the periphery, the urban health centres (where established) or the UFWCs along with maternity homes provide a minimal range of services in primary care, with a focus on family planning and a limited menu of reproductive and child health services. In most cases, these may be limited to immunisation and antenatal care and to institutional deliveries in the maternity homes and some level of symptomatic minimalist curative care.

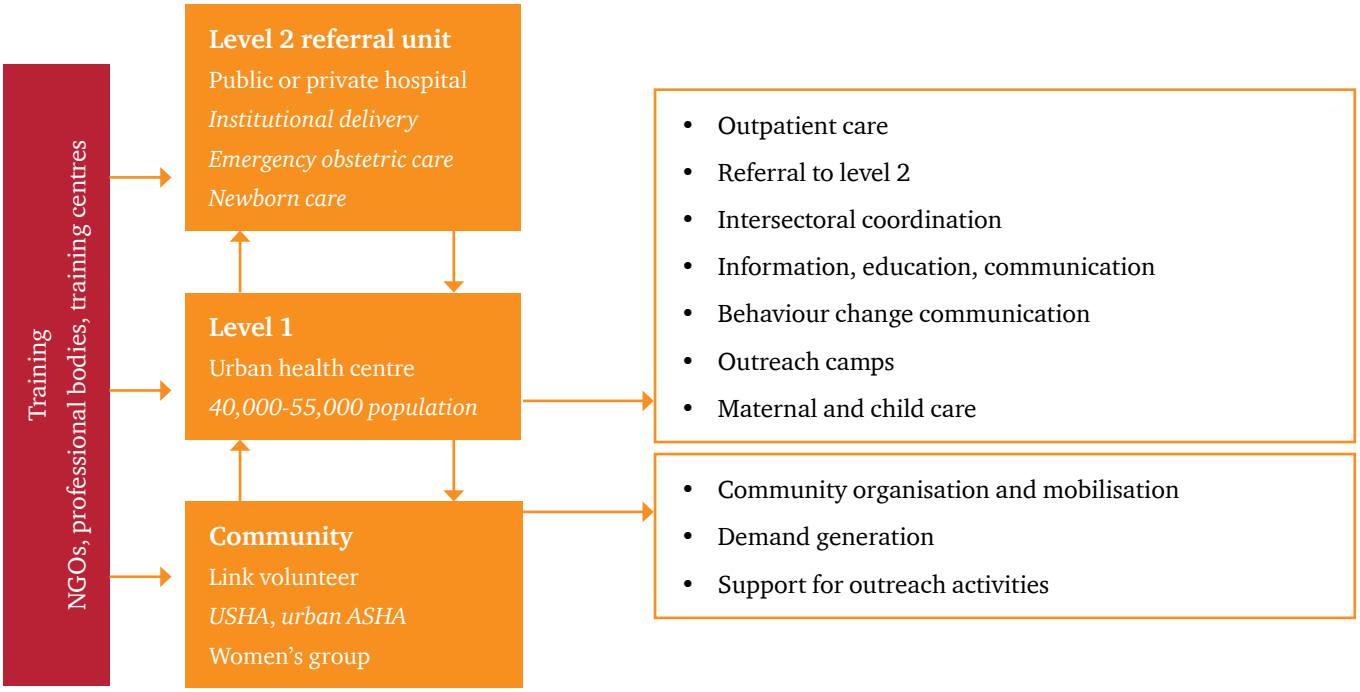
Developing referral mechanisms

NUHM is currently setting up well-identified primary healthcare facilities for each segment of the target population that can be accessed conveniently. The UPHC will act as a common platform for availability of all services. Mechanisms of referrals should be operationalised, to make the PHC effective. The PHC will also provide outreach services. This will be done by the female health worker, who will be provided mobility support for the purpose. Services will be universal in nature. Community participation will be encouraged by a community link volunteer urban ASHA. Creation of community-based institutions like MAS involving 50-100 households will empower women so that they can demand services. The MAS will be provided an annual grant of 5,000 INR every year. This can be used for meetings, sanitation, hygiene or emergency health needs. Self-help groups of women established under other programmes can also play the role of MAS. The NUHM also proposes incentives to the group on the basis of the targets achieved for strengthening the savings. Although these guidelines set the pattern for creation of these structures, states have the flexibility to decide which model suits them best. States should involve NGOs to facilitate communitisation, especially when reaching out to vulnerable groups.

Apart from this, the 12th Plan document notes that "inadequate regulatory standards in many health and health related fields have been a major problem in India." The document further lists the following advances made in regulation of private and public health services in the 11th Plan period:

- Enactment of the Clinical Establishments (Registration and Regulation) Act, 2010 and the notification of Clinical Establishments (Central Government) Rules, 2012
- Creation of a National Health Regulatory and Development Authority to regulate both public and private healthcare providers. The powers of these would include overseeing contracts, accrediting healthcare providers, developing ethical standards for care delivery, enforcing the patient's charter of rights, formulating legal and regulatory norms and standard treatment guidelines and management protocols for the National Health Package so as to control entry, quality, quantity and price.

Referral mechanism



RMNCH+A service package for urban areas

In urban areas, reproductive, maternal, newborn and child health + adolescent (RMNCH+A) strategy focuses on unreached people in underserved localities, particularly slums, the homeless, street children, ragpickers, temporary migrants and construction workers. A systematic plan has been developed for urban areas, including a service package. RMNCH+A will be monitored with a scorecard covering 16 indicators. Maternal, newborn and child health indicators are the prime.

Best practices of NGOs, government, etc

Since urban health involves the convergence of domains, a number of programmes and policies implemented by the Ministry of Housing and Urban Poverty Alleviation are also important. Launched in 2005 and revised in 2009, the Jawaharlal Nehru National Urban Renewal Mission (JNNURM) covers the provision of basic services for the urban poor (BSUP) and the Integrated Housing and Slum Development Programme in 65 cities. The Swarna Jayanti Shahari Rozgar Yojana (SJSRY, revised 2009) targets skill

Photo credit: Chhandak Pradhan/Save the Children

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 RAY envisages a slum-free India and proposes affordable housing by merging the AHIP and ISHUP and extending JNNURM support to states that are willing to assign property rights to people living in slums. The idea is that existing slums will be formalised and provided with amenities.

A few city initiatives and innovations in Uttar Pradesh, Maharashtra and Gujarat have definitely brought forth the evidence of effectiveness of Behaviour Change Communication (BCC), Kangaroo Mother Care (KMC) and other innovative strategies in urban areas.

Public-private partnerships

Through policy dialogue, the Government of Gujarat and the Urban Health Alliance have addressed public-private partnership in a number of ways. Major initiatives include the Chiranjivi Yojana and the Balsakha Yojana, both of which aim to improve newborn survival. In 2011-2012, 72% of deliveries in Gujarat took place in private healthcare institutions and 13% were covered by the Chiranjivi Yojana. Some of the initiatives are described below.

Private maternity and child care for lower-income families

The Lifespring initiative responds to the preference for private healthcare in lower-income groups. In 2005, a chain of hospitals was set up in Hyderabad, Andhra Pradesh, by a partnership between Acumen Fund, a private enterprise social fund, and HLL Lifecare Ltd, a public sector company. Small private maternity hospitals have been set up in urban slums to provide affordable, high-quality maternity care at low cost. Complicated maternities are referred to nearby charitable hospitals. The model is for-profit, but aims at cost-minimisation through the use of leased buildings, collaboration with government ambulance services, deployment of nurse-administrators and auxiliary nurse midwives, and careful stock control for drugs and consumables.

Merrygold model of maternal and child care (Uttar Pradesh)

In Uttar Pradesh, Merrygold has implemented a private sector social franchise that provides maternal and child care through 70 hospitals, 700 clinics and 10,000 workers across about half the state. The franchise hospitals have 15-20 beds each and pay a licence fee that effectively buys them into a multi-partner private sector system with protocols, information systems, purchasing and supply networks and quality assurance.

Photo credit: Prasanth Vishwanathan/Save the Children

Behaviour change communication and community mobilisation

In the context of multiple providers, it does seem possible to help families to choose appropriate practitioners to care for their newborn infant's illness. A study in urban Lucknow, Uttar Pradesh, examined the effect of BCC at two public hospitals on newborn care-seeking with qualified clinicians. Mothers were counselled and provided with a Neonatal Well-Being Card (Navjat Shishu Raksha Card). The odds of consulting a qualified practitioner doubled after the intervention. Along with BCC, social mobilisation should be a component of efforts to improve perinatal health. In Mumbai, the Society for Nutrition, Education and Health Action (SNEHA) introduced a combination of supply- and demand-side approaches to newborn health in slums. One axis sought to address low uptake of antenatal care at health posts, lack of protocols for case management, disorganised referral systems, and technical and interpersonal skill deficiencies among public health workers. The other axis hoped to build on the success of community participation through women's groups.

Gujarat Urban Health Alliance

Gujarat is the third most urbanised state in the country with approximately 15% BPL population and 18% urban slum population. Increase in the number of urban poor is a big challenge for the state. The Gujarat Urban Health Alliance has attempted to achieve convergence through a series of plans: an urban health system plan; an urban health administrative structural plan including state, regional, and zonal bodies; an urban reproductive and child health service plan, an urban health monitoring plan; and the formation of urban health societies.

Urban Health Initiative (Uttar Pradesh)

Their goal is to improve maternal and infant survival in urban settings, with an emphasis on strategies to expand access to and use of family planning. It supports: a) individuals to use services and supplies and practice health behaviours that enable them to achieve their desired family size, maintain good health, and enhance their chances of survival; b) providers to deliver evidence-based quality services and supplies that are responsive to client need, choice, safety, and satisfaction; c) programmes and policies to expand access and utilisation of services and supplies associated with improved health.

Sure Start (Maharashtra)

A recent commission on healthy cities recommended the option of trying out a range of approaches to improving urban health and choosing successful features from among them. Implemented by PATH, the Sure Start initiative aimed to improve maternal and newborn health through action in slums in seven cities in Maharashtra. In each case, a common minimum programme was implemented and city-specific models—developed in partnership with NGOs, academic institutions, public health training institutions, and municipal corporations—piggybacked on it. Seven municipal corporations tested strategies pertaining to mobilising communities through volunteers and self-help groups; integrating HIV and maternal and newborn care; establishing emergency health funds; public-private partnership between the municipal corporation, community-based organisations and professional bodies; establishment of client satisfaction norms; establishing community resource centres; and community-based health insurance mechanisms.

Conclusion

There are wide variations in urban accommodation between cities and states, and a long history of debate about the urban slum policy and practice. Socio-economic inequalities and environmental concerns pose major challenges for children. Healthcare is concentrated in urban areas, but health outcomes are subject to variations in pluralistic provision and a lack of clarity in protocols, communication, referral, and transfer between institutions. Fragmented and weak public health systems, a multiplicity of actors and limited public health planning capacity compromise the delivery of affordable quality healthcare for children. Moreover, data on urban child health are both limited and difficult to use to provide useful epidemiological and planning information. Though, within the National Health Mission, the NUHM provides an opportunity for strategic thinking and actions to improve urban child health, evidence on effective strategies and implementation mechanisms is much required. Above all, the RMNCH+A initiative offers an opportunity to integrate healthcare over the lifecycle.

Recommendations

- Efforts are required to generate evidence on the indicators of child health, specifically poor versus non-poor and slum versus non-slum in urban areas.
- It is important to develop and implement models of child care for urban populations with a focus on the poor within the NUHM framework. Currently, the Saving Newborn Lives (SNL) project of Save the Children is working in the cities of Pune and Bhubaneswar[181] on building quality evidence to identify opportunities and gaps in health system, factors affecting programming and service delivery, and potential strategies to address specific maternal and newborn healthcare needs of the urban poor in India.
- Policies and efforts on convergence mechanisms of public, private and third sector institutions whose work affects urban newborn health, water and sanitation, urban planning, transport and building should be made.
- Redefining the roles of urban local bodies in public health, including child health is required.
- Training, deployment and support for human resources for urban healthcare remain central to efforts to improve child survival.
- Staffing norms need to be defined for public and private urban health facilities, both within and outside NUHM.
- It is worth considering partnerships with professional bodies like National Neonatology Forum, IAP Indian Academy of Paediatrics, and Federation of Obstetric and Gynaecological Societies of India for service delivery, to develop standard norms and protocols, training and quality assurance.
- There should be operations research to demonstrate sustainable urban models of child healthcare.

Malnutrition among children in urban India

Dr Sheila C Vir

Introduction

The immense challenge of addressing malnutrition in urban children has gained increased attention in the last decade. The State of the World's Children Report of UNICEF 2012 states, "Children in urban areas are often better off than their rural counterparts. This is a result of high standards of health, protection, education and sanitation. But urban advances have been uneven. Millions of children in a marginalised setting confront daily challenges and deprivations of their rights."[182]

The problem of undernutrition in children is of a serious magnitude in urban India. Increasing urbanisation poses a significant challenge to the nutritional status of children, especially those living in urban slums or in poor regions which are not registered as slums. Due to the lack of investment in public utilities (discussed in more detail in the Chapter on Urban Governance) coupled with substantial growth in the urban population due to a poverty-led massive rural to urban migration, most urban dwellers have poor access to health and education services as well as inadequate availability of water, sanitation, drainage and garbage collection services. A significant majority of the urban poor resides in informal settlements and slums which are usually overcrowded, devoid of basic amenities and surrounded by a hazardous environment. The grave urban scenario of undernutrition confirms the hardships faced by poorer urban children.

Besides undernutrition, there is also a rapidly emerging problem of overnutrition, especially in middle and upper wealth quintiles, with accelerated increase in the incidence of non-communicable diseases during adulthood.

Nutrition situation in urban India: An overview[183]

Malnutrition is a broad term which includes both undernutrition and overnutrition. It may be noted that the term malnutrition is commonly, and acceptably, used as an alternative to undernutrition. The term undernutrition refers to deficiencies of both macro (protein energy) and micronutrients. Nutritional status is measured using the following three anthropometric indicators:

- Stunting
- Underweight
- Wasting

The micronutrient status is assessed using clinical and biochemical measures. The malnutrition data for urban India is primarily from the National Family Health Survey (NFHS 3) 2005-06 which also includes special data of eight selected cities.

Underweight and stunting in urban children

An analysis of urban and rural Indian children below five indicates that the prevalence rate of underweight, stunting, wasting and SAM is much lower in urban areas than in rural areas. At an all-India level, 32.7% urban children under five years are underweight compared to 45.6% in rural regions while 39.6% of urban children are stunted as compared to 50.7% in rural areas. However, with rapid urbanisation, the number of undernourished children in absolute numbers remains high in urban India.

No gender difference has been reported for all-India prevalence rates of undernutrition. The percentage prevalence of undernutrition measured in terms of stunting, wasting and severe wasting is similar in male and female children while the prevalence of underweight is slightly higher in female children and severe wasting slightly lower. The difference in prevalence rates is evident in the wealth index—six out of 10 children under 5 years is stunted in the lowest wealth index as compared to 2.5 children out of 10 in the highest wealth index. It is of concern that a quarter of children in the highest wealth index are also undernourished.

Measures of undernutrition

Stunting is a measure of height for age, underweight is a measure of weight for age and wasting is a measure of weight for height. Stunting is a measure of chronic malnutrition. Underweight can result from either chronic or acute malnutrition or both. Wasting is a measure of acute malnutrition. These are often not visible[184] nor identified as problematic conditions unless in case of severe wasting or SAM. MUAC below 115 mm is a measure of SAM.

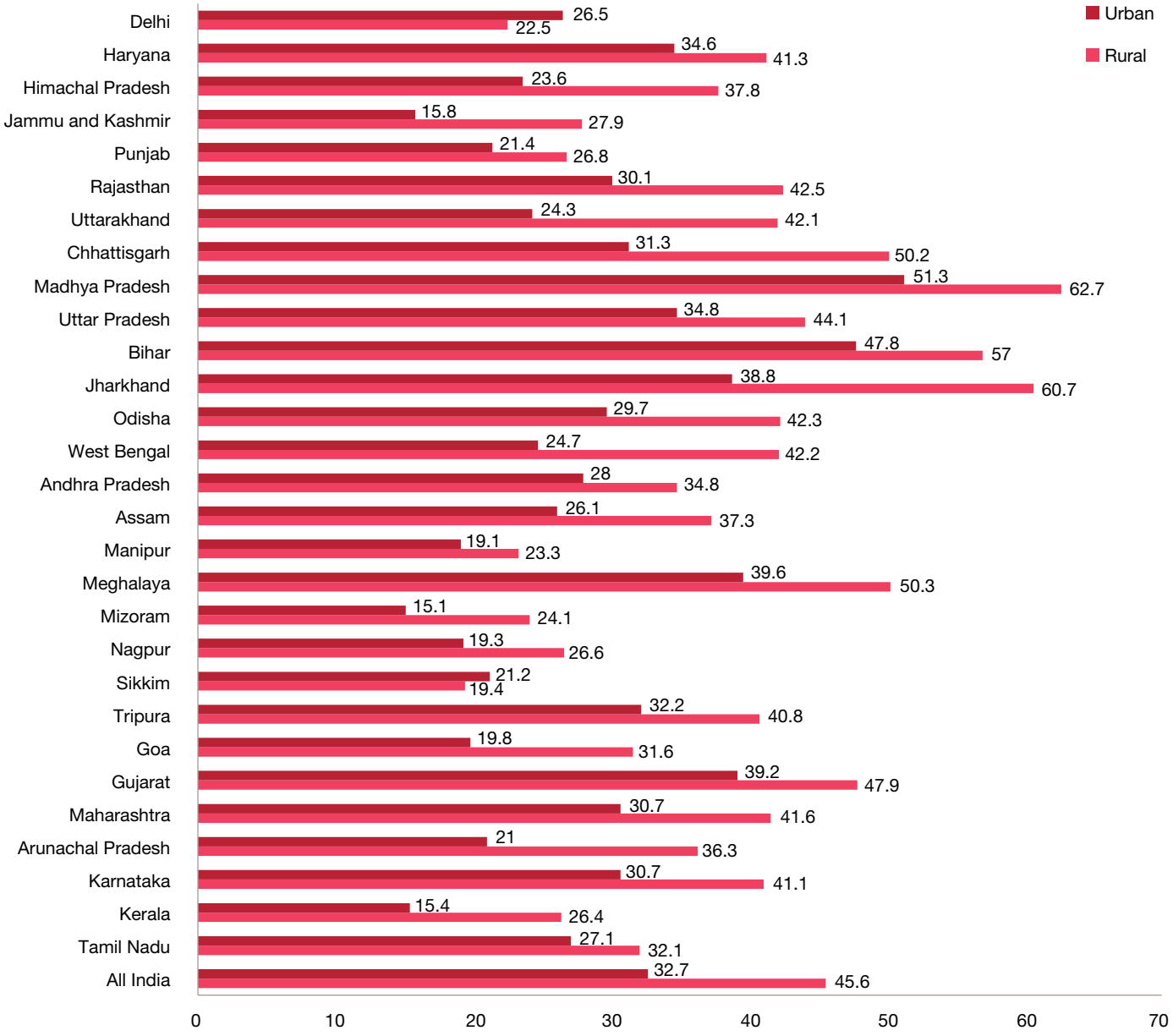
Undernutrition prevalence among U-5 children by residence, gender and wealth index[185]

Characteristic	Undernutrition prevalence (%)			
	Underweight	Stunting	Wasting	Severe wasting
Residence				
Urban	32.7	39.6	16.9	5.7
Rural	45.6	50.7	20.7	6.7
Gender				
Male	41.9	48.1	20.5	6.8
Female	43.1	48	19.1	6.1
Wealth index				
Lowest	56.6	59.9	25.0	8.7
Highest	19.7	25.3	12.7	4.2

Source: NFHS-3, 2005-06

State-wise analysis of rural and urban nutritional status data indicates that there is a wide variation among states. Underweight prevalence rate in children under 5 years is the lowest in Kerala (15.4%) and highest in the state of Madhya Pradesh (51.3%).

State-wise prevalence of U-5 children classified as underweight by rural and urban residence

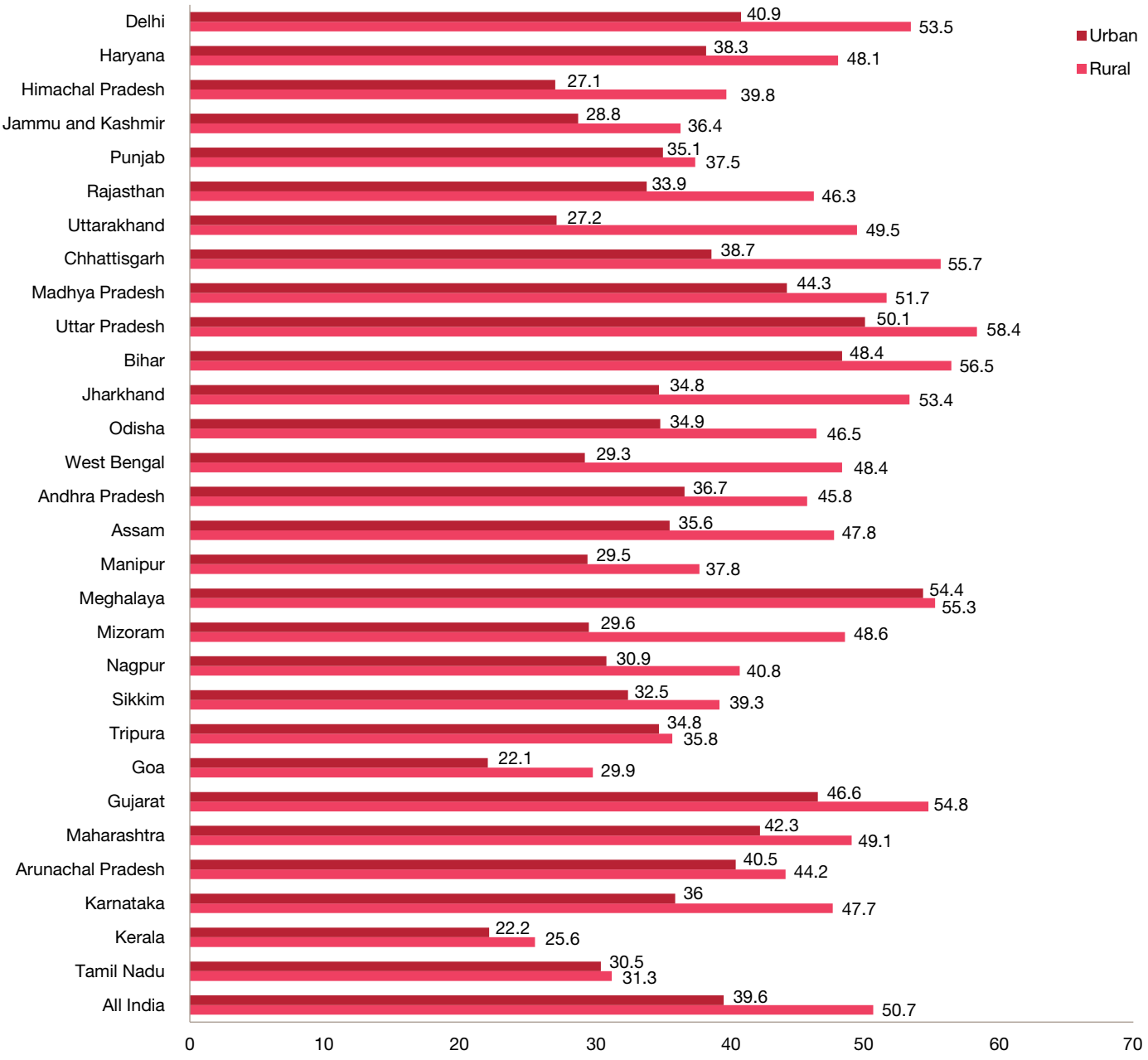


**includes children who are below -3 SD from the International Reference Population Median*

Source: NFHS-3, 2005-06

Similar to underweight rates in children under five years, stunting rates or chronic undernutrition show a wide difference in urban regions of various states. As per the last national survey data, the stunting rate of children is lowest in Goa and Kerala (22%) and highest in Uttar Pradesh (50.1%).

Stunting prevalence in U-5 children classified by rural and urban residence



**includes children who are below -3 SD from the International reference population median*

Source: NFHS-3, 2005-06

An analysis of undernutrition in different urban population groups indicates that the percentage of children of 0-59 months with underweight and stunting is highest among the urban poor and is in fact higher than overall rural.

Undernutrition prevalence in U-5 children in different urban population[152]

	Urban poor	Urban non-poor	Overall urban	Overall rural	All India
Underweight	47.1	26.2	32.7	45.6	42.5
Stunting	54.2	33.2	39.6	50.7	48

An analysis of under-nutrition data of eight cities also reports that the poorest quartile has the worst underweight and stunting status as compared to the rest of the urban population.[186]

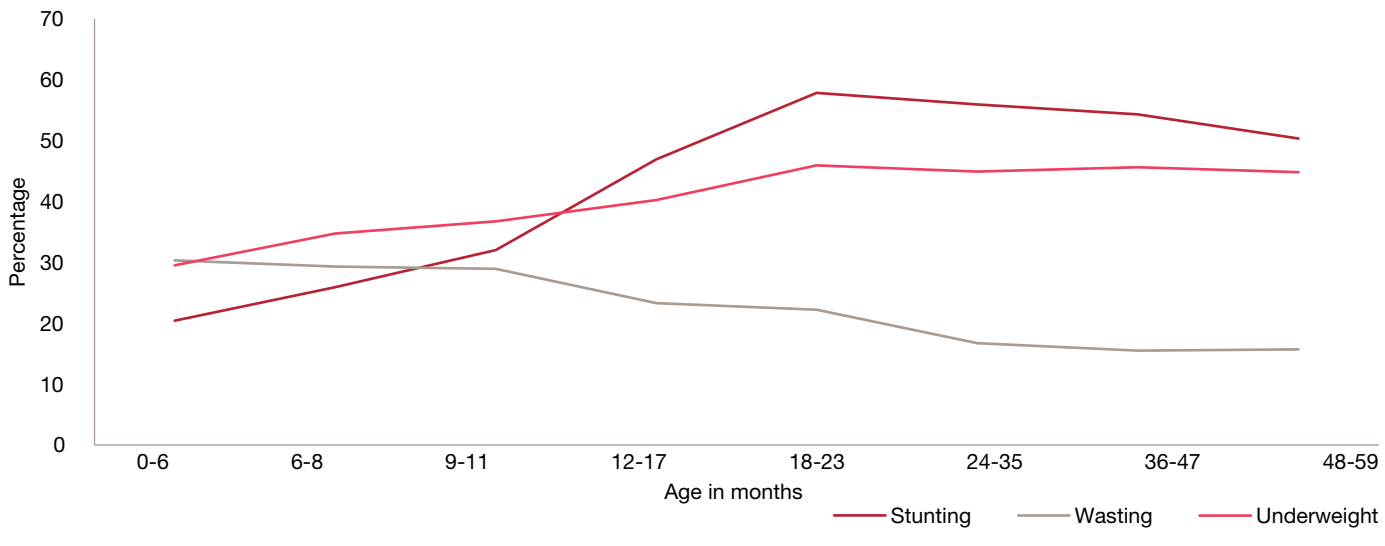
Percentage prevalence rates of underweight and stunting in children (less than 5 years) in eight selected cities according to poorest quartile population and slum and non-slum areas.

Percentage prevalence (-2SD) in children less than 5 years								
State	Underweight				Stunting			
	Poorest quartile	Census slum	Census non-slum	Total	Poorest quartile	Census slum	Census non-slum	Total
Delhi***	45.5	35.3	23.9	26.5	57.3	50.9	37.9	40.9
Meerut	43.9	26.3	30.3	28.4	65.0	46.2	41.6	43.8
Kolkata	32.0	26.8	15.6	20.8	39.1	32.6	23.1	27.5
Indore	56.7	49.6	36.7	39.3	48.9	39.6	30.6	32.5
Mumbai	45.8*	36.1	25.8	32.6	46.8*	47.4	41.5	45.4
Nagpur	44.8	41.7	28.4	33.6	48.4	47.5	26.5	34.7
Hyderabad	37.0	26.0	18.4	19.8	52.3	32.4	32.0	32.1
Chennai	42.7	31.6	20.6	23.1	55.7	27.6	24.8	25.4

**For Mumbai, poorest quartile based on 25-49 unweight cases ***Delhi is one of the five HUP cities*

Source: Health and Living Conditions in Eight Indian Cities Report, NHFS-3, 2005-06[187]

All India age trend for undernutrition in children under five[189]



With reference to the underweight prevalence rates, the difference in the various population groups is comparatively low in Kolkata and Nagpur. However, in terms of stunting, in most cities, the difference in percentage of children stunted is much higher in the poorest quartile as compared to urban slums while the difference is comparatively much lower between urban slums and non-urban areas. Studies in urban areas in developing countries indicate that nutritional status may be highly heterogeneous within urban slum regions indicating no possible clustering in particular areas.[188]

As per NFHS-3 data, 21.5% newborns in the country are LBW. The impact of LBW is also evident in age-wise trend data which indicate that the underweight and stunting prevalence rates are much higher in infants even before reaching the age of six months. By six months of age, 21.4% children are stunted and 29.5% are underweight. This can be attributed to poor birth weight. LBW children are at a disadvantage right from birth and find it difficult to catch up in weight unless special care is taken. By 12 to 23 months, the prevalence rates of undernutrition continue to increase sharply with an estimated 52.4% children stunted and 43.1% underweight. The stunting that occurs in under-twos is often irreversible. The increase in rates of undernutrition is rather negligible after 24 months. The period of under two years, extending from conception to the first 24 months of life, is therefore, considered the 'window of opportunity' for preventive measures. This period of the first 1000 days of life is also the window within which good nutrition yields maximum returns in terms of education, income, chronic disease and other outcomes.

Severe acute malnutrition (SAM)

The magnitude of the undernutrition problem is often unappreciated since most undernourished cases unless in the severe stage are not visible. The prevalence rate of SAM is 5 to 7%. SAM children have seven to eight higher chances of dying compared to a well-nourished child.

Micronutrient deficiencies

Micronutrients are nutrients required in micro or very small quantities for maintaining health. In India, as in many other developing countries, deficiencies of iron, folic acid (a type of vitamin B), vitamin A, iodine and zinc are a public health concern. Deficiencies of these nutrients are not felt or apparent and are referred to as 'hidden hunger'. The impact of micronutrient deficiencies on growth is well documented. Micronutrient deficiencies lower immunity and aggravate the severity and duration of infectious diseases, which in turn leads to mal-absorption of several micronutrients with adverse impact on child growth.[190] Besides physical growth, deficiencies of micronutrients result in other grave problems of anaemia, poor brain and cognitive development and lowering of IQ.

Iron deficiency: IDA is a major public health problem with 71.5% rural and 63% children of six to 59 months reported to be anaemic. Anaemia prevalence rate is very high, across the wealth index—76.4% in the lowest and 56.2% in the highest wealth index.[191] The primary reason for IDA are children being born with low iron stores due to mothers being anaemic, low-dietary intake and bioavailability of iron against increase in iron requirements, frequent infectious disease and parasite infections and adolescent pregnancy.

An analysis of anaemia prevalence rate in different urban population groups indicates that any anaemia as well as severe anaemia rates are much higher in urban poor children as compared to urban slum or non-poor urban children. Anaemia is as severe in the urban poor as in rural children of six to 59 months.[192]

Anaemia in children (six to 59 months) in India

	Urban poor	Urban non-poor	Overall urban	Overall rural	All India
Anemia	71.4	59	63	71.5	69.5
Severe anaemia	5.1	2.2	3.1	2.8	2.9

The findings regarding the prevalence of anaemia in children in eight cities also indicates that the anaemia prevalence rate is higher in the poorest urban quartile and slum region as compared to non-slums. In Chennai, the anaemia prevalence rate in the poorest quartile is noted to be as high as 83%. The prevalence of anaemia is reported to be over 50% in all urban regions, except in Mumbai.[193]

Percentage of children aged six to 59 months classified as having anaemia for the poorest quartile and slum or non-slum areas in selected eight cities, India[194]

City	Percentage of anaemic children (haemoglobin level less than 11.0 g/dl)			
	Total	Poorest quartile	Census slum	Census non-slum
Delhi***	56.2	67.2	71.4	51.6
Meerut	67.7	73.3	68.8	66.7
Kolkata	55.0	66.0	54.7	55.3
Indore	54.7	71.6	59.8	53.4
Mumbai	49.1	51.7*	50.2	46.9
Nagpur	63.0	77.5	71.1	58.4
Hyderabad	54.3	63.8	59.0	53.1
Chennai	62.8	83.0	72.2	59.9

**For Mumbai, poorest quartile based on 25 to 49 unweighted cases*

Studies indicate that the prevalence of anaemia in school children starts to increase from 10 years old upwards and remains high until 18 years of age. The highest prevalence of anaemia is between the ages of 12 and 15 years.[195] According to NFHS 3, anaemia prevalence in women in the reproductive age of 15 to 49 years is high throughout the life cycle across all states and all socio-economic groups. In urban India, 50.9% women of 15 to 49 years and 17.7% men are reported to be anaemic. The anaemia situation in poor urban population indicates that in each of the eight cities studied, over 40% women in the reproductive age are anaemic while the prevalence rate in male population is between 10.6 and 20.2%.

Anaemia is primarily caused by the deficiency of iron available to the body from the daily cereal based diet which is poorly absorbed as compared to iron from animal sources. It is caused when the daily diet is low in green leafy vegetables resulting in poor intake of iron as well as folic acid. Iron deficiency has serious implications on birth weight, physical and mental development of the growing foetus as well as in early childhood. These have adverse implications in concentration in school and overall productivity. Deficiency of iron is often accompanied with the deficiency of folic acid. Folic acid deficiency in early pregnancy (in the first four weeks of pregnancy or even prior to pregnancy) results in NTD in newborns. NTD is a preventable disability.

Vitamin A deficiency (VAD): Data on VAD in children, especially those from the urban areas, is limited. As per the reports from Pune quoted in NUHM framework in 1992, the incidence of VAD was reported to be 5.3 to 5.6% for 0-2 years and 16.3 to 19.6 % for two to five years.[196] Clinical cases of VAD have decreased significantly.[197] However, sub-clinical VAD has a serious impact on a child's immunity, severity and duration of illness and mortality. VAD is preventable by increasing daily dietary intake of foods rich in vitamin A. With poor food diversity and a low consumption of dietary vitamin A, the government has introduced a policy of six-monthly administration of VAS in the form of syrup to children from 6 to 59 months. The coverage of VAS has increased with the introduction of the policy of the fixed month biannual strategy. Six out of 10 children in urban regions are reported to have received a dose of VAS in the preceding six months[198].

Iodine deficiency: The inadequate intake of iodine results in permanent brain damage. Iodine deficiency adversely affects the health of a pregnant woman and the brain development of a growing foetus. As per a MoHFW survey, iodine deficiency is reported from every state in India.[199] The reason is lack of iodine in the daily diet resulting from the depletion of iodine from the soil. The universal consumption of iodised salt i.e. the daily consumption of salt fortified with at least 15 ppm of iodine as potassium iodate at consumption level is recommended. The situation of iodised salt consumption has improved with almost 95% families consuming it with iodine and 83.2% of urban families consuming it with the recommended level of iodine in salt.

Zinc deficiency: Data on zinc nutrition is unavailable. However, the Indian vegetarian diet is poor in zinc content. A zinc supplementation dose for 14 days along with ORS is recommended for the prevention and cure of diarrhoea. Use of zinc supplementation reduces the severity of diarrhoea by up to 24%. However, the coverage as well as use of zinc supplements for 14 days remains low.

Overnutrition in children: Escalating problem of overweight and obesity in urban India

The other emerging problem of urbanisation is the rising incidence of overweight and obesity. This trend contributes to the double problem of public health nutrition, the prevalence of both overweight and underweight being high, especially among middle and upper middle-class urban children. The linkage of poor birth weight and undernutrition in early childhood is also associated with the rising incidence of overweight and non - communicable diseases. Analysis of the long-term New Delhi Cohort Study of newborns confirms the situation and also highlights that the poor are not spared of the problem of over-nutrition. This is because it has been observed that with changes in the economic situation, there is a rapid transition in lifestyle contributing to overnutrition in adulthood.[200]

Research by the Diabetes Foundation (India) reports the prevalence of overweight among children (14 to 18 years) in the public schools of Delhi city to be between 29 and 32%, while in government schools, overnutrition was observed to be rare.[201] Another study of 5,000 children (10 to 15 years) in Vadodara reported overweight and obesity to be serious public health problems but none of the schoolchildren attending the city's municipal corporation schools were classified as overweight or obese as per their BMI.[202] A study in Patna reported the prevalence of overnutrition to be less than 2% among the paediatric population studied.[203] A study from an urban Kolkata survey reports overnutrition to be high in schoolgirls aged 12 to 18 years from public schools wherein 28.5% are overweight and 4.2% are obese.[204] Change in lifestyle', poor food habits with high consumption of sugar, fat and refined cereals along with reduction in physical activity in urban India are the contributing factors of the increasing incidence of overweight.

Implications of undernutrition on overall development

Undernutrition fundamentally reduces mortality as well as adversely influences people's ability to grow optimally physically and mentally with serious implications on overall development. Child undernutrition is a leading cause of child morbidity and mortality. Child malnutrition weakens immunity and resistance to disease. Overall, child malnutrition is a risk factor for 22.4% of India's total burden of diseases.[205] A third of the deaths in children is avoidable if undernutrition is prevented. It is estimated that the cost of treating malnutrition is 27 times more than investment required for its prevention.[206]

The consequences of undernutrition are not limited to the health, physical development and survival of children. Undernutrition, including deficiency of specific micronutrients such as iron, folic acid and iodine, has serious consequences on mental, brain and cognitive development of our children. These adversely influence school enrolment, school retention rate as well as school performance, higher school completion rates as well as learning outcomes at a later stage. This is well reflected in a multi-country study of 2007 which reports that for every 10% increase in the prevalence of stunting (a measure of chronic undernutrition), the proportion of children reaching the final grade of school drops by almost 8%.[207]

Implications of iron deficiency on productivity are well documented. Studies from developing countries have reported that childhood malnutrition results in the reduction in lifetime income of 10%. Undernutrition in children is estimated to reduce the nation's economic advancement by at least 8% due to direct productivity losses, poor cognition and reduced schooling.[208]

The long-term consequences of chronic malnutrition are far-reaching since the adverse impact in the first 24 months of life itself is largely irreversible. The impact of undernutrition in the girl child has serious inter-generational effects. A stunted young girl is likely to grow to be a stunted adolescent girl and later a stunted woman with increased chances that her children will be born undernourished. The adverse effects of malnutrition are, therefore, not limited to children but have serious implications throughout the life cycle, eventually resulting in adversely affecting the health, education, productivity and economy of the state.

Such a wide range of implications of undernutrition on human, economic and social development hinders in the attainment of MDG goals pertaining to not only child survival and maternal health but education, gender equity, etc.

Undernutrition which is also evident from the high incidence of LBW or weighing less than 2500 gm is associated with the increased incidence of adult onset non-communicable chronic diseases such as diabetes, cardio-vascular diseases, etc. Moreover, LBW babies, weighing 2000 to 2499 grams at birth are 2.8 times more likely to die of all causes and twice as likely to contract infectious diseases within newborn period.[209] In Mumbai, 72,000 babies are reported to be LBW per year[210]. The serious implications of LBW are not limited to mortality. They also contribute to the increasing prevalence rate of non-communicable diseases in adulthood in urban India.


Photo credit: Parth Sanyal/Save the Children

Determinants of undernutrition in urban India

The determinants of child undernutrition are not limited merely to poverty and the resulting inadequate access to food. Child nutrition outcomes are determined by immediate, underlying and basic factors such as complex interaction of food, care and health. The immediate causes of undernutrition in children are low intake of nutrients as well as frequent infections such as diarrhoea, acute respiratory infections, measles, sepsis, etc. Children residing in informal settlements and impoverished neighbourhoods are at the highest risk of suffering from undernutrition. They most often do not have access to medical services and social protection. These immediate causes are governed by underlying factors such as access to adequate quantity and quality of food, appropriate health and water sanitation services as well as women's education and status which influences time, knowledge and resources for appropriate child-caring practices, including feeding. The immediate and underlying causes are influenced by political priority accorded to addressing undernutrition, economic situation and quality of governance, etc.

The conceptual framework of undernutrition in children[211]

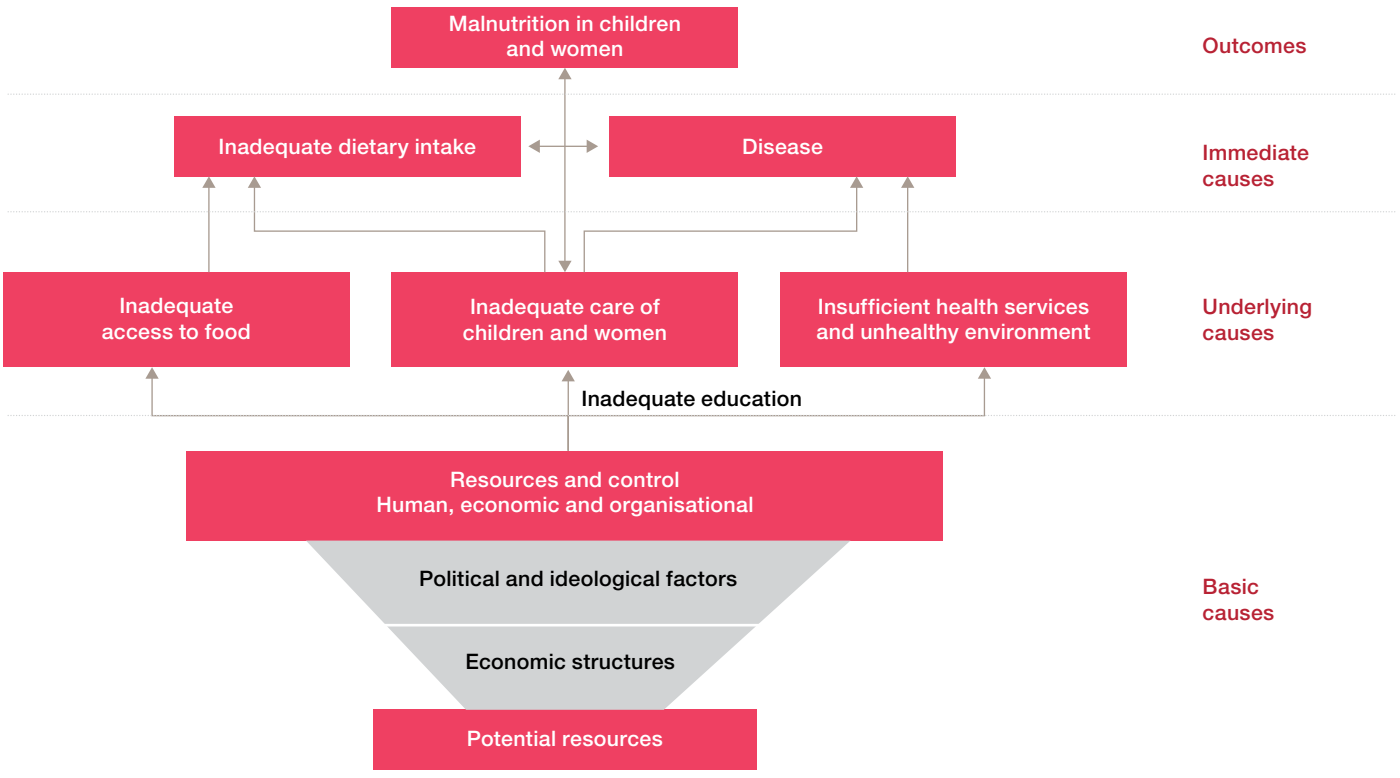


Photo credit: Lucia Zoro/ Save the Children

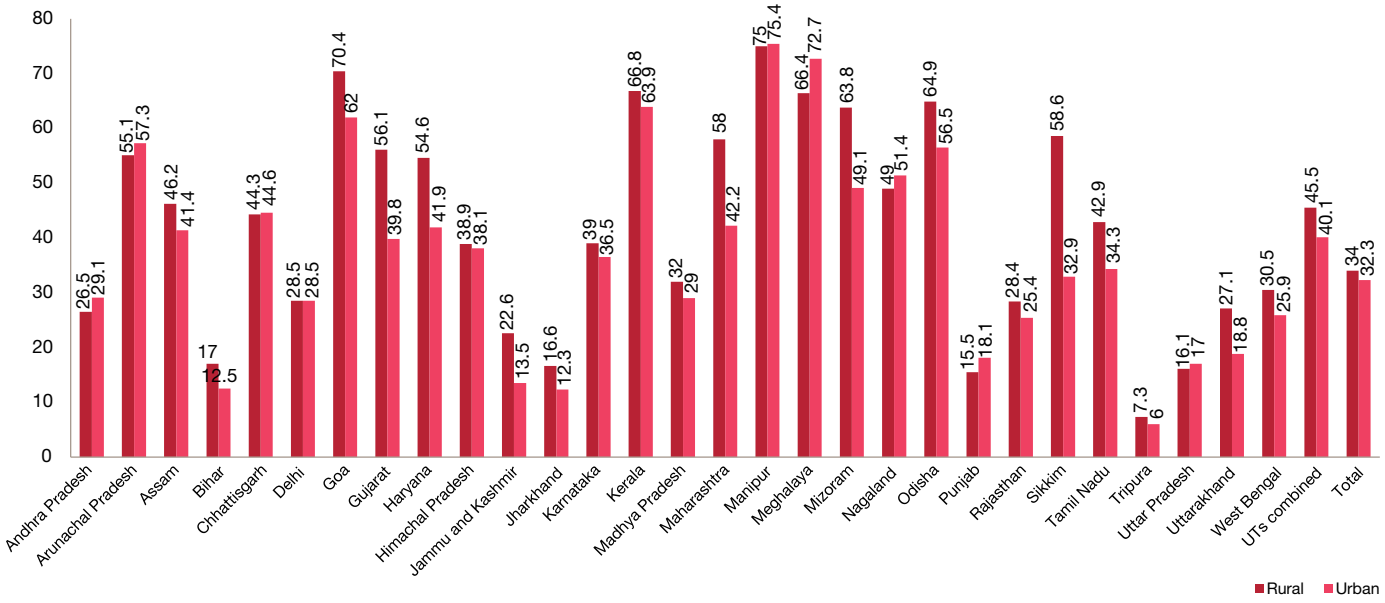
Immediate causes of undernutrition

Infant and child feeding (IYCF) practices

The IYCF practice has a direct impact on the nutritional status of children and is an important cause of undernutrition in urban and rural India. As per the international and national evidence, newborns should be put to breast within an hour of birth (also referred to as early initiation of breastfeeding) and only breast milk and no other liquid, including water i.e. EBF is advised for the first six months of life. Feeding semi-solid food or CF in appropriate quantities and energy density, along with the continuation of breast milk, is recommended to be introduced after six months. Frequency of feeding CF, at least three to four times in a day, is recommended.

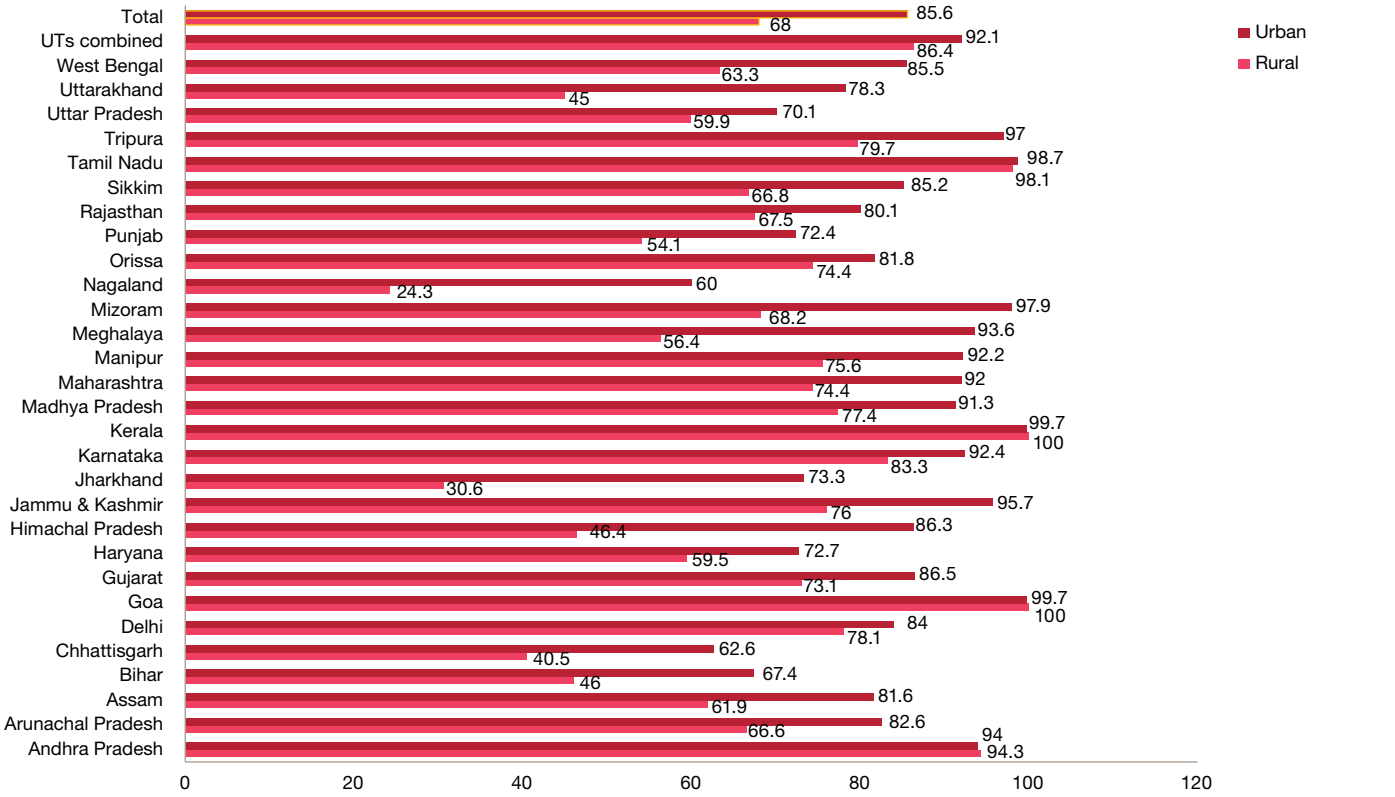
Only about a third of urban as well as rural children are fed breast milk within one hour of birth.[212] There is a wide state-wise variation with only 6% urban population in Tripura starting breastfeeding within one hour compared to 75.4% in Manipur.

State-wise data of mothers who breastfed the child within one hour of birth according to urban and rural residence[213]



It is noted that the early initiation of breastfeeding is not practised despite a higher percentage of mothers opting for institutional delivery in urban as compared to rural regions. Such a situation highlights the poor use of the contact opportunity in counselling and convincing mothers about early initiation of breastfeeding.[214]

State-wise data of women who opted for institutional delivery: Urban and rural



Source: Coverage Evaluation Survey, 2009

The EBF practice in various urban population groups is better among the urban poor compared to the non-poor urban but is slightly poorer than all rural or the all-India percentage figures. However, it is far as being satisfactory with only four out of 10 children being exclusively breastfed).[181]

Breastfeeding practices in urban India as compared to rural and all India[215]

Breastfeeding practices	Urban poor	Urban non-poor	Overall urban	Overall rural	All India
Children less than 5 years fed breast milk within 1 hr of birth (%)	27.3	31.5	30.3	22.4	24.5
Children less than 5 years given pre-lacteal feed (%)	44.0	52.1	50.2	59.8	57.2
Children age 0 to5 months exclusively breastfed (%)	44.7	38.6	40.7	48.6	46.4

The CES 2009 data for all-India situations reveals that the percentage of mothers practising EBF reduces sharply after two months–from 81% at less than two months to 56.8% at four to five months. Early introduction of other milk and water in early infancy is reported. In the urban regions, 48.6% infants are introduced to water and 30.9% to other than breast milk in the first six months. The corresponding rural figures are 47.2% and 29.9%.[216] In both urban and rural regions, the primary reasons for introducing other milk are as follows:

- Incorrect perception of the mothers that breast milk secreted is insufficient
- Mothers being away due to work
- Poor support systems at home that is rapidly moving towards nuclear family system and
- Poor knowledge of lactation management

As per CES data, only 45.8% urban infants as compared to 40.2% rural infants are introduced to solid foods between six to nine months.[217] State-wise data of NFHS 3 reveals that complementary feeding practices in almost all states are better in urban regions as compared to rural but are much below the desirable level in terms of nutrient-rich foods and nutrient density food. The data on young child feeding practices do not show a gender difference in terms of diversity of food groups introduced or regarding frequency of feeding. Higher wealth index children are observed to have better complementary feeding practice.

Complementary feeding practices among children in India[218]

States	Appropriate minimum frequency of feeding (6 to 23 months)			
	Appropriate number of food groups^		% fed minimum times ^^	
	Urban	Rural	Urban	Rural
All India	40.6	33.5	43.4	40.8
Delhi	47.4	56*	53.5	64*
Haryana	39.3	26.3	42.9	28.9
Himachal Pradesh	66.2	66.2	33.8	47.5
Jammu and Kashmir	43.5	47.3	29.4	40.3
Punjab	41	36.9	28.6	31.8
Rajasthan	28.2	18.3	44.4	35.8
Uttarakhand	65.6	42.4	47.9	36.5
Chhattisgarh	44.4	31.9	48.1	52.7
Madhya Pradesh	27.2	22.3	46.4	45.1
Uttar Pradesh	34.8	35.5	33.9	32.7
Bihar	37.0	33.2	46.4	54.3
Jharkhand	39.0	25.2	41.2	43.4
Orissa	56.8	42.1	62.4	54.6
West Bengal	69.7	56	41.8	37.8
Andhra Pradesh	34.1	22.4	26.4	24.3
Assam	43.4	30.7	40.8	40.8
Manipur	63.8	51.6	69.1	61.5
Meghalaya	46.5	33	45.3	41.7
Mizoram	49	22.4	57.7	47.4
Nagaland	38.2	27.2	63	58.3
Sikkim	79.2	69.2	49.1	66.2
Tripura	54.5*	56.5	51.5*	42
Goa	62	67.1	52.1	60.1
Gujarat	38.5	30.9	42.7	40.8
Maharashtra	28.9	13.2	42.9	26.4
Arunachal Pradesh	38.8	32.1	71.6	59.9
Karnataka	45.4	42.9	44.9	41.9
Kerala	84	69.6	85.1	77
Tamil Nadu	54.4	38.9	61.5	45.7

**Based on 25-49 unweighted cases.*

^Three or more food groups for breastfed children and four or more food groups for non-breastfed children

^^Fed solid or semi-solid food at least twice a day for infants of six to eight months, three or more times for other breastfed children, and four or more times for non-breastfed children.

CF practices among urban population groups indicate that a lower percentage of urban poor introduce timely semi-solid food (56.2%) as compared to urban non-poor (66.1%). Besides this, poor frequency of feeding semi-solid food is noted across urban and rural regions but the situation is worse in urban poor. Feeding of foods rich in iron is less than 15% across all population groups in urban and rural populations. Feeding of vitamin A rich food to urban poor children is also the lowest, 35.7%, for the urban poor as compared to 44.3% in urban non-poor. Low income, to a great extent, constraints households from feeding children with a high micronutrient content food items comprising pulses, vegetables, milk and animal products.[219]


Photo credit: Lana Slezic/Save the Children

Complementary feeding practices amongst urban population groups and in rural population[220]

Complementary feeding	Urban poor	Urban non poor	Overall urban	Overall rural	All India
Children age six to nine months receiving solid or semi-solid food and breast milk (%)	56.2	66.1	63.1	54.7	56.7
Children age six to 23 months fed food rich in vitamin A (%)	35.7	44.3	41.7	37.4	38.5
Children age six to 23 months fed food rich in iron (%)	13.7	15.1	14.6	10.1	11.3
Children age six to 23 months fed complementary food in appropriate frequency (%)	38.0	45.7	43.4	40.9	41.5

The practice of feeding during diarrhoea or illness is observed to be poor in both rural and urban regions. Less than 4% children are given more food during or after an episode of diarrhoea. Interestingly, as per NFHS3 findings, a gender bias towards male children is noted in the practice of withholding food.[221] This possibly reflects that caregivers strongly but incorrectly believe that reducing food intake is beneficial and male children, compared to female children, are actively not given additional food during diarrhoea. Less than 10% urban caregivers follow the correct practice of feeding additional fluids during illness.[222]

Feeding practices and treatment received by children less than two years who had diarrhoea[223]

India states	Feeding during illness								
	Breastfeeding				Fluids intake				Oral rehydration therapy given
	Rural		Urban		Rural		Urban		
	Less than usual	More than usual	Less than usual	More than usual	Less than usual	More than usual	Less than usual	More than usual	
All India	30.2	8.1	30.0	5.6	34.1	9.7	35.6	9.8	42.8
Chhattisgarh	16.4	5.7	14.5	4.1	16.9	5.2	14.1	10.5	61.5
Uttar Pradesh	13.0	1.0	8.3	0.0	14.3	7.6	8.1	5.0	14.3
Rajasthan	10.9	7.4	10.7	5.0	9.4	1.7	12.7	3.8	39.2
Orissa	28.5	12.1	7.5	2.1	13.6	16.8	14.5	3.8	61.8
Uttarakhand	19.3	1.1	21.9	4.1	21.7	0.9	24.0	5.5	13.4
Jharkhand	20.9	3.1	13.8	1.7	22.8	5.2	13.8	7.1	21.6
Bihar	16.4	6.4	4.0	4.1	18.5	5.4	5.2	6.0	22.4
Madhya Pradesh	15.2	1.0	11.4	1.6	16.7	1.8	14.4	3.0	41.5

Complementary feeding and intake of nutrients by children is dependent not only on the availability of food but also on the effort made by a caregiver or mother to feed a child. The feeding practices followed depend on the knowledge of the mother on how to feed a child and what to feed a child as well as the time and effort taken by the mother to actively feed her child. The lack of food is not always the primary cause of poor intake of food by young children. This is confirmed by studies by the NNMB.[224] Mothers and caregivers need to spend time and effort to feed a young child appropriately.

The consumption of diversified food remains a major problem due to poor access to pulses, oils and vegetables. NSSO data of 1993-94 and 2005-6 confirms poor per capita consumption of pulses, green leafy vegetables, fruit and milk.[225]

Average monthly per capita consumption of selected food items in urban areas of major states[226]

All India	Mean monthly per capita consumption of food items in urban India (in kg)		
	2004-05	2009-10	2011-12
Cereals	9.94	9.37	9.28
Pulses	0.82	0.78	0.90
Milk	5.10	5.36	5.42
Oil	0.56	0.66	0.85
Eggs	0.19	0.22	0.39
Fish	0.20	0.21	0.25
Meat	0.20	0.07	0.08
Sugar	0.90	0.87	0.87

Note: One litre of milk is taken to weigh 900 grams. One egg is taken to weigh 125 grams.

In urban poor families, besides lack of knowledge, lack of time available with a mother to cook and feed her child is a primary constraint in child care. Mothers from poor clusters are often employed in unorganised sectors and have little time to take care of children. Challenges to income generation, food security and nutrition are the special problems of urban poor women who often seek employment resulting in scarcity of time for self and child care. Moreover, the working women often do not have access to facilities for child care, except in factories or NGOs.

Infection, infestation and access to health services

The urban poor in India struggle for the most basic services such as housing, water and sanitation. Inadequate access to safe drinking water and sanitation, lack of ventilation, overcrowding, use of hazardous cooking fuels in badly ventilated places and inadequate natural light increases the risk to illness such as diarrhoea, worm infestation, ARI, tuberculosis and undernutrition. Eighty-eight per cent of diarrhoea cases world-wide are attributed to unsafe water, inadequate sanitation and poor hygiene practices. These childhood diseases are immediate causes of undernutrition.

Frequent and prolonged untreated illnesses are one of the most important factors contributing to child undernutrition.[227] It is reported that 16.3% children suffer from diarrhoea in the two weeks that preceded the survey.[228] Children living in slums are 1.3 times more likely to suffer from diarrhoea than in non-slum areas.[229] Another study from Tamil Nadu reports that a child living in an urban area suffers from about 12.5 illness episodes in a year.[230] Most of these illnesses remain untreated due to inadequate public health infrastructure as well as poor knowledge of feeding. Besides diarrhoea, poor awareness of the dosage of immunisation as well as poor coverage (less than 70% of infants are covered with full immunisation) increases the chances of infections, especially in the urban environment due to high population densities and migratory trends. Such a situation sets up a vicious cycle of infection, poor utilisation of food consumed, increasing loss of appetite and undernutrition.[231]

Undernutrition and infection cycle[232]

Underlying factors contributing to undernutrition in children

Access to food, status of women, water and sanitation facilities play a central role as underlying factors which operate at household and community levels and influence the nutritional status of children. Additionally, the contributory factors of undernutrition among poor and non-urban poor children are, to a great extent, under utilisation of healthcare services, poor body mass index of mothers and lower levels of parental education.[233] The child healthcare index, including both preventive and curative health services (births in medical facilities, births assisted by health professionals, children fully vaccinated, children suffering from diarrhoea brought to health facility) are strongly associated with stunting.[234]

Food security, food availability and dietary intake

Food availability in urban households, unlike rural households, is solely dependent on purchasing food and is influenced by the market. Food and nutrition security of urban households is much more vulnerable to price shocks than in rural India. The food security situation in urban India is dependent on the extent and nature of employment opportunities available. The NSSO data of 2004-05 indicates that expenditure on food accounts for 50% or more of the total expenditure of urban households.[235] In the absence of an appropriate controlled marketing system, there are fluctuations of prices susceptible to seasonal changes which adversely influence food intake, especially food diversity. With food prices rising from 2009, the expenditure pattern of these households has further been adversely affected, especially with reference to the diverse food items consumed. The NNMB data on food consumption status confirms that in urban areas, there is a declining trend in the consumption of cereals and pulses. The FAO Report on the State of Food Insecurity in the World (2009) refers to the fact that in order to cope with the consecutive crises of hunger and cash crunch, poor people reduce their dietary diversity and spending on essential items such as education and healthcare.[236]

Female employment contributes to improving the quality of food, especially in the poor sections of the urban population. However, the employment of women in urban India is much below the desirable level with the WPR being nearly three times lower for females as compared to males. This situation has implications on the family food basket. Households with poor access to food are those with low and irregular wages and these conditions are more common in families employed in the unorganised or informal sector as well as those who have informal employment in the formal sector resulting in poor access to food.[237] Within such groups, women caregivers play a critical role. The situation of unemployment or irregular employment in females is worse in smaller towns. A predominant section of workers, particularly female workers, in smaller towns are unorganised and earn less than minimum wages. Thus, the urban poor and slum population of small towns are more vulnerable to undernutrition.

As per the food security index for the urban region available for 15 states, Punjab, Kerala, Assam and West Bengal are the least urban food insecure states while Bihar, MP, Orissa, UP and Rajasthan are the top five food insecure urban states.[238] Improvement in food security measures is reported to be rather modest between the period 1998-2000 and 2004-6 and such a trend is reported in MP, Bihar, Gujarat and UP. However, high cereal dependency and poor food diversification adversely influences the availability of foods rich in proteins and micronutrients.[239]

The urban food security index has been calculated using the six composite and two variant index.[240]

Composite index

- Percentage of population consuming less than 1,890 kcals per day
- Number (per 1000) of urban male workers not in employment
- Number (per 1000) of urban female workers not in employment
- Percentage of households without access to toilets
- Percentage of ever-married urban women (15-49 years) with any anaemia
- Percentage of ever-married urban women (15-49 years) with chronic energy deficiency

Variant I index

- Percentage of urban children six to 35 months with any anaemia
- Percentage of urban children six to 35 months stunted

Distribution of states by category of Urban Food Insecurity Index 1998-2000 and 2004-06[241]

Index class interval, Variant 1	1998-2000	2004-06
0.278-0.380 (very low insecurity)	Kerala, Punjab	Kerala, Punjab
0.380-0.483 (low insecurity)	Assam, West Bengal, Maharashtra	Assam, West Bengal, Uttar Pradesh
0.483-0.585 (moderate insecurity)	Andhra Pradesh , Haryana , Karnataka, Tamil Nadu	Andhra Pradesh, Haryana, Karnataka, Tamil Nadu, Gujarat, Maharashtra
0.585-0.688 (high insecurity)	Orissa, Rajasthan, Gujarat, Uttar Pradesh	Orissa, Rajasthan, Bihar, Madhya Pradesh
0.688-0.790 (very high insecurity)	Bihar, Madhya Pradesh	—

Poor intake of diversified food has an adverse impact on nutrition. As per the NNMB, there has been higher intake of milk and milk products and vegetables (especially roots and tubers), especially in the urban areas. However, the protein calorie adequacy has declined—54.6% in 1975 to 36.6% in 2002.[242] Moreover, the food pattern analysis indicates a much lower intake of milk and pulses by urban poor women as compared to the urban slum or urban population as a whole. Smaller towns suffer worse conditions when compared to larger cities and metropolitan areas with regard to food security.[243] Unplanned migration further worsens the access to non-cereal or staple foods. Such a food pattern results in poor food diversity and the inadequate consumption of micronutrient-rich foods.

Frequency of consumption of specific foods by women in India[244]

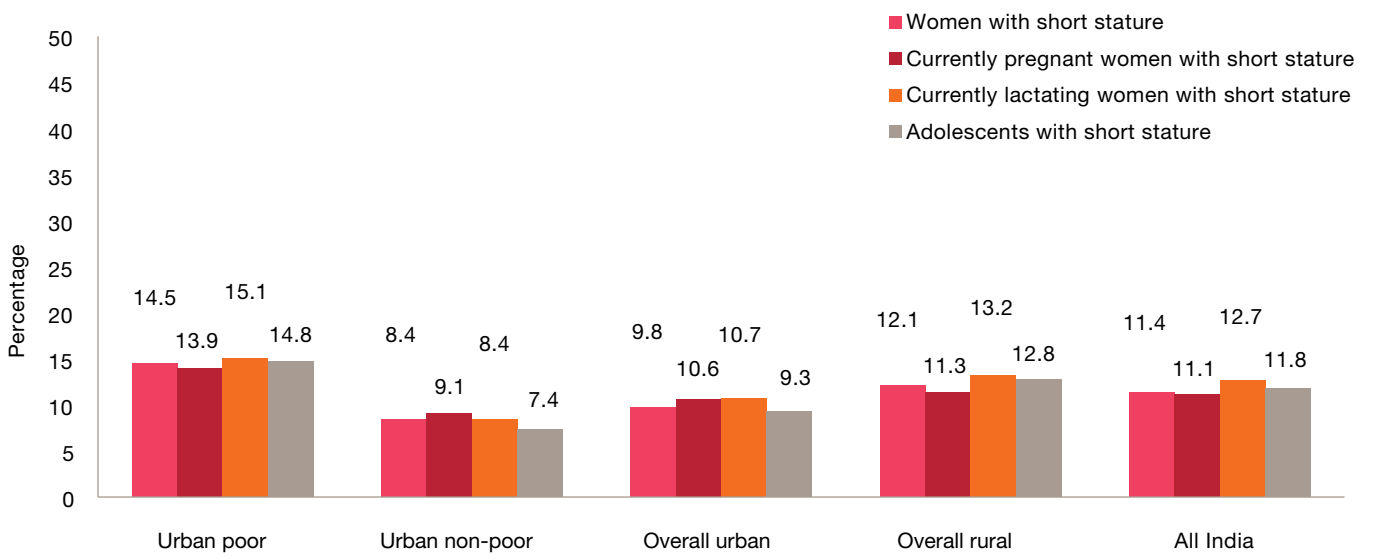
Frequency of food items consumed	Urban poor	Urban non-poor	Overall urban	Overall rural	All India
Milk and curd on a daily basis (%)	29.1	52.8	47.4	36.1	39.8
Pulses and beans on a daily basis (%)	48.2	63.7	60.1	49.1	52.7
Dark green leafy vegetables on a daily basis (%)	62.9	70.7	68.9	62.0	64.2
Fruits at least on a weekly basis (%)	34.5	66.2	58.9	30.5	39.9
Eggs at least on a weekly basis (%)	41.8	38.4	39.1	28.9	32.3

Women's health, education and social status

Early onset of pregnancy (below 20 years), poor age interval between children and the inadequate adoption of family planning measures resulting in large families adversely affect the nutrition and health status of the mother-child dyad. The poor nutritional status of the mother, including chronic energy and micronutrient deficiencies, before and during pregnancy is strongly associated with the size of newborns. Evidence suggests that LBW children are disadvantaged even before they are born and rarely catch up in growth. Undernourished children are more likely to grow up to be short adults (stunted). A regression analysis reveals that women's status such as age of marriage, height of mothers less than 145 cms, education and emotional violence are the most important risk factors which influence underweight and stunting in children under two.[245] The underutilisation of maternal healthcare services is also identified as a key determinant of the nutritional status of urban poor children.[246] In the urban poor population, almost 15% of mothers are shorter than the minimum acceptable height of 145 cm as compared to nine to 10% in overall urban. A third of women are undernourished with low BMI while anaemia is high across all the wealth quintiles. Moreover, once pregnant, most poor mothers gain only five to six kgs of weight during pregnancy against the recommended minimum gain of 10 to 12 kgs. These mothers have a high chance of suffering from intra-uterine growth retardation of foetus and the birth of LBWs. All these factors set up an inter-generational cycle of low birth weight, growth failure and undernutrition and a cycle of under nutrition to be repeated over generations.[247]

Photo credit: Parth Sanyal/ Save the Children

Women in India with height less than 145 cm in urban and rural population groups[248]



The poor rate of higher education, particularly for female children of the urban poor, remains a major contributor to undernutrition. Improving the mother's education, to a minimum of 10 years is central to breaking this cycle since higher education is a proxy indicator of empowerment and increase in the decision-making power of women, reflected in a number of indicators e.g. reduction in percentage of adolescence marriage, low BMI and underweight prevalence in children.

Care of women during pregnancy is critical for the health of women and child. However, many urban mothers received inadequate care during the prenatal stage. The lower use of health services among urban mothers is due to several barriers ranging from cost of care, transportation and low awareness of health promoting behaviour. This is evident from the fact that despite health and ICDS, the coverage of women with at least three ANC services in 2009 is reported to be low in urban areas (36.1%) but better than in rural areas (22.8%). Only 45.8% urban mothers are reported to have received IFA tablets while 39.7% reported having consumed the IFA tablets received.[249] An analysis of the urban population reveals that the situation is worse among the urban poor and less than 20% urban poor as against 41.8% urban non-poor reported having consumed over 100 IFA tablets.

Integrated child development services (ICDS)

ICDS is a major system of the government for addressing the nutrition challenge. The 12th FYP aims to universalise ICDS centres (Anganwadis or AWCs) with a special focus on SC/ST and minorities. The goal is to establish 14 lakh centres in the country, which is important considering that only 53% of urban poor children were covered by AWCs as in 2011. The financial outlay of the programme has increased substantially from 12,147 crore INR in the 10th Plan, it increased to 44,400 crore INR in the 11th Plan. During the 12th Plan, an allocation of 1,23,580 crore INR was approved. ICDS beneficiaries are pregnant and lactating women, children six months to six years and adolescent girls. NFHS-3 shows only 22.6% of children had received supplementary nutrition and only 12% regularly received it. ICDS services usage by urban poor is also extremely low with 81.5% of children in 0-71 months group having received no ICDS service despite living in an area covered by ICDS centres or Anganwadis. The focus on children 0-3 years has remained weak and is being addressed under the 12th Plan.

Sources:

Steering Committee on Urbanisation, Planning Commission. (October 2011). Report of the working group on urban poverty, slums and service delivery system.

Press Information Bureau. (2013, March 15).

NFHS-3

Water, sanitation and hygiene practices

Poor water, food hygiene and personal hygiene contribute to a high incidence of diarrhoea with a loss in body weight and nutrients. Poor availability of water in terms of quantity and quality and poor use of toilets are increasingly recognised as contributing causes of undernutrition. There is a growing evidence of the link between the linear growth of children and household sanitation practice and infections.[250] As per the NFHS-3 data, in the eight metropolitan cities of Chennai, Mumbai, Nagpur, Hyderabad, Meerut, Kolkata, Delhi and Indore, the access to toilets for the urban poor is far worse than that for slum and non-slum.[251] The impact of open defecation is somewhat larger in the urban areas, presumably because of greater population density strengthening the disease vectors associated with open defecation.[252]

Besides the quantity of water, accessibility and availability of piped water also have implications on energy conservation in women and in the prevention of undernutrition. The lack of access to drinking water within household premises means that women have to spend long hours collecting it. These have adverse

implications not only on the health and nutritional status of women but also on child care practices and nutrition. Only 26.6% urban households are reported to have access to safe drinking water within their dwelling premises.[253]

The HUNGaAMA study shows that less than 15% mothers wash their hands with soap and water after defecation.[254] Lack of water and soap as well as ignorance of the importance of washing hands with soap and water after defecation, prior to cooking or prior to feeding is a significant contributor of undernutrition.[255] In such conditions of poor access to water, sanitation facilities and poor personal hygiene practices such as not washing hands with soap and water leads to an increased transmission of infection. The ingestion of faecal bacteria by young children through mouthing soiled fingers and household items leads to intestinal infections which affect children's nutritional status by diminishing appetite, reducing nutrient absorption, and increasing nutrient losses. In urban India, frequent consumption of contaminated food, especially street food also contributes to gastrointestinal infections and undernutrition.

Undernutrition in children in urban India: Key observations

- Urban poor clusters and urban slum population have the highest prevalence of underweight and stunting.
- First 1000 days of life from conception to 24 months of life are crucial for preventive measures.
- Access to food is not the only cause of undernutrition. Even in the high wealth index population, a quarter of children are stunted.
- Immediate causes of undernutrition comprise poor infant and young child feeding practices and high rates of infection and poor coverage of health services.
- Underlying causes are inadequate access to water and sanitation, poor education and status of women with jobs in the informal sector, lack of time, high energy expenditure, inadequate crèche facilities and violence at home.
- Urban food security is governed by the fact that the urban poor depend on cash income for food and non-food items.
- The employment of urban women reduces time and energy for child care practices at the family level.
- Healthcare during pregnancy and preventing anaemia in women and adolescent girls as well as adolescent conception and low birth weight is crucial
- Appropriate IYCF is far from being a universally followed practice despite much better antenatal care and institutional delivery services and contacts of mothers and caregivers with the health sector.
- Increasing problem of overnutrition must be recognised and measures must be introduced for its prevention.

Addressing malnutrition in urban India: The way forward

A two-pronged strategy with focus on evidence based direct ENI package as well as strengthening interventions pertaining to indirect nutrition influencing actions such as education of women, improving access to water-sanitation-hygiene and social security and empowerment of women are crucial. [256] Such achievement of ENIs coverage is estimated to reduce undernutrition by at least 20%. India has policies in place for each of these interventions except an explicit policy on women's nutrition and community based care of SAM children. Two systems are primarily involved in its implementation–the health system and ICDS.

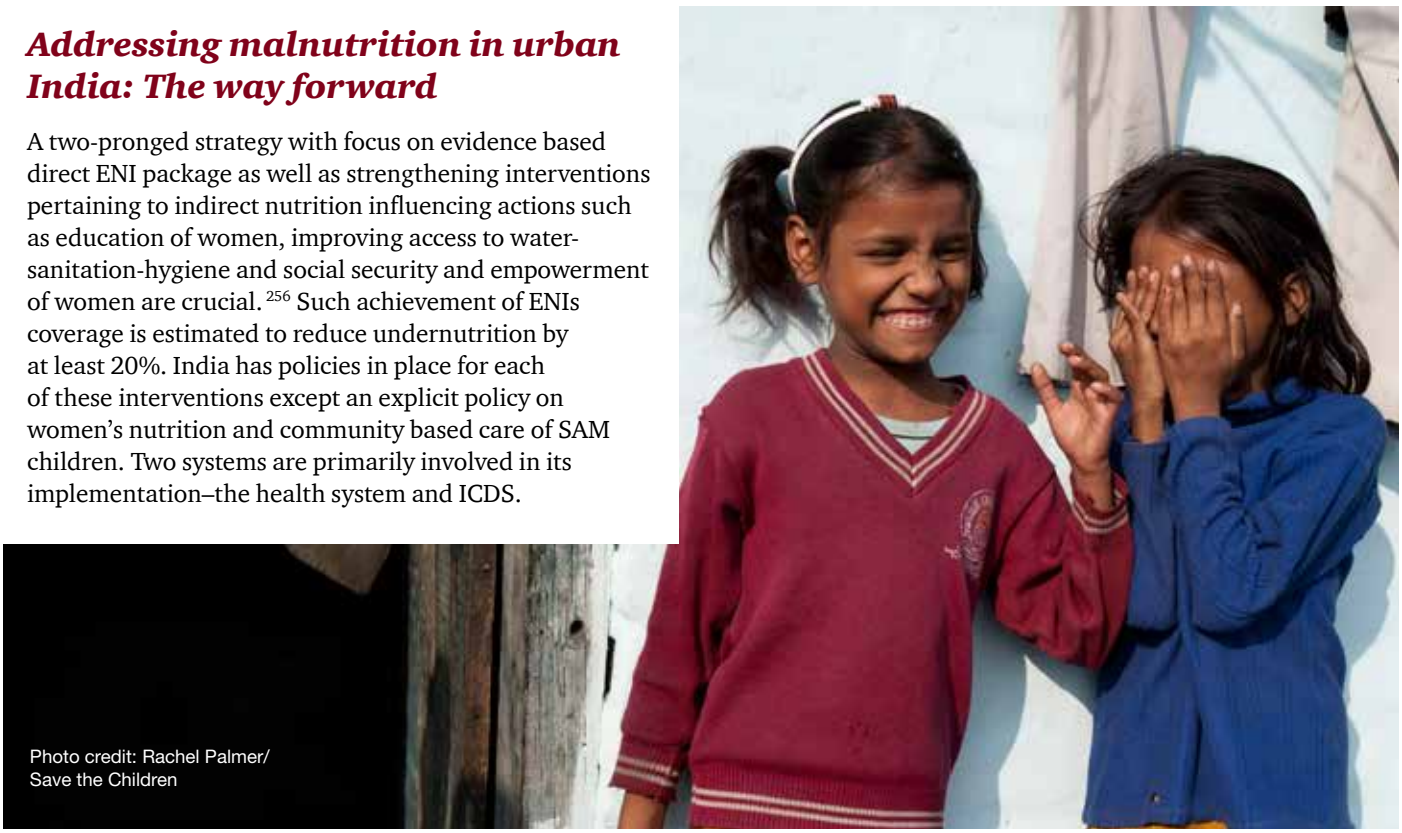


Photo credit: Rachel Palmer/ Save the Children

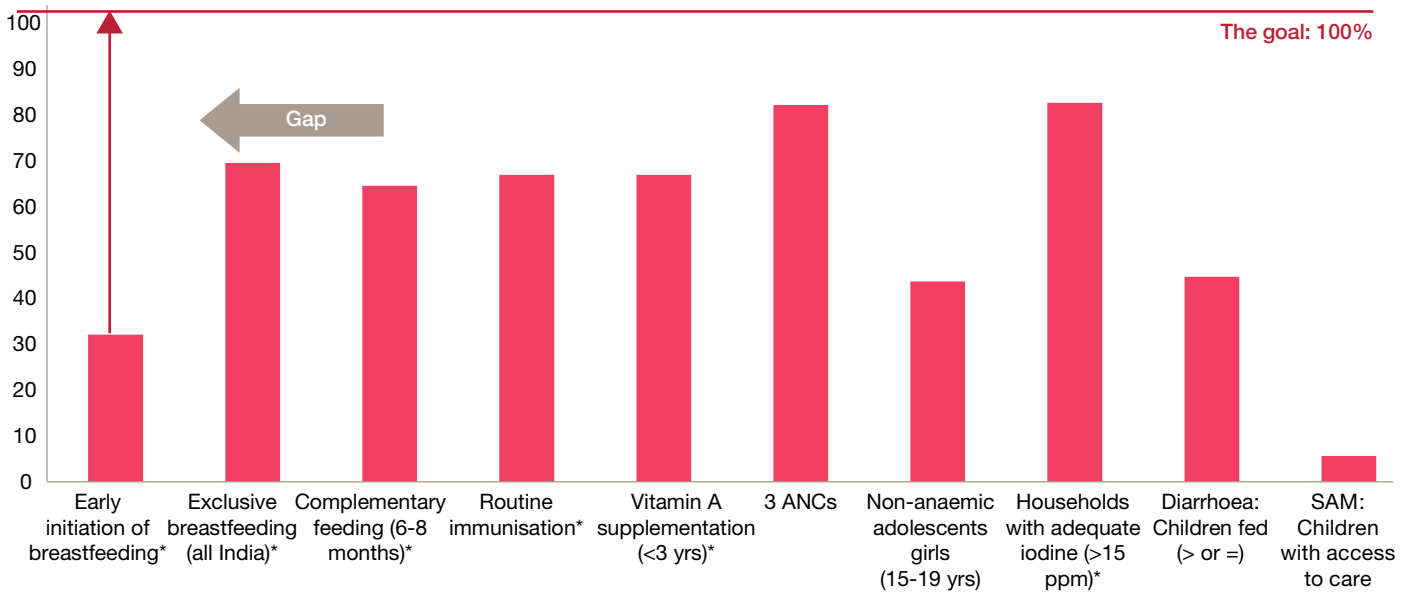
Proven essential direct interventions and government policies[257]

	Pregnant and lactating women	Infants and children	Adolescent girls
Interventions	Improved food and nutrient for adult women, including during pregnancy and lactation: • Antenatal care services, including maternal nutrition care*Monitoring weight gain and iron folate supplementation* • Promote improved dietary intake, including usage of iodised salt* • Provision of ICDS food supplements* • Maternal de-worming in pregnancy*	• Promote appropriate infant and young child feeding: – Timely initiation of breastfeeding within one hour* – Exclusive breastfeeding for first six months* – Timely and age appropriate complementary feeding six to 24 months (quantity, quality and frequency)* – Frequent, appropriate and active feeding for children during and after illness including oral rehydration zinc supplementation during diarrhoea** – Safe handling of complementary foods and feeding practices* • Full routine immunisation biannual vitamin A supplementation and de-worming* • Timely and quality therapeutic feeding for all children with severe acute malnutrition+	Improved food and nutrient intake for adolescent girls particularly to prevent anaemia: • Weekly IFA* • Biannual de-worming prophylaxis* • Family life education* • Prevent early marriage and early pregnancy
Policies	**Ministry of Women and Child Development (MoWCD)** ICDS: Supplementary Nutrition Programme, Health and Nutrition Counselling IGMSY Scheme **NRHM: Ministry of Health and Family Welfare (MoHFW)** *Policy for Control of Nutritional Anaemia: National Nutrition Anaemia Control Programme and National Iron Plus Initiative (NIPI) *Antenatal Care (includes monitoring weight gain) *JSY Scheme * Policy On National Iodine Deficiency Control Programme * RMNCH+A Approach (5x5 approach)	**MoWCD** • National Infant and Young Child Feeding Guidelines, 2006 • Supplementary Nutrition Programme, ICDS • Growth Monitoring and Promotion ICDS • Nutrition and Health Counselling • IGMSY Scheme Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Amendment Act 2003. (Ims Act) **MoHFW** * Guidelines for Enhancing Optimal Infant and Young Child Feeding Practices,2013 *Policy for Control of Anaemia: Guidelines for Control of Iron Deficiency Anaemia (National Iron Plus Initiative, 2013 #Policy on Management of Vitamin A Deficiency: The National Prophylaxis Programme for prevention of Blindness Due to Vitamin A Deficiency, 1991(Revised 2006) * Policy on Diarrhoea Management, 2006 * Operational Guidelines on Facility Based Management of Children with Severe Acute Malnutrition, 2011 * Policy on National Iodine Deficiency Control Programme, 1992. * A strategic approach to RMNCH+A in India, 2013	**MoWCD** • ICDS: SABLA Scheme (includes weekly iron supplement to non-schoolgoing girls). • Supplementary Nutrition Programme under ICDS (Revised 2009) **MoHFW** • Weekly Iron and Folic Acid Supplementation (WIFS) to Adolescents, 2011 • Guidelines for Control of Iron Deficiency Anaemia (National Iron Plus Initiative) and Iron Plus Initiative

*Note: *Actions are already a part of RCH or ICDS programme. @ Flour fortification ongoing with private sector collaboration. #Specific situational cases + to be introduced;*

However, there is a vast gap between the current status and the universal coverage goal.[258]

Coverage of essential nutrition direct interventions to reduce malnutrition[259]



Addressing child malnutrition in urban areas requires paying special attention to those living in slums, informal settlements or unauthorised slums. A system also needs to be established to ensure the tracking of all pregnant mothers from conception to two years after giving birth as is being already done in rural areas. The aim should be to influence family-based care and feeding practices, create demand for health and nutrition services and increase response to services. Special effort is also required to ensure that the equity issue is addressed. Poor clusters and urban slums, especially in small and medium towns, need to be identified and reached. The following urgent actions are crucial:

- **Mapping urban poor clusters and the services:** As a part of urban planning, urban poor pockets and families with under-twos in urban India as well as with newly-weds and SAM need to be identified and linked to ICDS and public or private health services. Such families are the families who are at the highest risk of being undernourished.
- **Promote home-based care practices and improve the demand and response to health and nutrition services:** Caregivers, families and communities need to be educated about the significance of appropriate infant and child-feeding practices as well as appropriate hygiene and sanitation practices. Additionally, it is important to motivate caregivers to seek timely health services. Community members, especially families of under-twos, therefore, need to be reached through inter-personal counselling, mass media campaigns, community and *basti* health nutrition days. Community link workers such as ASHAs of the NUHM, AWWs of ICDS or a community worker who is a member of community-based groups such as MAS, women's mohalla groups, etc. can perform this task. It is imperative to ensure that communities are informed and convinced about the use of diversified food for feeding children and of the adoption of hygiene practices as well as to proactively seek health and nutrition services provided by the health department such as micronutrient supplements, immunisation, and maternal health, family planning and care services.

Appropriate advocacy for sensitising concerned sectors such as the staff of urban ICDS projects and health posts and urban family welfare centres on issues related to the significance of the effective implementation of evidence based essential nutrition interventions for universal coverage is needed. The cost-effectiveness of concentrating actions in the first 1000 days of life needs to be emphasised. In this context, developing the capacity of the private medical network is equally important and cannot be ignored, especially in urban slums.

Society for Nutrition Education and Health Action (SNEHA) in urban region[260]

SNEHA, an NGO, founded in 1999, addresses the health and nutrition needs of slum communities in Dharavi, Santacruz, Ghatkopar and Kandivali. The community link workers, called *sakhis*, map out slum communities, identify women of childbearing age. The interventions focus on maternal and neonatal health and child health and nutrition. SNEHA works closely with the ICDS and health system. The primary focus is on creating awareness of good health and nutrition practices in communities, as well as enhancing access to public healthcare services. Intensive health education commences from pregnancy up to when a child is three years old. Intensive education is the focus from pregnancy to the first 28 days to ensure that healthy mothers give birth to healthy babies.

Moreover, *sakhis* form nutrition committees in the community which works closely with the ICDS staff in implementing essential nutrition interventions, including health services. SNEHA has demonstrated the ability to operate at scale. By 2010, it had reached 25,000 households influencing practices in 500 families, training over 100 community link workers and training staff at 10 anganwadi centres. SNEHA also provides a continuum of care by running one day care centres for SAM children aged 0 to 3 years and training caregivers on IYCF. SNEHA by 2010 had reduced the rates of malnutrition among day care centre children by about 60%, educated 500 mothers on appropriate IYCF practices, established 10 nutrition committees in two vulnerable pockets of Dharavi and trained adolescent girls as nutrition counsellors. By March, 2013, 6460 children under three years of age were reported to have been screened with an overall reduction in acute malnutrition from 15.6 to 10.4% in six months.

A higher focus on strengthening interpersonal counselling sessions, media campaigns and other social mobilisation activities is crucial. This implies ASHAs and AWWs being trained to identify and provide timely counselling to families at risk (i.e. families with newly-weds, pregnant women, a child below one, an LBW infant). The focus needs to be on the following selected interventions—the promotion of appropriate IYCF (appropriate breastfeeding, complementary feeding and feeding during illness practice) and hand-washing with soap and water after defecation and prior to feeding, strengthening actions for the prevention and management of diarrhoea in children, including appropriate feeding during illness, ensuring health and nutrition care during pregnancy and care of LBW babies. Such actions have been effectively undertaken by the link workers of NGOs operating in urban areas.

- **Focus on universal coverage with micronutrient supplements:** The provision and consumption of micro-nutrient supplements is an integral part of essential nutrition intervention. An appropriate urban-specific strategy needs to be developed and implemented for universal coverage with recommended doses of iron folic acid supplements during childhood as well during adolescence and pregnancy. As per the government policy, effective coverage of children with a biannual dose of vitamin A supplements and de-worming is also essential besides ensuring universal consumption of iodised salt. Effort needs to be made to ensure that private and public schools are also informed of the importance of a weekly dose of IFA supplements for the prevention of anaemia in adolescent girls and for adopting mechanisms to reach adolescent girls in schools not covered by the government system.
- **Care during pregnancy and maternity benefits policy:** A focus on weight gain of 10 to 12 kgs and prevention of anaemia during pregnancy is important to reduce the chances of LBW. Special efforts are important to ensure that pregnant mothers below 45 kgs or of BMI less than 17 are provided with special energy-protein dense foods fortified with essential micronutrients. Social marketing of such products by the private sector or the small-scale production of traditional high-energy protein products fortified with micronutrients is important and needs to be explored along with measures to supply and promote the daily consumption of IFA tablets by pregnant women. A system to reach newly-weds to counsel and improve their nutritional status prior to the onset of conception is important along with the effective implementation of measures to delay first conception prior to 18 years of age.

There is a need to sensitise employers of the significance of creating working conditions which facilitate women workers' proximity to their babies at least for the first six months of life. Monetary compensation to pregnant mothers during maternity leave is, therefore, critical not only for the formal but also for the informal sector. In the absence of such benefits, mothers resume work leaving young infants unattended. A policy for maternity leave in the non-formal sector is considered essential.

- **Institutional support to care for 0-3 years in crèches:** Mothers of young children need to be often employed to meet the financial needs of the family. Their young children need to be cared for when the mothers are away working. Moreover, these women need to be counselled on what actions can be taken to express and store breast milk in order to ensure that they continue to breastfeed despite being away from infants for some time. The establishment of crèches attached to the ICDS centres or a local NGO and community support organisation is recommended for the benefit of the children. The mobile crèches in Delhi and Mumbai have demonstrated a high quality childhood development services to the migrant children of construction workers through an integrated programme. The mobile crèches in Mumbai also train women labourers to become informed caregivers.[261]

- **School health and nutrition programme:** Besides health referral and the administration of iron-folic acid supplements (WIFS), health and nutrition education to school children is crucial to influence healthy eating practices, knowledge on the feeding of young children and personal hygiene, feeding during illness, significance of preventing undernutrition and acquiring optimum growth, importance of regularly consuming only iodised salt, and the schedule of routine immunisation. Education at the school level needs to also stress on physical activity and balancing food and energy requirements in order to prevent overweight and obesity. These actions need to be clearly stated under the school health programme or school health nutrition programme in both government and private schools. This is of great significance since the NSSO 2012 clearly indicates a rising trend in the consumption of unhealthy foods such as cold beverages and processed foods such as potato chips, biscuits, etc.[262] School children also need to be informed that food is purchased from street vendors who follow unhygienic practices.

Ensure establishment and functioning of PDS: Members of the urban community and women's groups need to also be sensitised to their entitlement to subsidised food from the PDS. The state of Chhattisgarh has demonstrated an effective PDS model in urban and rural areas. Lessons learned can be used to improve the reach and effectiveness of PDS in urban areas. Moreover, policy issues for broadening the food basket need to be considered for improving food diversity, especially for higher amounts of pulses and oils for families of under-two's persons.

- **Ensure periodical nutrition surveys** are undertaken in the country and include data on the urban situation. However, for the time being, the data available from NFHS 3 2005-6 and CES 2009 can be used as the basic information for the development and execution of urban slum plans. The urban nutrition data is also expected to be released soon by the NNMB and by HUNGaMA Report.
- **Monitoring** includes a set of indicators pertaining to nutrition improvement in the comprehensive social development plan for the urban sector.

Achievement of the projected coverage will facilitate in achieving the 65th World Health Assembly Goals of Maternal, Infant and Child Nutrition by 2025 i.e. 40% reduction in the global number of stunted children, reduction of wasted childhood to 5%, 50% reduction in anaemia in women in the reproductive age, 30% reduction in LBW and no increase in childhood overweight (WHO 2012, WHA 65.5).[263]

It is important that policymakers and implementers prioritise the above actions since achievement of these targets are of significance not only for quality of life but also because these targets have significant economic implications. Reduction in number of children with childhood stunting is of great significance in terms of reducing loss in economic productivity.[231] One percent loss in adult height due to childhood stunting is associated with 1.4% loss in economic productivity.[265] This is also reflected in the estimation of theearning capacity in adulthood--stunted adults who earn 20% less than non-stunted adults.[266]

It is assessed that stunting can reduce the country's gross domestic product by 3%.[267] It is, therefore, important that direct nutrition actions and nutrition sensitive programmes are targeted to the identified geographical vulnerable urban population pockets with a view to rapidly achieve the WHA targets and reduce the existing gap in various wealth categories. It is imperative to understand the urgency of actions and invest in the above set of cost-effective interventions for which policies of the government are already in place.[268]

Indicators for monitoring process

- Ensure 90% newborns are tracked up to one year for ensuring full routine immunisation, exclusive breastfeeding up to six months and for the establishment of appropriate complementary feeding practices.
- Ensure at least 80% low birth weight babies born in an institutional set-up are tracked up to 24 months for care and ensuring adequate 'catch up' growth.
- Ensure at least 90% pregnant mothers are covered with appropriate antenatal care services and those severely undernourished (of weight of less than 45 kgs during antenatal registration) are provided with energy-protein dense multi-micronutrient fortified food supplements.
- Ensure at least 90% newlyweds and 80% adolescent girls in school receive and consume weekly IFA tablets.
- Ensure at least 90% mothers receive and consume at least 100 IFA tablets.
- Ensure 50% children of six months to two years bi-weekly receive and consume IFA syrup.
- Ensure minimum 90% households consume iodised salt with at least 15 ppm iodine.
- Provision of two doses of vitamin A supplement to at least 90% children nine to 59 months.
- Introduce fortified foods such as iron fortified wheat flour, in collaboration with the private sector, in the public distribution system as well as in the urban and rural markets.


Photo credit: Rachel Palmer/Save the Children

WASH in urban areas

Akhilesh Gautam

> *"There are no bins on the road where the waste can be dumped and hence, it gets scattered all over the area that leads to a foul smell. The lack of clean water in the area is also a problem.*
>
> - A girl of 16 in Govandi area, Mumbai

Introduction

WASH: Interconnections with the various aspects of well-being

Water and sanitation are crucial for a child's survival, health and nourishment, the health status of adolescent girls and women and national developmental outcomes.

Global studies report a reduction in child mortality by 25 children per 1000 due to improved access and use of the safe drinking water, sanitary toilets and adoption of hygiene practices. A total of 2.2 million child deaths can be averted in developing countries with water, hygiene and sanitation interventions along with other benefits such as reduced morbidity, time costs and environmental hazards.[269] Studies on India also suggest a similar reduction pattern. Households who merely improved their access to a sanitary toilet, did not lead to reduced child mortality or improved nutritional status, suggesting a need to prioritise hygiene education that enables them to make right use of these toilets and other hygiene practices.[270] Urban parts of India are reporting a consistent decline in IMR from 50 in 1990 to 43 in 2000. It further declined to 29 in 2011. There is immense scope for further reduction if the vulnerable communities get access to improved WASH facilities and the utilisation increases. Investment in the sanitation sector will help achieve its target to reduce total IMR from 44 to 25 by the end of the current FYP in 2017.

There is a growing body of scientific evidence indicating that school attendance and retention rates for girls from the middle and higher classes, are particularly affected in the absence of proper, separate and well-functioning sanitation as well as school hygiene facilities and their poor maintenance. This puts girls and women at a greater risk. It is estimated that 24% girls drop out of school and more than 30% women from the marginalised groups are violently assaulted every year for reasons related to the lack of basic sanitation.[271]

In households without access to toilet, women are unable to defecate during the day due to lack of privacy and for the fear of harassment. Waiting for long hours increases the chances of chronic urinary tract infections as well as bacterial vaginosis (these proportions are in the range of 25% to 60% and 15% to 25% respectively) leading to adverse pregnancy outcomes such as low birth weight, pre-term birth[272] and slow post-natal recovery. Also, travelling long distances to access public facilities or going out to defecate at early dawn makes them vulnerable to sexual assault. According to a UN study, in Delhi slums, almost 70% girls experience verbal harassment and 50% have faced serious physical assaults.[273]

The cycle of impact continues into the infancy and childhood of children born in insanitary conditions. There is now conclusive evidence from meta-studies that the stunting and underweight of 48% children suffering from malnutrition in the country is strongly linked to the lack of access and use of WASH facilities. Multiple studies indicate that improved hygiene and sanitation can reduce diarrhoea by 26%.

Improvements in hygiene and sanitation lead to an increased standard of living in cities, propelling economic growth. Investment made towards a safe water supply and access to improved sanitation has multiple economic returns. According to the Ministry of Health and Family Welfare, more than 12 billion INR is spent every year on illnesses[274] resulting from poor sanitation. According to a 2010 World Bank report, India loses 240 billion INR annually due to the lack of toilets, hygiene.[275]

For every 1 USD invested, there is a projected benefit of 3 to 34 USD.[276] The benefits range from time savings and productivity gains, to budget savings on healthcare. Per capita gains for the developing world population can reach at least 15 USD per capita per year. It is well established that women safety, dignity and well-being are intrinsically linked to the improved availability, access and usage of sanitation and drinking water facilities.

Against this backdrop, it becomes imperative to analyse the status of the sanitation (including safe disposal systems) and water supply so as to gain insights into the steps required to improve the situation, as this will be crucial in improving the health and nutritional status of the deprived children.

But as data indicates, safe water and sanitation remain far from the reach of a huge section of the human population. Approximately, 780 million people still have no access to improved water sources and more than 2.5 billion people (roughly 37% of the world's population) do not have access to improved sanitation as defined by the WHO and the UNICEF in their 2012 Joint Monitoring Programme Report. OD is one of the main causes of diarrhoea. Eighty per cent diseases in developing countries are caused by unsafe water and poor sanitation.[277] UNICEF estimates that more than 90% deaths from diarrhoea in young children can be attributed to unsafe or inadequate WASH practices.[278]

- Every 20 seconds a child dies as a result of poor sanitation and an estimated 1.8 million children die globally [279] before the age of five from diarrhoea and related water-borne diseases every year.
- In this, India alone is responsible for more than half a million diarrhoeal deaths.[280] Approximately 443 million school days are lost as a result of water- and sanitation-related diseases.[281]
- Over 40% of the world's six billion people have no acceptable means of sanitation, and more than one billion people draw their water from unsafe sources.[282]
- Importantly, evidence shows that in areas with better community sanitation, reducing the concentration of faecal coliform by two orders of magnitude can lead to a 40% reduction in diarrhoea.[283]

The under-served and unserved urban areas are inhabited by the poor of the cities where the insufficient water supply and sanitation coverage combined with overcrowding, tend to maximise the possibility of faecal contamination.[284]

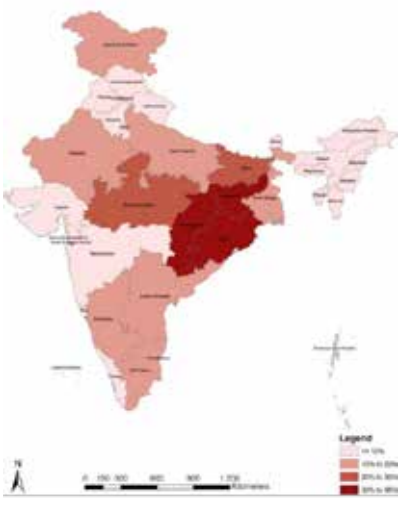
International conventions and pronouncements have recognised the crucial need for safe drinking water and sanitation. Article 24 of the UNCRC commits its signees such as India to ensure the highest attainable standard of health for every child, everywhere and at all times. This extends to providing clean drinking water and eliminating the dangers of environmental pollution. The UN General Assembly Human Rights Council in its resolution adopted on 9 October 2012 during the 21st Session, recognised the right to safe drinking water and sanitation as a human right.

Water, sanitation and hygiene: The Indian situation

Among the fast growing BRICS economies, India has 51.7% of its total population practicing OD as compared to 7.4% in South Africa, 3.6% in Brazil and 1% in China.[285] In terms of urban sanitation, while India has about 11% of the worlds' urban population, it sadly accounts for nearly half the global population defecating in open.[286]

The situation of OD is better in urban areas than in rural. According to the Census 2011, nearly 12.6% of urban households resort to OD as compared to 67.3% in rural areas. In urban India, another 6% use public or shared toilet facilities. The situation is far worse in smaller cities (population below 100,000) with OD rates around 22% and in slums where it is 18.9%.[287] Though significantly less prevalent than in rural India, OD in urban settings poses more serious challenges. With higher population densities and a lack of safe spaces, OD affords little dignity and poses grave security risks for women and children. Moreover, recent literature suggests that OD causes stunting among children, particularly in the more dense urban areas.[288] Elimination of OD, which has a profoundly harmful impact on the health of the poorest communities, needs to be a priority for improving the health and nutritional status of our children.

Open defecation in urban areas (2011)



Safe water supply is another critical determinant of the health and nutritional status of the urban deprived children. According to Census 2011, 70.6% urban households have individual water connections,[289] as against 91% in China, 86% in South Africa and 80% in Brazil. The duration of water supply in Indian cities ranges from one to six hours, as against 24 hours in Brazil and China and 22 hours in Vietnam. The supply of water in Indian cities ranges from 37 litres per capita per day to 298 lpcpd for a limited duration, while Paris and Mexico continuously supply 150 lpcpd and 171 lpcpd respectively, for 21 hours a day.[290]

Tap water is the source of drinking water for 70.6% urban households in India while for slums it is 74% (2011 census). In addition, over 43.3% households in slums report that these sources are located outside the premises as against the overall urban figure of 28.8%.[291] Shared water sources in a rural area are only shared by a handful of people whereas in a crowded slum, hundreds compete for the same water source. Further, public taps in slums often offer little or no water supply. A study conducted[292] in four slums located in the peri-urban areas of Bengaluru reported availability of water throughout the year in public taps for only around 30% of the slum residents, with one slum reporting water supply only once a week.

"Water is one of the earth's most precious and threatened resources. Health is one of each person's most precious resources. We need to protect and enhance them both. Water for Health"

– WHO

Water and sanitation in urban areas

The combined effects of inadequate sanitation, unsafe water supply and poor personal hygiene are responsible for 88% childhood deaths attributed to diarrhoea and cause over 3,000 child deaths per day (more than a million per year).[293] India is a signatory to the UN led Millennium Development Declaration that affirms its commitment to Goal 7, which is to reduce by half the number of people without access to improved sanitation by 2015. The national FYP for the period 2012 to 2017 has identified the urban sector as one of the 11 priorities in the country.

Sanitation

Investment in sanitation generally concentrates either on household toilets or sewerage construction. Sludge ends up being dumped in untreated drains, waterways and on marginal land, where it poses a huge health risk, again mostly affecting the poorest communities. OD is one of the biggest challenges in managing sanitation situation in India. Faecal sludge from on-site sanitation systems particularly from the non-sewered septic tanks in more than 40% urban households is another important challenge.

About 18.6% households in the urban areas of the country do not have access to a sanitary toilet within their residential premises; this amounts to a total of 14 million households. Out of these, 9.96 million households practice OD, representing 12.6% of the total urban households in the country while the remaining 6% use shared public sanitation facilities. At the all-India level, 31% slums had no latrine facility, the figure being 42% for non-notified and 16% for notified slums.

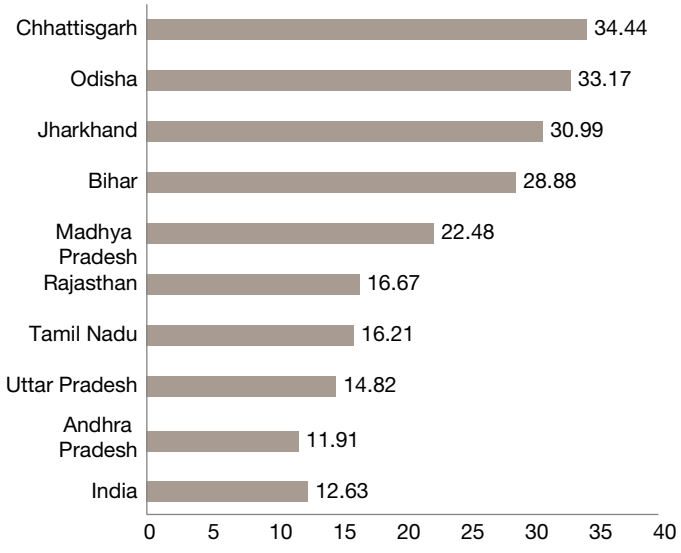
Some studies[261] undertaken suggest that up to 74% urban households in the slum areas do not have a toilet due to non – affordability, while 18% cited lack of adequate space in their home for the construction of a toilet.

Open defecation and sharing of toilets

Challenges highlighted by children in FGD

India lags behind other developing nations in terms of access to sanitary facilities and this is reflected in the proportion of households defecating in the open. According to Census 2011, no state in India is open defecation free (ODF).[295] OD may be a socially and culturally accepted behaviour at large, however in urban areas it is forced behaviour due to lack of toilet facilities. Additionally, lack of safe disposal systems of human excreta poses significant health risks to the citizens.

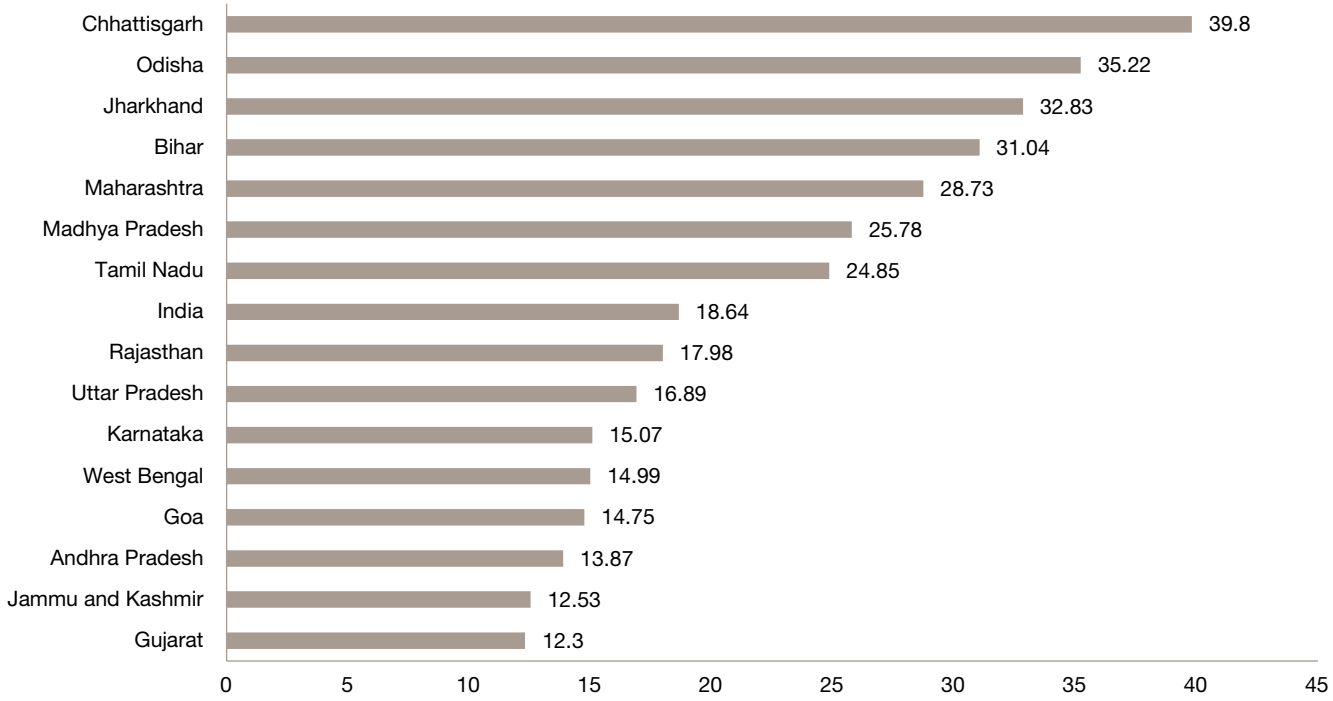
Open defecation in urban areas: Top 10 states



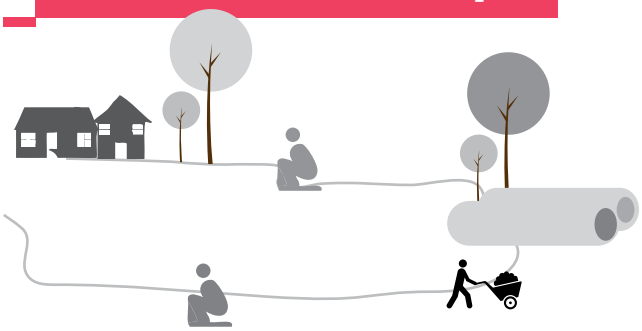
The 12th FYP (2012-17) targets an ODF status for urban India. The NUSP announced in 2008, entrusted state governments to achieve this vision for sanitised, liveable and healthy cities.

Evidence suggests that the mission mode campaign style of programming will help the state reach an ODF status faster but the outcome will not be sustainable. There is always a risk losing the ODF status unless the campaign is run in the demand responsive approach fully backed by IPC hand washing and menstrual hygiene), mass media and IEC activities.

Urban households without toilets (in percentage)



9,960,011
households defecate in the open



4,743,807
households do not have access to toilets at home or within their residential premises

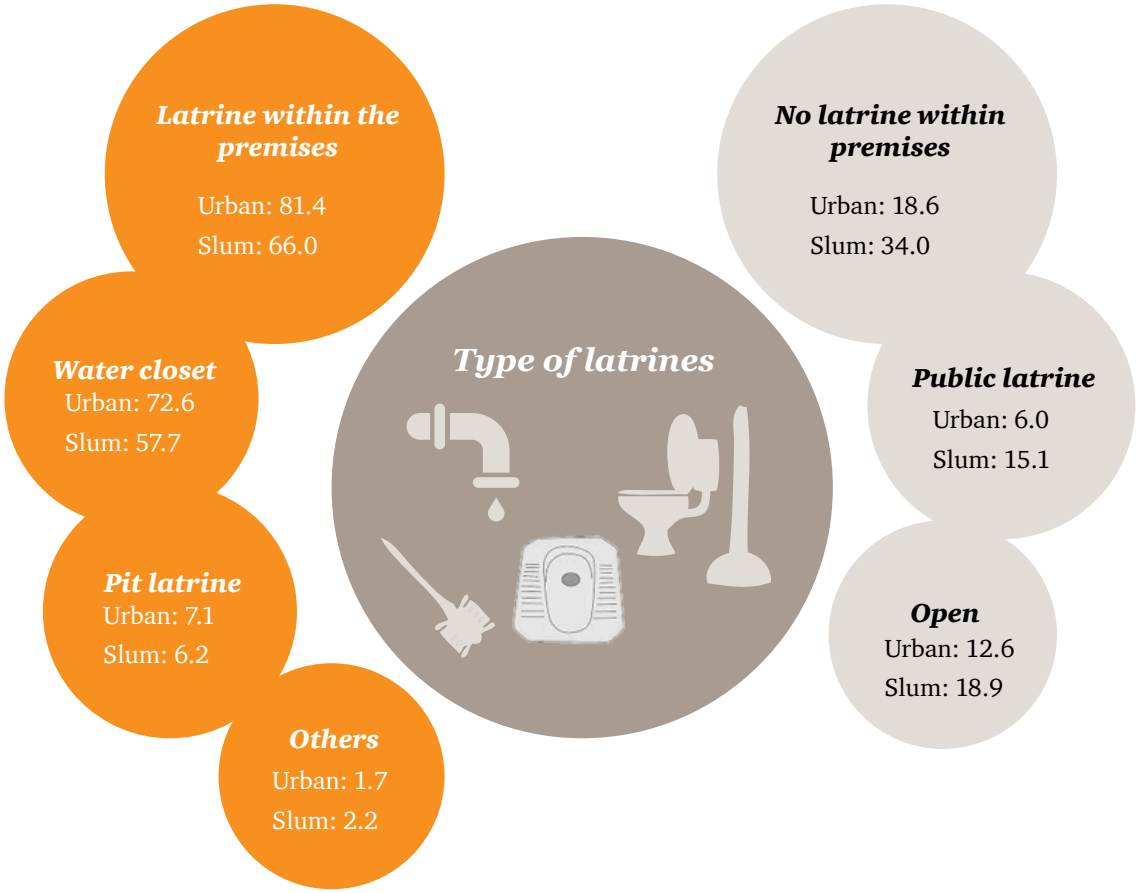
According to the 2011 census, more than one in two households in rural areas and around one in five households in urban areas do not have a household toilet and have to depend on shared facilities.

Every third household without access to a sanitary toilet within the residential premises belongs to someone with a SC/ST background. About 34% such households do not have access to a sanitary toilet within their residential premises.

About 17.4% of the urban population dwells in slum areas with 36.1% being in notified slums, 27.6% in recognised slums and another 36.3% in identified slums. Public sanitation from the viewpoint of women's safety, dignity and well-being is critically important. Toilet facilities within residential premises are available only to 66% households in slums and to 81.5% in urban areas. India has about 27 million households with female heads of family who are also primarily responsible for maintaining their homes. More than 50% of such households have no toilets and, therefore, have to either use a public toilet or defecate in the open.

As per the WHO-UNICEF JMP, use of shared facilities is not considered improved sanitation. Sharing of a toilet among two or more families is unhygienic and it is, therefore, desired that these additional households that share the toilet facility should be considered a part of the target group for ensuring access to safe sanitation. In case of paucity of land within the residential premises, a toilet complex can be considered with individual household ownership rather than adopting a community toilet approach.

Access to different types of latrines in urban India[296]



"There are few useable public toilets in our area. These toilets have neither water nor electricity and women feel scared to use them in the evenings."

- A girl of 14 near Bibvewadi slum, Pune

"1800 of us have to share one toilet, which is dirty and unfit for use. Moreover, we don't use it as boys tease us when we go there."

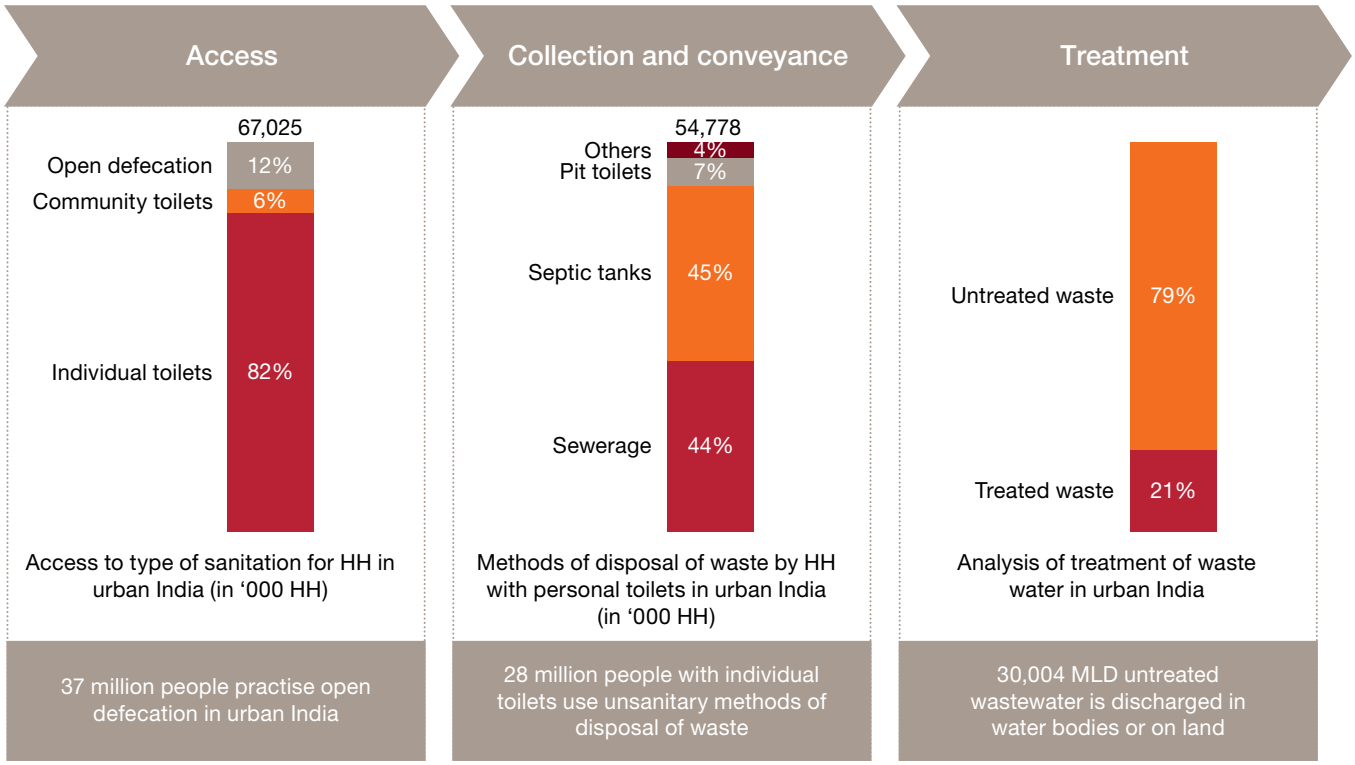
- A girl of 14 near Govandi slum, Mumbai

Insufficient sewage treatment

Untreated sewage poses a major risk to health as it contains water-borne pathogens that can cause serious human illness. It also destroys aquatic ecosystems, eventually threatening human livelihood.[297]

Safe disposal of human faeces is one of the principal ways of breaking the faecal-oral disease transmission cycle. Seventy-nine per cent of sewage in India is untreated and flows directly into the nation's rivers, polluting the main sources of drinking water. Indian cities produce nearly 40,000 million litres of sewage every day and barely 20% is treated.[298] A 2011 survey by the CPCB[299] revealed that only 160 out of nearly 8,000 towns had both a sewerage system as well as a sewage treatment plant, reflecting the seriousness of the problem.

Access to toilets, collection of waste and treatment of waste water: Process diagram[300]



Drainage for waste water and sewage

Discharge of untreated sewage is one of the primary causes for the pollution of surface and ground water. The large lag between the generation and treatment of domestic wastewater aggravates the issue. Not only does the treatment capacity need to be improved, but safe conveyance and household level connectivity are also urgently required. Rejuvenation of the existing sewer networks in a ULB and its congruity with the adjacent growing suburbs is a challenging task for the authorities.

Census 2011 informs us of the extent to which sewage is safely channelled through closed drains in urban India. In comparison with the overall urban households, the slum-based households in India are exposed more to the open drains (44% as against 37%) and as a result, to the health hazards caused by such exposure.

Drainage for waste water outlet[301]

Drainage connectivity	Urban (HH in percentage)	Slum (HH in percentage)
Closed drainage	44.5	36.9
Open drainage	37.3	44.3
No drainage	18.2	18.8

Wastewater treatment is planned, engineered, and managed to remove, treat, and dispose waste in the liquid medium, away from human and environmental contact. Successful wastewater treatment should provide a point of waste collection, waste conveyance, treatment as well as storage, final discharge and disposal of the treated waste. This requires for wider planning that integrates various social and engineering issues. In Mumbai's Slum Sanitation Programme,[302] 25% of the newly built toilet blocks did not have a water connection to flush the toilets and about 70% were not connected to sewerage. This project, sponsored by the World Bank, was unlikely to receive a full return on its investment. The infrastructure limitations rendered the project ineffective with no significant improvement in the living conditions of the concerned slums.

In the Mumbai Sewage Disposal Project, sewerage was successfully connected to the sewage treatment plant, but the huge amount of sludge that was produced created a new problem of solid waste disposal. The civil administration had not anticipated this and did not know how to deal with it; the project had to be stopped as a result. An estimated 1500 metric tonnes of sludge gets generated daily from 2300 million litres of water. Sludge treatment not only costs a lot (as much as 50% of the total cost of wastewater treatment),[303] but is also a public health hazard as treated sludge cannot be dumped within the local environment. Sludge concentrates the pollutants from the sewage and if not disposed of properly, can pose a new environmental threat by contaminating land and clean water sources.

The City Sanitation Plans as mandated by NUSP and Swachh Bharat Mission (urban) is the appropriate meso planning exercise that can take a citywide perspective to strategic technical sanitation options in a holistic way, following an incremental approach. In the interim, many cities are likely to have multiple operational sanitation systems.

Water for consumption

Source of drinking water[304]	Urban HH (percentage)	Slum HH (percentage)
Taps	70.6	74.0
• From a treated source	62.0	65.3
• From an untreated source	8.6	8.7
Wells	6.2	3.0
Hand pumps	11.9	12.7
Tube wells or boreholes	8.9	7.6
Others	2.5	2.8

In urban areas, 62% households have access to tap water from a treated source that is used for drinking purpose. Another 8.2% households use tap water but from an untreated source. Hand pumps are used by 11.9%.

"The government water that we get in our houses is dirty and not consumable. So we are forced to buy water cans for 20 INR each. Also, we get water bills even when there is no water supply. We have raised this issue to our local MLA."

- A girl or 16 Tughlakabad area, Delhi

While Census data (such as 71% households having a drinking water source within the premises and 62% having access to a treated source) may make the reader believe that most of the urban households enjoy access to clean water (and indeed, India has reportedly achieved the MDG #7c of halving the number of those without access to safe drinking water before time in 2013), a recent survey of water quality has opened our eyes to a disturbing reality.

Location of the drinking water source	Urban HH (percentage)	Slum HH (percentage)
Within premises	71.2	56.7
Outside premises	28.8	43.3

This study was done by a team of researchers from Pratham Education Foundation, Delhi, Montreal University and Harvard Centre for Population and Development Studies between May and October 2013. It covered 685 households in a slum of Delhi (Kirti Nagar). Apart from interviews, the survey carried out tests on the water used by these households for drinking purposes using a UNICEF-validated rapid test for coliform bacteria. This test determines whether the water carries bacteria that originate in human faeces. Water was found contaminated in 41.5% (284 of 685) of the urban households. In urban homes, 24% children had suffered from diarrhoea in the past 15 days and 34% urban children reportedly had fever. Bad water has the most harmful effect on children because their immunities are under-developed. The survey found that 11% urban homes and 23% rural homes had experienced the death of an infant. This highlights the urgent need to relook at the flawed data that helps the government claim that the MDG-7c has been achieved.[305]

"In summers, with acute water shortage, we are made to stand in queue from 4 am to get water from government tankers. We stand in the line so that our mothers can come after finishing their chores. Bitter fights break out and I feel ashamed to have to stay here."

- A girl of 17 near Tughlakabad area, Delhi FGD

According to the 2011 Census, the source of drinking water is outside the premises of over two-fifths of the households in slum areas. However, the situation may vary across various slums. According to a baseline study conducted in four states,[306] and part of which was conducted in selected slums of Delhi, 82% respondents indicated their source of drinking water was outside their premises (a public source). In Delhi slums, this percentage was even higher (96% in programme areas and 98% in comparison areas). The major public source of drinking water was the piped water supply in Delhi (71%) though 20% others depended on tankers. Though adequacy of water was not an issue with 93% respondents, average time taken to fetch water in urban slums (42 minutes) was significantly higher than the average time taken overall (22 minutes). In Delhi, the limited duration of water supply from Delhi Jal Board and the dependency on tankers makes it difficult for residents to access water sources. Discrimination within the community also makes access more difficult for certain sections.

Non revenue water[307](NRW) accounts for 50% of the water production in India as compared to 5% in Singapore. For 70% users, there are water leakages at the connecting point from the supply network. Malfunctioning meters are another prominent cause; most Indian cities do not even have metering for home connections.[308]

Given the dependency on public taps in slums and related problems of poor water supply and large number of users for each public tap, these households are often forced to spend large amounts for accessing drinking water. In a study conducted on the water distribution system in a Mumbai slum[309], it was found that depending on the season, households spend 52 to 206 times more than the standard municipal charge of 2.25 INR per 1000 litres for water. In the same Mumbai slum, 50% point-of-source water samples were contaminated during monsoon. Despite absence of point-of-source water contamination in other seasons, stored drinking water was contaminated, with rates as high as 43% for E. coli and 76% for coliform bacteria.

Another important finding was related to the post-source contamination during storage in the household, except during the monsoon season, when there was some point-of-source water contamination. This suggests that safe storage and household water treatment interventions are capable of improving the quality of water for consumption in slums. Exorbitant rates, inadequate quantities and poor point-of-source quality are some of the imminent challenges of drinking water supply in slums despite an accelerated coverage over the last few decades.

"We have taps in the house but the connection doesn't work and we don't get water at home. So people have to use the common taps and there are major fights due to that. Sometimes it affects our friendship as our mothers fight to fill water for our homes."

– A girl of 15 near Govandi area, Mumbai

"Fights are common between neighbours around issues such as water and waste. Reasons range from dumping waste closer to others' homes to accusing the neighbours of stealing water stored and kept outside the house due to the lack of space."

– A girl of 16 near Govandi area, Mumbai

NSSO 69th round reports that during 2012, a person in urban India who had to go outside the premises for fetching drinking water spent, on an average, 15 minutes a day on the task. Jharkhand ranked the highest (40 minutes) followed by Rajasthan (33 minutes). Delhi has the lowest (6 minutes) average time a person spends on fetching drinking water.

Households where members had to go outside the premises to fetch drinking water not only required to travel (and spend time) to reach the respective source of drinking water and return from it but also had to wait in a queue before they could collect drinking water from the source. Therefore, for a typical household, the average waiting time (in minutes) at the principal source of drinking water can be considered an important indicator for adequacy of drinking water facilities. Members of urban households had, on an average, to wait for 16 minutes. Among urban areas, Rajasthan had the longest (24 minutes). It is interesting to note that while Delhi may have shortest travel time of 6 minutes, it has a waiting time of 19 minutes, higher than the national average.

Consumers are charged tariffs for their usage of water but there is no tax levied for recovering the capital expenditure incurred by the ULBs. Hence, the ULBs are dependent on grants from the state government for meeting their capital expenditure. The lifting of water requires high electricity consumption. The average pumping cost of water can go as high as 30 INR to 33 INR per KL which may constitute up to 60% of the total cost of water production.

The following is the list of emerging challenges with respect to drinking water:

- **Inadequate water sources**: Available water sources in the vicinity of the cities have been tapped to the maximum extent possible. All nearby water sources have been utilised and the currently available one are insufficient. There is hence, a need to explore and develop additional water sources to meet the current and future water demand. This will require water resource recovery, reuse as well as recycling.
- **Leakage of water**: Physical and administrative losses to the extent of more than 50% cause revenue loss and contribute to inadequate water supply at the tail end in certain areas.
- **Poor service levels**: On an average, 70% households are covered by the piped water supply networks. The average water distribution time is only 45 to 90 minutes and depends upon the water pressure in the network. The water supply is also usually characterised by low pressure.
- **Sector inefficiency leading to high cost of water supply**: Water supply has been subsidised to the extent of 88% for domestic water. However, a large part of it is lost due to the sectoral inefficiencies such as non-revenue water and distribution losses. The ULBs are able to recover only a fraction of the cost of providing water to the consumers excluding the bulk water purchase cost. This not only leads to water wastage but also leaves the ULBs in a poor financial situation.
- **Lack of skilled manpower**: Technical capacities of the municipal workers need to be continually enhanced in order for them to keep pace with technological advancements in the area. Refresher courses for municipal plumbers have not been conducted for many years now.

As per the Constitution, 'water' and 'sanitation' are classified as state subjects. 'Water' is included in Entry 17 under List II (the State List of Seventh Schedule, explained as: *"Water, that is to say, water supplies, irrigation and canals, drainage and embankments, water storage and water power subject to the provisions of Entry 56 of List I"*). 'Sanitation' is a subject matter included in Entry 6 of the State List as established through Article 246 of the Constitution. This essentially means that without empowering the states and local-level governments, the above challenges cannot be successfully met.

Solid waste management

Drinking water can be affected by solid waste landfills and indiscriminate solid waste disposal because source water can be potentially contaminated by leachate (liquid that has come in contact with or been released from solid waste). This problem gets accentuated for slum children.

Basic sanitation, safe water and proper solid waste management are the key health equity interventions in deprived urban areas.[310] Globally, in most cities especially in the developing countries, solid waste management remains a challenge. According to the World Development Report of June 2012, solid waste is a silent problem that is growing daily. Rapid urbanisation and population growth have contributed in straining social amenities such as solid waste management. The irregular collection of waste from most high-density suburbs leads to illegal dumping in nearby open spaces.[311]

In urban India, no state has 100% households equipped with a garbage collection system that can ensure that waste is collected and dumped away from the residential areas.[312]

About 75.8% households in urban areas are covered by some system of garbage collection and disposal. The state of Uttarakhand has the highest percentage (91.2%) of urban households with garbage collection systems while Kerala has the lowest (24.3%).

A CPCB report estimates 127486 TPD of municipal solid waste generation in India during 2011-12. Out of this, 89,334 TPD (70%) is collected and only 15,881 TPD (12.45%) gets processed or treated.

About 1.5 million[313] people across India depend on managing solid waste for their livelihood. Most are in the informal sector and belong to the poorest households of our cities. A study conducted by the National Labour Institute[314] in 1997-1998 found waste picking to be the fourth-largest occupation for street children in Delhi. In this city alone, about 80,000 persons work as waste pickers, with 30% of them being children. In the wake of the increasing number of private sector companies taking over the municipal solid waste management in the country, families are now depending on more hazardous and informal waste collection activities. This calls for an urgent rehabilitation for these families.

Photo credit: Lana Slezic/Save the Children

Impacted families have reported decreased incomes and school attendance for children. In 67%, lack of money was cited as the reason due to which they had to enlist children to work as labourers. Even though women in general work more than men, they experience greater income instability. This has been reported by *Chintan* from the studies that they conducted at the Okhla Waste to Energy (WtE) where the primary source of livelihood (approximately 88%) was from the waste at the plant site. Education is a particular challenge for these children. Even if they do enroll in a government school, many end up dropping out because of the discrimination against them. These children go to waste dumps and pick out things they can sell to recyclers. While many live alone and have to support themselves, others come from extremely poor families and have to work for their sisters and brothers to be able to eat. The study reports that out of the children engaged in this work, 84% were severely anaemic. Also, 14% had tuberculosis and 24% complained of frequent fever. The more they work in dumping grounds, the more they are exposed to toxins, worsening their health.

In addition to health issues, these children have also listed the following concerns:

- Harassment by the police and absence of any dialogue with them to solve problems
- Physical abuse and great humiliation by residents, communities, *chowkidars*, etc.
- Lack of any acknowledgement by residents, municipalities and other authorities
- Poor access to medical facilities
- Poor knowledge of their rights and laws related to waste management

The major issues identified in the solid waste management service sector are:

- **Quality and quantity**: There are no existing records on the weight and composition of biodegradable, recyclable or inert flows. As a practice, only raw estimates (in metric tons) are available based on transportation containers.
- **Improved occupational safety**: Workers, whether in the formal or the informal sector, need to be equipped with machines and safety gear. Children and women working in waste related activities need to be provided with rehabilitation support.
- **Coverage of SWM services**: Door to door collection is successfully carried out in few towns. While some cities are now starting, there are many that remain unreceptive to the prospect. In a few cities, door-to-door solid waste collection was abandoned due to user charges not being paid or political interference.
- **Lack of waste segregation**: Missing door-to-door collection or collection of unsegregated waste at source is resulting in mixed MSW being collected. As a result of this, waste cannot be optimally processed, directly impacting investment and service costs.
- **Reuse and recycling**: Limited segregation of recyclables and recycling processes are put in place by service providers except the informal sector. Plastic can be segregated at the ULB level and sold to PWD, which can then down-cycle it and use it for road construction. Himachal Pradesh and Delhi have taken the initiative of banning plastics for packaging.
- **MSW recovery or processing**: The existing composting and treatment facilities are co-financed by the state and central governments across ULBs. Many facilities are non-operational as the ULBs cannot operate and manage them due to lack of land, capacities, process understanding and financial sustainability.
- **Scientific disposal of MSW**: No organised scientific land-filling is in place and the waste collected is either dumped in the allocated dumping grounds or is openly burnt causing enormous negative environmental impact.

- **Governance, administrative structure and human resources:** Administrative structures for municipal corporations and councils as well as NPs need to be defined with respect to MSW. Operational management structures in this field are weak and inadequate for execution and monitoring of MSW services. The Human resources' ability to plan for and manage MSW operations is severely constrained owing to the limited know-how on processes, operations, management and cost recovery, which further hampers the proper management of MSW services.

States are required to develop comprehensive MSW management strategies that outline the short-term as well as the long-term plans for ULBs to handle MSW in accordance with Draft Municipal Solid Wastes (Management and Handling) Rules, 2013. The ULBs will need to have capacities and preparedness to undertake segregation of waste at source, door-to-door collection and transportation, set up processing and treatment systems as well as dispose only the inert materials in scientific landfills. The strategy will need to look at the regional or district-level facilities for treatment and scientific land filling due to the scarcity of land. They will need to take adequate measures to reduce, reuse and recycle (plastic waste management) in order to minimise costs as well as land requirements for regional facilities. Options such as composting of organic waste, co-processing of dry fractions of municipal waste in cement or power sectors and waste incineration for energy production need to be explored. Ensuring financial sustainability of ULBs should also be included in the strategy for the development of an environmentally compliant and sustainable solid waste management system.

New Municipal Solid Waste Rules 2013: Salient features

- Detailed roles and responsibilities allocated to MoEF, MoUD, CPCB, SPCB, MC, generator
- Preparation of a state policy and MSWM strategy for states and UTs in consultation with stakeholders and in alignment with the State Sanitation Strategy (SSS) under National Urban Sanitation Policy (NUSP) within one year of notification
- Environmental standards while adopting various technologies for processing and treatment, including heavy metals, dioxins and furans
- Emphasis on IEC
- Segregation of waste into three categories: wet, dry and special waste (domestic hazardous)
- Identification of a designated site as a material recovery facility
- Compliance criteria and incineration standards

School sanitation

The provision of sanitation in schools is one of the primary needs for the holistic development of a child. There are a total of 1.52 million schools spread over 662 districts across 35 states and UTs.[315] Out of these, 12, 91, 276 (85.06%) are in rural areas and 2, 26, 218 (14.90%) in urban areas.

The following data shows that the status of availability of toilets in schools, especially that of girls' toilets, is very good in urban India.[316]

Type of school (All figures in percentage)						
Toilet category	Primary only	Primary with upper primary	Primary with upper primary and secondary or higher secondary	Upper primary only	Upper primary with secondary or higher secondary	Total
Boys' toilets	81.51	92.13	96.1	81.59	92.59	87.54
Girls' toilets	84.59	94.8	97.59	86.31	94.9	90.32

Photo credit: Raghu Rai/Magnum for Save the Children

Annual Survey of Education Report (ASER 2013), a civil society initiative covering almost 7 million children in 13,000 rural government schools in 522 districts reported that schools without toilets have decreased from 12.2% in 2011 to 8.4% in 2012 while the number of schools with useable toilets has increased from 47.2% in 2010 to 56.5% in 2012.

While this data indicates that the availability of school toilets in both urban and rural India has generally improved, the quality and functionality remains unsatisfactory.

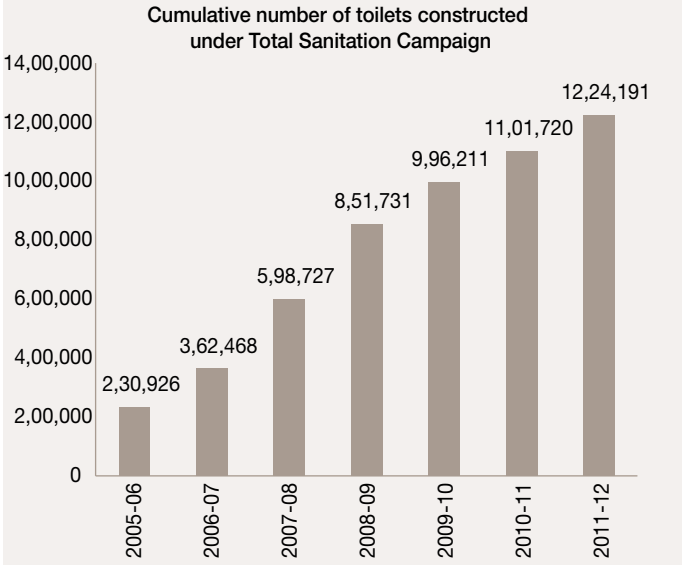
> *"We never use school toilets as they are very dirty and so are the tanks that contain drinking water. We also carry our own lunch as the meals provided in schools have dust, pebbles and sometimes dead rats."*
>
> – A girl of 15 near Gowandi area, Mumbai
>
> *"There is a separate water filter for teachers and children have to drink dirty water and the toilets are extremely dirty. Boys have no choice but to defecate outside."*
>
> – *A* Boy of 17 near JJ colony, Delhi

Sanitation facilities need to be age and gender appropriate. Children's participation in the management of sanitation facilities with respect to design, siting, upkeep and maintenance requires constant encouragement. With this objective in mind, several initiatives at the state and national level are currently under implementation.

The availability of drinking water and toilet facilities in schools is equally good in both rural and urban areas except some state-specific differences. Water facilities are functional in more than 90% schools over 13 states. In Arunachal Pradesh, Manipur, Meghalaya and Tripura, however, less than 65% schools have functional toilets.[317] The number of schools having a separate toilet facility for girls has increased from 0.4 million (37%) in 2005-06 to 1.24 million (88%) in 2012-13. More than 89 million girls in schools now have access to toilet facilities.

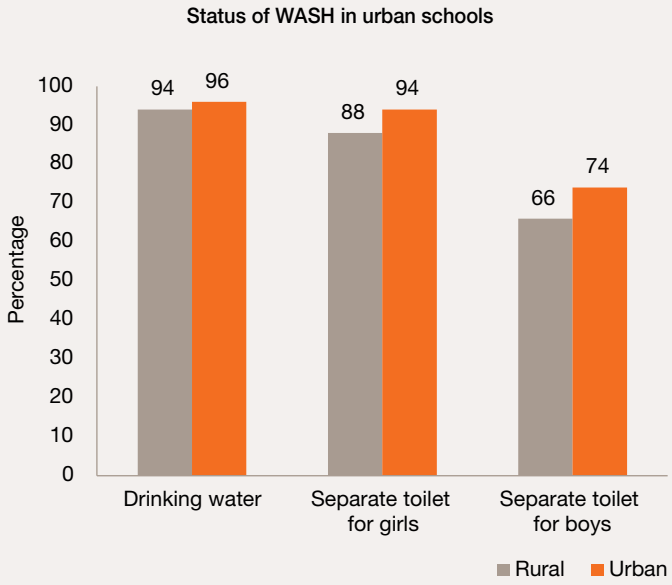
However, 7 million (7%) girls have no access to this facility as 25% schools still have non-functional toilets. According to a report, in India, majority of the girls drop out of school due to the lack of toilets. Only 22% manage to even complete class 10.[318] According to another study by Dasra, almost 23% girls drop out when they start menstruating. In some places, nearly 66% skip school during menstruation and one-third of them eventually drop out. In Andhra Pradesh, Odisha and J&K less than 40% schools have functional girls' toilets. Around 23 million (22%) boys too lack access to separate toilet facilities. Improving access in Andhra Pradesh, Madhya Pradesh, Odisha and West Bengal alone will reduce the gap by 50%. Similarly, improving access to girls' toilets in Andhra Pradesh, Assam, Bihar, Odisha and West Bengal will reduce the gap by 60%.[319]

Availability of drinking water stands at 95% in urban schools across India. However, 5.23 million children (2.6% of the total enrolment) still do not have access. Andhra Pradesh, Assam, Bihar and Rajasthan account for more than 50% children without access to drinking water facilities in schools.



The Nirmal Bharat Abhiyan supports the School Sanitation and Hygiene Education programme. Nearly 1.22 million toilets have been constructed in rural government schools under the programme.

Source: http://tsc.gov.in Ministry of Drinking Water and Sanitation, Government of India



The situation in urban schools is also similar to those in rural areas.

Source: U-DISE 2012-13, NUEPA, New Delhi

However, following are certain issues that have an implication on the overall management of school sanitation with respect to facility access and use:

- Functional status of the toilets
- Operation and maintenance issues
- Hygiene curriculum
- Clarity in terms of roles for urban schools and their administrations amongst municipal bodies, district board, education department (SSA) and management of private schools.
- Design of school drinking water, sanitation, waste water and solid waste disposal requires to be in correspondence with the city infrastructure such as sewage connections.

Access to toilets remains a major problem for girls, especially those in their puberty. Separate toilets are still an unrealised goal in many areas, they miss school during menstruation and this adds to being one of the several reasons for dropping out of schools.[320] Also, 40 per cent of schools lack functional toilets.[321]

The National School Sanitation Initiative

In order to improve the state of sanitation in schools, CBSE in collaboration with the Ministry of Human Resource Development, Ministry of Urban Development and GIZ instituted the online rating of schools in 2009. The rating is given according to the sanitation status of schools in five colour categories signifying infrastructure, institutional sustainability, environmental sustainability, health and hygiene and pedagogic aspects. Around 3,114 schools have been rated so far.

The programme lays emphasis on personal hygiene, proper sanitation, clean toilet habits, safe drinking water and separate toilets for girl students, disposal of waste water, waste water recycling, waterless urinals, waste segregation and composting, food hygiene, creation and conservation of green spaces.

Policies and programmes for urban water and sanitation

The evolution of urban drinking water and sanitation programmes focusing on the marginalised communities can be broadly organised into the following three distinct phases:

The **first** phase stretches from the 2nd FYP (1956-61) that espoused CDB for urban areas and carried out few pilots in the country until the 74th CAA came about in 1993. It is in this phase that the programmes and schemes focused on the urban poor and slums were designed. The 3rd Five Year Plan expanded these programmes through financial assistance to the state governments and local bodies to enable them to clear some of the worst slums in big cities. The 4th Five Year Plan focused on the environmental improvement of slums. It was only from 5th Five Year Plan that the small and medium towns attracted some attention in the formulation of the IDSMT. Both these programmes have continued in some form or the other since 1970s. During the 80s, which was the international decade of water and sanitation, 'Urban Basic Services' were implemented across two Five Year Plans (1980-85 and 1986-1990). This period also witnessed community mobilisation and organisation that led to participation in the micro level planning and management of basic services in low income settlements.

The **second** distinct phase in the post liberalisation era of economic reform also saw the arrival of the 74th CAA, empowering urban local bodies with the delegation of funds, functionaries and functions. The focus made a gradual reversal towards infrastructural improvement in the slums through the National Slum Development Programme and also marked the beginning of large scale urban programmes through the National River Conservation Directorate, the most important being the Ganga Action Plan. This phase also marked the expansion of the Integrated Low Cost Sanitation Programme largely driven by the aim to eliminate manual scavenging.

HPEC has estimated that urban infrastructure will require a total investment of 39.2 lakh crore INR over the next 20 years, with 8 lakh crore INR for sectors delivering urban services such as water supply, sewerage, solid waste management and storm water drains. By rough estimates, the universal toilet coverage will require 13,000 crore INR by individual households. A large part of the deprived households belonging to poor families will require financial support while a significant number of families especially in slum pockets will require innovative and technical trouble shooting.

12th Five Year Plan: Call for multi-sectoral action for children and women in urban areas

Ministry of Urban Development

- City planning to also be made child friendly: Key indicator of good governance
- Replication with urban local bodies what the Ministry of Panchayati Raj has done with PRIs
- Inclusion of child care as a 'basic service' not to be denied to communities with no legitimacy or security of tenure, living in unrecognised urban poor areas
- Progressively ensuring access to healthcare, education, skill development and livelihood for urban poor families with social protection for women and children as well as physical amenities like potable water supply, sewerage, sanitation and drainage for all
- Nutrition related concerns to be integrated into the second phase of JNNURM with the incorporation of child-friendly criteria

Ministry of Housing and Poverty Alleviation

- Allocation of land or building for AWC especially in urban poor settlements
- Inclusion of nutritional safety nets in resettlement plans for migrant and unrecognised urban poor groups
- Support to the development of innovative city models run by ULBs within the 200 high burden districts initiative, linked to JNNURM
- Piloting of community canteens for the urban poor, based on plans
- Actions by the state governments as urban water supply and sanitation are state subjects and a function of the urban local bodies

The **third** phase is marked by the announcement of NUSP endorsed in 2008. The NUSP made an ambitious vision for "all cities and towns to become totally clean, sanitised, healthy, liveable, ensuring and sustaining good public health and environmental outcomes for all citizens, with a special focus on hygienic and affordable sanitation for the urban poor and women".

The NUSP requests all state governments to develop State Sanitation Strategy (SSS) that would guide ULBs to develop their CSPs as a city level instrument for sanitation sector planning. The SSS is a major fillip in making state governments accountable to lead the sanitation sector in partnership with municipal authorities to prepare and operationalise CSPs as a supplementary tool to the CDPs and Master Plans on land use. The newly announced **Swachh Bharat Mission** (urban) has reinforced the focus on SSS and CSP by making it a pre-condition from the state governments and ULBs to access funds of the national flagship programme.

As a part of this policy, the MoUD initiated the rating of various cities to act as a monitoring and evaluation tool. They will be rated as per their performance in sanitation improvements based on a set of objective indicators outputs (9), processes (7) and outcomes (3). The first National Sanitation Rating of 423 Class I Cities covering 72% of the urban population conducted between November 2009 and March 2010 found that none of the cities were in the green category of being liveable, healthy and complete with sanitation.

The MoUD adopted the SLB Framework in 2008 and published a handbook on SLB monitoring service delivery parameters and for measuring their performance levels against the benchmarks. A total of 28 indicators adopted across four sectors (water supply (9), sewerage (9), solid waste management (8), storm water drainage (2). The 13th Finance Commission has recommended the notification of SLB by cities with municipalities and municipal corporations with effect from 2010-11 as a mandatory condition for accessing performance grants. Around 1,500 cities and towns have notified benchmarks. It has also recommended a grant of 23,111 crore INR for disbursement to ULBs for the period from 2011 to 2015.

Unlike the *Nirmal Bharat Abhiyan* for rural sanitation in the village areas, till November 2014, there was no programme for the urban areas in the country.

In the absence of a flagship programme for urban sanitation, the commensurate programme delivery structures, budget, guidelines, monitoring mechanisms do not exist as they do for the rural areas sanitation programme. The value to invest in such a programme structure for urban sanitation has been seriously marginalised in the policy framework.

There is a national programme called ILCS that largely responds to the conversion of dry latrine into sanitary latrine so as to ensure that manual scavenging gets eradicated. This scheme is funded in the following proportions:

- Central subsidy (75%)
- State subsidy (15%)
- Beneficiary share (10%)

It is, therefore, proposed that following the funding pattern of rural sanitation programme, the urban sanitation programme should also have an 80% ratio for toilet construction support, 15% for IEC, mass media, hygiene IPC and award schemes and the remaining 5% for hiring administrative and human resource.

The municipal authorities by way of ULBs have a major role to play in the effective and efficient delivery of drinking water and sanitation services. The overall situation in the country for ULBs in effective discharge of service delivery is not very good, primarily on account of its weak technical and financial resources. The FC has successively increased its share in the grant-in-aid to the municipal bodies. A total of 23,311 crore INR for a five-year period was recommended as grant-in-aid by the 13th FC as compared to the 12th FC which had recommended 5,000 crore INR. For the 13th FC, Maharashtra (13.75%), Uttar Pradesh (12.78%), Tamil Nadu (10.26 %), Karnataka (8.62%) and Andhra Pradesh (8.30%) made the highest allocations.[322]

Conclusion

WASH in urban areas is much more complex than in its rural counterpart with dynamic multi-layered relationships amongst dimensions of technology, environment, institutional, economic, capacity development and inclusiveness. It therefore, requires a systems outlook in a social protection framework that has children, women and the poor at the heart of urban water and sanitation infrastructure, services and its independent regulation.

The health and environmental outcomes of the urban water and sanitation are a result of a complex interplay of its sub-sectors: solid waste, drainage, sewerage and faecal sludge management. It is, therefore, important to explore the interconnection and forged synergies in an integrated way with a systems approach.

The normative framework for urban planning, infrastructure designing and services delivery benchmarks needs to be re-oriented and aligned with the needs and aspirations of children in the urban areas now recognising their overwhelming one-third representation in the total urban population of India. Public policies, budgets and programmes need to accord to children, the first right over these resources.

The government's first call of duty is to prioritise sustainable water and sanitation services for homeless children in urban areas, who do not have any option except defecating and bathing in the open. As per Census 2011, there are about 1 million homeless persons with 10% being under the age of 6 and 33% being women.

Occupational hazards and social stigma suffered on account of manual scavenging needs immediate attention of the public welfare systems so as to break the cycle of poverty, disease and poor health.

NUSP has rightly laid the focus on under and un-served areas, poor as well as women. This requires to be further qualified to unequivocally also focus on children". As requested by NUSP 2008 and considering that sanitation and drinking water are state subjects, state governments formulate the SSS and the CSPs that are developed by the ULBs which highlights a clear need to focus on the needs and aspirations of children.

The progress in eliminating OD has been further expanded in its definition and scope to focus on faeces disposal in the open, covering the entire sanitation chain which includes containment, collection, transport, treatment and safe disposal or reuse.

Drinking water access and usage for the poor and low-income families in terms of adequate quantity, quality and reliability is inadequate and is being further threatened by the increasing cost of drinking water production on account of sectoral inefficiencies. Sector reform guidelines as a part of JNNURM have established an operational framework for improvement in urban water and sanitation, which has so far seen limited success and therefore, needs to be pursued further at the state and municipal levels in order to achieve universal drinking water coverage with 24x7 availability, right quality and quantity.

The monitoring and database maintenance of the urban WASH needs further strengthening through establishing categories for children, poor and women. The city sanitation ratings and ranking led by the MoUD needs to be taken to a scale that encompasses all cities in the country while being grounded at the ward level.

Photo credit: Sanjit Das/Panos for Save the Children

Education of urban children

Ajay Kumar Singh

This chapter presents an overview of the schooling of urban children in India. More specifically, it focuses on the educational deprivation among urban children, highlighting the peculiarities of education in the urban context. The fast growth of urban centres also brings forth a need to examine whether or not there has been a parallel growth or decline in educational (and other essential) facilities in cities, and if so, to what extent. Such an examination may enable special planning in order to respond not only to the quantitative expansion but to the problems of high dropout rate and low-quality education in government schools, especially in schools located in slums (as indicated in PROBE, 1997).[323]

The chapter is broadly divided into four sections. The first section sets out the context, including the policies and legal framework impacting the overall educational scenario, with specific focus on urban areas. This is followed by an analysis of the trends in access, equity and quality of learning in the second section while the third section outlines the specific challenges and problems of schooling in urban areas. The chapter concludes with good practices and the way forward for strengthening the education for the urban deprived child.

Overall context, including policy and legal framework

Growing urbanisation in India has led to the emergence of certain concerns and questions with regard to the adequacy and quality of basic facilities to meet various rights of children, particularly those who live on the margins of urban centres. These rights are not only enshrined in the Constitution of India but have also emerged from various legal initiatives that have gained strength over the last decade and a half. Children's right to free and compulsory education (guaranteed by the RTE Act of 2009) is one such right around which this chapter revolves.[324]

While, in many developed countries, urban education is a well explored area in academic discourse, in India not only is there a paucity of academic literature in the area but even in terms of policy focus, there are hardly any targeted efforts to understand the specific geo-spatial contexts (whether urban or rural). It is particularly difficult to find literature highlighting the critical gaps and issues in the domain of education of children in urban contexts.[325] For instance, statistics published by the MHRD (*Selected Educational Statistics*, *Selected Information on School Education* or reports on *Results of High School and Higher Secondary Examination*) do not reflect the rural-urban gap. This is probably because urban areas are usually considered 'privileged' in the given geo-spatial polity of the country. In this regard, the policy and legal reforms apparently formulated around educational rights of children need to be examined vis-à-vis the reality of the urban child in general and of the *deprived* urban child in particular.

Some recent publications have highlighted certain specific issues of deprivation among urban children. A large number of schools catering to deprived children in urban areas, especially those running in rented premises, face a space crunch since the rentals are very high. The lack of space forces managements to run the schools in double shifts, which ultimately translates in a lack of time actually available for children in school. Moreover, as Tsujita (2009)[326] observed, "parental perception of education and financing education are major constraints in urban areas… there are both demand and supply-side reasons that discourage slum children from attending schools." If we factor in these issues with the relevant systemic issues such as teachers' absenteeism,

teachers' involvement in non-academic work and uneven distribution of teachers, the actual time spent in classroom transactions is much lower than expected. This influences the quality of education and children's learning levels.

There is a need to understand how we categorise urban deprived children. Ramchandran (2005)[327] suggests that urban deprived children are largely seen as synonymous with homeless street children. Though this is certainly one of the most deprived categories, there are other categories and sub-classifications of urban deprived children, such as children living on railway platforms and worksites, children of migrant labourers and those living in orphanages and juvenile homes. For these children, access to education is a big challenge.

Indian cities are increasingly attracting a large floating population of street children, homeless children and children from migrant families. A study by Save the Children in Delhi (2011) found that at least 1% of the urban children are homeless, whereas a broad estimate pegs the number of children involved in seasonal migration in India alone at 4 to 6 million (Glind, 2010).[328] Efforts have been made by some state governments, such as Gujarat and West Bengal, to establish bridge centres for these groups of children. However, since these centres are supported by the Sarva Shiksha Abhiyan (SSA), they have access to limited funds on ad hoc basis. This is also supplemented by the efforts of some NGOs such as Mobile Crèches for children under six.

Banerjee (2014)[329] observes that "education-related problems of urban deprived children are diverse and range from difficulty of access to schools, attitude of teachers, and low quality of schooling, to congested living conditions and lack of support at home. Apart from this, there are also problems of constant threats of demolition and displacement, harassment from police and other authorities, and constant danger of exploitation and abuse." The threat of displacement is a particularly important issue, as it is directly related to the child's legal right to live in an urban space and the issue of proof of identity and citizenship demanded by the state when one claims this right. The recent discourse[330] brings to light issues related to 'identity proof' for these children. This leads us to another set of questions that revolve around the relationship between access to school education and identity of urban deprived children, as recognised by the state.

This is not merely an administrative issue; there are some ongoing processes of negotiation of citizenship between the state and urban children with no identity proofs of the kind demanded by the state. This issue creates a problem in estimating the true number of children who are homeless, living in slums and from migrant families. Even if some families have such identity proofs, the frequent relocation of urban poor settlements complicates this problem.

This section explores areas for intervention to augment access to education and improving learning outcomes among urban children. It reviews the policy framework for education in India and its impact on education of urban children with the help of secondary sources.

Policy and legal framework

The Indian Constitution in its original form defined education as a state subject. After the 42nd Constitutional Amendment in 1976, education became a subject of a concurrent list that enables the central government to legislate for education. Further, India is signatory to a number of international covenants such as the Jomtien Conference Declaration (1990), UN Convention on Rights of the Child (1992), UN Millennium Development Goals (2000), Dakar Framework for Action (2000) and SAARC SDG Charter for Children, which reaffirm the nation's commitment to making education a reality for all children. These constitutional provisions and commitments to the international community were reflected in the National Policy on Education 1968 and 1986 (revised in 1992).

The EFA declaration, adopted at the Jomtien Conference of 1990, is a pertinent case in point because after this declaration, the Government of India started an unprecedented large scale programme for education with the help of international funding agencies. The worldwide declaration for EFA was signed by 155 countries and around 150 non-governmental and inter-governmental organisations to meet the agenda of 'making primary education accessible to all and remove illiteracy by the end of the decade' and had more implications for the developing world, especially for India. The post-1990 phase is also witness to important shifts in economic policy such as structural readjustment and changes in financing patterns of education, scaling up of funding for UEE, shifting the responsibilities from the state to private partners and small-scale interventions for vulnerable children through philanthropic and civil society organisations. A close examination of some key events and shifts in policy and the legal scene from 1990s onwards in India indicates that disadvantaged children usually find a mention in various plans and policy documents but adequate recognition for the magnitude of their problems is missing. For example, the SSA provides support of 50 lakh INR per district for this category along with some other categories (SC/ST/girls), which seems like a token amount for the education of urban deprived children. This support is usually in term of remedial classes or providing supplementary materials to selected children.

The demand for 'education for all' in India intensified during the 1990s, which found an echo in some serious policy reformulation and legal reforms, such as the reformulation of the National Education Policy in 1992 on the basis of the review in 1990,[331] the Supreme Court judgment to read Article 21 of the Constitution in 1993 (KP Unnikrishnan vs State of Andhra Pradesh), the flow of external aid to primary education under the DPEP. Some authors have termed the DPEP as "the implementation of 'adjustment with a human face' under the economic liberalisation in 1991".[332]

However, the interventions resulting from these policy pronouncements were more or less oriented towards rural India and, hence, were unable to cater to the needs of urban children. Implementation of the DPEP with the help of international partners in selected districts (273) and selected states (18) in 1994 was broadly focused on rural areas. This programme was

largely supported by the World Bank, which had advised that initially the programme should cover villages where the female literacy rate was below the national average of 39.2% (as per Census 1991). Decentralisation and community participation in education was encouraged under the DPEP and later on under the SSA. However, the ideas and strategies of community participation were developed around a deep-rooted idea of village structures. The programme ignored the fact that urban setups are different than what is visualised under various schemes. For example, in urban areas, weak social networks make it relatively difficult for the community to form a committee like the village education committee. Moreover, the economic engagement pattern in urban locations also prevents the smooth functioning of such committees.

Free and compulsory basic education from six to 14 years of age, as a fundamental right, was introduced through the 86th amendment in 2002, and was supplemented by legislation in 2009 (RTE Act 2009). In addition to the general limitations of the Act, some unusual implications have been observed during the past four years. For instance, the Act provides a right to the child to be admitted in Class 1 at the age of six years but it does not debar a child at age of five years to get admission in the school. Prior to the passing of the Act, in the case of absence of pre-school facilities in urban slums, primary schools were used for educating children between the age of four and five years. However, after 2010, school administrators (usually heads and teachers) have begun to interpret that the RTE Act does not allow a child below the age of six years to be admitted to Class 1. This limits the access to education for younger children. However, ECE services were also considered a part of the constitutional commitment. Article 45 of the 86th amendment, states: "The state shall endeavour to provide ECCE for all children, until they complete the age of six years". However, urban areas are still neglected in terms of government ECE facilities. A recent report indicates that only 13% of all ICDS projects are situated in urban areas (Education for All Global Monitoring Report, 2007)[333] and only around 31% of urban schools also provide preschool services.

S. No.	Year	Number of schools	Percentage of schools with pre-primary facilities
1	2011-12	1,97,541	27.09
2	2012-13	2,01,767	28.93
3	2013-14	2,06,799	31.58

Source: DISE 2012, 2013, 2014

Since the 1990s, privatisation of education has been a growing phenomenon, reflected in the growing number of private schools (in 2012-13, private schools account for 22% of the total number of schools in the country, according to the DISE 2013-14 data) and the unprecedented mistrust among poor parents towards the government system. It is claimed that masses have lost faith in government schools.[334] At the same time, the classes are reportedly overcrowded in urban government schools. The apparent class difference was increasingly observed between teachers and learners in the urban government schools. The learning levels are going down and there was no accurate data on school dropouts in urban areas. Unlike villages, neither is there a record of children enrolled in urban schools nor are the teachers aware of the catchment area of the school. This general scenario of education in India implies that educational opportunities and attainment for the urban deprived are much lower than those for the affluent classes. The recent rapid private school growth and relative lack of attention to urban government schools, has possibly intensified multi-dimensional deprivation, including deprivation of educational right, in urban areas. Tsujita (2009)[335] claims, "children in slums are most likely to go to government schools rather than to low-fee private schools" and hence, there is a need to strengthen the government school system in slum areas.

A worldwide advocacy for a social safety net has been reflected in the form of voucher systems and quotas in private schools (the EWS quota provided under the RTE Act 2009 is an example). A massive rise in low-fee private schools across Asia and Africa raises certain questions regarding the quality of state provision for the poor and inequitable gains for different social groups from education.

Alongside these, researches in education have been constantly highlighting the experience of discrimination and exclusion within school settings. School and classroom ethnographies from various parts of the world testify to this fact since the 1970s[336] and the same trend is seen in the Indian context.[337] Yet the policy-level focus is still on outcomes and not on processes and experiences of education.

Access, equity and quality: Trend analysis

This section takes stock of trends in urban schooling on three indicators that hold a central significance in Indian educational discourse, viz access, equity and quality. Schooling of children has to somehow find a way to deal with the elusive triangle of access, equity and quality,[338] which together cover a broad area of child entitlement in terms of schooling.

The basic aspect of access is the provision of a school in the proximity of a child, and includes all social and systemic barriers. Once a citizen has achieved access to education close to home, the goals of equity and quality are to be achieved at the institutional level. While equity implies the state's commitment to give equal opportunity to all citizens to learn in a classroom environment free from discrimination, quality of education is to be ensured through training of teachers, development of a child-friendly curriculum and appropriate pedagogy. However, these two elements are not separate from one another.

Preschool education

Children under the age of six experience the most rapid period of growth and development during the human lifespan, in terms of both physical and intellectual capacities. They make sense of the physical, social and cultural dimensions of the immediate world, learning progressively from their activities and their interactions with other children. This is one of the most important phases of life. An ongoing longitudinal study supported by the CECED (2014)[339] shows

that PSE/ECE helps children complete their schooling and provides evidence that investment in good quality ECE brings maximum returns. Hence, the study recommends that PSE/ECE facilities of acceptable standard must be provided in the government sector. The early years of a child's life are normally a period of maximum growth, maximum vulnerability and maximum dependence on adults. At this stage, care by a trained, nurturing and responsible adult in a clean, secure and stimulating environment is critical to laying the foundations for health, learning capacities and personality.

The National Policy of Education 1986 (revised in 1992) recommended strengthening of the ECE programme, which is expected to prepare all children for primary education supplemented by some nutritional support and child care. The idea was to holistically support children from EWS where the mother is a working woman and the responsibility of caring for young children lies with an elder sibling. The recognition of ECE's role in successful completion of primary education places on the state an extraordinary responsibility to provide it to all children.

One of the providers of ECE/ ECCE/ECCD in India is the ICDS network,[340] one of the flagship programmes of the Government of India and one of the world's largest programmes for ECCD. But this huge programme is skewed towards rural areas. As discussed above, large swathes of the urban population are still unserved. There are 13.42 lakh AWCs in all (Annual Report WCD). In 2007, only around 13% were situated in urban areas.

It has been claimed that the children in urban areas have better chances to avail pre-school education "particularly in the case of attending any pre-school programme in the private sector"[341]. However, given the low availability of AWCs and pre-primary sections in schools in urban areas, the high access to ECCE for urban children is due to the presence of a large number of fee-charging pre-school centres, which the urban deprived children still cannot access. Analysis of available secondary data and report indicates that there is a gap in ECCD in urban areas, as also an under-representation of urban slums under ICDS.

The Education Commission (1964-66), while recognising the significance of PSE and its critical linkages with enrolment, retention and learning outcomes at primary level recommended that the state should take up the overall responsibility for ECE. Subsequently, in 1968, the Committee for Preparation of Programmes for Children also recommended for the first time, that government should invest heavily on PSE/ECE. Later, while the National Policy on Education (1986), viewed ECCE as "an integral input in the human resource strategy, a feeder and support programme for primary education and a support service for working women", the Programme of Action (1992) came out with specific targets concerning operational and teacher training strategies of ECCE. The National Curriculum Framework (2005) also maintains the same spirit. This policy position is strongly supported by existing research. Many national and international studies have emphasised the role of pre-primary education in improving the learning outcomes.[342]


Photo credit: Rachel Palmer/ Save the Children

The RTE Act has provided for pre-primary education for underprivileged children enrolled in private schools in the 25 per cent earmarked seats. States should also be free to obtain services from reputed privately aided and unaided institutions or NGOs and to compensate them on a cost-recovery basis. Communities can also be empowered and provided the financial resources to hire qualified local youth on a contractual basis for pre-school teaching. It is to be noted that the spread of ECCD facilities, particularly in terms of crèches and day care centres and pre-primary sections of schools has been phenomenal but the coverage of urban slums is still poor. Additional data is needed to provide a more accurate picture of urban ECCD. Proper implementation of the 25% EWS quota could somewhat address this problem. In urban areas, the inter-sectoral convergence between school day care centres and ICDS is necessary for the success of any ECCD intervention.

The report by a working group of child rights for 12th Five Year Plan indicated that a comprehensive child development approach is imperative to children's survival, growth, development and learning. This report emphasised the specialised urban strategy for universalisation of ECCD[343].

Towards this end, it is important to consider various approaches and modules to cater to diverse needs of the urban deprived population.

Approach 1: As suggested under 12th Five Year Plan, every primary school will have a pre-primary section to deliver a school readiness programme for at least one year for children in the age group of four to six years. The concept of 'early learning units' would be introduced to integrate the pre-primary and early primary grades into one unit.

Approach 2: ICDS should be strengthened in urban slums and an AWC should be established in each primary school in urban slums. This also requires adequate number of trained teachers for these centres and specialised curriculum and teaching learning material for the children.

Some of the modules are already available to boot up the facilities of ECCD.

Module 1: Mobile Crèches has been in the field of early child care since 1969. As more and more crèches were set up across construction sites and slums of Delhi, Mobile Crèches became a trusted presence among the women wage labourers. They left their young ones in the care of *didis* (older sisters) who fed, nurtured and tutored them, sowing the seeds of a secure childhood and a confident adulthood. The day care centre became the hub of the organisation's activities, and the launching pad to help spread its wings to take up larger issues, such as negotiating with builders for greater financial support and responsibility sharing, lobbying with policymakers for progressive laws and programmes and advocacy among the community of parents to follow better childcare practices at home and demand better services outside. Mobile Crèches is a pioneer in ECCD.

This module supports migrant rural poor coming to the city with their children. The men and women often find work as daily-wage earners on a construction site. They live in shanties on the site, work under very harsh conditions and almost never get the legal minimum wage. Their children, uprooted from their traditional habitat and thrown into an alien environment of urban poverty, are left to fend for themselves, with no secure home, health services, schools or playgrounds to go to. Mobile Crèches provided a worthy model to meet this challenge.

Module 2: *Balwadis* provide PSE to children in the age group of three to five years. These are run in urban areas where children from low-income families do not have access to an AWC run by the government or any other pre-school facility run by the private sector including NGOs. *Balwadis* are run in the community itself, in a public place or in the house of the instructor or of another community member. No rent is paid for the space where it is run and the location is always close to the child's home. Approximately 20 to 25 children gather every day for about 3-4 hours and learn to engage with numbers, shapes, colours, stories, poems and songs. The teacher belongs to the same community as the children. The *balwadis* build the social, emotional, motor and cognitive skills of the children, thereby preparing them to adjust to the school atmosphere while spending time in productive activities. This also helps tackle the problem of retention and achievement early on.

Photo credit: Hedinn Halldorsson/ Save the Children

Some other initiatives have been taken by states under the umbrella scheme of ICDS. For instance, the Focus on Children Under Six (FOCUS) Report, 2004 reported that the ICDS functioning in Tamil Nadu has initiated a few good initiatives such as longer opening hours, regular payment of salaries to AWC staff, improvement in basic infrastructure and involvement of women from the local community to improve the quality of services, who helped make health and nutrition political issues and also hold the system accountable. These are the good examples worth replicating in other urban slums.

Growth of schools and enrolment at each level of schooling

In this sub-section, we analyse the growth in the number of schools and enrolment of students at each level: primary, elementary and secondary. Overall, urban schools are expected to be better than rural schools with regard to availability, quality of education, general governance, quality of human resources, etc. However, triangulation of data from Census 2001 and 2011 with the 7th and 8th All India Educational Survey shows that these notions are ill–founded.

In the urban areas, proportion of schools that have not received the School Development Grant or Teaching Learning Material Grant, or that have not constituted the SMC or are operating without a regular headmaster is significantly higher than that in rural areas. Similarly, fewer schools were inspected in the urban areas *vis-à-vis* the rural areas during the previous academic year, fewer teachers received in-service training and the average number of working days spent on non-teaching duties was higher in the urban schools than in rural schools.

Crowding is a bigger issue in urban schools than in rural schools. The percentage of schools having a pupil-teacher ratio above 30 (for primary schools) and above 35 (for upper-primary schools) is higher in urban areas than that in rural areas. This is apparently because the number of urban schools in the elementary segment is less than one-sixth of that of rural schools. As against 12,29,001 rural schools, there are only 2,01,767 urban elementary schools in India (DISE 2011-12). As a result, in comparison to a mean enrolment of 118 students per school in rural areas, the mean enrolment is more than 229 students per school in the urban areas. The student-classroom ratio is also higher in the urban areas. Not surprisingly, the use of a single school building as double-shift schools to accommodate more children is seen more often in urban areas (11.05%) than in rural (2.03%).

On the positive side, the presence of female teachers is much stronger in the urban schools (over 66%) than in the rural schools (less than 40%). Urban schools are better equipped in terms of infrastructure such as separate toilets for girls and boys, and boundary walls. (DISE 2011-12)

Flagship schemes

The changes in the policy and legal frameworks are credited to have led to an increase in the enrolment in schools as reflected in the Annual Report 2013-14 of MHRD (GOI, 2014). The aim of RTE Act 2009 and Sarva Shiksha Abhiyan (SSA) (initiated in 2001 and modified in 2010 with respect to RTE Act) is to provide equitable education of satisfactory quality to all children in the age group of six to 14 years which is supplemented by a subsequent implementation of the flagship scheme for the universalisation of secondary education, viz. the RMSA in 2009.

Universalisation of education includes the goal of achieving social parity. In the urban context, parity will be achieved when the urban deprived children have access to education. There is an increasing trend in enrolment and schooling facilities provided by the state, which points at our progress towards social parity. But analysis shows that just as in the case of pre-primary education, even these schemes have very limited impact on urban children in general and children from deprived community in particular. (Details are already provided in 6.2.1) Though these schemes have the potential to cater to the needs of urban deprived but various 'opportunities' are lost in the established inertia where the policy and legal framework are not conducive to the urban needs.

Rashtriya Madhyamik Shiksha Abhiyan (RMSA)

RMSA is the flagship scheme of Government of India to ensure universal secondary education. The vision for secondary education is to make good quality education available, accessible and affordable to all young persons in the age group of 14 to 18 years. The aim is as follows:

- Provide a secondary school within a reasonable distance of any habitation, which should be 5 km for secondary schools and 7-10 km for higher secondary schools.
- Ensure universal access to secondary education by 2017 (GER of 100%) and universal retention by 2020.
- Provide access to secondary education with special references to economically weaker sections (EWS), girls and the disabled children residing in rural areas and other marginalised categories like SC, ST, OBC and EBMs.

The increasing trend of enrolment in primary and secondary schools in urban areas as reported by various surveys (including the All India Educational Survey by NCERT and U-DISE from NUEPA) does not provide a complete picture of education in urban India. The surveys do not take cognisance of the corresponding growth in the population of urban children. This chapter highlights this gap and presents the corresponding growth in terms of availability of schools, infrastructure and teachers at various stages. Due to limited availability of data, this analysis shows only the trends of enrolment and facilities of schooling *vis-à-vis* the population growth of urban children in India but even this trend is sufficient to demonstrate the negligence towards urban deprived children.

Growth of schools: Urban versus rural

While approximately 27.4% of the children in the age group of 7 to 18 years reside in urban areas (Census 2011), only 17% of the schools are located in urban areas (refer table below). This could be on account of the focus on rural education by the programs like DPEP and SSA. Further, the growth rate of schools in rural areas is seen to be much more than in urban areas. During 2002 to 2009, the rate of growth of schools in urban areas was far lower (17%) than in rural areas (29%) even though the rural population grew by 12% while the urban population grew by 31% according to the 2011 census.

There is an apparent lack of initiatives for augmenting the availability of schooling in the urban areas. As the following table shows, the percentage increase in the number of facilities at all levels has been lower in urban areas as compared to the overall increase.

Growth of educational facilities

S No	School Stage and Areas	No of schools in 2002			No of schools in 2009			Percentage change		
		Total	Rural	Urban	Total	Rural	Urban	Total	Urban	Rural
1	Primary	6,51,064	5,72,814	78,250	7,59,686	6,75,084	84,602	17	8	18
2	Upper primary	2,45,322	1,93,947	51,375	3,65,902	3,04,832	61,070	49	19	57
3	Secondary	90,741	63,576	27,165	1,17,006	82,856	34,150	29	26	30
4	Higher secondary	43,869	22,847	21,022	64,398	36,949	27,447	47	31	62
	Total	10,30,996	8,53,184	1,77,812	13,06,992	10,99,723	2,07,269	27	17	29

Source: 7th and 8th AIES, NCERT[344]
Note: For the sake of comparability, we used the AIES data and not the DISE data. The captive area for DISE data has changed over a period of time.

Photo credit: Hedinn Halldorsson/Save the Children

It seems that the existing number of schools is insufficient to accommodate all children in urban schools and its impact are obvious on enrolment and retention of children in the school as discussed in following pages.

> *"The school in our locality has classes only up to Class 8 and the high school is located at a distance which is not walkable. Therefore, most girls are forced to stop their education after Class 8 as it becomes expensive for parents to continue their schooling and don't want their girls to travel long distance."*
>
> — A girl aged 14 from a slum in Govandi, Mumbai

Enrolment trends: Non-proportionate growth of enrolment in urban schools

This section provides an overview of the children's participation in elementary and secondary stage[345] on the basis of the seventh (cut-off date 2002, published: 2007) and eighth (cut-off date 2009; initial trends published: 2014) round of the AIES. The triangulation of the reports of various AIES rounds (sixth, seventh and eighth) provides an overview of the changes during 1993-2009. DISE reports provide subsequent data from 2010 onwards. This sub-section also describes the changes in terms of neighbourhood schooling facilities (focus on state schools) for education of children in urban areas.

The growth of schools in rural areas is accompanied by a corresponding growth in enrolment. Enrolments in upper primary, secondary and higher secondary sections in rural areas has been significantly higher as compared to urban areas. This is despite the fact that the population of children in the age group of 10 to 19 years is growing faster in urban areas. While part of the growth in rural enrolment could be explained by the improved access to schooling by a larger proportion of the population in rural areas, the gap in urban areas does raise valid concerns regarding the absence of focus on schooling in urban areas. Further the situation in slums needs to be examined closely so as to get insights into the situation of the urban deprived children.

Change in the population of children from 2001 to 2011

Urban population (in years)	Census 2001			Census 2011			Percentage increase in total
	Boys	Girls	Total	Boys	Girls	Total	
4 - below 6	62,64,864	55,67,617	1,18,32,481	68,26,705	61,17,150	1,29,43,855	9.39
6 - 11	1,66,26,516	1,50,86,342	3,17,12,858	1,80,78,953	1,61,46,451	3,42,25,404	7.92
11 - below 14	95,21,472	86,89,154	1,82,10,626	1,10,38,839	99,29,292	2,09,68,131	15.14
14 - below 16	65,34,078	58,75,880	1,24,09,958	75,68,238	68,09,816	1,43,78,054	15.86
16 - below 18	59,86,291	53,20,893	1,13,07,184	73,69,322	65,57,866	1,39,27,188	23.17
Total	4,49,33,221	405,39,886	8,54,73,107	5,08,82,057	4,55,60,575	9,64,42,632	12.83

Source: Census 2001 and 2011

Increase in child enrolment from 2002 to 2009 (in numbers)

Age	Urban		Rural		Change	
	2002	2009	2002	2009	Urban	Rural
Primary	2,98,17,341	3,03,68,867	9,30,97,960	9,75,92,383	5,51,526	44,94,423
Upper primary	1,62,78,895	1,71,72,866	3,05,66,950	3,89,76,058	8,93,971	84,09,108
Secondary	92,82,218	1,08,77,876	1,26,06,680	1,77,60,014	15,95,658	51,53,334
Senior secondary	69,08,008	87,49,823	45,29,875	74,97,607	18,41,815	29,67,732

Source: 7th and 8th All India Educational Survey, NCERT

Increase in child enrolment from 2002 to 2009 (in percentage)

	Primary		Upper primary		Secondary		Sr secondary	
	Total	Girls	Total	Girls	Total	Girls	Total	Girls
Rural	5	9	28	43	41	65	66	94
Urban	2	2	5	7	17	21	27	35
Total	4	7	20	29	31	45	42	57

Source: 7th and 8th All India Educational Survey, NCERT

Comparison of above tables shows that the enrolment in urban area schools is much lower than the growth of population of urban children. Only 2% annual increase in enrolment is reported for urban children at primary level and 5% at secondary level. This needs attention.

Increase in schools and enrolment during 7th and 8th AIES (2002-09; in percentage)

School stage	Rural		Urban	
	Schools	Enrolment	Schools	Enrolment
Primary	18	5	8	2
Upper primary	57	28	19	5
Secondary	30	41	26	17
Higher secondary (degree college attached)	62	66	31	27

Source: 7th and 8th AIES

Gender analysis

On the aspect of gender parity, the seventh survey shows that girl's enrolment in urban areas is at 47.88%, which is the same as that in the eighth survey as the overall increase in total enrolment and girls' enrolment are equal in the initial trends of the eighth survey (including private schools). At upper primary level, according to the seventh survey, there are 4,68,45,845 children enrolled at the upper primary stage (Classes 6 to 8). In urban areas, the percentage of enrolled girls is 46.58%, which increases by 7% in the eighth survey as compared to a total increase of 5%. On the gender parity aspect in secondary and higher secondary levels, the seventh AIES reported that in rural areas, the percentage of enrolment for girls is 39% whereas in urban areas it is 45%.

The eighth AIES registered an impressive increase in enrolment at higher secondary level. Compared with the seventh survey, there is a total 27% increase in urban enrolment and 35% increase in enrolment of urban girls. The seventh survey reported that at the higher secondary stage, 1,14,37,883 children are enrolled (41.2% girls and 58.7% boys) and the urban areas have a share of 60.4% in total enrolment. In rural areas, the percentage of girls enrolled is 38.3%, whereas in the urban areas, this percentage is 43.2%.

It is important to note that due to various efforts towards universalisation of elementary education and RTE Act, a significant growth was registered at secondary and senior secondary levels in the last two years.

Availability of teachers in urban areas

Change in number of teachers (from 2002 to 2009)

S no	Year	Increase in teachers % from 2002 to 2009		Increase in schools % from 2002 to 2009	
	Areas	Total	Urban	Total	Urban
1	Primary	25.25	10.34	17	8
2	Upper primary	32.31	9.66	49	19
3	Secondary	30.60	26.18	29	26
4	Higher secondary	33.90	22.62	47	31

Source: 7th and 8th AIES of NCERT

The growth in the overall number of teachers in urban areas is not only much lower *vis-à-vis* the overall growth of teachers but it is also not matching with the growth of population particularly in the age group of secondary and higher secondary level. Further the increase in teachers is lower than the increase in schools specifically for upper primary and higher secondary schools, further adding to gap of teachers.

Para teachers at urban schools

S no	School stage	Total number of teachers	No of para teachers	Percent-age of para teachers
1	Primary	3,89,512	59,562	15.29
2	Upper primary	4,60,367	51,923	11.28
3	Secondary	4,39,059	46,450	10.58
4	Higher secondary	6,75,172	67,328	9.97

Source: 7th and 8th AIES

It has been observed that there is an increasing tendency to deploy less paid and relatively less qualified teachers, with a usually unsecure job, in the schools. This is a kind of ad hoc-ism that impacts the quality of children's education. The issue is not only of availability of qualified teachers in the urban school system (10-15% of the teachers are para teachers), but also of the deployment of teachers. As per the DISE report, the number single-teacher schools in the years 2010, 2012 and 2013 are as follows:

Percentage of single-teacher schools in urban areas

Year	Primary	Upper primary	Primary school with PTR >30	Upper primary school with PTR >35
2010-11	6.06	4.39	41.95	31.62
2011-12	6.37	7.0	43.37	30.94
2012-13	4.15	4.41	39.23	25.68

While these are quantitative indicators of the status, some qualitative studies indicate that there is a clear 'social distance' (among teachers and students) in urban government schools.

There are issues related to the capacity of teachers. Low quality of teachers training (NCERT 2012) is common and the training provided hardly caters to the diverse needs of teachers in complex urban scenarios.

For example, the large proportion of migrant children in urban centre requires multilingual teaching, but it seems that multilingual teaching and related training under SSA are restricted to tribal areas.

> *"There is only one teacher for three classes in the night school. One faces a lot of disturbance as classes is separated by wooden plank and boys also tease and beat the girls. That is why I will leave the school soon."*
>
> — A girl aged 15 from a slum in Govandi, Mumbai

Quality of schooling as explained by various achievement surveys

The impact of slow growth in numbers of schools, insufficient facilities and irrational teacher's distribution is obvious and it reflects in term of quality of education. The quality of education can be measured on several indicators, and the learning achievement is one of them. The following analysis shows that there are serious issues related to learning achievement. Selected achievement surveys suggest that there is a continuous decline in learning levels among urban children with respect to their rural counterparts in general. In particular, the achievement level of students of government schools in urban areas is much lower.

Comparison of National Achievement Survey[346] findings between Round 1 round BAS conducted during 2002-05 and Round 2 MAS conducted during 2005-08 indicated stagnancy in the learning achievements of urban children at the primary level, upper primary level and at the beginning of secondary education at the end of Class 8.[347] The following are the trends of Classes 3 and 5:

Class 3: Mean achievement in mathematics and language

Area /gender	Rural		Urban		Total	
	Mean % BAS	Mean % MAS	Mean % BAS	Mean % MAS	Mean % BAS	Mean % MAS
Mathematics						
Boys	58.56	62.36	58.49	61.4	58.54	62.16
Girls	57.7	61.85	58.56	60.82	57.95	61.62
Total	58.14	62.1	58.52	61.1	58.25	61.89
Language						
Boys	62.81	67.69	63.3	67.78	62.94	67.71
Girls	62.84	67.9	64.45	68.2	63.31	67.96
Total	62.82	67.79	63.87	67.99	63.12	67.84

Source: NAS baseline (Round 1) and mid-term evaluation (Round 2) by NCERT

Round 3 of the achievement survey was conducted during 2012. This round used a different methodology and hence, is not comparable with the earlier one. Tentative results were published by the MHRD during 2014. The above trend shows that the 'improvement' in learning achievements of urban children is relatively lower than that of their rural counterparts during 2002-2008.

Class 5: Achievement in mathematics, language and environment studies (Comparison between Round 1 BAS and Round 2 MAS)

	Rural		Urban		Total	
Area/Gender	Mean % BAS	Mean % MAS	Mean % BAS	Mean % MAS	Mean % BAS	Mean % MAS
Mathematics						
Boys	46.72	48.83	47.36	47.51	46.9	48.54
Girls	45.54	48.42	47.29	48.23	46.09	48.37
Total	46.15	48.63	47.32	47.88	46.51	48.46
Language						
Boys	57.95	59.85	61.36	61.73	58.94	60.27
Girls	57.37	59.58	61.89	62.91	58.79	60.35
Total	57.67	59.72	61.63	62.33	58.87	60.31
EVS						
Boys	50.14	52.32	51.69	51.56	50.59	52.15
Girls	49.43	52.18	51.21	52.40	49.99	52.23
Total	49.8	52.25	51.44	51.99	50.3	52.19

Source –NAS baseline (Round 1) and mid-term evaluation (Round 2) by NCERT

The above table indicates stagnancy among Class 5 students in urban areas with respect to mathematics, language and environment studies (EVS). NAS Round 3 for Class 5 reports that while rural boys scored significantly better than their urban counterparts, urban girls scored significantly better than urban boys in EVS. Similarly, in mathematics, rural children scored significantly better than their urban counterparts and urban girls scored significantly better than urban boys.

NAS (2012) Class 8: In science and mathematics, rural students outperformed urban counterparts. In social science, both groups were at similar levels, but in reading comprehension urban students performed better than their rural counterparts.

Round 3 survey results for Class 8

	Mathematics	Science	S Science	Reading
Urban	241	249	245	252
Rural	246	252	248	247

Source: Round 3, NAS, Class 8, 2012, NCERT

The overall learning achievement shows *status quo* or slight decline in government school children of urban areas. Overall, these achievement surveys raise serious issues about classroom processes and students' learning.

Observations

The Census 2011 report shows that the child population (0-18 years) increased by 12.8% in urban areas during the preceding decade, but the analysis above shows that neither the corresponding enrolment at school stage nor the number of education facilities and teachers has increased proportionally. The result has been a huge number of dropouts and low learning achievement among the children. It is worth mentioning that slow development in educational facilities is directly impacting access to education in urban areas. The Government of India acknowledges[348] that only 8% households have benefited from the Midday Meal Scheme and the ICDS scheme benefited only 1.8% households in urban India. Only 82.5% of urban households had a school providing middle level education within a kilometre. This indicates a huge gap in terms of the approach and policy adopted by the state. Some specific problems of urban children are discussed below. Fast-growing population in the urban scenario demands a regular institutional estimation of the educational facilities required in urban areas, which includes opening of new schools, appointment and redeployment of teachers, and construction of new classrooms.

Challenges of schooling in the urban context

This section describes some selected problems related to the schooling of urban children. To start with, the question is how the existing policy framework and provisioning creates multiple problems for children in difficult circumstances, such as working children, street children and out-of-school children. The State of the World's Children report (UNICEF, 2012)[349] states, 'The experience of childhood is increasingly urban. Over half the world's people—including more than a billion children—now live in cities and towns.' It also reported that 'many children enjoy the advantages that urban life offers, including access to educational, medical and recreational facilities. Too many, however, are denied such essentials as clean water, electricity and healthcare—even though they may live close to these services. Too many are forced into dangerous and exploitative work instead of being able to attend school. And, too many face a constant threat of eviction, although they already live under the most challenging conditions—in ramshackle dwellings and overcrowded settlements that are highly vulnerable to disease and disaster.'

In India, these problems are further aggravated due to a high percentage of out-of-school children, high risk of dropout, shrinking time on task due to double shift of school, adverse PTR, students and teachers attendance. Inadequate infrastructural facilities demotivate children. For example, adolescent girls get demotivated from attending school due to lack of hygienic and functional toilets.

It has been observed[350] that state policy and plan are not responding to urban deprived children because of difficulties in tracking them as they belong to floating population, such as street and working children, slum and pavement dwellers, children living on railway platforms, children of sex workers, etc. Frequent relocation of poor and urban slums also causes difficulties in tracking the children.

In most of the recent educational programmes such as ICDS, SSA and RMSA community participation is a critical component. However, in urban areas the idea of community is very different. Due to diverse communities in urban areas the community mobilisation embedded in educational programmes needs a different approach and should be constituted so as to incorporate a range of education providers in urban areas. Special attention has to be given to unique urban situations by making special provisions such as rent for schools, urban resource centres, multi-storey school buildings, maintenance of school buildings, special training centre on rented building and civil works construction by the state.

There is a need to understand the problems in the following three categories: (1) Issues of children out of the school system; (2) Issues of children in the school system; and (3) Issues of systemic reform in the urban context.

Children out of school

EdCIL, MHRD, commissioned an All India Survey of Out-of-School Children in the age group of 6-13 years. The survey has been jointly conducted thrice by IMRB and the Social and Rural Institute in 2006 (cut-off date 2005), 2010 (cut-off date 2009) and 2014 (cut-off date 2014). The details of these surveys are as follows.

Change in number and percentage of out of school children in urban areas

S no	Year	Estimated number of out of school children	Percentage of out of school children
1	2005	21,06,137	4.34
2	2009	11,26,500	3.18
3	2014	13,68,711	2.54

Sources: IMRB Survey Reports 2006, 2010, 2014

According to the above survey (IMRB, 2014) an estimated 1.12 crore urban children live in slums. Out of the total children living in slums in the urban areas, 2.14% are out of school. This is lower than the previous round, where 3.74% of the slum children were found to be out of school. (2010). Though the percentage of out-of-school children is decreasing, their absolute numbers have increased from 2009 to 2014. Given the drive on enrolment, a critical indicator to examine the real picture is the ratio of enrolled children who have never attended school. Small scale studies, in the absence of any large scale studies, reveal a concerning picture.

Tsujita (2009) in the study of urban slums in Delhi observed that the ratio of children who have never attended school (i.e. those might be enrolled but have never attended) to total children is 31.5%. Only 2.2% of those children were reported to have engaged in paid work in the previous 365 days. This implies that majority of children who have never attended school neither work nor attend schools. Among girls, the proportion of those who never attended school is 32.9%, a little higher than that for boys (30.5%). Reasons for "never attended" are being underage (46.5%), financial constraints (36.6) and parents' negative perception of education *per se* (10%). This study claims that a high overage and dropout ratio exists among slum children. Being over age is often the outcome of late admission to school, which is caused both by demand side (migration from rural areas to slums) and by supply side factors (lack of school capacity for all children, short period of admission, requirement of birth certificate, etc.). School availability at a short distance does not explain why quite a large number of slum children are still less educated. Economic problems were one of the main reasons why children did not attend school.

NFHS-3 data shows that around 9% of urban children are engaged in work while a later report[351] states that 8.6% of urban children (age 5-14 years) are engaged in work. The percentage of children engaged in work activities decreases steadily with mother's increasing education, father's increasing education and increasing wealth quintile.

Private schools and reservation for EWS

A strong demand for English and poor quality of government school education provide conducive conditions for flourishing of private schools. However, the cost and cultural differences in private schools are major barriers to access these private schools. An EdCIL (2014) study indicates that the presence of low-fee private schools in slum areas has increased to cater to the needs of LIG and EWS. However, most slum children in this household study attended government schools. What is worse is that half of the private school-going-children dropped out.

Twenty-five per cent reservations for EWS category in private schools is one of the most widely discussed issues since the introduction of RTE Act 2009. Schools are not only reluctant to give admissions but have also adopted various mechanisms to segregate the EWS and non-EWS students (particularly in elite urban schools). In Delhi, well before RTE Act in 2004, the Supreme Court judgment, followed by the Delhi government notification of reserving 20-25 per cent seats for EWS children by recognised, private and unaided schools in Delhi led to a great resistance from private schools. The problems faced by the private schools in providing admission in EWS quota in this regard also needs to be recognised. These schools are typically merit-oriented schools and are known for their success rate in various board examinations. So they feel that holding joint classes for both categories of students may affect the performance of the school.

Segregation of children is another issue that requires attention. It is disconcerting that along with an indifferent attitude towards the predicament of the children, schools attempt to segregate the children within the school by organising extra classes. Often these students are taught in the evening shift by another set of low-paid unqualified teachers. There are some relevant questions raised by some research studies. For example, is 'admission to the EWS quota' equal to 'free education'? What will be the possible criteria of entry against such EWS quota? How can the children be enabled to catch up with the pace of studies and to adjust to their new surroundings? Are teachers teaching at elite urban private schools sensitive towards specific life situation of the children getting admission under the EWS quota? Are schools adopting any discriminatory practices against these children, and if yes what will be the way out?

Though there are provisions for reimbursement of costs to private schools under the SSA, there is a need to make the scheme more conducive to children through a rigorous orientation of teachers about life in urban slums and resettlement colonies. School support should be mandatory for such children.

The twelfth FYP (2012–2017)[352] acknowledges that the requirement for schools earmark 25% of their seats for children from disadvantaged groups and weaker sections will require support for related costs: uniforms, bags, books and bridging and supplementary support. SSA norms would need to be revised to provide for the reimbursement of cost to private unaided schools against such admissions and also for other costs mentioned above. In order to cater to the high population density in urban areas, the norms for establishment of new schools in urban areas should be defined in terms of the number of children served per school rather than the distance. Migration brings huge challenges for children, wherein regular school programmes will not work. States must be encouraged to use specific approaches that have been tried and established as useful.

Low attendance rate in urban schools

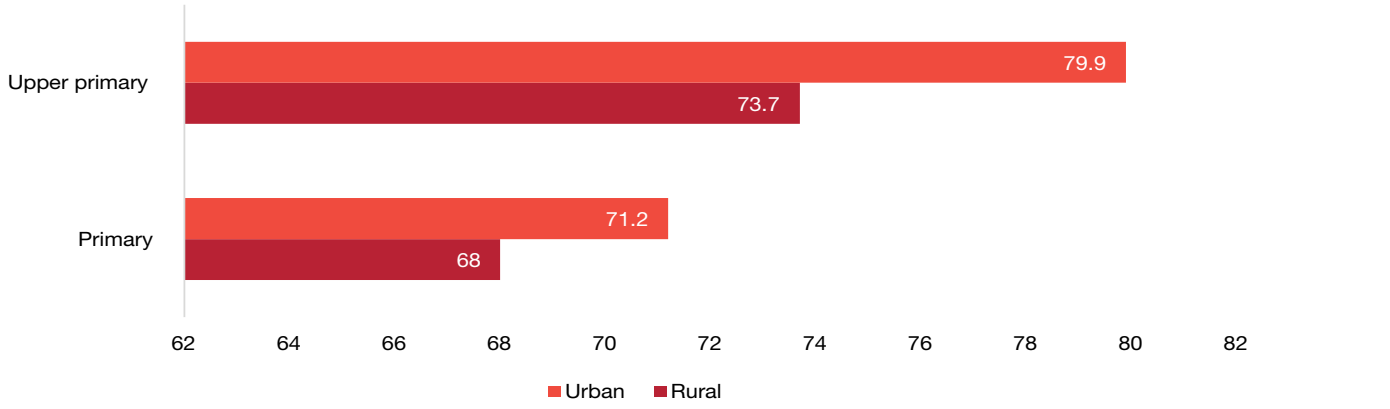
A study conducted by the MHRD (2006-2007)[353] shows that the overall attendance rate was 71.2% in urban primary schools. Even at the upper primary level, the overall student attendance rate was low. The details are as follows:

The attendance rate in primary schools in rural areas is not less than that of urban schools in every state. The states in which attendance rate in rural schools (primary) is higher than that of urban schools are Andhra Pradesh, Chhattisgarh, Haryana, Himachal Pradesh, Odisha, Punjab, Tamil Nadu, Uttar Pradesh, Uttarakhand and West Bengal. The states in which attendance rate of students in rural schools (upper primary) is higher are Andhra Pradesh, Haryana, Punjab, Uttarakhand and West Bengal. In all other states, the attendance rate in urban areas exceeds that of rural areas.

Migration

Due to constant migration into cities, there are children from multiple linguistic groups in one classroom, and many of these languages are not known to the teachers. Hence, communication for such children becomes a major barrier to access and a cause for dropouts.

Attendance rate in urban school



A study conducted by NEG FIRE (2009)[354] summarised the issue of migrant children. This study, covering migration from Bihar to Jalandhar city (Punjab), reveals that very few children from the migrant families go to school. The number further shrinks when it comes to girl children. These areas have both government schools and private schools. Some children go to the government school where they get mid-day meals. Households that have better livelihood options, send their children to private schools where the fees range from 100 to 150 INR per month. Generally children do not feel any discrimination but language is the biggest barrier as Punjabi is compulsory in the schools in Jalandhar. Textbooks are in Punjabi and teachers also use Punjabi as the medium of instruction in the classroom. This leaves the children in a situation where they are unable to understand what is being taught. Hindi plays the role of a bridging language in this situation.

Parents of migrant children face a tough time getting their children admitted into schools, largely because schools can only admit children during a very brief period (mostly from April to August). In the remaining months, there are no admissions. As a result, a large number of children remain out of the education system. Most often the work sites, where children reside are located very far from the regular schools. Hence, transportation and security become their biggest hurdles. Parents are also unable to afford the travelling expenses. Additionally, parents are also apprehensive about who will take care of the house and the younger siblings once the child leaves for school. Thus, they invariably prefer keeping the children at home. The girl child suffers the most, as in most cases, the entire burden of sibling care falls on the girl child. It has been seen that even if girls are admitted into schools, they are repeatedly withdrawn.

Different backgrounds of teachers and students in urban government schools

Some recent studies indicate that the distance between teachers and students is very wide in urban areas. Teachers hold low academic expectations of certain segments of students and tend to treat them (consciously or unconsciously) in a negative manner. Studies also reveal that the discriminatory attitude of the teachers' is the most significant reason for the children to drop out.[355] Students complained of the rude behaviour of teachers towards them. They reported that teachers would pick on them and take disciplinary action often for no fault of theirs.

The study found that the teachers had the requisite qualifications but lacked the competence and commitment. Children who had dropped out perceived the teachers to be more interested in taking private tuitions than in teaching in the classroom. Apathy of the teachers made these children disengaged from school activities and finally pushed them out of school (Sunita Chug, 2008). There needs to be a continuous development and a deep understanding of the backgrounds and strengths of the children as well as the need and role of education in the process of social change. The issue regarding the teacher's gender needs to be understood better. It has been argued by some researchers that gendering of the teaching profession is most conspicuous in urban areas. There is a large percentage of women teachers in urban schools. This has serious consequences, particularly on the socialisation of older ones (10-14 year olds). However, this also creates a kind of confidence among girl children attending the school.

> *"Sometimes the teachers hit these small kids by wooden rulers, bamboo sticks, steel rulers, etc. Some girls have fallen sick or fainted because of this."*
>
> — A girl aged 15 from a slum in Govandi, Mumbai

Bridging centre/special training and open schooling

First-generation learners are not only required to be brought into the schools but also needs to be supported to prevent dropouts. The communities they come from also require social support. However, these needs were usually ignored during the planning process. At the elementary level, this support is available only for out-of-school children under special training. Under RMSA, only 20% (upper limit) of children can avail such support. Both bridging and support classes needs to be integrated in plans with appropriate budget allocation.

WASH and schooling

The challenge of retention and providing a safe environment for both boys and girls in urban schools is much greater than in rural areas and requires special efforts. The onset of menstruation[356] is one of the most important physiological changes occurring among girls during adolescence.

According to a report,[357] girls, particularly adolescent girls, were disadvantaged in terms of toilet facilities. While boys expressed less concern about sanitation facilities, interviews with girls showed that there was an almost total absence of sensitivity to the requirements of menstruating girls. Girls who were menstruating often had nowhere to wash their clothes or dispose of their sanitary pads. The design of facilities also did not allow them necessary privacy and dignity. The result was that girls who were menstruating either carried on in a state of continual anxiety or simply took days off. Both the girls and their mothers were aware that this was detrimental to their studies.

It is all about identity

Lack of legal 'identity' of vulnerable children, including street children, children in slums and those from migrating families, seems to be a cross-cutting issue that affects schooling of urban children. This issue starts from day-to-day negotiation between the children and state actors including teachers. RTE has mandated that birth registration certificates are no longer needed for admissions. However, the documentation required at the time of admission is still a daunting factor for migrant children. Sometimes, teachers refuse to give admission to children in the absence of age proof, when parents are not able to prove the minimum age of children.

Possibilities and good practices

The 74th Constitutional Amendment underlined the role of ULBs with respect to the provision and governance of education. Schedule 12 of the amendment identified education as one of the functions to be devolved to the ULBs. It states that the ULBs are responsible for the promotion of cultural, educational and aesthetic aspects[358] with respect to education.


Photo credit: Lucia Zoro/Save the Children

The SSA mission in different states maintains linkages with different government bodies such as ULBs for proper implementation of its interventions in urban areas. The special focus of these bodies is on the needs of the urban deprived children and OoSC in terms of educational indicators, access and quality. For example in West Bengal, the Paschim Banga Sarva Shiksha Mission maintains linkages with the government bodies such as the Kolkata Municipal Corporation for proper implementation of its interventions. The major focus of the state in the convergence is on enrolment and retention of SC/ST and minority children, improvement in school infrastructure in the light of RTE Act, child tracking for better retention and special coaching for children admitted in age appropriate classes.

In addition, ULBs in different states are also working for the cause of improving the quality in education. Some ULBs, such as the one in Ahmedabad, are helping in addressing the issue of space such as the allotment of land and buildings (temporary/ permanent) while in some states they also provide teachers to schools and organise in-service training and development activities. A state-specific example of activities that have an implication on access, retention and learning levels is seen in Gujarat, where summer camps were organised for children of Classes 5 to 8 and for OoSC in the age group 10-14 years. Vocational training included courses in cycle repairing, computers, soft-toy making, pottery, hand embroidery, book binding, detergent and soap and shampoo making.

In Andhra Pradesh, four urban residential schools have been set up in Hyderabad, Khammam, Krishna (Vijayawada) and Visakhapatnam. Survey of the urban deprived children has been taken up in all the urban areas (municipal corporations and municipalities) in the state.

Conclusion

It appears that there is a certain negligence with respect to providing public educational facilities in urban areas. It might be a result of a scattered approach towards schooling of urban children at various stages. Analysis also shows that government funded PSE facilities are negligible in urban areas. ICDS is one of the largest service providers of PSE but Annual WCD reports of 2006/07 indicate that only around 13% facilities of this service is located in urban areas, while only 31% of schools situated in urban areas have PSE facilities. Growth of population in urban areas is not in sync with and thus does not reflect the growth of enrolment in urban schools at various stages. Moreover, the growth of population in various age groups of urban children does not match the growth in educational facilities and availability of teachers.

There are different categories of children in difficult circumstances in urban areas, namely street children and working children, slum and pavement dwellers, children living on railway platforms, children of sex workers, and children of migrant labourers, and there is no essential institutional provision to estimate or track these children. The learning achievement of urban children is as low as that of their rural counterparts, despite common perception to the contrary.

Recommendations

The peculiarity of the problems faced by urban children needs a new set of policies to protect their legal rights. It will be possible only through research-based advocacy for urban children.

Considering the lower coverage of ECCE, there is a need of separate urban strategies (as mentioned in the 12th Plan working group report) to established public funded pre-schools in urban areas with a carefully designed age appropriate learning curriculum and adequate trained teachers and AWWs. These strategies must factor in the complex reality of slum life pattern and challenges of families in migration.

As discussed above, there are large floating populations in many urban areas. However, there is no national-level mechanism for tracking children in migration (though there are some efforts at the state level, such as in Odisha). This need can be addressed through an institutional mapping and tracking of these children at regular intervals. There is a requirement for training teachers on multi-lingual teaching strategies and providing supplementary support to address the pedagogical needs and requirements of the floating population, dropout and OoSC in urban areas, particularly with focus on children from migrant families.

Slow growth in educational facilities at urban areas is another concern. Allotment of land or buildings for the construction of new schools needs to be facilitated through a central policy (like that introduced by the Indian Railways). Lack of space in urban areas may be addressed by a plan for vertical development of the school space with proper security and comfort measures. These efforts also require coordination among various government departments and agencies. An urban education cell should be established under the education department for each urban area, mainly to facilitate the progress and monitoring of the progress of its execution. This cell may also work for convergence between the various education providers to address the lack of coordination among them.

There needs to be a special focus on children who are more vulnerable to drop out from school. Children in difficult circumstances not only require bridging into schools but support to sustain in schools. Both bridging and support classes need to be integrated in the educational planning. It is also necessary to set up systems for identifying and tracking children at risk in different categories and ensuring the required number of schools, centres, hostels, etc. Each city should have a process of mapping and enumerating children in the 0-18 year age group and should update it at least once every year (this could be the part of child tracking). Children who are especially vulnerable and those belonging to deprived categories—girls, minorities, tribes, castes, children from BPL families—should be separately enumerated and tracked. Proper policy and programmes should ensure their participation in the school system in a dignified manner.

Frequent relocation of the urban poor demands a policy to ensure identity of children and subsequent entitlement in terms of the right to education. The heterogeneous nature of community in urban areas requires a proper orientation or training for smooth functioning of SMCs.

Child protection in urban India

Paramita Banerjee

Introduction

No place to call 'home'

Sharanappa was born in a small village in Raichur (Karnataka) to a poor family that couldn't fend for itself. There was no secure source of income as both parents could not get a job and the family was debt-ridden. They often lived on the brink of starvation. When the situation got worse, the parents insisted Sharanappa to beg to support the family for food. However, things did not improve. A day finally came when his parents could not take it any longer and decided to commit suicide, leaving him all alone in this world.

With nobody to support him, Sharanappa came to Bengaluru to make a living. He neither had a place to sleep nor a job. He started doing odd jobs in restaurants, begging, ragpicking and anything that fetched him some money and food. He spent days without food and slept wherever he found a place like on footpaths, railway stations, parks and so on. However, policemen would throw him out whenever they saw him sleeping in a public place. It was a daily nuisance. Another revelation which he made was that he was sexually abused by the rowdy gangs of older street children, who would even take away his money. He was so scared of the police that he never made an attempt to contact them with his problem.

One day, he was rescued by Bosco, an NGO, which took him to join their shelter home. He has recently joined this shelter home where a secure environment and a roof over his head has given him a more positive outlook in life. In his words, he feels more settled now as he does not fear sexual abuse by his peers on the street or harassment by the police.

This report recognises children's right to protection within the framework of the UNCRC. Governments that have ratified the convention, are committed to formulate appropriate legislative, administration and social measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse whether they are in the care of parent(s), legal guardian(s) or any other person[359].

With 17% of urban households in India living in slums, the children from these slums as well as those on the streets face extreme vulnerability and deprivation of basic entitlements.

Sites of vulnerability

Child in slums

Even though there is much anecdotal evidence on how unsafe the slum environment is for children, there are no comprehensive studies to show what makes children vulnerable in slums. A Save the Children report[360] about the cities of Mumbai, Chennai and Bengaluru throws light on the vulnerabilities of children residing in the slums in these cities. Some excerpts from this report are reproduced below:

Mumbai: Over 200,000 BPL children in the age group of 0-15 years are estimated to be living in the slums of Mumbai with their families. Certain areas have a high rate of child trafficking and children involved in illegal activities and even the police has been unable to effectively counter these activities because of various political and regional issues. Regions such as Malwani and Malad in P-North Ward and Govandi in M-East Ward are the hotspots in the city for crime against children and those that involve children.

Chennai: Over 260,000 BPL children in the age group of 0-15 years are estimated to be living in the slums of Chennai with their families. Relocation sites such as Kannagi Nagar, AIR site, and Semmancheri are the ones most vulnerable for children since gambling, prostitution, trafficking, etc are rampant here. Besides this, vulnerable children can also be found in Sathya Nagar, Thilagar Nagar and other Chennai slums.

Bengaluru: More than 260,000 BPL children in the age group of 0-15 years are estimated to be living in the slums of Chennai with their families. The most neglected slums are around the railway lines and there are 64 slums located on the railway line in Bengaluru. Slums are the most vulnerable locations where children are exploited and cases of sexual abuse and violence are not even reported from these regions. Significantly, police penetration in slums is also limited. Most cases presented in front of child welfare committee come from areas in the vicinity of railway and bus stations.

We thus see that even though children who live in slums have the support of their families, the environment makes them vulnerable to drug abuse, trafficking, gambling, etc. It has emerged clearly from the CRSA that there are very few inroads the police has made in these slums, which again creates law and order problems which affect children who live there, the most.


Photo credit: Lucia Zoro/Save the Children

Children from families 'at risk' or household as a site of violence

'At risk' families have been defined in the JJ Act as families prone to disintegration due to social, cultural, economic or any other reasons. Thus, a big category of children in 'at risk' families are those who have experienced 'domestic violence'. However, domestic violence has been studied from the point of view of how it affects women while largely ignoring its impact on children. Studies on children in difficult circumstances often point out that domestic violence affects them deeply. A UNICEF report states: 'Children who are exposed to violence in the home may have difficulty learning social skills, exhibit violent, risky or delinquent behaviour, or suffer from depression or severe anxiety… Several studies also reveal that children who witness domestic violence are more likely to be affected by violence as adults–either as victims or perpetrators. Children who are exposed to violence in the home are denied their right to a safe and stable home environment. Many suffer silently, and with little support. Children who are exposed to violence in the home need trusted adults to turn to for help and comfort, and services that will help them cope with their experiences'[361]. The report estimates that 27.1 million to 69 million children are exposed to domestic violence in India.

One of the chief reasons for children running away from their homes and ending up on the streets is domestic violence and conflicts. An examination of prevalence of gender-based violence in NFHS3 shows high prevalence of violence among families that live in urban slums. "In every city except Indore, spousal violence is much more prevalent in slum areas than in non-slum areas. In Delhi, women in the slum areas are more than twice as likely to have experienced spousal violence as women in non-slum areas. The differentials in the experience of spousal violence by women in slum and non slum areas are almost as high in Meerut and Nagpur. In every city, poor women have experienced particularly high levels of spousal violence, especially poor women in Chennai (68%), Meerut (67%), and Indore (64%). In Chennai, more than half the married poor women reported experiencing spousal physical or sexual violence in the 12 months preceding the survey"[362]. Thus in these households, children are growing up with greater exposure to violence.

Child on the streets

"I do not like school or staying at home because of the problems between my father and mother. I'd rather stay on the street all the time even when there is no work. When I am working, I do not mind the number of hours. Most of the time at home, there is shouting and beating. My father takes out his anger on us and beats us without mercy. Sometimes, I run away to my grandfather's place. Once, I slept in the yard of a mosque. Sometimes, I feel hatred towards my parents because they have turned the house into a hell."

– A boy of 11 near Capital Mosque, Kharvel Nagar, Bhubaneswar

No official estimate of the approximate number of children living on/of the streets and railway stations (with or without their families) is readily available. In fact, the Union Ministry for Women and Child Development acknowledges the lack of reliable data[363] and refrains from stating any numbers. However, the Indian embassy estimated 314,700 street children in cities such as Bengaluru, Chennai, Hyderabad, Kanpur, Kolkata, and Mumbai; and around 100,000 street children in Delhi. Also, in 2006, UNICEF estimated 11 million such children in India[364] inevitably concentrated in urban areas. Another source[365] has referred to 18 million street children in the country.[366]

In the absence of official data, let us refer to the data collected by Save the Children to estimate the number of street children in Delhi[367]:

- There were 51,000 street children in Delhi; 20% being girls.
- Among them, 70% were on the street despite having homes in Delhi.
- Majority of these children (61%) were in the 7-14 age group, with 23% in the 15-18 age group[368].
- Half of them were illiterate; and 87% earned a living–20% as rag-pickers, 15.8% as street vendors, 15% by begging.
- Over 50% had suffered verbal, physical or sexual abuse.
- Fewer than 20% had ID cards or birth certificates, thereby missing out on government benefits.

Living and working on the streets in cities across India

Save the Children in 2013 began implementing a project titled, ***Stronger Voice to Excluded Children in, Government and NGO Policies and Programmes****, International NGOs Partnership Agreement (IPAP). The project was supported by the DFID and the key objective was to facilitate the access of socially excluded children to benefit from the development programmes, policies and schemes of government, donors and NGOs. Under this programme, SC conducted a survey of street children in the cities of Hyderabad, Kolkata, Bhubaneswar and Jaipur in 2013-14. As a part of this exercise, an estimation of the number of street children was conducted and the city-wise findings are as follows:*

City[369]	Children living on street	Children working on street	Children from street families	Total number of street children	% to total city population[370]
Kolkata	3,172	7,080	9,778	20,030	0.45
Hyderabad	1,784	4,593	3,743	10,120	0.15
Bhubaneswar	458	2,592	484	3,533	0.42
Jaipur	519	1,991	1,959	4,469	0.15

Gender

Gender-wise analysis revealed that most of the children found on the streets are boys (71.6%). The proportion of boys is highest in Jaipur i.e. 80.7% and the proportion of girls is highest in Bhubaneswar (39.2%). The low presence of girls in the street child population indicates that as girls grew up, they left the street. This requires further independent probing. With boys, it was the opposite. More boys were seen on the street in the above-15 age group. And compared to boys, fewer girls were seen in the very young age group i.e., less than five years of age. This trend reversed in Bhubaneswar.

Age group

The age group of street children across four cities showed that most (69.3%) of the boys and girls found on the street are in the 6-14 age group, followed by 15-18 years (29.7%), and below five years of age (0.9%). Similarly, the city-wise analysis revealed that the highest percentage of children under the 6-14 age group category is in Kolkata (82.5%), followed by Jaipur (74.6%), Hyderabad (41.8%) and Bhubaneswar (23.6%).

In 2013, Save the Children also conducted a census of street children in the cities of Kolkata, Hyderabad, Bhubaneshwar and Jaipur.

Reason for being on the street

In the study of street children in Kolkata, Hyderabad, Bhubaneshwar and Jaipur conducted by Save the Children in 2013[371], the reason for being on the street differed from child to child. Of the total 4,224 street children across four cities, 52% cited mobility of the entire family as the reason why they ended up on the streets. The other reasons were search of jobs (14.5%), poverty (13.6%), sent away by parents (4.7%) and runaways (4%).

Respectively 71.4%, 66.2%, 39.8% and 37.4% street children in Bhubaneswar, Kolkata, Jaipur and Hyderabad responded that they had ended up on the street with their family. These four cities are capitals and provide more economic and livelihood opportunities as compared to rural hinterlands or other cities in these states. Therefore, the landless poor migrate to these capital cities in search of livelihood opportunities. Migration is the only option available to these people. They are also among the most vulnerable groups on the streets of these big cities due to their migrant status.

The study also found families on the street due to slum displacement. This happens when there are no proper slum rehabilitation plans in place. As a result, slum-dwellers become street dwellers that are largely on the move for work.

"My father and uncle after three days of toil had made a temporary hut, but these people came and demolished the structure without even thinking. We have nobody to look up to."

– A girl of 11 at Patancheru near Jama Masjid, Hyderabad

Distribution of reasons: Why children ended up on the streets (%)

Reasons/city	Kolkata	Hyderabad	Bhubaneswar	Jaipur	Total
Ran away from home	0.5	6.8	2.2	5.7	4.0
Banished from home, parent sent him/her away	2.9	7.7	0.5	5.8	4.7
In search of jobs, income	12.1	13.7	20.4	13.6	14.5
Came with family members	66.2	37.4	71.4	39.8	52.0
Lost family while travelling, visit	5.2	2.2	0.4	0.6	2.3
Lost family during calamity	0.1	2.2	0.0	0.7	0.9
Kidnapped, trafficked	0.0	0.7	0.0	0.3	0.3
Poverty, hunger	9.1	13.7	3.5	27.0	13.6
Just landed here	0.3	8.7	0.5	.2	3.0
Slum displacement	1.0	4.4	0.5	6.0	3.1
Don't know, can't say, no response	1.7	2.2	0.5	0.1	1.3
Other (specify)	0.9	0.3	0.0	0.0	0.3
Total	100.0	100.0	100.0	100.0	100.0

Across four cities, 32.8% of the children had reached the streets in search of income (14.5%) and poverty, hunger (13.6%) either by themselves or were sent by their parents (4.7%). This trend is highest in Jaipur (46.4%) followed by Hyderabad (35.1%), Bhubaneswar (24.4%) and Kolkata (24.1%). The study also found children on the street who had run away from home (to escape from abuse, domestic violence, or other family issues), just landed in the city, lost family while travelling, lost family during calamity and were kidnapped or trafficked. These children constituted 10.5% of the total number of street children across the four cities.

Place of stay last night	Kolkata	Hyderabad	Bhubaneswar	Jaipur	Total
At home in a slum, squatter settlement	42.6	28.9	81.6	46.8	46.3
Shelter home, short stay home	17.6	3.6	1.4	4.8	7.3
In the open[372]	36.0	47.9	6.5	40.9	35.6
Within workplace, in work premises	3.3	10.8	7.9	4.3	6.7
Dormitory accommodation provided by employer	0.0	3.9	2.1	0.6	1.8
In construction site or other temporary arrangement	0.4	4.8	0.4	2.6	2.3
Total	100	100	100	100	100

The lack of protection for children on/of the streets living with or without their families has been captured rather starkly by the 2007 study on child abuse undertaken by the Ministry of Women and Child Development. The study had covered 2317 street children as respondents across 26 districts of 12 states from different zones of the country. Among these respondents, all of whom were in urban spaces, 55.28% were boys and the remaining girls. The graffiti of abuse reported by them is presented below:[373]

> *"My parents died many years ago. My aunt and her fiancé use to beat me everyday as I was lazy, according to them."*
>
> – A girl of 16 in Jhalana, Jaipur

Street children reporting physical abuse by family members and others, MWCD 2007

State	Boys		Girls	
	No	Yes	No	Yes
Andhra Pradesh	34.25	65.75	60.87	39.13
Assam	19.81	80.19	10.29	89.71
Bihar	22.77	77.23	16.67	83.33
Delhi	7.44	92.56	7.59	92.41
Goa	61.26	38.74	46.81	53.19
Gujarat	44.12	55.88	19.19	80.81
Kerala	71.76	28.24	32.73	67.27
Madhya Pradesh	31.90	68.10	39.02	60.98
Maharashtra	23.53	76.47	50.51	49.49
Mizoram	0.00	100.00	0.00	0.00
Rajasthan	10.10	89.90	26.26	73.74
West Bengal	65.09	34.91	54.35	45.65
Total	34.01	65.99	32.08	67.92

'Others' include teachers, employers, NGO workers, caregivers, strangers and any other person with whom children have faint acquaintance

This table reflects that with the exception of Mizoram, there are both girls and boys living on the streets and most of them face physical abuse of some kind. All boys on/of the streets in Mizoram mentioned facing such abuse, followed by Delhi and Rajasthan. On the other hand, a majority of street boys in Kerala reported never encountering physical abuse, followed by West Bengal in second place and Goa in third. As for girls, maximum reporting of physical abuse has been from Delhi, followed by Assam and Bihar. Only in three states, more girls have reported not facing physical abuse: Andhra Pradesh, West Bengal and Maharashtra. However, the ratio of the majority: minority in West Bengal and Maharashtra is marginal.

In terms of sexual abuse faced by street children, this study looked at severe forms of sexual abuse, as also other forms such as:

- Assault, including rape and sodomy
- Touching or fondling a child
- Forcing a child to exhibit her/his private body parts
- Photographing a child in the nude

> *"This boy who grew up with me tried to rape me while I was sleeping. He is a nice boy but was under the influence of alcohol, and the police took him and thrashed him so hard that he was unable to walk for a week."*
>
> – A girl of 17 in Patancheru, Hyderabad

Within other forms of sexual abuse, the following were included:

- Forcible kissing
- Sexual advances towards a child during travel or marriage situations
- Exhibiting in front of a child
- Exposing a child to pornographic materials

Taking both severe and other forms of sexual abuse together, 54.5% of street children respondents confirmed experiences of sexual abuse. The distribution across different forms of sexual abuse is as follows:

Form of abuse	Percentage of street children reporting abuse
Severe forms of sexual abuse	
Sexual assault including rape and sodomy	6.53
Being forced to touch private body parts	17.7
Being forced to exhibit private body parts	15.1
Forcibly photographed in the nude	5.39
Other forms of sexual abuse	
Forcible kissing	21.99
Facing sexual advances during travel	26.16
Forced to watch exhibition of private body parts	20.32
Exposed to pornographic pictures	31.06

Photo credit: Veera Reddy/ Save the Children

Street children respond to abuse or attempts of abuse and intimidation in different ways. Some of these are direct retaliation and ganging up with the stronger, older children.

Unfortunately, this study does not report the findings on emotional abuse and neglect of girl children disaggregated on the basis of respondent categories. **Even then, the pictures of physical and sexual abuse faced by children on/of the streets reflect quite clearly that safety nets for protecting these children are hopelessly inadequate, if they exist at all.**

"If someone troubles me, I hit him with my sandal. Then everything settles down."

– A girl of 14 near Hawa Mahal, Jaipur

"We have much brotherhood among ourselves. Whenever I am in trouble, I approach the big boys who help us. Yes, this has always been the case…"

– A boy living on the street near Sindhi Camp, Jaipur

Abuse of the child living on the streets

Of the total 4,224 children covered in the study of street children in Kolkata, Hyderabad, Bhubaneshwar and Jaipur[374], 90.6% children reported they face risk on the street in the form of threat to limb/life, police harassment, parental abuse and sexual abuse. Overall, 9.3 % children did not respond when asked about risks faced by him or her on the street.

Of the total, 37.5% reported they face threat to life and limb while on the street followed by police harassment (27.8%), parental abuse (23.8%), theft (23.7%), sexual abuse (13.1%), other risk (5.3%) and no response (9.3%). City-wise analysis also presents the same scenario:

City	Police harassment	Sexual Abuse	Threat to life / limb	Theft	Parental abuse	Others	No response
Kolkata	39.3	5.6	15.8	11.5	19.9	3.7	25.1
Hyderabad	20.2	14.6	37.4	32.8	16.9	6.5	7.2
Bhubaneswar	18.1	7.6	54.3	18.5	43.1	0.8	0.4
Jaipur	32.2	24.6	50.3	29.6	22.7	9.0	0.5
Total	27.8	13.1	37.5	23.7	23.8	5.3	9.3

Places of threat faced by the child

Of the total 4,224 children, 42.2% children responded that they faced more threats on the road during the day followed by in the sleeping place at night (39.3%), at the workplace (28%), at home (17.3%) and other places (2.6%).

> *"Bathing in the open is asking for danger."*
>
> – Girls living on the street near Jaipur railway junction

Distribution of places of threat faced by child (%)

City	On the road during daytime	In the sleeping place in night	At home	At workplace	Other	No Response
Kolkata	24.4	42.8	17.6	10.2	3.0	24.7
Hyderabad	36.2	39.8	11.5	40.3	5.2	9.4
Bhubaneswar	56.1	28.1	27.5	22.1	0.3	1.7
Jaipur	60.7	43.5	17.1	36.8	0.2	1.6
Total	42.2	39.3	17.3	28.0	2.6	10.4

This study also explores any linkage of threat and abuse reported by children with their place of stay. It was found that children living in open (railway platforms, below flyovers, on the footpaths) are prone to police harassment. Interestingly, the children living in slums and shelter homes are also abused by the police. The children also reported that they are prone to the threat to life and limb in open places such as the space below a flyover, a footpath, or a railway platform or bus stand, workplaces, construction sites, dormitories and at home in slums and squatter settlements. Beside this, a higher percentage of children reported risk of theft at locations such as within the workplace, dormitories and construction sites more than in open spaces.

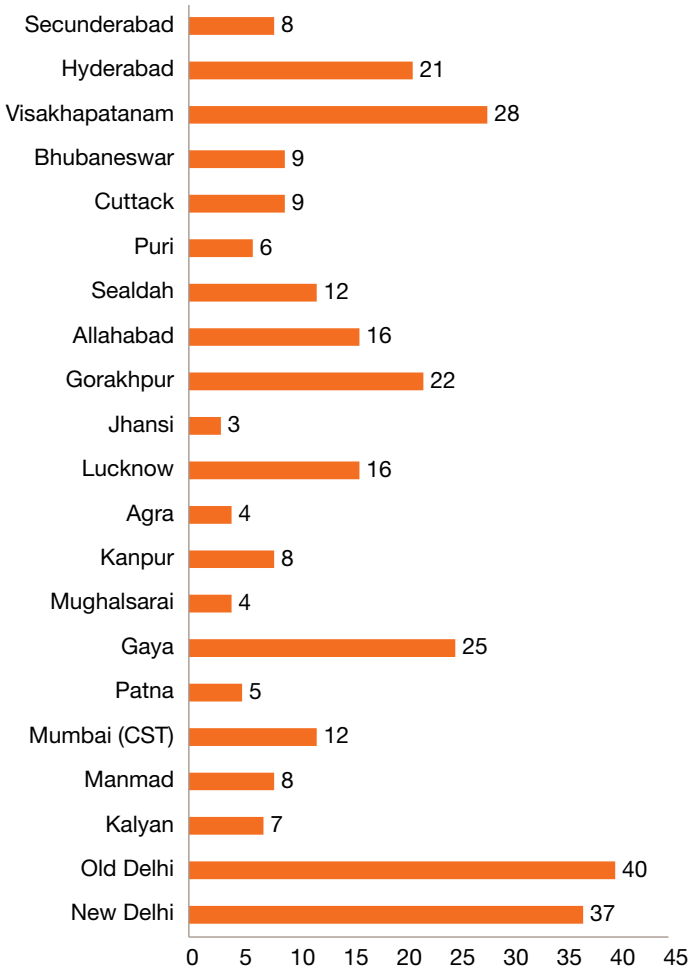
Children on railway platforms

> *"If I do not work, it will be hard for my family back home in Bihar to survive as my father is dead and my mother cannot raise my six siblings alone."*
>
> – A boy of 16 at Secunderabad railway station

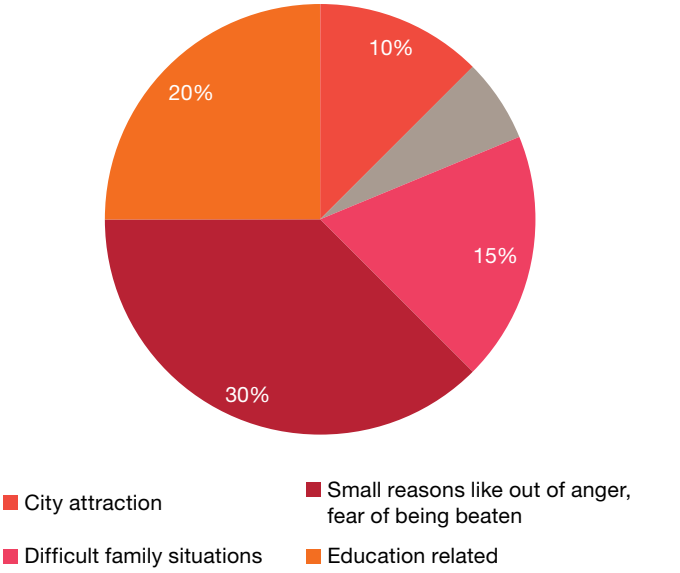
The railway stations and platforms located in big urban set-ups are home to many children who either come to work or live there. Many children use the transport networks of the railway to run away from their home or get lost while travelling with their families. In a study presented to the MWCD,[375] it was found that more than 7,000 new children start living on railway platforms every year. each day and become vulnerable to all forms of abuse in the absence of care and support of their families.

When asked about the reasons for leaving home, most of the children named very impulsive and emotional factors such as anger, fear of being beaten up, etc. Economic, educational and familial reasons were found to be less important.

Daily inflow of children at major railway stations



Reasons for running away from home



Other children

Police officers harass children who sell magazines at the signal

Other urban deprived children include those working at construction sites, dhabas, factories, motor mechanic shops and garages and other urban sites. As mentioned elsewhere in this report, the newly emerging census towns and satellite cities around the metros are buzzing with economic activity. Many of these activities are hazardous in nature and employ children on a large scale. A government-sponsored study in Bengaluru (Urban District)[376]—one of the rapidly growing cities of India—found in 2012 that there were 14,980 child workers there, 90% employed in hazardous jobs (e.g. construction, garage mechanics, hotel and bar boys, butchers, scavenging, granite works, blacksmiths and incense stick manufacturing). More than 3/4th of the children were boys. Importantly, it found that girls started working at a younger age and their involvement in hazardous occupations was also higher. One-third of the children worked for over eight hours a day all seven days a week, but got no extra wages. Also, 11% of the children suffered from some form of sickness or occupational hazard. Only 5% took a bath regularly. Though 15% had been punished by employers at some point of time, around 60% were still willing to continue with their jobs indicating a lack of feasible options.

"We are five sisters and three brothers. After one point of time, our parents asked us to go and earn something. They are also helpless."

– A girl of 9 near Road Traffic Corporation crossing, Bengaluru

Child in domestic work: A story of abuse and misery

An important sub-category of the urban deprived children are the children who work as domestic help. What is the impact of domestic service on girls who are engaged in it? A study conducted by Save the Children in West Bengal in 2005 points to the conditions in which girls in domestic service live. The sample for the study consisted of 1,020 domestic workers mostly living in urban West Bengal. Most of the girls interviewed were single migrants who end up in domestic work after being trafficked. The study challenges the popular perception that children do not get abused in domestic set-ups and employers who take in girls into domestic service are actually doing them a favour.

Most of the girls interviewed were aged 11 years or above. They started work between eight to 12 years of age. These children have reached a maximum of Grade 5 and earn as little as 200 INR per month for the kind of arduous work they do for 15 hours a day with as little as two hours or no rest in between. Most of them have minimal contact with their family and are allowed to meet them only once in six months. This lack of contact with the family makes the children further vulnerable and the control of the employer almost absolute as the workplace is in the home of the employer away from the public eye.

Almost 70% of the children reported that they had been physically abused by slapping, kicking, burning, etc. Almost 86% reported various forms of emotional abuse including being shouted at, locked in a room, etc. Most shameful were the findings with regard to sexual abuse, as 32.2% of the respondents reported that their private parts had been touched by an adult, 22.4% have been made to touch the abuser's private parts and 20% made to watch pornography.


Photo credit: Prasanth Vishwanathan/Save the Children

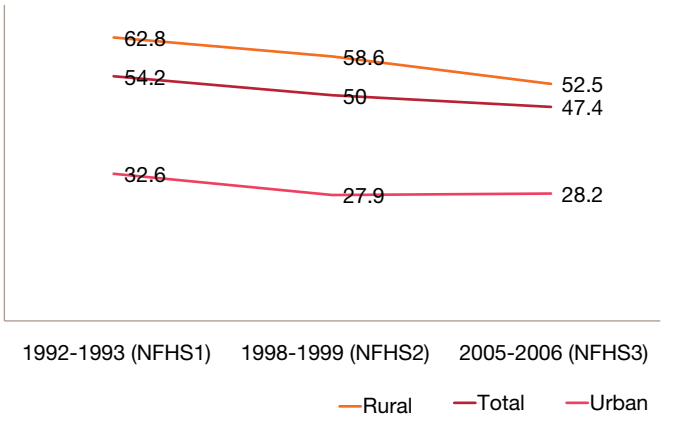
Measuring vulnerability

Child marriage

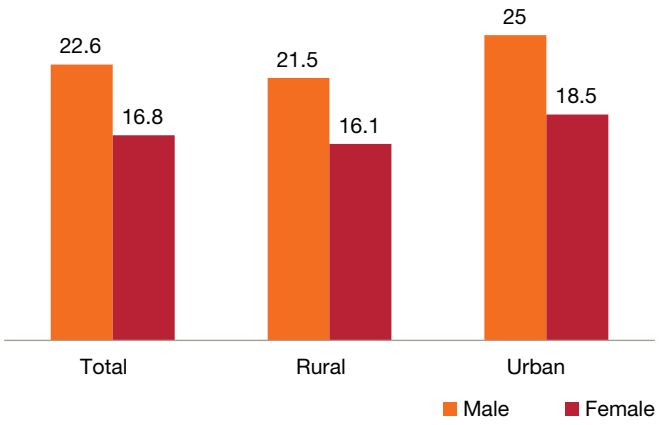
While drawing our attention to the impact of child marriage, ICRW states for child brides, "They suffer health risks associated with early sexual activity and childbearing, leading to high rates of maternal and child mortality as well as sexually transmitted infections, including HIV. And they are more likely to be victims of domestic violence, sexual abuse and social isolation".[377]

The rate of the decline of child marriage in India has been very slow. However, when it comes to urban settings, it is heartening to note that children who live in urban settings get married later in life. But like the national rate of decline, the rate of decline of instances of child marriage in urban areas has been extremely slow. We see that women between 20 and 24 years who reported to have married before they reached the age of 18 years in NFHS 2 was 27.8% which in fact rose to 28.2% in NFHS-3. Compared to this, in the same category in rural areas, in NFHS-2, the instance of child marriage stood at 58.6% which fell to 52.5% in NFHS-3.

Chart[378]



In rural areas, the aggregate age at marriage for both boys and girls tends to be lower in comparison to urban areas.



Thus, the average age of marriage for girls in urban areas is 18.5 years which is within the legal age limit of 18 years.

Crime against children

There has been a 24% increase in crimes against children between 2010 and 2011. While no separate data is available on the rural-urban split of this increase, it is to be noted that 12.8% of these crimes are concentrated in Delhi alone, which is an urbanised area.[379] Also, **the National Crime Records Bureau 2013 report on crimes against children reflects a 52.5% increase in incidence (from 38,172 cases in 2012 to 58,224 cases in 2013). While no urban-rural distribution is available, the fact that Delhi and Maharashtra are third and fourth in the list at 12.4% and 11% of total crimes is an indicator that such crimes are not rare in urban areas at all since Maharashtra is the most urbanised state in the country and Delhi is at sixth position**[380].Also, a newspaper report[381] quotes NCRB 2012 to reflect the role of some of the major cities with reference to crimes against children: **Bengaluru tops the list of 88 cities across the country with 551 cases; Mumbai stands second (517) and Delhi comes third (363)**.[382]

At the backdrop of all of these is the crime rate in the mega cities of the country, many of which directly and indirectly affect children. As per the NCRB records, in the 53 million+ cities of the country[383] taken together, the total crime rate stands at 294.2, while the rate is 196.7 if all the states where these cities are located are taken together. While no separate data is available for crimes against children in mega cities, the following offences are worth a look, since they definitely include children, especially girls, if not restricted to them only:[384]


Photo credit: Raghu Rai/Magnum for Save the Children

Crime	Percentage of total crimes in mega cities	Impact on children
Trafficking of girls from foreign countries	16.3	All victims are within 21 years of age.
Dowry death	I8.3	With 48% underage marriage of girls among the urban poor, this might also include married girls below 18
Kidnapping and abduction of women and girls	14.5	Includes girls below 18
Rape	12.1	Includes child rape

In addition, crimes against women,which will also include girls married under 18–stands at 47.8% of total crimes in mega cities, substantially higher than the national rate of 41.7%. Delhi, Bengaluru, Kolkata, Hyderabad and Vijayawada are the worst offenders in that order.

Child labour: Agriculture, small industrial workshops and small- to middle-scale hazardous industries, service establishments, domestic work, ragpicking, porter work and vending are the sectors reflecting a concentration of child workers. In addition, there are children in prostitution and bonded labour.[385]As per the latest available data on urban-rural distribution[386] out of a total of 9.07 million child labourers in the 5-14 age group, nearly 7.44 million (82%) were in rural areas. In terms of absolute numbers, urban child workers in the 5-9 age group are 0.08 million while those in the 10-14 age group are 1.44 million. The state-wise division of child labour in urban India as per the same report is as follows (sorted in descending order of share of urban child labour in total child labour workforce):[387]

State	Urban child labour	Percentage of total child labour
Delhi	10,000	100%
Punjab	21,000	47.7%
Tamil Nadu	79,000	45.4%
Goa	2,000	40.0%
Kerala	4,000	36.4%
West Bengal	217,000	30.8%
Gujarat	77,000	25.9%
Uttar Pradesh	459,000	22.1%
Jharkhand	38,000	18.5%
Haryana	14,000	14.4%
Madhya Pradesh	68,000	14.1%
Rajasthan	110,000	13.4%
Chhattisgarh	31,000	12.1%
Andhra Pradesh	140,000	11.7%
Maharashtra	84,000	11.2%
Bihar	30,000	8.30%
Karnataka	41,000	7.44%
Assam	8,000	6.06%
Odisha	22,000	5.05%
Uttaranchal	3,000	4.84%
Himachal Pradesh	1,000	2.70%

In Delhi, where almost the entire population (97.5%) is urbanised, urban child labour makes up the entire population of child labour. Delhi is followed by Punjab (almost 48%) and Tamil Nadu (45%). In the major states, child workers in urban areas account for 16.4% of the total child labour force. But again, it is to be noted that these figures refer only to children up to 14 years, so the workforce participation of 15- to 18-year-olds is invisible.

"Work is there but nobody respects or cares about us. We are seen as garbage in this society."

– A boy of 16 in Hasanpura, Jaipur

Photo credit: Rachel Palmer/ Save the Children

In terms of the WPR of child workers also, urban areas reflect a marginally lower rate than rural areas. The WPR of child workers in urban areas disaggregated by age and sex is as follows:[388]

Year	Girls			Boys			All children		
	5-9	10-14	5-14	5-9	10-14	5-14	5-9	10-14	5-14
1993-94	0.48%	4.51%	2.52%	0.47%	6.63%	3.58%	0.48%	5.63%	3.08%
1999-00	0.21%	3.40%	1.85%	0.28%	4.88%	2.65%	0.25%	4.18%	2.27%
2004-05	0.30%	3.28%	1.89%	0.21%	4.78%	2.59%	0.25%	4.05%	2.25%

It is to be noted that the overall trend of WPR for child workers in urban India reflects a declining trend over the years, though the rate of decline is more between 1993-94 and 1999-2000, than between 1999-2000 and 2004-05. However, the WPR for girls in labour in the 5-9 age group has increased marginally in 2004-05 in comparison to 1999-2000, so that the overall WPR of girls engaged as child labour has also increased.

If the findings from the child abuse report referred to above[389] are juxtaposed with the number of child workers in cities, the utter lack of protection becomes clear, especially since most of these respondents, except a small group engaged in agricultural work, were found in urban spaces:

- A total of 2,447 children among the respondents were child workers. As per the Government of India notification, 56.4% of the children were employed in hazardous occupations.
- More than half of these children (50.2%) work seven days a week.
- As much as 30.8% of these child labourers had to work for more than 58 hours a week; 36.2% worked between 33 and 56 hours a week; and 33.1% for up to 32 hours.
- A total of 58.8% of them reported physical abuse by family members and/or employers. Among them, 52.7% were boys and 47.3% were girls.
- Among child workers, 61.6% reported facing sexual abuse, the break-up of which is as follows:

Form of abuse	Percentage of child workers reporting abuse, MWCD 2007
Severe forms of sexual abuse	
Sexual assault including rape and sodomy	8.70
Being forced to touch private body parts	17.83
Being forced to exhibit private body parts	16.35
Forcibly photographed in the nude	4.75
Other forms of sexual abuse	
Forcible kissing	25.68
Facing sexual advances during travel	33.09
Forced to watch exhibition of private body parts	21.24
Exposed to pornographic pictures	37.84

"My sister's husband used to press my body parts at night."

–A girl living with a caregiver

"Many a times, the policemen on night vigil come to us and engage us in sexual acts. When we hesitate, we are beaten black and blue."

– Girls living on the street near Bainsgodam flyover, Jaipur

It has to be remembered that all data related to children at work refers to children in the 5-14 age group only, leaving the experiences of those in the 15-18 year group in the labour market obliterated.

Child trafficking

Trafficked children are sourced mostly from rural areas, their engagement–whether in the sex trade, or in any other form of labour–happens mostly in cities. This is why probing available data about this group of children is important in the context of studying the situation of children in urban India.

The only official nation-wide study on trafficking and CSE is the one carried out under the aegis of the NHRC, carried out in 2002-03 and published in 2005.[390] Though dated, this report is relevant both as the only official document available, as also for its special focus on the metropolitan cities of Bengaluru, Chennai, Delhi, Hyderabad, Kolkata and Mumbai.

Flowcharts provided in this study identify specific sites in the respective states as the destination points of victims of trafficking for CSE, and the inevitable role of urban India becomes quite clear through a tour of these points. Either they are highly urbanised districts, or are districts that have industrial or mining areas featuring urban characteristics, even if they are located in backward regions. Though the report does not explicitly state so, it may also be safely inferred that the concentration of trafficked girls is more in industrial and mining townships than in the rural areas of these districts, since high concentration of single male migrant labour and ready cash at hand in the form of wages are important factors that fuel the demand of sex trade.

This report also presents the following numbers of children reported missing from metropolitan cities between 1996 and 2001, and the link between children going missing and their being trafficked is well-known:

Cities	1996	1997	1998	1999	2000	2001	Total in six years	2001: 1996 percentage of increase/decrease
Bengaluru	1,884	1,877	1,846	1,753	1,734	1,824	10,918	3% (-)
Chennai	956	961	1,040	1,117	1,077	1,093	6,244	14% (+)
Delhi	6,193	6,525	6,474	5,793	6,223	6,151	37,359	1% (-)
Hyderabad	713	837	805	837	762	878	4,832	23% (+)
Kolkata	NA	1,027	1,057	995	2,519	2,397	7,995	133% (+)
Mumbai	4,959	4,489	3,235	4,226	4,070	4,112	25,091	17% (-)
Total	14,705	15,716	14,457	14,721	16,385	16,455	92,439	12% (+)

Source: Data received from the state police agencies

Missing children

The term has been loosely used and in different contexts. Who is the missing child? Is the phenomenon of a missing child prevalent in urban areas also? There are two ways in which 'missing children' are defined. Missing children are those who have been missed out during the counting process of the NSSO rounds—either as schoolgoing or as child labour. The two categories—a child attending school and a working child—are exclusive categories as they are defined on the basis of the amount of time spent in the primary activity; a child can spend majority of his or her time either in school or at work. Thus, a child who primarily goes to school but also spends some time working is recorded as a schoolgoing child. In the 2004-05 round of data collection, the NSSO rounds showed that there were 43 million children counted as other', as children who are neither in school nor working. Thus, the NCPCR report on child labour states, "These children are also called variously as *nowhere children, potential child labourers* and *'reserve child labour force*. NGOs, commissions, activists and scholars bracket them as 'child labourers' as they are all deprived of 'education'".[391] Adding these 43 million to child labour numbers will increase the number of working children significantly.

Considering the fact that in urban set-ups, the nature of work for adults is shifting from agriculture to self-employment like, selling eatables on the roadside to conducting petty business, etc, the number of children helping their parents in these set-ups is high. Keeping in mind the limitation of data sets such as NSSO, it is difficult to know the number of children actually working in urban, or for that matter, in rural areas.[392]

The second prevalent way of defining 'missing children' has been through the reporting on missing children in police records and other such means. The NHRC observes, "These cases of missing children represent a conglomeration of a number of problems, including abductions and kidnappings by family members, abductions and kidnappings carried out by non-family members or strangers, children who run away on their own or are forced to run away due to compelling circumstances in their families and extended surroundings, children who face an unfriendly and hostile environment and are asked to leave home or who are abandoned, children who are trafficked, smuggled or exploited for various purposes, and children who are lost or injured. Undoubtedly, each of these groups of children exemplifies different social problems. Since, as a group, missing children are so heterogeneous, there is no adequate data or consistently applied set of definitions to describe them." The report on 'missing' children points out that several cases are not reported but almost 44,000 children are reported missing every year out of which 11,000 remain untraced.

What is interesting to note is that the report states that most of these children end up in urban set-ups especially in case of runaway children who have dropped out of school or have chosen to leave their families due to domestic conflicts. The report observes, "The glamour and lure of big cities often make them blind to the stark realities of urban life. Being vulnerable, they often fall prey to promises of jobs or careers in films or modelling and eventually end up as sex workers or as domestic help or labourers in homes, small hotels and restaurants, tea shops and unorganised establishments, many of them hazardous. Many of the runaway boys and girls become victims of organised begging rackets, pick pocketing, drug peddling, etc. Most are also trafficked and further abused, physically or sexually, and their cases are not even brought to the knowledge of the police."

Photo credit: CJ Clarke/Save the Children

"From a young age, I have been begging. My mother trained me to beg and she used to watch me from a corner. This temple is now my home."

- A girl outside Lingaraj Temple, Bhubaneswar

It is, therefore, difficult to estimate the number of such vulnerable children in the cities even though cities have become default homes for many of them. Thus, missing children may be an ambiguous category but significantly, an urban phenomenon and represents a challenge to the protective structures in the city such as the police, Childline and child welfare committees. Such children are vulnerable to multiple forms of abuse while working, while in transit or living on the streets, etc.

Child victims of substance abuse

"We always keep some money to buy items such as Iodex and Corex. They give us much energy and are not bad for health either."

- A boy of 12 near Easamia Bazar, Hyderabad

There is no specific data to measure the relative spread of children across rural and urban India who are into substance abuse. However, there is a bulk of anecdotal reference from organisations and activists working with children on/of the streets about the high prevalence of substance abuse, glue-sniffing in particular, among such children, who are concentrated in urban areas.

In addition, there is a study conducted by NCPCR on substance abuse among children, which offers a glimpse of the urban situation. The study[393] was carried out in 27 states and two union territories across 135 sites in cities and towns, with 4024 child respondents in the age group of 5 to 18. Among them, 95.8% were boys and 4.2% were girls and 69.8% of the respondents lived in urban spaces. A majority of them (58.8%) were out of school; 28% were in formal schools and 12.9% were in open schools. Children living at home comprised 78%, while children living on/of the streets with or without families comprised the remaining 22%. The substance abuse pattern of these children is as follows:

Substance	Respondents reporting use	Average frequency of use in a month
Tobacco	83.2%	Almost daily
Alcohol	67.7%	13 days
Cannabis	35.4%	17 days
Inhalants	34.7	Almost daily
Pharmaceutical opioids	18.1%	16 days
Injectables	12.6%	13 days
Sedatives	7.9%	16 days
Heroin, smack, brown sugar	7.9%	17 days

Children lacking a legal identity

Identification documents like the UID or birth certificates is the legal right of a child and has been mandated by the Article 7 of UNCRC which states, "The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and as far as possible, the right to know and be cared for by his or her parents." According to UNICEF, "Apart from being the first legal acknowledgement of a child's existence, birth registration is central to ensuring that children are counted and have access to basic services such as health, social security and education. Knowing the age of a child is central to protecting them from child labour, being arrested and treated as adults in the justice system, forcible conscription in armed forces, child marriage, trafficking and sexual exploitation. A birth certificate as proof of birth can support the traceability of unaccompanied and separated children and promote safe migration. In effect, birth registration is their 'passport to protection'".[394]

The rate of registration of births in urban India was 91.8% in 2010 with urban areas in states such as Punjab, Rajasthan, and Haryana reporting 100% registration.[395] However, even in these states, vulnerable children like children on the streets miss the bus. Thus, the street child survey conducted by Save the Children in the cities of **Hyderabad, Kolkata, Bhubaneswar** and **Jaipur** shows that vulnerable street children do not possess legal documents that can most importantly get them access to basic services.

The city-wise analysis revealed that of the children possessing identity documents, Jaipur has the lowest percentage of children (10.6%; 102 out of 960) as compared to Hyderabad (33.9%; 456 out of 1344), Kolkata (56.3%; 648 out of 1152) and Bhubaneswar (69.7%; 535 out of 768)

Identification documents (percentage)

City	Yes	No	Total
Kolkata	56.3	43.8	100.0
Hyderabad	33.9	66.1	100.0
Bhubaneswar	69.7	30.3	100.0
Jaipur	10.6	89.4	100.0
Total	41.2 (1,741)	58.8	100.0

The children (1,741 out of 2,422) who responded that they have identification documents were asked the type of document they possessed. Of the total 1,741 children, 44.5% reported to have an Aadhaar card[396] followed by a ration card, birth certificate and education certificate.

Possession of different types of identification documents (% of children)

City	Birth certificate	Education certificate	Ration card	Aadhaar card	Other government identity card	Others
Kolkata	84.6	10.3	28.4	14.0	0.3	2.2
Hyderabad	2.2	1.5	96.3	42.3	0.4	0.0
Bhubaneswar	17.9	8.8	.2	90.1	0.0	0.2
Jaipur	11.8	13.7	70.6	8.8	0.0	1.0
Total	38.3	7.8	40.0	44.5	0.2	0.9

The protective cover: Mechanisms of the state

The WINGS 2014 Report of Save the Children points out, "Traditionally, policymakers have addressed child protection by looking at each manifestation of abuse in isolation, almost like silos. Research and programmes that aimed to protect children addressed categories of abuse and neglect in isolation. For instance, 'street children', 'children affected by manmade or natural disaster', 'children in conflict with law', 'children who need alternative care set-ups' would all be tackled separately".

Holistic approach to protection

Over the last few years, however, there has been a global move in international NGOs and UN systems towards establishing a protection system rather than dealing with protection as an isolated issue. UN bodies and NGOs such as Save the Children now state that governments need to adopt national budgets, policies, practices and monitoring mechanisms through a 'rights-based approach'. Governments also need to encourage public discussion of child protection issues, because legislation alone is not sufficient unless awareness is raised and attitudes are changed.[397]

The benefits of looking at a 'holistic service structure' is that it encompasses all children. "Such systems seek to protect all children and to unite all stakeholders behind a common set of goals, creating a long-term response that is robust, properly coordinated and adapted to evolving problems."[398] In a holistic approach, there is also the identification of child protection systems at all levels, from national to community levels with the scope to include community-based informal systems in families and neighbourhoods that have the potential to protect children.

Integrated Child Protection Scheme

It is in this spirit that the Integrated Child Protection Scheme needs to be seen. Thus, "the scheme outlines a specific implementation plan. It discusses the need for the convergence of services to give the child. This is achieved through the coordination of all departments, ministries and NGOs involved".[399] The scheme is mandated to form child protection units at block, village and ward levels.


Photo credit: CJ Clarke/Save the Children

At the block or urban ward level, the committee consists of members of district level child protection functionaries, ICDS functionaries, representatives of education and health departments, chairpersons of village-level child protection committees and representatives of civil society, etc. The DCPU on the other hand, is responsible for bringing about convergence of services at the district level. The revised ICPS guidelines state that it is the DCPU's role to "identify families at risk and children in need of care and protection through effective networking and linkages with ICDS functionaries, SAAs, NGOs dealing with child protection issues and urban and rural local bodies". It is also the role of the DCPU to maintain inter-sectoral linkages with the departments of health, education, urban basic services, etc. Thus, we see that maintaining linkages with urban departments in ensuring the protection of children is the specific role of the DCPU, while at the ward level, stakeholders with diverse backgrounds form membership in CPCs ensure the protection of children in the specific area.

Statutory structures for child protection and their feasibility in urban settings

***Child welfare committees**: India has taken many important policy steps regarding child protection and a number of statutory bodies have been set up. The most important mechanism for child protection is the CWC, designed to protect all categories of CNCP. Every single district in the country is supposed to have a CWC and while these are not mechanisms meant only for vulnerable children in urban centres, the advantage is that the CWCs are located in district headquarters, which are cities or towns across the country.*

However, the real problem lies in the implementation of laws, policies and schemes. An NCPCR study reports that till August 2011, eight of the 33 states and union territories covered in the study had not set up CWCs. Out of the seven states reviewed, only Andhra Pradesh, Maharashtra and West Bengal had set up CWCs in every district.

State/ union territory	Andhra Pradesh	Delhi	Karnataka	Maharashtra	Tamil Nadu	Uttar Pradesh	West Bengal
No of districts	23	9	28	35	32	70	19
No of CWCs	23	3	25	35	18	9	19
Functionality of CWCs	3 defunct	All functional	All functional	All functional	All functional	All functional	All functional

However, this study mentions that CWCs in urban centres such as Mumbai and Bengaluru function better than others due to 'stronger linkage efforts amongst concerned stakeholders, higher literacy levels in the district and/ or effective child-rights awareness activities.' However, the report also highlights a long list of problems that need to be addressed for CWCs to function more effectively:

- Constitution of CWCs and support bodies in each district is to be ensured, with special focus on the constitution of recognised child protection units for CNCP.
- Irregularities in the composition and member selection process of CWCs need to be corrected, with special attention to correcting the gender disparity in committees.
- Infrastructure and management of CWCs need to be improved, with special attention to child-friendliness. An official definition of what constitutes child-friendliness is also important.
- A wide range of child referring sources, including children themselves, needs to be ensured along with effective gate-keeping by CWCs. No community outreach programmes by CWCs to create such a community referral system was found to be implemented.
- Creation of clear SOPs for all categories and sub-categories of CNCP is necessary. This will improve CWC case management and record-keeping simultaneously.
- CWC decision-making processes and outcomes need vast improvement, especially with reference to non-institutional care mechanisms and possibilities. CWC decisions were found to be distinctly biased towards institutionalisation of CNCP and thorough capacity-building has been recommended.
- CWC responsibilities and functions need to be fulfilled with reference to follow-up monitoring of both institutionalised and restored children, which was found to be non-existent.
- Case documentation and reporting practices need to be improved by adopting standardised documentation and reporting formats and innovative use of technology.

There is no update on whether the situation of CNCP–including those in urban areas–has improved in the last three years. Most activists would argue that nothing has changed on the ground. Moreover, a government presentation[400] mentions that CWCs had not been established in all districts in Uttar Pradesh, Bihar, Chhattisgarh, Delhi, Puducherry, Tripura, Andaman and Nicobar Islands and Arunachal Pradesh. This will affect all vulnerable children, including those in urban spaces.

***Juvenile justice boards (JJBs)**: These are designed to protect CCLs by ensuring that their offences are addressed in accordance with the Juvenile Justice (Amendment) Act, 2006. In urban spaces, most JJBs are located in major cities and towns. However, the urban-rural split of CCLs is not available and hence, no comparative analysis is possible. But, the non-establishment of JJBs will affect all CCLs, including those in urban spaces. It is worth mentioning that JJBs had not yet been established in all districts in Uttar Pradesh, Chhattisgarh, Delhi, Jharkhand, Andaman and Nicobar Islands, Arunachal Pradesh, and Tripura*[401].

City-specific protection structures

While at the administrative level, the structures of child protection do not differ in urban and rural areas, the ICPS recognises the need for several additional and different structures in the city.

Childline

Childline started out as an emergency helpline for rescuing children in situation of distress in some cities. It has now been scaled up by the MWCD under the ICDS to reach out to children in situations of distress across both rural and urban centres. However, the structures in Childline still retain an urban specific character, possibly with the recognition that urban centres see a larger scale of children in situations of distress.

Childline (urban)	Childline (rural)
Mother NGO	Mother NGO
City-level advisory board	District level advisory board
Nodal organisation	Nodal organisation
Collaborative organisation	Collaborative organisation
Support organisations	Support organisations
	District sub-centres

The ICPS states, "The city and district level advisory board shall comprise of the seniormost functionaries of government departments in the city or district. These departments include departments of social welfare and woman and child development, labour, railways, telecom, information and broadcasting and the chairpersons of the child welfare committee and juvenile justice board, etc. The district magistrate or collector will be the chairperson of the city and district level advisory board." The advisory board will assess the functioning of the Childline in the city and ensure that the system remains child-friendly. However, in spite of the fact that the protection needs of children in cities are higher, the ICPS also states that the city or district level advisory board will be merged with the district child protection committee when it comes into existence.

To increase outreach in urban centres where the number of vulnerable children is likely to be high and to raise awareness about its services, Childline has a base of support organisations. These are community-based organisations, in touch with children in various parts of the city and can link them to Childline in situations of distress.

Open shelters

In addition to this, the ICPS has given due recognition to the fact that there are special categories of 'children in need of care and protection in the cities'. These include the children who are driven by rural-urban migration or displaced due to a disaster or are deserted, orphaned or trafficked and thus, end up, with or without parental support, at traffic intersections, railway stations, streets, vegetable markets, etc. They can be seen begging for alms, wiping automobile windscreens, rag picking, vending wares, performing on streets, etc. and may also be involved in petty thefts, drug peddling or controlled by a begging or stealing mafia. Many of these children also peddle sex for survival and paedophilia is common. These children are very often victims of adult abuse of all kinds--physical, sexual, emotional as well as economic exploitation. Inhuman and violent life conditions turn many of these children into law offenders, criminals, drug abusers and exploiters themselves and make them a huge drain on society. Mainstreaming these children and meeting their special needs is a responsibility of the state.[402] It is to mainstream them that these children are accommodated in open shelters.

Lot of children sleep at the night shelter with families.

The objective behind opening these shelters is the following:

- To attract children to a safer environment
- To wean these children away from vulnerable situations by sustained interventions
- To guide these children away from high-risk and socially deviant behaviours
- To provide opportunities for education and develop their potential and talent
- To enhance life skills and reduce their vulnerabilities to exploitation
- To re-integrate these children into families, alternative care and community
- To carry out regular follow-ups to ensure that these children do not return to vulnerable situations.

The open shelters complement the institutional structure, by slowly 'weaning' away children from life on the streets by gainfully engaging them in music, dance, art, education, etc. Open shelters thus are transit homes for children and protect them from the harmful ways of the streets. It is recognised that children who access these shelters will come through an outreach service which will be carried out by the voluntary organisation running the shelter in vulnerable points such as railway platforms, crowded market areas, tourist destinations, bus stands, etc.

Data gaps and impediments to planning

In this endeavour to scrutinise how protected our urban deprived children are, several data gaps became evident, making a comprehensive, evidence-based assessment extremely challenging, if not downright impossible. Such gaps need to be addressed urgently for effective interventions towards making our cities and towns safer and more secure for our children:

- No official estimate of children on/of the streets in urban areas
- No NCRB records on comparative analysis of the ratio of crimes against children perpetrated in rural and urban areas, though they do highlight that the crime rate in mega cities is much higher than the national rate
- No official estimates of the number of underage girls rescued from the sex trade in major cities and other townships of the country
- No official estimates of 'missing children'

Conclusion

Thus, we see that the city space is one where the child faces multiple vulnerabilities whether it is in the streets or within the household as reflected in the crime statistics of mega cities. In the city space, multiple vulnerabilities often coincide. Thus, a child who is 'missing' could be a working child who has been trafficked and could be facing all forms of abuse in his or her workplace. Additionally, this child could be living on the streets and be addicted to sniffing glue.

We also see that in the ICPS, a welcome step has been taken towards making cities safer for children by introducing open shelters for vulnerable children, by introducing an outreach component in Childline and by directing DCPUs to play the role of convergence agencies. Some key steps that need to be taken are strengthening the tracking and identification of vulnerable children in slums and building an evidence-based plan for addressing child protection needs.

Photo credit: Save the Children

Recommendations

Based on our findings we recommend the following:

- There should be a comprehensive national-level census of children living and working on the streets. This will generate robust data on the demographics and living conditions of these children and enable local governments to plan effectively for shelter and rehabilitation services, either in the form of care homes or drop-in shelters.
- Child marriage threatens to emerge as a big problem in urban settings, where the number of girls who are married before the legal age seems to be still high. As recommended in the WINGS Report 2014, the goal to eliminate child marriage needs to be time-bound.
- As the data indicates, domestic violence in slums is quite high. Urgent steps need to be taken to identify the reasons behind domestic violence and how its impact on children can be mitigated. AWCs or gender resource centres can address violence against children.
- Children living in slums grow up in a volatile environment where safety is always in question. City administrations need to take into account the unsafe living environment that low-cost housing areas offer and increase surveillance to protect children better. Also, law enforcement agencies such as the police need to be trained more intensively to act in a child-friendly manner as laid out by the JJ Act.
- Keeping in mind that children on the streets in urban areas are prone to substance abuse, cities need to have de-addiction facilities for children.
- Tracking and rehabilitating missing children needs to be made stronger, as our cities have become the hubs of trafficked, working and street children who very often have gone missing and have the tendency to face multiple vulnerabilities while they are on the streets.

(Statements of children quoted in this chapter at various places are taken from the Street Child Survey of four cities conducted by Save the Children India in 2013).

Urban resilience and rights of children in India

Mihir Bhatt and Rayappa Kancharla

Natural[403] disasters and extreme climatic conditions affect children differently than they do adults and pose a serious threat to a child's survival and well-being.

Such exposure and vulnerability adversely affect urban resilience and violate the rights of children. Though much has been written about the resultant impact on children, little insight has been offered into the kind of activities and actions that are capable of strengthening urban resilience and protecting the rights of children in the urban context. The existing data and studies on this subject are also limited.

This chapter is an attempt to throw light on the ways in which cities and children can be made more resilient with a rights based approach or framework. The chapter suggests that children can be potentially instrumental in making India less vulnerable to disaster losses and damages. It draws from central and state-level documents as well as other national publications and data.

We have taken into account experiences of children, leading children's organisations and disaster risk reduction agencies such as UNICEF, Save the Children. The opinions of governments at the national as well as local levels regarding urban resilience and rights of children in India have also been considered.

Based on personal interviews as well as case studies, we have provided examples of policies, projects and initiatives that can potentially bring children back into the urban development and risk reduction agenda.

There is a growing need for a new national, forward-looking framework that redefines the purpose, scope, objectives as well as outcomes which will help build urban resilience and strengthen children's rights in India. A national consensus for principles that guide related actions and thought processes, is also required.

Urban risk scenario

Weather-related disasters have more than tripled over the last 30 years and are on a constant rise, world - wide.[404] The rapid growth in the number of people living in cities is increasing the world's susceptibility to natural disasters. This risk increases when people move to earthquake, storm and flood prone areas.[405] Two distinct but intertwined trends of the 21st century (urbanisation and the increasing numbers of disasters affecting more people, causing an increase in economic losses) indicate that the world's growing population is getting concentrated in urban centres and disaster responses are increasingly being mounted in complex urban environments.[406]

Photo credit: Save the Children

The urban poor living in slums and dejected areas of the city are at a particularly high risk. They live on the most vulnerable land within the cities, typically areas deemed undesirable and unfit by others. Residents are exposed to landslides, rise in sea-levels, flooding, and other hazards. Slums are often located along riverbeds or lakes without adequate provisions for safe drinking water and sanitation facilities such as household latrines and community toilets. This exposes children to floods as well as water-borne diseases, including malaria. Socio-economic exclusion leads to lack of access to basic necessities and spaces on the grounds of ethnicity, religion, social status, caste and age and makes such sections more vulnerable.

Considering the growth in urban areas, especially large cities, there is an emerging concern about several Indian cities becoming more vulnerable to disasters on account of unsafe construction.[407]

Cities and towns in India face numerous challenges with respect to urban risk management. The lack of adequate knowledge and administrative capacities; weak finances; lack of coordination between departments; weak law enforcement mechanisms are some examples. Exposure to risks in urban India get aggravated by the high population density, concentration of economic activities, poor living conditions, unsafe houses and inadequate infrastructure, including a lack of essential services in key areas such as health, water and sanitation.

Vulnerability and impact of disasters on children in urban areas

Children represent one of the most vulnerable and excluded sections of our society when it comes to the formulation of disaster risk management policies and practices in urban areas. As per a Save the Children 2008 report, more than 50% of those affected by natural disasters worldwide are children.[408] Children and women are 14 times more likely to die than men during a disaster, according to International Union for Conservation of Nature.[409] According to UNICEF, between 2000 and 2009, 8.45 million children under five years of age were affected by disasters in India, every year; of these, 1.25 million children were malnourished.[410]

Disasters can kill, injure and disable children, often turning them into environmental refugees in their own country. They hinder education by disrupting and delaying formal and informal educational activities and adversely impact the education quality. The sudden loss of income and increase in expense for meeting day-to-day family needs during disasters makes it extremely difficult for poor parents to provide their children with safety, nutrition or education; often forcing children into hazardous labour. Disasters are capable of instilling a deep sense of fear and insecurity among children. Such instances require specialised psychological intervention due to losses, trauma, or unresolved grief, which is often inaccessible to children belonging to a poor household.

Urban resilience

In such a risk scenario, it is important for cities to develop resilience against a variety of disaster risks. Urban resilience is defined as the "capability to prepare for, respond to, and recover from significant multi-hazard threats with minimum damage to public safety and health, the economy, and security" of a given area.[411]

City and disaster risk reduction

In India, 85% of the land is vulnerable to one or multiple hazards and most cities are located on such terrains. For example, about 60 cities with a population exceeding half a million are located within zones III, IV and V, where the impact of an earthquake is most severe.[412] Moreover, 53 Indian cities have a population of more than a million (2011 census) and 25 are in coastal states[413] which makes them extremely susceptible. In a global list of cities facing the highest climate change risk in the coming decades, Indian metropolis Kolkata is ranked seven, Mumbai eight and Delhi 20.[414] Cities such as Chennai, Ahmedabad and Bengaluru, which have substantial public-private investments and a population growth that is draining the already limited resources, are also potentially at risk.

The risk faced by cities and towns in India can be best explained with UNISDR's terminology of intensive risk. It's "the risk associated with the exposure of large concentrations of people and economic activities to intense hazard events, which can lead to potentially catastrophic disaster impacts involving high mortality and asset loss".[415]

Cities in flood-prone areas (Guwahati and Patna): Many cities in India are located in flood prone areas and are extremely vulnerable to the effects of climate change. Guwahati, the state capital of Assam, is the commercial and educational hub of the North East. Guwahati is situated on the south bank of the river Brahmaputra. As per the 2011 Census, the total population of the city is just below one million. As per the Guwahati Municipal Corporation (GMC) survey of 2012, the city has 217 slum pockets. The city is prone to earthquakes as it falls under seismic zone 5 and frequent flooding due to poor river-basin management as well as an inadequate drainage system. Almost every year, heavy rain induced flash floods and water logging inundate low-laying areas of the city, causing economic damage to households as well as loss of education for children.

Patna, apart from being the capital, is the largest city of Bihar. It is the largest riverine city in the world with a population of 16,83,200 as per the 2011 Census. A survey in December 2010 recorded the presence of 108 slums with 16,277 households (GoB: 7). The city is prone to hazards such as floods, earthquakes as well as droughts. Thousands of people in Patna suffer from annual flooding when the Ganges and its tributaries overflow.

Srinagar floods, 2014

The Srinagar deluge of 2014 is ranked as the worst since 1903 when the bund between Sonwar and Ram Munshi Bhagh was strengthened. Though the various measures of flood protection fostered an illusion of safety, the city has been expanding without any foresighted plan all these years. From 3 to 9 September 2014, the world watched helplessly as Srinagar, with a population of 1.3 million drowned up to 26 feet[416]. Amitabh Mattoo tearfully said, "My beloved Srinagar, the only city I have ever called home, was gone. I was there when our home was violated by what we held more precious: water. What wrong had we done collectively to deserve this fate?[417]" By conservative estimates, about 6,00,000 people were severely impacted, including 2,50,000 children who suffered enormously without safe drinking water, medical assistance, nutrition and safe spaces. Even the residents of the valley who have traditionally been resilient due to the extreme weather conditions that render this area a no-work zone for half the year, experienced a fatal blow.

India has also witnessed some of the worst disasters caused by human error and negligence. Thirty years ago, on 2-3 December 1984, India experienced one of the worst 'toxic tragedies' history has ever known. The devastating consequences of this disaster ranged from immediate (death due to suffocation, blindness and vomiting) to medium and long-term (spontaneous abortions, lung, kidney, liver and brain damage). While 20,000 died, approximately 5,73,000 (according to the Supreme Court admission, 2004) suffered respiratory, gastro-intestinal, neurological, psychiatric ailments, cancer as well as genetic mutations.[418] Even after 30 years, there is hardly any sign of closure. "Another disaster remained forgotten. We now know, after extensive laboratory analysis, that hazardous waste dumped by Union Carbide on the factory compound is contaminating ground water" says Sunita Narain, Director, Science and Environment.[419]

City and climate change adaptation

Climate change poses serious threats to child rights pertaining to survival, food security, health, as well as access to water and sanitation, education and protection. It is estimated that in the next decade, up to 175 million children will be affected every year by climate-induced disasters[420] and children from the poorest families are up to 10 times more vulnerable.[421]

Climate change is often understood as a slow-paced event with largely invisible changes such as decadal increase in mean temperature. However, more visible environmental changes that directly affect children's well-being, such as shrinking of green spaces and rise in vehicular and industrial pollution, needs to be taken into consideration. Environmental degradation owing to extreme climatic phenomena such as cold and heat waves, flooding of low-lying areas, droughts, results in unpleasant consequences and disruption of livelihoods. The resultant migration to urban areas in search of livelihoods puts city children at a greater risk of trafficking and violation, apart from numerous other ill-effects.

The cost of climatic change inaction is greater in the long-term compared to the cost of timely adaptation and risk reduction investment.[422] Shifting the world economy to a low-carbon footing will cost around 0.5% of the current decades GDP, which is significantly lower than the actual and projected costs of responding to climate change and maintaining a carbon-intensive economy.[423] It is estimated that global warming amounts to a rise of 2°C can lead to a loss of about 1% to 2% of the global GDP. In Asia's middle and low income countries, however, these losses can be as high as 6% of the total GDP.[424] Another report has warned that if no concerted action is taken, the number of extremely poor people living in the 49 countries most exposed to the full range of natural hazards and climate extremes can be as high as 325 million by the year 2030, the majority being in South Asia and sub-Saharan Africa.[425]

Cities and towns in India are increasingly becoming vulnerable to the effects of natural disasters and climate extremes. Intensity of disasters and damage is usually very high in urban areas; of late, there has been an alarming increase in the frequency of such disasters. According to the National Institute of Urban Affairs, the substantial increase in extreme precipitation (similar to what happened in Mumbai in July, 2005 and in Gujarat in 2005 and 2006) expected over a large area of the west coast and central India will require significant revision of urban planning practices across city and neighbourhood scales in order to integrate flood and climate change mitigation as well as adaptation measures into day-to-day urban development and service delivery.[426]

India must use Assessment Report 5 (AR5) of the IPCC and its projections for drafting more accurate and long-lasting disaster risk management plans for districts and cities across India. The current ones do not comprehensively include climate risks. These plans are of great relevance to national flagship programmes such as MGNREGS, RTE or Right to Food. Cities in India can benefit more if mayor-to-mayor city-level partnerships are formed and implemented. City-to-city and community-to-community knowledge sharing is cost effective and reduces the upfront investment as well as running costs.[427]

Visible environmental phenomena that affect children

This section highlights the environmental phenomena that usually fail to make it to discussions related to resilience, but are nevertheless largely affecting our urban centres.

Heat waves

The recent IPCC report has revealed that it is likely that the frequency of heat waves has increased in large parts of Europe, Asia and Australia[428] and it is very likely that heat waves will occur with a higher frequency and duration in the coming years[429]. Indian cities are extremely vulnerable to heat waves. In 2010, a heat wave in Ahmedabad killed 300 people in a single day, with temperatures hitting a high of 48.6 degrees celsius.[430] In spite of the fact that India witnesses hundreds of heat-related deaths each year, the government does not recognised heat wave as a calamity.[431]

Infants and children up to four years of age are extremely sensitive to the effects of high temperatures, and rely on others to regulate their environments and provide adequate liquids.[432] After the elderly, young people remain the most vulnerable to heat waves, which presents direct dangers, such as heat stroke and burns, as well as the more long-term harm of air pollution exacerbated by the rise in temperature.[433]

Addressing the heat: Health vulnerability in rapidly urbanising regions of Western India[434]

In May 2010, Ahmedabad experienced a rather severe heat wave which resulted in numerous deaths. This prompted the city's government to take action. The Natural Resources Defense Council (NRDC), in partnership with the Indian Institute of Public Health, Gandhinagar and the Public Health Foundation in India, developed an innovative set of strategies, including an early heat-health warning system, to be set out in a Heat Action Plan and implemented by local government officials in the city. In April 2013, the Ahmedabad Municipal Corporation launched the ground-breaking: *Ahmedabad Heat Action Plan 2013: A Guide to Extreme Heat Planning in Ahmedabad, India*.

Air pollution: A rapidly growing concern

According to the WHO, New Delhi is the most polluted city in the world. Within India, Patna, Gwalior, Raipur and Ahmedabad have the worst air pollution readings after New Delhi.[435] In the WHO report, India fares so poorly that 15 cities feature among the 30 most polluted in the world.[436] Almost all cities are reeling under severe particulate pollution while newer pollutants like oxides of nitrogen and air toxics have begun to add to the public health challenge.[437] Air pollution is the largest killer in India, the cause of approximately 6,20,000 deaths in 2013. South Asia is home to 85% of the world's most polluted cities.[438]

Children are more vulnerable to its toxic effects; diarrhoea and respiratory infections are the number one cause for child deaths in India.[439] Children living in polluted cities have higher chances of developing brain inflammation and neurodegenerative changes that raise the risk of Alzheimer's or Parkinson's, according to researchers.[440] While a lot of data on air quality is available from the central as well as state pollution control boards and independent monitoring agencies in India, there is no authentic national-level data on the impact of air pollution on children's health.[441]

Cloud burst

India has seen most devastating cloud bursts in the last decade. For example, in August 2010, cloudbursts in Leh left over 250 people dead. In June 2013, a multi-day cloudburst in Uttarakhand caused devastating floods and landslides. Even though the frequency of cloud bursts has been increasing, India does not have a system to predict cloudbursts resulting in flash-floods like the one for cyclones.[442] AIDMI and Save the Children's work in Leh and Ladakh shows that cloud bust can affect children directly as well as indirectly, especially in a region where alternative options and opportunities for child education, health-care etc. are extremely limited.

Photo credit: Save the Children

Cold waves

Cold waves during winter have become quite frequent across the northern and eastern parts of India. In the first week of January 2013, Delhi recorded a temperature of 1.9 degrees, the lowest in 44 years.[443] Almost every year, cold waves have a devastating effect on the homeless, elderly as well as children.

Cold waves often force schools to shut down. At the city level, though some shelter homes are being made available to the poor, every year people are killed by cold waves. Cold waves gravely affect newborns as they are highly vulnerable to hypothermia. Doctors claim that underweight and malnourished infants and new-borns are even more susceptible if the temperature frequently dips below 10 degrees Celsius.[444] Cities have a large number of homeless street children, which makes it absolutely necessary that special measures are taken to protect them during winter.

Protecting children's rights in times of disasters

Under the UNCRC, children have inalienable rights in all circumstances - including disasters, when they are at their most vulnerable - and the right to participate in decisions that ultimately affect them.[445] Violation of child rights during disasters and climate extremes is yet to become a major concern for governments and humanitarian agencies in India. Although, both government and humanitarian agencies are legally, morally and politically obligated to ensure that recovery efforts are consistent with the human rights of victims,[446] child rights protection remains a marginal concern.

The lack of priority and importance is visible at the following two levels: (a) policy-making and legislation and (b) disaster management operations. The central government has various policy frameworks and laws for mitigation and preparedness during and after natural disasters.[447] However, in these frameworks, not much emphasis has been placed on child rights. These gaps become even wider and more visible at the state and city level. Cities must not have disaster management plans and teams without authorities and budget. It is important to identify key polices and plans, including important stakeholders at the city-level to integrate DRM issues of children in execution of these plans and policies.

Disaster management system in India: Introduction and criticism

India has provided an elaborate system for disaster management at the national, state and city levels. In 2005, a legal institutional framework was developed based on the provision of the 2005 Disaster Management Act across the country. In this structure, NDMA is the authority for formulation of policies and guidelines with respect to all disaster management work in the country. The state authorities further lay down the guidelines for departments of the state and districts falling in their respective jurisdictions. Similarly, district authorities direct the civil administration, departments and local authorities such as the municipalities, police department and civil administration. Typical city level disaster risk reduction activities include, preparation of the city or district disaster management and resilience plans as well as the implementation of various projects funded by the national and state governments.

The Disaster Management Act of India (2005) doesn't include any references to vulnerable groups. Similarly, the National Disaster Management Policy 2009 subsumes children under its general considerations for vulnerable groups. The same situation exists at the state level. For example, Odisha's State Disaster Management Policy can be considered Exhibit A.[448]

An analysis of the district disaster management plans of Jaipur and Guwahati suggests that, though not comprehensively, some issues of children are being recognized. The Jaipur DDMP includes a section on the incidence of children falling into open bore wells[449] and the Draft Guwahati City Disaster Management and Response Plan discusses the importance of including children as one of the most vulnerable groups in vulnerability assessment and response, including some guidelines on the protection of children in do's and don'ts.[450] However, none of these plans contain age-disaggregated data on children for response planning. Sadly, except Guwahati, none of the cities discussed in this paper have a city-specific disaster management plan in place.

The same is true for post-disaster assessments as well. While short-term needs of children affected by disaster, such as food, water, health, schooling and shelter are comparatively easily addressed in the urban context; long-term needs are often overlooked in relief-oriented responses. Long-term needs of children following a disaster include continued support for education, immunisation and nutrition, development of child-friendly infrastructure and adequate provision of WASH


Photo credit: Save the Children

facilities. As found in a study by Save the Children,[451] securing the livelihoods of parents, provisioning disaster protection measures and building awareness are essential for preventing child trafficking as well as other ill-effects that disasters have on children.

But all of these require a detailed assessment of specific needs of the children. However, the data in damage and need assessment reports is hardly disaggregated by age and gender, which makes many long-term needs of children completely invisible. In such scenarios, special needs of infants and young children with disabilities requiring special protection get overlooked. Proper collection, analysis and use of SADD are crucial for crisis management agencies to deliver assistance more effectively and efficiently.[452]

In India, the MoUD as well as the MoHUPA have primarily been entrusted with urban development, housing, and urban poverty alleviation in India. At the city level, governments are expected to play an important role in risk mitigation and adaptation as well as in providing basic urban infrastructure and services. But with the compartmentalisation of disaster risk management, climate change planning, and urban development as separate policy streams in India, it becomes difficult to address disaster and climate change risk in a synergetic manner under a single umbrella.

It is hence, necessary to ensure that important urban initiatives such as the JNNURM, insist on a component for making basic services like water supply, hospitals, schools, etc. disaster resistant.[453] Even today, most of the government housing schemes does not take into account safety features relevant to natural hazards and the opportunity for integrating disaster risk reduction components and environment friendly materials and technologies is mostly unexplored.[454] Use of a legal compliance mechanism is important to ensure that the private sector adheres to the norms of environmental impact assessment and building codes and regulations intended to reduce the overall impact of disasters and climate extremes in cities.

The Planning Commission of India has noted that the convergence of different regional and master Plans, CDPs, RAYs, city sanitation plans, vulnerability disaster or resilience plans, needs to be ensured through better coordination among the concerned authorities.[455] Similarly, projects such as the World Bank-funded National Cyclone Risk Mitigation Project and USAID-supported Climate Risk Management in Urban Areas through Disaster Preparedness and Mitigation project offer a number of opportunities to integrate resilience with risk mitigation and urban development.

Dabwali fire tragedy (NDMA)[456]

Crowd management has recently received renewed interest from Indian authorities, following the NDMA guidelines. Children are the most vulnerable entities in stampedes in schools and public places. In March 2010, at Ram Janaki Temple, Pratapgarh, Uttar Pradesh, 65 (nearly all women and children) died in a local ashram (NDMA).[457] Most event organisers in India are yet to fully comply with the prescribed safety guidelines.

On 23 December 1995, DAV Public School, Dabwali was holding its annual prize distribution function at Rajiv Marriage Palace. A *pandal* with a steel super structure of GI sheets at the top and partially covered from three sides by curtains with a false ceiling supported by bamboo sticks, had been setup for the function. There were about 1500 persons including men, women and children at the venue in spite of an original seating capacity of 500 to 600. The *pandal* caught fire due to a short circuit in an electric generator; which spread quickly and blocked the main entrance as 1500 people tried to escape through the only exit door (proving to be too small to let everyone under the pandal run to safety). A total of 446 people, mostly children and women, died and more than 200 people suffered burn injuries and disfiguring in the stampede.[458]

International processes and protocols

Disasters can strike anywhere and affect children in all spheres of life – protection, education, well-being and dignity. Some of the international protocols apply equally to all children – rural or urban; since natural disasters have a universal impact. Some of these have been introduced and discussed in this section.

Child centred resilience and adaptation: What works and how?

CC-CBDRBA has been in practice for more than a decade. Prior to the Tsunami-related DRR interventions (2004), one credible model that emerged from river basin management in Cuba, had C&Y play a major role in leveraging their leadership in building awareness, adoption and action at the municipality level. C&Y enabled risk mapping, action planning and engaged with the local governance and communities by addressing the mindsets of people as well as the authorities to ensure 'zero' loss of lives and build back better.

CC-CBDRBA works on a Panchsheel principle called 'PREMA' that positions C&Y at the heart of resilience and adaptation and uses the following measures:

- Strategic preparedness
- Resilience
- Early warning systems
- Mitigation and adaptation

These are in turn, aligned to the following five pillars of action:

- Child participation
- Community level action
- Strengthening the local, regional or national institutions including implementers
- Dynamic engagement with planners I
- Incorporation into the government's disaster risk management and climate adaptation plans.

Child protection in humanitarian action (CPiHA)

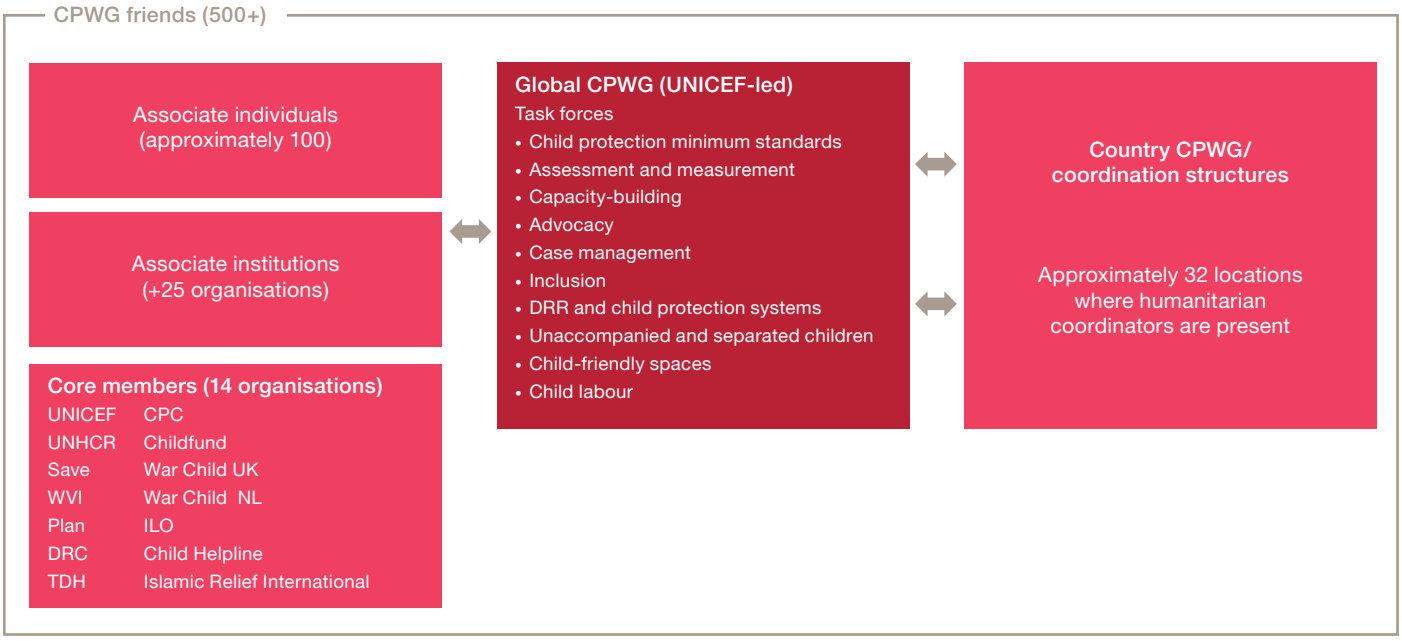
UNCRC has been interpreted and contextualised progressively. General Comment 13 (GC13) institutes a child rights-based approach to child care giving and protection. Through GC13, the Committee encourages a paradigm shift in order to understand and apply Article 19 (Right of the child to the freedom from all forms of violence) within the CRC's overall perspective on securing children's rights to survival, dignity, well-being, health and development as well as participation and non-discrimination.[459]

CPWG[460] is the global level forum for coordination and collaboration on child protection in humanitarian settings.

It brings together NGOs, UN agencies, academics and other partners under the shared objective of ensuring more predictable, accountable and effective child protection responses in emergencies.

Established in 2007 by the IASC as a part of the cluster approach, CPWG is under the Global Protection Cluster led by the Geneva-based CPWG coordinator. It supports field-level groups in coordination and its RRT provides technical assistance in humanitarian situations in order to strengthen the child protection responses.

In the urban risk reduction agenda, it is important to include this as a specifically contextualised mechanism. Adequate human resources need to be trained as well as made a part of the local governance both at the ULB and district governance level.[461]



Education in humanitarian action (EiHA)

According to the Right of Children to Free and Compulsory Education Act (Article 21A) notified on 1 April 2010, all children between the age of 6 to 14 years are entitled to quality education. Therefore, even during humanitarian crises, the state is obligated to ensure that learning and development remain uninterrupted. Destruction of school buildings, displacement of teachers, loss of teaching and learning materials, etc. in the wake of a disaster can lead to schools being closed for weeks, months and sometimes years. The absence of such safe spaces increases children's exposure to violence, abuse and neglect.

Globally, the education cluster is a platform for addressing these needs. This model needs to be incorporated in urban contexts to ensure a coordinated action backed by sound analysis and community participation.

An inter-agency network promoting access to quality, safe, and relevant education for everyone affected by the crisis has also been constituted.[462]

Recommendations

Following are some of the recommendations that can help pave the way:

- There needs to be more clarity on the role of key stakeholders in urban resilience planning and execution at national, state as well as local levels.
- The private sector needs to be engaged more aggressively and responsibly in making cities resilient through meaningful public-private partnerships in areas of green growth and livelihoods as it has the highest investment in urban development as well as carbon emissions.
- Participation of children in resilience building activities needs to be promoted through activities of municipal education boards.

Sendai Framework for Disaster Risk Reduction 2015 – 2030 - NEW

On March 18, 2015, 187 States, 100 ministers, 25 Heads of State/ Governments, 42 Inter Governmental Organisations, 236 NGOs, 300 Private Sector representatives, 38 UN entities, 900 accredited journalists and over 6,500 delegates adopted a new framework towards "Shaping The Future" in Disaster Risk Reduction at the Third World Conference on Disaster Risk Reduction in Sendai, Japan, where the Tsunami happened in March 2011. This replaces the erstwhile Hyogo Framework for Action, 2005–15. The Conference presented a unique opportunity for countries to adopt a concise, focused, forward-looking and action-oriented post-2015 framework for disaster risk reduction and to complete the review of the implementation of the HFA 2005-15.

Expected Outcome:

Substantial reduction of disaster risk and losses in lives, livelihoods and health and in the economic, physical, social, cultural and environmental assets of persons, businesses, communities and countries.

Expected Goal:

Prevent new and reduce existing disaster risk through the implementation of integrated and inclusive economic, structural, legal, social, health, cultural, educational, environmental, technological, political and institutional measures that prevent and reduce hazard exposure and vulnerability to disaster, increase preparedness for response and recovery, and thus strengthen resilience.

Priorities for Action:

1.Understanding disaster risk;

2.Strengthening disaster risk governance to manage disaster risk;

3.Investing in disaster risk reduction for resilience;

4.Enhancing disaster preparedness to "Build Back Better" in recovery, rehabilitation and reconstruction

Source: Retrieved from http://www.wcdrr.org/

- A vulnerability-based approach to risk, resilience and adaptation, that is child-centred, needs to be adopted. DRR action plans for 'make my city resilient' and climate action plans need to incorporate this approach and make it work for children in urban locations.
- Deprivation, disruption, disasters are the manifestations that compound poverty and risk. Not addressing these with an assured delivery of finances to the most vulnerable will hamper the progress and in turn, increase the risks. Any future investment must be made after considering this as a '*conditio sine qua non*' for ensuring the safety and progress of our future leaders.
- Government's smart cities plan needs to embrace this approach that has children at its centre. Further, innovative family tracing and re-unification platforms and mechanisms for separated, unaccompanied and orphaned children need to have a place in the urban agenda.
- Comprehensive school safety, early child care centres as well as 'safety of out-of-school children' are critical aspects of school disaster management and hence, need to be prioritised.
- Children and youth as tomorrow's leaders of change is the first step towards delivering safety and progress for the next generation.

There is a growing need for a new forward-looking national framework that redefines the purpose, scope, outcome as well as the goals of the processes that will help build urban resilience and strengthen the rights of children.

In conclusion, we suggest national partnerships for implementation and follow-up processes. These will include investments needed in understanding disaster risks from the point of view of children, strengthening the city and welfare governance to protect them from disaster risks and encouraging them to be the agents of change (as in the case of CC-CBDRBA). There is also the need for supporting national programmes for preparedness as well as greater and more effective investments in building social, economic as well environmental resilience for and by the children of urban India.

Photo credit: Prasanth Vishwanathan/Save the Children

Conclusion

As the world's largest, and youngest, democracy, India needs to acknowledge her children and youth as active citizens. Our status as the signatory to the UNCRC makes this obligation even stronger. Appropriate measures are needed to protect the basic rights of children and fulfil their needs for growth and development. This is particularly true in the case of urban children, since India is urbanising at a fast pace and children form almost 30% of her total urban population. However, the concerns and voices of children have more or less remained out of the precincts of urban policy-making.

With the growing focus on the development of urban areas, it is an opportune time for the country's urban planners and administrators to find ways to make our cities child-friendly, which essentially means that the current processes of urban planning and policy-making needs to be more inclusive and representative. It is this urgent need that this report articulates.

A child-friendly city or institution has to respond to the needs of the children located at the lowest rung of socio-economic development, more than anyone else. Key indicators of child development are the proportion of children reaching their first or fifth birthday, children going to school and those gaining access to improved sanitation. Historically, while assessing the well-being of children based on certain parameters, we find that those living in urban areas tend to fare better than their rural counterparts in terms of many of these indicators. Yet, we need to recognise that within urban India, there are vast inequities of wealth and opportunity.

Thus, within the urban averages, there are the hidden stories of large numbers of vulnerable children living on/of the streets and in the slums. For these children, the experience of deprivation and vulnerability is no less than that of children in the rural areas. Our analysis also shows that the numbers of these vulnerable children is increasing in the cities, which will eventually turn our cities into hotbeds of child poverty.

Our analysis shows the struggles faced by this section of urban children. At the outset, poor access to quality health services especially to Iron Folic Acid tablets, institutional deliveries and immunisation, threatens their survival. As they grow, they do not receive appropriate nutrition thus falling prey to various diseases and infections. Many lose their lives even before turning two. Those who survive beyond infancy are forced to live in unhygienic conditions, where access to basic services such as clean water, toilets and playgrounds is poor and cleanliness of surroundings and air quality is lacking.

Schooling is yet another important issue. Most publicly funded urban schools do not have pre-school education facilities. Educational facilities in cities are growing slowly. There is total absence of sensitivity to the requirements of menstruating girls in urban schools. Refusal by schools to give admission to migrant children in the absence of age proof is another issue. Together, these barriers ensure that the access of vulnerable children, especially girls and migrant children, to school education is seriously hampered.

Photo credit: Save the Children

Children engaged in labour and those living on/of the streets are worse off. The absence of data on their numbers makes them 'invisible' citizens. Lack of safety nets pushes them towards all kind of abuse—drugs, physical, sexual and emotional. Some also become a part of the criminal networks in the cities. Girls especially face intense abuse either in the form of sexual assault or are pushed into commercial sexual exploitation. The rapidly increasing amount of economic activity in the expanding cities and satellite towns has been accompanied by a rise in the demand for child workers, even in hazardous occupations. Child labourers are vulnerable to abuse both at the hands of employers and the police.

While these are some of the harsh realities, we conclude this report by looking at some of the measures already taken to protect and nurture them, reflect on issues that need to be addressed and ways to tackle these concerns.

The last two decades have brought forth several positive developments that have proved to be beneficial to children. These include new laws, policies and programmes. The following points is a brief overview of these measures:

Initiating new policies: The 12th FYP has been significantly inclusive in its coverage. The concerns with regard to children in urban areas has emerged quite clearly whether with regards to the working group on urbanisation stating the need for representation of children's issues in urban planning or the recognition that ICDS centres in urban areas should provide child care facilities.

Constitution of children's collectives: Some states such as Kerala and Karnataka are successful examples that can be replicated. The initiatives in these states have empowered children through the constitution of *bal sabhas* or children's assemblies by creating necessary platforms to voice their views and concerns to adult elected and state officials.

Policy advancement: The convergence of child protection programmes through ICPS has meant that child protection structures at the district level converge to track and reach vulnerable children especially missing ones, better. Even though the child-tracking mechanism needs to be strengthened, the progress through the Track Child initiative is a move in the right direction.

Additional protective structures: The ICPS recognises the need for additional structures in the city to ensure their protection and safety. This has been done by instituting open shelters which have been conceived as transit spaces where children on the streets are gradually weaned off street life, through therapy and counselling. Considering the size of the cities and the volume of missing children, Childline has an additional layer of a city-level advisory board also.

Right to Education Act: The past two decades have seen a steady rise in the enrolment of children in school, especially at the primary level. The Act has provided the much-needed legislative push to the state's effort to widen access to education. Also, by removing the compulsion of having to produce a document of legal identity for admission and reserving 25% of the seats for economically weaker sections, the law has benefitted more children who have got no such legal documents, a common feature of rural migrants living in non-notified city slums, and those coming from poorer families.

National School Sanitation Initiative: This initiative has reaffirmed the importance of providing appropriate sanitation services at school thereby ensuring higher attendance rates. Efforts of the government in this direction have been fruitful as one can see a rise in the percentage of drinking water and toilet facilities.

Integrated Child Development Services (ICDS): This system addresses the nutrition challenge in the country. The 12th Five Year Plan aims to universalise ICDS centres (anganwadis) in the country with a special focus on SC/ST and minorities.

Launch of the National Urban Health Mission: This Mission underlines the government's commitment to specifically look at the urban scenario. It proposes to strengthen and revamp existing facilities into an urban primary health centre with outreach and referral facilities, to be functional for every 50,000 population on an average.

In the area of disaster risk reduction, there is not much by way of positive developments, except that in 2005, a **legal institutional framework was developed** based on the provision of the 2005 Disaster Management Act across the country, with NDMA being assigned the authority for the formulation of policies and guidelines. This marks a beginning towards systematic interventions in disaster management but we are still far from child-sensitive disaster management planning.

Gaps to be addressed

While the measures taken so far are laudable, a lot of ground is still to be covered. The following are some of the areas requiring urgent action:

Insufficient data: Data on the vulnerabilities of urban children is not only grossly inadequate but also hides the inherent inequities, missing out a sizable number of unlisted slums in most of the cities. India's cities also lack information management systems that can help with urban planning, particularly in terms of slum areas. These hinder the steps needed to improve the lives of such children. Also, in those areas where the data is available, there is no disaggregation to provide the details of particularly vulnerable groups, such as the homeless.

There is no official estimate of the number of children living in situations of urban poverty, not to mention the categorised data about the number of children in identified, recognised and notified slums, resettlement colonies, on the pavements or in railway stations. For example, the lack of data on the number of street children living on/of the streets constrains the ability of the concerned ministries to construct adequate shelters and take appropriate measures to keep them safe. Thus, the majority of children live in the open, unprotected from the threat of physical and sexual abuse. Data on urban child health are limited and difficult to use, to provide useful epidemiological and planning information.

With regard to education, the 'increasing trend of enrolment' in primary and secondary schools in urban areas is reported in detail, though it does not provide the complete picture as data on attendance is missing. Due to limited data, only the trends of enrolment and facilities of schooling vis-à-vis the population growth of urban children in India can be determined. However, it is insufficient to demonstrate the neglect of urban deprived children and fails to capture the quality of education that the children receive.

Data on urban child health is too limited to provide useful epidemiological and planning information. Most of the data is outdated and national surveys are not undertaken at regular intervals. For instance, the National Family Health Survey was last published almost a decade ago and provided data for the urban poor for very few cities. The urban scenario has undergone significant changes during this period.

Absence of children's issues in major urban development schemes: In the endeavour to make our cities inclusive, it is imperative that associated policies and schemes include children's rights as they are constitutionally recognised as citizens. However, urban renewal policies and schemes fail to capture them and do not allocate the budget needed to specifically address their concerns. There are no specific indicators that capture the child's living conditions, well-being and development concerns. With the introduction of urban renewal policies in the form of the RAY and the JNNURM, urban local governments are busy transforming houses to *pucca* to meet targets with no attention to providing an environment conducive for children living in these houses.[463]

Improper execution of policies: While preparing this report, we met with many children across four cities, some of whom mentioned that the absence of legal identity forces them to remain out of school. Although the Right to Education (RTE) Act has officially stated that children regardless of identity documents should be admitted to schools, the principle of inclusiveness that is at the heart of the Act is not followed in reality.

Similarly, the CWC was designed to protect all categories of children in need of care and protection. Every single district in the country is supposed to have a CWC. However, the real problem lies in the implementation of this idea. A study conducted by the National Commission for the Protection of Child Rights reports that till August 2011, eight of the 33 states and union territories covered in secondary research had not set up CWCs. Out of the seven states reviewed through primary research, only the states of Andhra Pradesh, Maharashtra and West Bengal had set up CWCs in every district.

Another example of poor implementation is the establishment of JJBs designed to protect CCLs by ensuring that their offences are addressed in accordance with the Juvenile Justice (Amendment) Act, 2006. However, the non-establishment of these boards will affect all CCLs, including those in urban spaces. Till now, JJBs had not yet been established in all the districts in Andaman and Nicobar Islands, Arunachal Pradesh, Chhattisgarh, Delhi, Jharkhand, Tripura and Uttar Pradesh.

Our recommendations

Urban governance

- For **inclusive cities**, a child-led planning process is essential as it allows children to provide solutions to the challenges they encounter. The planning is then based on the child's knowledge, experience and analysis. The report has cited successful examples from Kerala and Karnataka that have created formal structures for children's participation in planning through existing children's neighbourhood networks. However, such initiatives need to be adopted and mainstreamed by the centre and other states as well.
- **Integrating child development elements in schemes and policies:** The government that took power at the centre in May 2014 is planning to execute a large number of new urban programmes with renewed vigour in order to increase focus on the economic centres of the country. These include the National Urban Development Mission covering 100 smart cities, secondary heritage cities and 500 towns. Every city and town with a population of 100,000 and above will be covered.[464] The Swachh Bharat Abhiyan (Clean India Mission) covers 4,041 statutory towns. There will be new programmes on low-income and affordable housing as well as a National Urban Livelihood Mission. It is the appropriate time to incorporate children's needs in the proposed programmes by demarcating a budget and conducting focussed surveys to analyse their concerns.
- **Convergence**: Urban local bodies, parastatal bodies and district administration need to work in tandem to deliver basic services to the urban poor and excluded sections like children. The woman and child welfare department needs to take the lead at the district level to ensure that children's needs are addressed at the planning and budgeting stages itself by making way for spaces and facilities such as child care homes, parks, schools, etc.

Photo credit: Susannah Ireland/ Save the Children

Photo credit: CJ Clarke/Save the Children

Child survival

- Implement policies and make efforts on convergence mechanisms of public, private and third sector institutions dealing with water and sanitation, urban planning, transport and infrastructure that have a direct impact on urban newborn health.
- Redefine the roles of urban local bodies in public health by including child health.
- Train, deploy and support human resources working in the area of urban healthcare as a central component in improving child survival.
- A mechanism for tracking all pregnant mothers from conception till 2 years after birth needs to be established and institutionalised in urban as well as rural areas.
- Urban poor pockets and families with children under 2 years of age, newly-weds and SAMs in urban areas need to be identified and linked to ICDS and public or private health services. Such families are the families who are at highest risk of being undernourished.
- Institutional support to care for 0-3 years in crèches: Mothers of young children are often employed to support the financial needs of the family. These women need their young children to be cared for when they are away on work. Establishment of crèches attached to the ICDS centres, local NGOs or civil society groups is recommended. Mobile crèches in Delhi and Mumbai have demonstrated high quality childhood development services for the migrant children of construction workers through an integrated programme. Such initiatives need to be replicated in other cities.

Education

- A separate urban strategy is required (as mentioned in the 12th Plan Working Group Report) to set up pre-schools in urban areas with a carefully designed, age-appropriate curriculum and adequate trained teachers or AWWs.
- Due to a large floating population in many of our urban areas, there is the need for institutional mapping and tracking of all urban poor children on a regular basis.
- Teachers are required to be trained on multi-lingual teaching strategies and addressing the pedagogical needs of the floating population, dropouts and out-of-school children in urban areas, with particular focus on children from migrant families.
- Frequent relocation of the urban poor demands a policy to ensure the identity of children and their subsequent entitlement in terms of educational rights.
- Students in difficult circumstances not only require bridging into schools but also support to sustain in schools. Both bridging and support classes need to be integrated in educational planning. Appropriate policy and programmes need to ensure their participation in the school system in a dignified manner.
- Systems need to be set up for identifying and tracking children at risk in different categories. Each city needs to have a process for mapping children and updating the data at least once a year.
- An urban education cell needs to be established in every urban centre in order to undertake half-yearly monitoring of the plan and its execution.

Photo credit: Suzanne Lee/Save the Children

Photo credit: Save the Children

Urban resilience

- There is the need to develop clarity in the role of key stakeholders in urban resilience planning and execution at the national, state and local levels.
- A vulnerability-based approach to risk, resilience and adaptation needs to be child-centred. DRR action plans for 'make my city resilient' and climate action plans need to incorporate this approach and make it work for children in urban locations.
- Deprivation, disruption and disasters are the manifestation that compound poverty and risk. Without addressing these with assured delivery of finances to the most vulnerable will degrade progress thus multiplying risks. Future investment must consider this as a '*conditio sine qua non*' for ensuring the safety and progress of future leadership.
- The government's new initiatives such as the Smart Cities Scheme must embrace a risk-sensitive approach with children at the centre of the approach and investment. Technology must be incorporated to address risk drivers. Further, innovative family tracing and reunification platforms and mechanisms for separated, unaccompanied and orphaned children need to be put in place in the urban agenda.

Protection

- Track and identify vulnerable children in slums and build an evidence-based plan for addressing child protection needs.
- Training to track vulnerable children at ward-level child protection committees to help combat child trafficking, and child labour: These committees can also inform special juvenile police units and CWCs to ensure their safety.
- Constitute additional CWCs and JJBs in megacities to reach out to the huge volume of children in distress in these set-ups.
- Identify focus areas for vulnerable children in cities through primary research and mapping to enable better formation of open shelters and better outreach by Childline to address the needs of distressed children.
- Identify areas from where children migrate to cities and address their needs at these locations to ensure that they do not move by themselves only to end up on city streets.

Water, sanitation and hygiene

- The inter-connections between all sub-sectors of WASH, namely, solid waste, drainage, sewerage and faecal sludge management, needs to be understood since the health outcomes of urban vulnerable children are a result of the interplay between these.
- Homeless children need to be treated as a priority group, since they are most vulnerable to the results of poor access to water and sanitation.
- The National Urban Sanitation Policy 2008 must include 'urban children' as a group that merits special attention.
- The state must make higher investment in the area of hygiene education, including toilet use and safe disposal of child faeces.
- Sector-level inefficiencies must be addressed so that good quality drinking water can be made available round-the-clock to all sections of the population, including the poorest, at an affordable cost.
- The database of the urban WASH needs to cover children as a special category, along with the poor and women, so that the targeting of these groups improves.

In the last two decades, the country has witnessed an increased focus on children, with specific policies and programmes to help them grow in a positive environment. In the wake of the RTE Act, more children have gained access to education, though urban deprived children, especially those unaccompanied by caregivers, still face the threat of abuse and the lack of legal identity bars them from getting access to basic services. The government and civil society must recognise them as citizens and create spaces and platforms for them to voice their opinions, concerns, and rights, particularly their right to play, learn and grow in a positive and healthy environment.

Photo credit: Prasanth Vishwanathan/Save the Children

Methodology

This note describes the methodology adopted by Save the Children and PwC in preparing this report. It details out the secondary and primary research conducted to acquire the necessary data for the report as well as the structure of the team appointed to manage the process of report preparation.

Secondary research

The findings and research are primarily based on secondary sources. In the process of writing this report, we have referred to a large number of secondary sources. Mainly published literature and government sources of data were used. The objective of secondary research was to develop an understanding of the macro-level scenario–global and national--on each theme. In order to describe the global scenario, international publications such as State of the World's Children (UNICEF), Estimates on the Use of Water Sources and Sanitation Facilities (WHO-UNICEF Joint Monitoring Programme), State of the World's Street Children, etc. were referred to. The national-level secondary sources of information mainly included the Census of India, estimates of the National Sample Survey Organisation, reports of NUEPA, and reports of the Planning Commission. Use of official secondary sources of data and standard definitions also lends credibility to the report. While using news items, only leading newspapers such as The Times of India, The Hindu and The Indian Express were referred to. Most of the secondary sources were accessed online.

Primary research

This report is mainly based on the analysis of secondary data. However, Save the Children also conducted primary research on a small scale and used various channels of collecting the views and perceptions of individuals. This included FGDs with children and interactions with the Advisory Group members, among others.

FGDs with children

To understand the living conditions and issues faced by children with regard to their health, protection and education and to know their aspirations in their own words (e.g what will you do if made a leader for a day?), we conducted FGDs with slum children and street children in Mumbai (two groups of 11 to 14 year-old and 14- to 18-year-old slum girls respectively and two groups of 11 to 17-year-old street boys of Salam Balak Trust and 15 to 18-year-old slum boys in Indira Colony and Padma Nagar areas of Govandi respectively), Pune (9 to 16-year-old boys and 9 to 13-year-old girls in Bibvewadi slum with the assistance of Sevadham Trust and 13 to 16-year-old runaway boys at a shelter run by Sathi) and Delhi (JJ Colony, Nehru Place, Sangam Vihar and Madanpur Khadar). In Badgam (Jammu and Kashmir), we met boys and girls in the age group of 12 to 15 years to know about the lives of children living in towns affected by civil strife.

Apart from the researchers of Save the Children, 20 employees from the Delhi, Mumbai and Pune offices of PwC India also participated in discussions with children. Each discussion took approximately two hours. Discussions were activity-based and chart paper, markers and worksheets were used.

Meetings with Advisory Group members and other resource persons

Save the Children and PwC set up an Advisory Group consisting of eminent persons from the development sector who specialised in the areas of WASH, education, urban demography, governance, etc. The group was chaired by Dr Isher Judge Ahluwalia, eminent economist, author and researcher. The group met three times during a six-month period (on 22 May 2014, 9 September 2014 and 11 November 2014). In addition, the editorial team also met representatives of organisations such as GIZ (India), ChildLine and International Federation of Red Cross.

Management structure

The project was overseen by a three-member steering committee comprising of the PwC India's COO, Save the Children's CEO and PwC Foundation's Vice Chairman. The committee met regularly to review the progress of work and offer guidance on operational issues.

The project was co-led by Swati Agarwal, Director, PwC India and Deepali Nath, Director, Knowledge Management, Save the Children. They were supported by a core team consisting of Prasann Thatte, National Manager (Research), Anubhuti Patra, Research and Documentation Consultant for Save the Children and Tushita Mukherjee, Assistant Manager, PwC India. This core team managed the preparation of the report by maintaining a continuous dialogue with the team of authors and the Advisory Group, providing the secondary data and links to data sources to the authors, organising and moderating the meetings of authors and advisors at Gurgaon and New Delhi, reviewing the drafts received from the authors and editing the chapters. The core team started with a kick-off meeting on 1 April 2014, and conducted status update meetings regularly till the end of the project.

Glossary

Antenatal care (ANC): This care package comprises a series of steps taken during pregnancy for maternal care, including three or more ANC visits during pregnancy by a health worker, two or more tetanus toxoid injections, consumption of iron folic acid tablets for at least 90 days and consumption of an intestinal parasite drug.

Basic services to the urban poor (BSUP): This is a mandatory urban poverty reform for all local bodies supported under JNNURM. Its goal is to (provide basic services (including water supply and sanitation) to all poor including security of tenure, and improved housing at affordable prices and ensure the delivery of social services of education, health and social security to poor people.' (Source: JNNURM- http://jnnurm.nic.in/wp-content/uploads/2011/01/Mandatory_Primer_6-PBSUP.pdf)

Child budgeting: This helps track development investments made by the state towards children. It helps identify gaps in resource investment leading to making real constitutional and national policy commitments.

Child-friendly city: In a child-friendly city, children will be able to:

- Influence decisions about their city
- Express their opinion on the city they want
- Participate in family, community and social life
- Receive basic services such as healthcare, education and shelter
- Drink safe water and have access to proper sanitation
- Be protected from exploitation, violence and abuse
- Walk safely in the streets on their own
- Meet friends and play
- Have green spaces for plants and animals
- Live in an unpolluted environment
- Participate in cultural and social events
- Be an equal citizen of their city with access to every service, regardless of ethnic origin, religion, income, gender or disability

Child marriage: Under the Indian law, this refers to a marriage in which either party is a child ie a girl below 18 years and a boy below 21 years of age.

Decentralisation: It refers to the process of transfer or delegation of decision-making powers authorising units, bodies and individuals at all levels of the organisation. In the context of governance, decentralisation can be understood by the devolution of powers on the part of the centre and state governments to various sub-states, districts and village-level organisations such as panchayats.

Drinking water: WHO and UNICEF provide the UN system's monitoring of progress on MDG target 10. The JMP defines safe drinking water and basic sanitation as follows:

- Drinking water is water used for domestic purposes, drinking, cooking and personal hygiene.
- Access to drinking water means that the source is less than 1 km away from its place of use and that it is possible to reliably obtain at least 20 litres per member of a household per day.
- Safe drinking water is water with microbial, chemical and physical characteristics that meet WHO guidelines or national standards on drinking water quality.
- Access to safe drinking water is the proportion of people using improved drinking water sources: household connection; public standpipe; borehole; protected dug well; protected spring; rainwater.

Dropout: A student who has left school and his/her name has been struck off from the school roster. A pass-out is also counted as a dropout if she/he does not pursue studies in another school during the following academic session. The percentage of dropouts of total enrolment who do not pursue studies in the same or some other school during the following academic session gives the dropout rate.

Exclusive breastfeeding: It refers to feeding of only breast milk to the infant for the first six months of life, with special emphasis on the advice that nothing be given to children other than breast milk in the first three days when the milk has not begun to flow regularly, so that the infant benefits from the highly nutritious first milk (colostrum) and the antibodies it contains.

Female foeticide: This is the act of aborting or terminating a foetus in the womb on account of it being female. Foeticide can be committed after determining the sex of the child before birth through ultrasound equipment. It is a punishable offence under the PC&PNDT Act 1994.

Full immunisation: According to the 1998 WHO guideline, full immunisation among children is defined as the receipt of one dose of BCG vaccine, three doses of DPT and OPV vaccines, and one dose of measles vaccine by infants in the age group 12 to 23 completed months.

Gross enrolment ratio: This is defined as total enrolment in a specific level of education, regardless of age, expressed as a percentage of the eligible official school-age population corresponding to the same level of education in a given school-year.

Homelessness: This is a state when people in urban areas cannot afford to rent or own homes due to high land prices.

Immunisation coverage: This is measured in terms of percentage of children under three years who have received the stated vaccine (eg BCG, DPT-3, MCV or Polio-3).

Infant mortality: The probability of dying before the first birthday.

Integrated Child Protection Scheme (ICPS): The ICPS is a centrally sponsored scheme aimed at building a protective environment for children in difficult circumstances, as well as other vulnerable children, through government-civil society partnership.

JJ Colony: A JJ cluster is a form of encroachment on public land; it is not considered as a slum and is resettled under a centrally sponsored scheme

Source of the definition: Risbud Neelima. Typology of Slums and Land Tenure in Indian Cities. National Resource Centre on Urban Poverty, School of Planning & Architecture, New Delhi

Malnutrition among children: It is measured in terms of three standard anthropometric indicators, i.e. weight-for-age for 'undernourished', height-for-age for 'stunted', weight-for-height for 'wasted'. The ICDS system of the Government of India captures the details of undernourished children, wherein the weight of children brought to the anganwadi centre is plotted against their age (as on date of visit) on a growth monitoring chart. It is a broad term which includes both under-nutrition as well as over-nutrition.

Millennium Development Goal (MDG): The MDGs are the world's time-bound and quantified targets for addressing extreme poverty in its many dimensions--income poverty, hunger, disease, lack of adequate shelter, and exclusion--while promoting gender equality, education and environmental sustainability. They are also the basic human rights of each person on the planet to health, education, shelter and security.

Mortality rate: The key mortality rates (viz neonatal mortality rate, infant mortality rate, and under-five mortality rate) are defined as the number of deaths per 1000 live births in the age categories of 0 to 28 days, zero to one year and zero to five years respectively. The maternal mortality ratio is the number of women who die as a result of complications during pregnancy or childbearing in a given year per 100,000 live births in that year. Deaths due to complications of spontaneous or induced abortions are included.

National Family Health Survey: This is a large-scale, multi-round survey conducted in a representative sample of households throughout India. Three rounds of the survey have been conducted since the first one in 1992-93. The survey provides state and national information for India on fertility, infant and child mortality, the practice of family planning, maternal and child health, reproductive health, nutrition, anaemia, utilisation and quality of health and family planning services.


Photo credit: Susannah Ireland/Save the Children

National Sample Survey Office (NSSO): This is a unique set-up to carry out surveys on socio-economic, demographic, agricultural and industrial subjects. NSSO collects data from households and from enterprises. It is a focal agency of the Government of India for the collection of statistical data in the areas vital for developmental planning. The National Sample Survey Directorate was first set up in the country under the Ministry of Finance in 1950. The Directorate was subsequently transferred to the Cabinet Secretariat in 1957 and subsequently in 1970, it became a part of the NSSO in the Department of Statistics under the Ministry of Planning. Since 1999, it has been under the newly created Ministry of Statistics and Programme Implementation (MOSPI).

Neonatal mortality: This refers to the probability of dying in the first 28 days of life.

Open defecation: This is when human faeces are disposed of in the fields, forests, bushes, open bodies of water, beaches and other open spaces. (Source: WHO- http://www.who.int/water_sanitation_health/publications/2013/jmp_fast_facts.pdf)

Post-neonatal mortality: This refers to the probability of dying after the first month of life but before the first birthday.

Public health: This refers to the entire system of curative and preventive healthcare rather than the eradication of a particular disease. It is concerned with disease prevention and control at the population level, through organised efforts and informed choices of society, organisations, public and private communities and individuals.

Public-private partnership (PPP): This is an arrangement between a government, statutory, government-owned entity and a private entity for the provision of public assets and/or public services from the public sector entity, complemented by investments and/or management for a specific period of time. There is a well-defined allocation of risk between the private sector and the public entity and the private entity receives performance-linked payments that conform (or are benchmarked) to specified and pre-determined performance standards, measurable by the public entity or its representative.

Pupil teacher ratio: It represents the average number of pupils per teacher in primary education in a given school year.

Retention rate: This is the measure of the rate at which students persist in their education at various levels.

Sanitation: This refers to the provision of facilities and services for the safe disposal of human urine and faeces. Inadequate sanitation is a major cause of disease worldwide and improving sanitation is known to have a significant beneficial impact on health both in households and across communities. The word 'sanitation' also refers to the maintenance of hygienic conditions, through services such as garbage collection and wastewater disposal. (Source: WHO-http://www.who.int/topics/sanitation/en/)

School-age population: This refers to the population of the age group which officially corresponds to the relevant level of education.

Sex ratio at birth (SRB): This is defined by the NFHS in terms of the number of females born in the five years preceding the survey per 1000 males. It is important to understand that this is different from the sex ratio (number of females per 1000 males in the population at a point in time) and child sex ratio (the number of females per 1000 males in the age group 0–6 years).

Slum: The Census has defined as a residential area where dwellings are unfit for human habitation for reasons of dilapidation, overcrowding, faulty arrangements and design of such buildings, narrowness or faulty arrangement of street, lack of ventilation, light, or sanitation facilities or any combination of these factors, detrimental to safety and health.

Social sector: The Union Budget of India includes in the purview of the social sector the following services and developmental activities: Education, sports, youth affairs, health and family welfare, water supply, housing, information and broadcasting, welfare of SC/ST and OBC, labour and employment, social welfare and nutrition, and development of north-eastern states.

Son preference: It is measured in terms of percentage of women and men age 15 to 49, who want more sons than daughters, as compared to the percentage who want more daughters than sons, the percentage who want at least one son, and the percentage who want at least one daughter

(Source: NFHS)

Total sanitation: This encompasses the use of improved latrines and stopping open defecation as well as improvement in personal, domestic and environmental hygiene. (Source: UNICEF)

Trafficking in persons: This crime includes the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.

Under-five mortality: This refers to the probability of dying before the fifth birthday.

Under-nutrition: This refers to deficiencies of both macro (protein-energy) and micronutrients.

Universalisation of education: Universalisation of education refers to the universalisation of provision, enrolment, retention, participation and achievement of education. The following terms occur in the report at various places and have been defined therein:

- Capability approach
- Child labour
- Educationally backward block
- Systems approach
-

Urban areas: The Census broadly defines urban areas as follows:

- All statutory places with a municipality, corporation, cantonment board, or notified area committee
- A place satisfying the following three criteria simultaneously:
  - A minimum population of 5,000
  - At least 75% male working population engaged in non-agricultural pursuits
  - A density of population of at least 400 persons per sq km
- Others which do not satisfy the above criterion are also classified as urban, if they have distinct characteristics such as major project colonies, areas of intensive industrial development, railway colonies, university campus, important tourist centres, etc.

Urban governance: It is defined as 'the sum of the many ways individuals and institutions, public and private, plan and manage the common affairs of the city. It is a continuing process through which conflicting and diverse interests may be accommodated and cooperative action can be taken. It includes formal institutions as well as informal arrangements and social capital of the citizens'. Good urban governance is one that includes the following::

- A process by which quality of life in the cities can be improved
- An efficient and effective response to urban problems by an accountable local government working in partnership with civil society
- A process for the efficient and effective way of running the cities
- An aim to promote civil society participation in city management along with municipal institutions
- An inclusive process to achieve a quality of life as desired by the citizenry, particularly the poor and the disadvantaged. It promotes inclusiveness, reduces poverty and involves all stakeholders in the political process of governing the city. (Source: JNNURM-(page 18) http://jnnurm.nic.in/wp-content/uploads/2012/05/Urban%20Governance.pdf)

Urban growth: There are four components of urban population growth--natural increase or organic growth, rural to urban migration, reclassification, and boundary changes of existing urban centres.

Urban resilience: This is defined as the "capability to prepare for, respond to, and recover from significant multi-hazard threats with minimum damage to public safety and health, the economy, and security" of a given urban area.

Urbanisation trends in India: India is inevitably on its way towards becoming an urbanised nation in two ways. The share of urban areas in the country's population is rising and secondly, an increasing amount of the country's GDP now comes from the cities.

74th Constitutional Amendment Act (CAA): It came into force in June, 1993 and gave constitutional recognition to ULBs and envisaged the ushering-in of a regime of empowered and strengthened urban governance in the country. Through this amendment, the ULBs were guaranteed the constitutional right to exist, regular elections, reservation for women and weaker sections, and the constitution of SFCs every five years.

Photo credit: Prasanth Vishwanathan/Save the Children

Acronyms

AHS	Annual Health Survey
AIDMI	All India Disaster Mitigation Institute
AIES	All India Educational Survey
ANC	Antenatal care
ANM	Auxiliary Nurse Midwife
aProCh	a Protagonist in every Child
ASER	Annual Survey of Education Report
AWC	Anganwadi centre
AWW	Anganwadi worker
AYUSH	Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy
BAS	Baseline Achievement Survey
BBMP	Bruhat Bengaluru Mahanagara Palike/Greater Bengaluru Municipal Corporation
BCC	Behaviour Change Communication
BMI	Body mass index
BRICS	Brazil, Russia, India, China, and South Africa
BPL	Below poverty line
BSUP	Basic services to the urban poor
CAA	Constitutional Amendment Act
CAG	Comptroller and Auditor General of India
CAGR	Compound Annual Growth Rate
CC-CBDRBA	Child centred and community based resilience building and Adaptation
CCA	Climate change adaptation
CCL	Children in conflict with law
CDBs	Community Development Block
CDPs	City development plan
CEB	Census Enumeration Block
CECED	Centre for Early Childhood Education and Development
CES	Coverage Evaluation Survey
CFC	Central Finance Commission
CFLG	Child Friendly Local Government (Strategy)
CSR	Child sex ratio
CLPRA	Child Labour (Prohibition and Regulation) Act, 1986
CLV	Community link volunteers
CNCP	Children in need of care and protection
CMCH	Coimbatore Medical College Hospital
CPCB	Central Pollution Control Board
CPC	Child protection centre
CPWG	Child Protection Working Group
CRC-KILA	Child Resource Centre, Kerala Institute of Local Administration

CrPC	Code of Criminal Procedure
CSE	Commercial sexual exploitation
CSS	Centrally Sponsored Scheme
CSSM	Child survival and safe motherhood
CSP	City Sanitation Plan
CWC	Child Welfare Committee
CWC	Concern for working children
C&Y	Child and young
DCPU	District Child Protection Unit
DDC	District Development Committee
DFID	Department for International Development
DISE	District Information System for Education
DPC	District planning committee
DLHS	District level health survey
DRM	Disaster risk management
EAG	Empowered Action Group
EBF	Exclusive breastfeeding
ECE	Early childhood education
ECCE	Early childhood care and education
ECCD	Early childhood care and development
EdCIL	Educational Consultants India Limited
EFA	Education for all
EHP	Environmental Health Project
EiHA	Education in Humanitarian Action
ENI	Essential Nutritional Interventions
ESI	Employees' state insurance
EWS	Economically weaker section
FAO	Food and Agriculture Organisation
FGD	Focus group discussion
FSI	Floor space index
FYP	Five Year Plan
GBC	Gender Budgeting Cell
GDP	Gross domestic product
GER	Gross enrolment ratio
GoI	Government of India
HPEC	High powered expert committee
ICDS	Integrated Child Development Services
ICPS	Integrated Child Protection Scheme
ICRW	International Centre for Research on Women

IDA	International Development Association
IDSMT	Integrated development of small and medium towns
IEC	Information, education and communication
IIHS	Indian Institute for Human Settlements
ILCS	Integrated low cost sanitation
ILO	International Labour Organisation
IYCF	Infant and young child feeding
IMR	Infant mortality rate
INR	Indian rupees
IPAP	International NGOs Partnership Agreement
IPC	Indian Penal Code
IPC	Interpersonal communication (Chapter: WASH)
IPCC	Intergovernmental Panel on Climate Change
IPP	India Population Project
JJ	Jhuggi Jhopdi
JMP	Joint Monitoring Programme of WHO and Unicef
JNNURM	Jawaharlal Nehru National Urban Renewal Mission
JSSK	Janani Shishu Suraksha Karyakaram
JSY	Janani Suraksha Yojana
KL	Kilolitre
KMC	Kangaroo mother care
LBW	Low birth weight
LIG	Low income group
LPCPD	Litres per capita per day
LPG	Liquid petroleum gas
LSG	Local self-government
M&E	Monitoring and evaluation
MAS	Mahila Arogya Samiti
MAS	Mid-term Achievement Survey
MCGM	Municipal Corporation of Greater Mumbai
MCH	Maternal and child health
MDG	Millennium Development Goal
MGNREGS	Mahatma Gandhi National Rural Employment Guarantee Scheme
MDM	Mid-day meal
MOHFW	Ministry of Health and Family Welfare
MHRD	Ministry of Human Resource Development
MoFALD	Ministry of Federal Affairs and Local Development
MoHUPA	Ministry of Housing and Urban Poverty Alleviation
MoUD	Ministry of Urban Development
MLA	Member of the Legislative Assembly
MML	Model municipal law
MPC	Metropolitan planning committee
MPCE	Monthly per capita expenditure
MSJE	Ministry of Social Justice and Empowerment
MSW	Municipal solid waste

MUAC	Mid-upper-arm circumference
MWCD	Ministry of Women and Child Development
NAC	Notified Area Council
NCERT	National Council of Educational Research and Training
NCPCR	National Commission for Protection of Child Rights
NCRB	National Crime Records Bureau
NDMA	National Disaster Management Authority of India
NDMC	New Delhi Municipal Corporation
NFHS	National Family Health Survey
NGO	Non-government organisation
NHRC	National Human Rights Commission
NIUA	National Institute of Urban Affairs
NLI	National Labour Institute
NNMR	Neonatal mortality rate
NNMB	National Nutrition Monitoring Bureau
NP	Nagar panchayat
NREGS	Mahatma Gandhi National Rural Employment Guarantee Scheme
NRHM	National Rural Health Mission
NRW	Non-revenue water
NSSI	National School Sanitation Initiative
NSSK	Navjaat Shishu Suraksha Karyakram
NSSO	National Sample Survey Organisation
NTD	Neural Tube Defect
NUEPA	National University of Educational Planning and Administration
NUHM	National Urban Health Mission
NULM	National Urban Livelihood Mission
NUSP	National Urban Sanitation Policy
OD	Open defecation
ODF	Open defecation free
OoSC	Out of school children
OPD	Outpatient department
PC&PNDT	Pre-conception and pre-natal diagnostic techniques (Act)
PDS	Public distribution system
PDL	Public Disclosure Law
PNMR	Post neonatal mortality rate
PHC	Primary health centre
PIP	Project Implementation Plan
PPP	Public private partnership
PRI	Panchayati Raj Institution
PSE	Pre-school education
RAY	Rajiv Awas Yojana
RCH	Reproductive and child health
RGI	Registrar General of India
RMSA	Rashtriya Madhyamik Shiksha Abhiyan
RRT	Rapid Response Team

RTE	Right to Education (Act)
SAARC	South Asian Association for Regional Cooperation
SADD	Sex and age disaggregated data
SAM	Severe acute malnutrition
SC/ST	Scheduled caste/scheduled tribe
SFC	State Finance Commission
SLB	Service level benchmark
SJSRY	Swarna Jayanti Shahari Rozgar Yojana
SMC	School Management Committee
SMMIMER	Surat Municipal Institute of Medical Education and Research
SRB	Sex ratio at birth
SRS	Sample registration system
SSA	Sarva Shiksha Abhiyan
SSS	State (Urban) Sanitation Strategy
SWM	Solid waste management
TAC	Town Area Committee
TB	Tuberculosis
TDRs	Transfer of development rights
TPD	Tonnes per day
UDA	Urban Development Authority
UEE	Universalisation of elementary education
UFWC	Urban Family Welfare Centre
UHP	Urban health post
UHRC	Urban Health Resource Centre
UID	Unique identification (Aadhaar)
UIG	Urban infrastructure and governance
UIP	Universal Immunisation Programme
ULBs	Urban local bodies
U5MR	Under-5 mortality rate
UNCRC	United Nations Convention on the Rights of the Child
UNFPA	United Nations Population Fund
UN-Habitat	United Nations Human Settlements Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	US dollar
UTs	Union Territory
VAD	Vitamin A deficiency
VDCs	Village development committees
WASH	Water, sanitation and hygiene
WHO	World Health Organisation
WPR	Work participation rate

Endnotes

Executive summary

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Urban governance

[97] In the 19-year period from 1995-96 to 2013-14, the Indian economy recorded a GDP growth rate of 7% or more than 10 times. The best period for the economy was from 2005-06 to 2010-11 when it clocked more than 8.5%, five times in a span of six years Retrieved from http://www.planningcommission.nic.in/data/datatable. All rates are computed at 2004-2005 prices (factor cost)]. Though the economy has slowed down in the last two years (2012-13 and 2013-14), when it grew at a rate of less than 5% per annum, The World Bank has predicted a reversal of this slump by projecting a GDP growth of 5.6% in 2014-15 and 6.4% in 2015-16. The Economic Times, 8 October 2014. This pace of growth is far better than the performance during the socialist era from 1951 till 1979-80, during which the mean GDP growth rate was merely 3.5% per annum, mockingly called the 'Hindu' rate of growth by many.

[98] See Picture 1 (b and c) in the chapter Urbanisation and urban life in India: An overview

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[104] Statement of objects and reasons:

1. In many states, local bodies have become weak and ineffective on account of a variety of reasons, including the failure to hold regular elections, prolonged super sessions and inadequate devolution of powers and functions. As a result, ULBs are not able to perform effectively as vibrant democratic units of self-government.

2. Having regard to these inadequacies, it is considered necessary that provisions relating to ULBs are incorporated in the Constitution particularly for the following reasons:

- Putting on a firmer footing the relationship between the state government and the ULBs with respect to the functions and taxation powers, and arrangements for revenue sharing
- Ensuring regular conduct of elections
- Ensuring timely elections in the case of supersession
- Providing adequate representation for the weaker sections such as SC, ST and women

3. Accordingly, it is proposed to add a new part relating to the ULBs in the Constitution in order to provide for the constitution of three types of municipalities: (i) nagar panchayats for areas in transition from a rural area to urban area (ii) municipal councils for smaller urban areas (iii) municipal corporations for larger urban areas

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[129] The process of land acquisition in urban areas for public purposes, especially for road widening, parks and play grounds, schools etc, is complicated, costly and time consuming. In order to minimise the time needed to complete this process, the concept of transfer of development rights (TDRs) has been developed. TDR means making available certain amount of additional built up area in exchange for the area surrendered by the owner of the land, so that he or she can use the extra built-up area either by himself or herself or transfer it to another in need of the extra built-up area for an agreed sum of money.

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[149] Urban averages often do not even include the poor, especially the marginalised or unrecognised settlers in colonies or those without a fixed address. One of the extensive efforts at disaggregating data was carried out by the World Bank, which developed an "asset index" to measure household wealth. Study populations were separated into wealth quintiles and also by "rural" and "urban." Health, population, and service utilisation data were then compared across quintiles.

A similar effort at disaggregating and comparing data was completed by Environmental Health Project (EHP) for Gujarat, using different databases. In spite of inadequacies, a search for data on neonatal mortality, under-five mortality, and maternal mortality; main causes of death; and morbidity and malnutrition for both urban slum and non-slum populations yielded results that compel us to look at the gross intra-city differences and inequities in slum versus non-slum child health status.

Although a few previous studies (e.g. Agarwal & Taneja, 2005; Agarwal, 2011; Kumar & Mohanty, 2011) have measured child health differentials within urban India, these studies have serious methodological limitations when it comes to accurately quantifying the inequalities and the critical pathways that determine such inequalities (Arokiswamy P., Jain Kshipra, Goli Srinivas and Pradhan Jalandhar. *Health inequalities among urban children in India: A comparative assessment of empowered action group and south Indian states*: J. Biosoc. Sci., (2012) 00, 1–19, 6 Cambridge University Press, 2012 doi: 10.1017/S0021932012000211).

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sustainability, and lack of need based management models as constraints.

[158] Depending on the spatial distribution of the slum population, the population covered by a UPHC may vary from 50,000 for cities with sparse slum population to 75,000 for highly concentrated slums.

[159] 74 cities have got added to this list since Census 2001, which reflects a rapid increase.

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[167] According to the NCRB 2005 data, among the 28 states of India, the mortality rate per million population due to RTA varied from as low as 20 in Nagaland to as high as 216 in Tamil Nadu. States with rapid and high growth in motorisation had a higher number of deaths. Nearly half the total road fatalities were in the four states of Tamil Nadu (14.5%), Andhra Pradesh (11.4%), Maharashtra (11.1%) and Uttar Pradesh (10.2%). Data from the Ministry of Road Transport and Highways indicate that 38%–40% (38% in 2000; 40% each in 2001 and 2002) of deaths due to RTAs in different states occurred on highways and nearly 15% of RTA deaths occurred in cities with a population of more than a million.

Data for major Indian cities reveals that the mean mortality and incidence of RTAs was 90 and 410 per million population respectively, with a ratio of 1:5. Many of the newly emerging cities had rates exceeding 90 per million population. The death to injury ratio was nearly 1:10 in some cities (Bengaluru and Vadodara), while it was on the negative side (5:1) in Indore, Faridabad and Kanpur, indicating variations in RTI reporting across cities.

Situation analysis

A quick look at the situation of RTA reveals that during 2010, all states and UTs reported 499,628 RTAs in the entire country, of these, about 23.9% (119,558) were fatal accidents and the number of persons killed in RTAs was 134,513, i.e. an average of one fatality per 3.7 accidents. The proportion of fatal accidents in total RTAs has consistently increased since 2001 from 17.6% to 23.9% in 2010. Apart from this, the severity of road accidents, measured in terms of persons killed per 100 accidents, has also increased from 19.9 in 2001 to 26.9 in 2010.

With a population of more than 14.68 million spread over the two banks of the River Hooghly, the Kolkata Metropolitan Area (KMA) is the major urban centre and port in eastern India which serves as a vast hinterland extending over 11 states of the country. The existing street network in Kolkata consists of arterial roads, sub arterial roads and local streets. The total length of highways, arterial and other major roads in KMA is about 700 kms.

The road-based passenger transport system of Kolkata mainly consists of cars, buses, minibuses, auto rickshaws (three-wheeled motorised vehicles), motorcycles, taxis, bicycles and hand-pulled rickshaws. In a number of corridors tramcars also share the same right of way along with other vehicles. The Kolkata transport system also includes an underground rail rapid transit system, suburban rail and cross-river ferry systems.

In Kolkata there were 568,482 registered motor vehicles in 1995 which increased to 821,188 in 2002, indicating a total growth of 44.45% over a seven-year period. Between 1995 and 2000, the number of buses increased by 19.43%, cars (including jeeps and taxis) by 34.83%, two-wheelers by 37.38% and three-wheelers by 68%.

In the city of Kolkata itself, in the year 2010, the total number of RTAs amounted to 2842 in number, of these 341 were fatal, resulting in deaths of 354 persons and injuries to 2239. The severity ratio was 12.5.

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[174] This represents the overall picture in urban India. According to NSSO 60th round, the percentage of cases receiving out-patient treatment from government sources in urban areas has decreased to 19 in 2004 as compared to NSS 52nd round (1995-96) and NSS 42nd round (1986-87). Similarly, for in-patient treatment, the share of public facilities was 382 cases out of 1000 in 2004 (NSS 60thround) while the corresponding figures were 431 in

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Urban resilience and rights of children in India

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Conclusion

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Acknowledgements

This report is the collaborative effort of PwC and Save the Children and was made possible by the inputs received from expert members of the Advisory Group in the fields of urban governance, WASH, nutrition, child rights, protection, education and disaster risk reduction.

We express our gratitude to the following individuals without whose support this project could not have been accomplished.

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Save the Children works in 120 countries globally and across 17 states in India for children's rights – To inspire breakthroughs in the way the world treats children, and to achieve immediate and lasting change in their lives. It is determined to build a world in which every child attains the right to survival, protection, development and participation. We deliver immediate and lasting improvements to children's lives worldwide.

A world which respects and values each child.

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PD 341- April 2015 Urban child report.indd
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