

STATUS OF CHILDREN IN URBAN INDIA

BASELINE STUDY - 2018
SECOND EDITION



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Foreword

Research shows that children's early experiences have effects that last a lifetime. Increasing evidence from the fields of public health, neuroscience, and economics proves that investing in early childhood development can translate to better health, greater ability to learn and work with others, and higher incomes in adulthood. Such investments lay a crucial foundation by ensuring that pregnant women, babies, and toddlers have access to proper nutrition and healthcare, protecting young children from neglect and violence, and giving babies and toddlers ample opportunities for early stimulation, care, and learning.

Cities play an critical role in these early experiences. They can be wonderful places to grow up in, rich with opportunities for learning and growth. Yet urban environments can also pose challenges for young children and their caregivers, and especially for the most vulnerable among these.

To make urban neighborhoods work for young children and their families, reliable and comprehensive data is paramount. In India, about 128.5 million children reside in cities, yet a lack of data on children poses a significant challenge in ensuring the inclusion of child-friendly practices in urban planning and programmes. A lack of disaggregated data, in particular, prevents decision-makers from taking into account the needs of different age groups of children. A three-year old child, for example, has very different needs in a city compared to a 12-year old.

The second edition of the Baseline Study on the Status of Children in Urban India makes an important contribution to the cause of young children and their place in our cities. It serves as an exhaustive resource on children in urban India, with disaggregated data to better inform policymakers and practitioners, highlight hidden patterns and trends, and encourage more robust, evidence-based decision-making. The report also underscores the urgent need to plug gaps in data that remain so that decision-makers can better understand and cater to the needs of children in cities.

Supported by the Bernard van Leer Foundation, the report is part of the National Institute of Urban Affairs' (NIUA) Child Friendly Smart Cities (CFSC) programme to include the needs of children in the urban policy and planning framework of Indian cities. Special thanks to NIUA and congratulations to the CFSC team for a well-researched and thorough data source on children in urban India.

Cities in India are ripe for policies, design interventions, and services that seek to improve early experiences and opportunities for their youngest residents. We hope that the momentum generated through this report and the CFSC initiative will continue to advance healthy, prosperous, and vibrant Indian cities where babies, toddlers, young children, and their families can thrive—ensuring our youngest citizens a good and fair start in life.

Rushda Majeed
India Representative
Bernard van Leer Foundation



Preface

The Child Friendly Smart Cities (CFSC) initiative was undertaken by the National Institute of Urban Affairs (NIUA) in partnership with the Bernard van Leer Foundation (BvLF) in 2014, with the aim of mainstreaming the needs of children in the urban policy and planning framework of Indian cities. It has been four years of intense learning, stakeholder engagement, and advocacy on a number of levels to mainstream the idea of child friendly urban environments.

While significant progress has been achieved by NIUA in pushing forward the agenda of child friendly cities, outstanding data gaps and insufficient or inaccessible data have proven to be a hindrance in prioritization of constituent issues and establishment of their relevance and significance.

This Baseline Report aims to serve as an easy-to-use reference for data on urban children. Our objective was to collate available data on urban children in one place and present it in a useful and disaggregated form to aid policy makers in understanding areas of concern for children of different age groups, gender, geographical locations and abilities. Children are generally not visible in datasets and are assumed as a given. Even more hidden are children of different age groups and contexts. This results in lack of focused interventions that would have catalyzed improvements in the living conditions, health and overall well-being and development of children. Hidden data signifies issues that are never brought to light. An example in case is the lack of data on early childhood, especially of children between 0-5 years. In fact, it is a matter of concern that India has not been able to present any data under this head in its progress report towards achieving the Sustainable Development Goals. This report is just a beginning towards making children visible in data.

Another issue that the team faced while preparing the report was the existence of disparate sources of data, none talking to each other. The effort is to enhance convergence and assimilation of information to understand any issue in conjunction with others. Similar thinking was behind the setting up of a 'Knowledge Repository' on the CFSC website in collaboration with UNICEF. The repository allows different organisations working in the area of children's rights and public policy and urban planning sphere to share publications, knowledge resources, toolkits etc. in one place. Ideally, every city must have a data repository on the subject of children. We should even consider repositories for and by children.

I am delighted to present the second edition of this Baseline Study on the Status of Children in Urban India with the hope that it would be utilised by practitioners and researchers alike. I congratulate the CFSC team led by Kanak Tiwari that worked very hard on this study to produce an excellent source of reference.

For the 472 million children in India, we have 472 million reasons to start counting children and making each one of them count.



Jagan Shah
Director, NIUA

ABBREVIATIONS

ARI	Acute Respiratory Infection	MoHFW	Ministry of Health and Family Welfare
AMRUT	Atal Mission for Rejuvenation and Urban Transformation	NCRB	National Crime Records Bureau
ANC	Antenatal Care	NCT	National Capital Territory
ARI	Acute Respiratory Infection	NDMA	National Disaster Management Authority
AWC	Anganwadi centres	NIDM	National Institute of Disaster Management
BCG	Bacillus Calmette–Guérin	NFHS	National Family Health Survey
BMI	Body Mass Index	NGO	Non-governmental Organization
BvLF	Bernard van Leer Foundation	NIUA	National Institute of Urban Affairs
CFCI	Child Friendly Cities Initiative	NPA	National Plan of Action
CFSC	Child Friendly Smart Cities	NSSO	National Sample Survey Organisation
C-Section	Caesarean Section	OBC	Other Backward Class
CSR	Child Sex Ratio	OPD	Outpatient department
CWC	Child Welfare Committees	OPV	Oral poliovirus vaccines
DALY	Disability Adjusted Life Year	PPPP	People Public Private Partnership
DPT	Diphtheria–Pertussis–Tetanus	RTE	Right to Education
ECE	Early Childhood Education	SAM	Severe Acute Malnutrition
GBD	Global Burden of Diseases	SD	Standard Deviation
GEAG	Gorakhpur Environmental Action Group	SDGs	Sustainable Development Goals
HEAL	Health & Education; Accomplished Living	SPM	Suspended Particulate Matter
ICDS	Integrated Child Development Services	TISS	Tata Institute of Social Sciences
ICPS	Integrated Child Protection Scheme	TT	Tetanus Toxoid
ILO	International Labour Organization	U5MR	Under 5 Mortality Rate
IMR	Infant Mortality Rate	UNCRC	United Nations Convention on the Rights of the Child
INR	Indian National Rupees	UNCRPD	United Nations Convention on the Rights of Persons with Disability
JJB	Juvenile Justice Board	UNICEF	United Nations International Children's Emergency Fund
LHST	Lung Health Screening Test	UT	Union Territory
MDGs	Millennium Development Goals	WASH	Water Sanitation and Hygiene
MHRD	Ministry of Human Resource and Development	WHO	World Health Organisation

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Introduction

1.1 Background

The National Institute of Urban Affairs (NIUA), a premier institute for research, capacity building and dissemination of knowledge in the urban sector in India, has partnered with Bernard van Leer Foundation (BVLF), a private grant making foundation based in the Netherlands, to build Child Friendly Smart Cities (CFSC) in India within the urban agenda of building smart cities. The goal of this initiative is to mainstream the needs of children in the urban policy and planning framework of Indian cities.

This document has been created by the National Institute of Urban Affairs (NIUA) under its initiative, 'Child-friendly Smart Cities' (CFSC), with the aim of providing a reliable information base about children in the urban context in India. This research study serves as a one-point reference, which informs on the status of children and brings together elements of quantitative and qualitative inquiry to the understanding of

children's status in urban India. This is an updated second edition of this Baseline, made more comprehensive by including additional data on young children (0–6 years), their needs and issues being distinct from other age groups.

1.2 Need for a 'Baseline for Status of Urban Children in India'

India is home to 472 million children (0–18 years) comprising 39 per cent of the country's total population.¹ The Constitution of India accords a special status to children as deserving of special provisions and protections to secure and safeguard the entitlements of 'those of tender age'². As many as 128.5 million Indian children reside in urban areas. Children constitute 34 per cent of the urban population, and it becomes imperative that we include and address the needs of children in planning and building sustainable cities. Urban areas offer great opportunities to secure children's



There are **472 million** children in India under the age of 18 years. This **constitutes 39%** of the total population in the country



Birth registration among children under age five years doubled between NFHS-3 and NFHS-4 **(from 41% to 80%)**



Every fourth child in India **(27.4 % of total children) lives in a city.**



rights and accelerate progress. At the same time, it is essential to note that children in urban settings face a particularly complex set of challenges with regard to their development and the fulfilment of their rights. Urbanisation has significant implications on the growth and development of children, especially those living in slums, homeless children or children living on streets and migrant children. For children growing up in cities, there is both a unique mix of advantages as well as disadvantages—access to better schools, sports facilities and healthcare is often in contrast to disadvantages like pollution, lack of independent mobility, inadequate play spaces, lack of recreational/public spaces and a break-down of community support structures.

Cities need to be planned and designed to be child friendly in order to function as nurturing, dynamic communities for all age groups. To make cities liveable, it is essential to put children at the heart of the planning and decision-making framework. Planning and designing cities from the vantage point of a child is the best place to start because if the city works for the youngest resident and her/his family, it will also work for other segments of the urban population such as women, senior citizens and persons with disability. The entire population would benefit from child-friendly policies and planning.

India is a signatory to the UN Convention on Rights of the

Child (UNCRC) wherein a child is defined as a “human being” below the age of 18 years.³ However, there are constraints faced by planners and decision makers due to lack of availability of official data about children (0–18 years). Sources are varied and piecemeal and the data fails to cover all age groups. The National Family Health Survey (NFHS) provides data disaggregated by gender, territory and category but not for different age groups. Comprehensive data that shows 6–14 and 15–18 age groups as distinct groups having requirements that are peculiar to them and which cut across sectors is rarely available. The early childhood and adolescent age group have a scattered presence in policy frameworks, whether it is the National Policy for Children 1974 or the National Charter for Children 2004.⁴ The study tries to overcome these challenges by drawing on surveys or studies concerning children done by credible organisations like UNICEF, Save the Children, DASRA and others.

1.3 Aims and objectives of the baseline study

The aim of the baseline study is to look at children's needs in a comprehensive manner through the lens of urban planning and design. The idea is to examine and analyse existing information on children in urban India across the following thematic areas:

- **Demography:** It covers demographic characteristics of urban children across states, presenting age disaggregated data.
- **Health and nutrition:** The aspects of maternal health, health and nutritional status of children, particularly those living in slums have been analysed. In addition, mortality rate and impact of water and sanitation on health of children have been studied.
- **Living conditions:** This section focuses on condition of housing, access to safe drinking water and improved sanitation facilities at household and school level, living arrangement of children and access to play areas.
- **Education:** This section presents gender disaggregated data on access to education and school drop-out numbers, besides education of children with disability, and early learning for very small children.
- **Safety and security:** This section has two sub-sections. While the first focuses on vulnerability of children against socio-economic issues such as crime and child-labour, the second sub-section looks at environmental risks such as pollution, climate change and disaster preparedness.

To advocate child-friendly policies, planning and practices it becomes imperative to have an informed standpoint. However, lack of reliable, collated and co-related data has led to lack of interest in involving children in the decision making, or even addressing their specific needs in planning. Reliable data can be a catalyst in mainstreaming the issues and needs of children, which otherwise get ignored. Co-related data sets in this report demonstrate how different aspects affect the daily lives of children, and how interventions in one area can lead to improvements in the other; for e.g., increased access to water supply shows co-relation with reduced school drop-out rates.

The study intends to provide an overview of the current scenario of children in urban India and identify key areas of concern to ascertain future areas of intervention for making cities child friendly.

Data and inferences drawn from the study will be shared with stakeholders from all walks of life: local government, policy makers, city managers, urban practitioners, civil society and academia to sensitise them towards the current status of children in different

states in India and further highlight the need for child-friendly cities. This would be a substantive first step in helping to initiate a dialogue with government and city agencies to encourage urban planning frameworks to shift towards being child friendly.

1.4 Methodology, scope and limitations of the study

Accessible and authentic data is an essential step in the process of recognising and improving the situation of children in urban areas.⁵ The study comprises data extraction, computation and analysis of statistics from varied sources like the Census of India and other largescale sample surveys like NFHS and National Sample Survey (NSS). Additionally, review of literature, reports published by government bodies, special studies by reputed NGOs/multilateral agencies and news highlighted in relation to urban children on mass media in last the 2–3 years are also considered. To ensure acceptability and credibility, the study is restricted to data generated by government/government supported agencies or other reliable sources.

One of the major limitations of the study is the lack of data on children across all age groups. The study is based on univariate analysis using available data sets and reports. An in-depth analysis of socio-economic, cultural, region specific factors of targeted group of children and demographic factors of caregivers has not been carried out for this report. However, information on selected factors is given from available research on the subject.





ISHLEEN KAUR

Demography

Children represent a significant percentage of India's population cohort. In fact, India is home to the largest number of children in the world. Every fifth child in the world lives in India.⁶ To design cities that are sensitive to the needs of children, it is imperative to first assess the various demographic aspects of this population group. This chapter tries to capture certain salient demographic features of urban children such as population in various age groups, sex ratio, population of differently-abled children. The section on vulnerable children tries to capture the demographic aspects of the urban disadvantaged children such as those living in slums, homeless and migrant children who face particularly complex set of challenges for their development and the fulfilment of their rights.

2.1 Population of children (0-18 years) in Urban India

India has 472 million children (0-18 years) comprising

39 per cent of the country's total population, out of which 247.5 million (52.4 per cent) are male and 224.6 million (47.6 per cent) are female (Table 2.1 & Map 2.1).⁷ Around 138.9 million children (29.4 per cent) are in the 0-5 years age group, 100.9 million children (21.4 per cent) are in the 6-9 years age group, 132.7 million children (28.1 per cent) are in the 10-14 years age group and 99.7 million children (21.1 per cent) are in the 15-18 years age group.

27.2 per cent of children in India live in urban areas (as shown in Map 2.2) with 67.7 million (52.7 per cent) males and 60.7 million (47.3 per cent) females. The urban population comprises of 128.5 million children out of which, 36.6 million children (28.5 per cent) are in the 0-5 years age group, 62.2 million children (48.5 per cent) are in the 6-14 years' age group, 29.6 million children (23.1 per cent) are in the 15-18 years age group (Table 2.2).



8.1 million
children in the age
group of 0-6 years live in
urban slums.

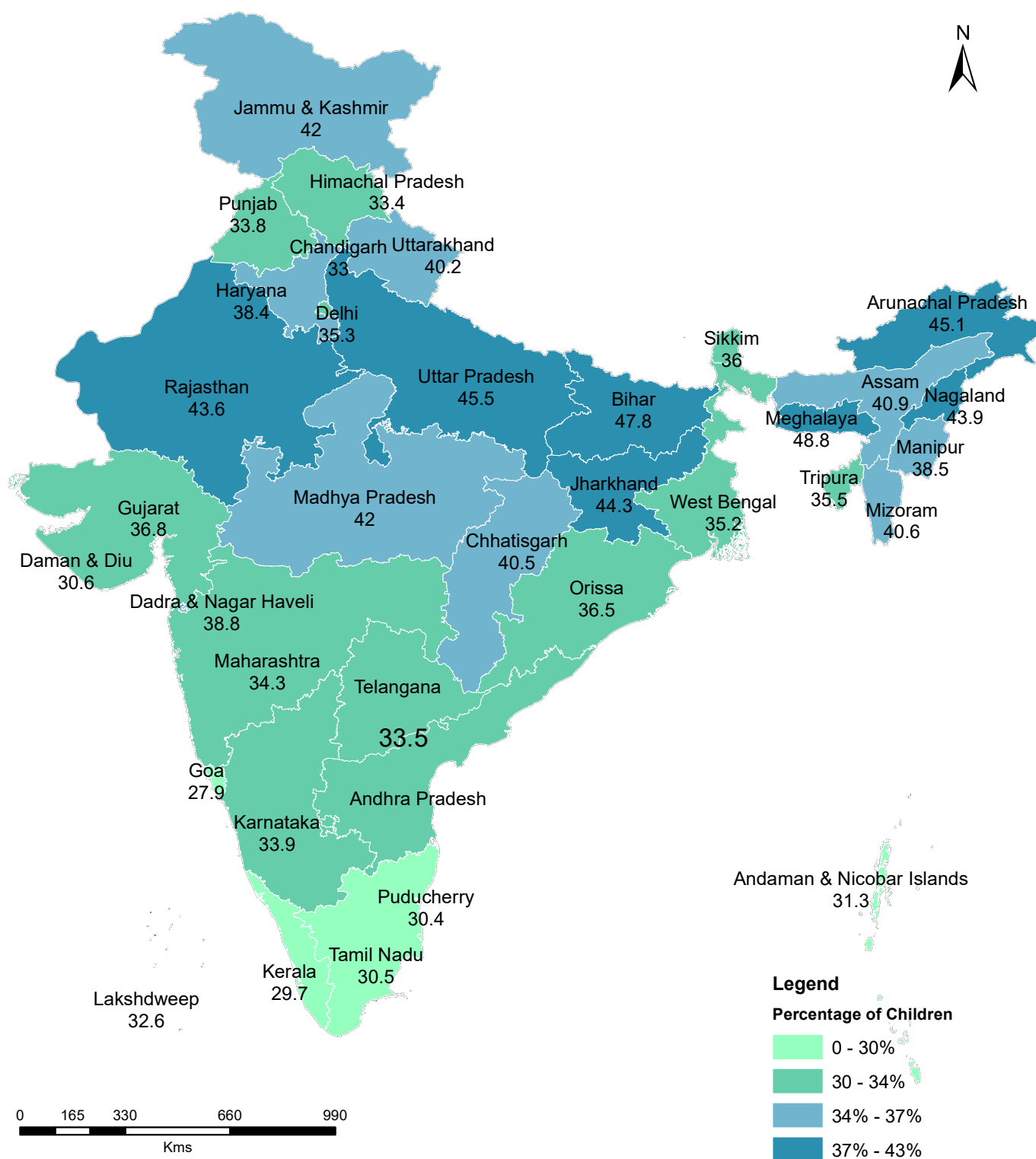


90 per cent
migrant children do not
have access to ICDS and
Anganwadi services



Children from
0-6 years constitute
15.3 per cent
of the total homeless
population in the country

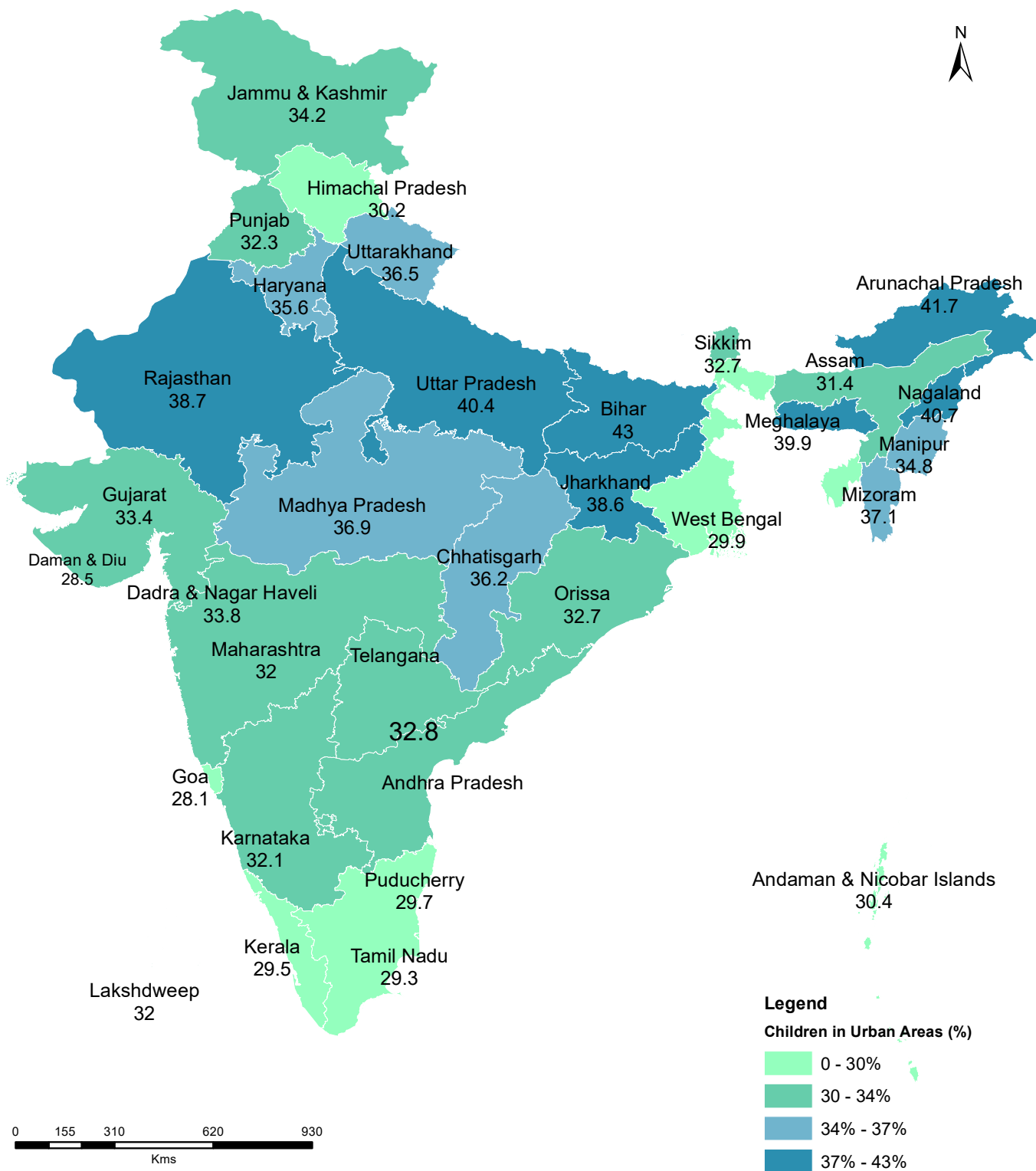
Map 2.1: Percentage of children in India (0-18 years)



Source: Census of India, 2011

"Note: The data for Telangana and Andhra Pradesh is the combined data for erstwhile Andhra Pradesh as separate data for both the states is not available in Census 2011."

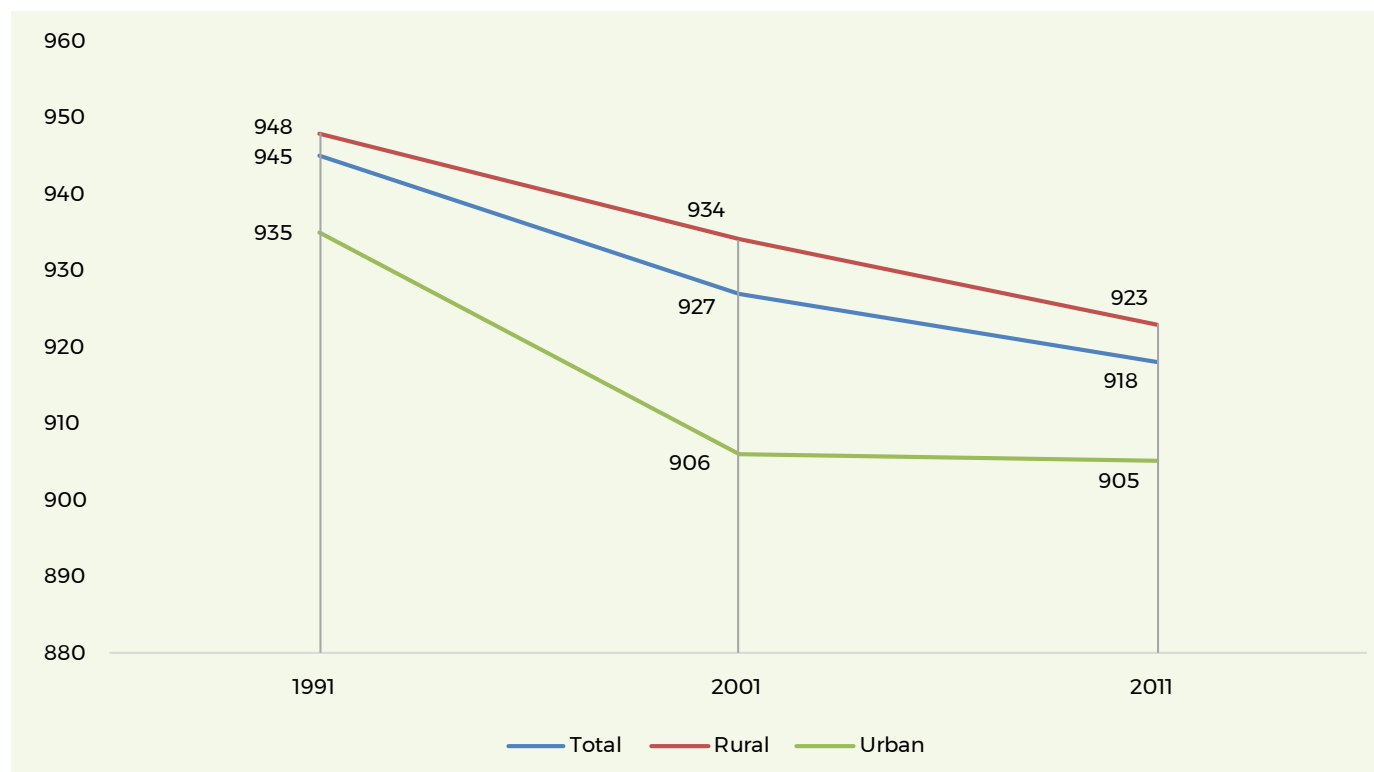
Map 2.2: Percentage of children in urban areas (0-18 years)



Source: Census of India, 2011

"Note: The data for Telangana and Andhra Pradesh is the combined data for erstwhile Andhra Pradesh as separate data for both the states is not available in Census 2011."

Figure 2.1 Child Sex Ratio in Age -Group 0-6 years



Source: Census of India, 2011

2.2 Child Sex Ratio (CSR)

The 2011 Census has shown a sharp decline in the sex ratio of children in the age group of 0-6 years (Fig 2.1). At national level, CSR has declined from 927 girls per 1000 boys in 2001 to 918 in 2011. The decline is observed in both urban and rural areas. In the previous decade, the decline for urban areas was even more alarming from 935 in 1991 to 906 in 2001.

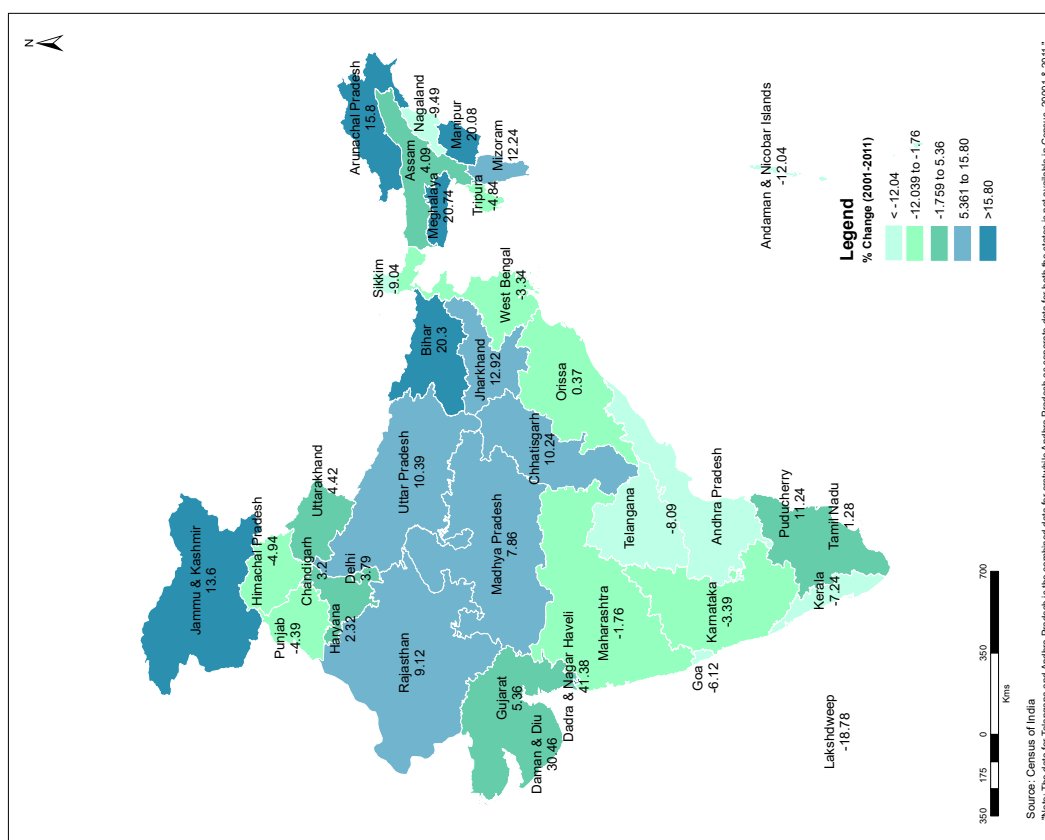
As the Map 2.5 shows the urban CSR has declined considerably between 2001 and 2011. Haryana, National Capital Territory of Delhi (NCTD), Chandigarh, Rajasthan, Uttarakhand, Gujarat and Maharashtra have recorded lower than 900 girls per 1000 boys. Majority of the large states like Bihar, Jharkhand, Odisha, Maharashtra, and Uttar Pradesh have also shown a trend of decline. Among the other states, only Punjab, Haryana, and Nagaland have registered more than 15 points increase. Some of the primary reasons associated with low child sex ratio are female infanticide and foeticide and deep-rooted gender discrimination among others.⁸ Sex ratio imbalances are expected to have serious socio-

demographic consequences, further reinforcing the subordination of girls and women. The issue therefore requires a multi-faceted response to enhance the value of girls, as well as legal measures to curb misuse of medical technology for gender biased sex selection.⁹ The Census (2011) states that low CSR negatively affects the overall sex ratio over time.

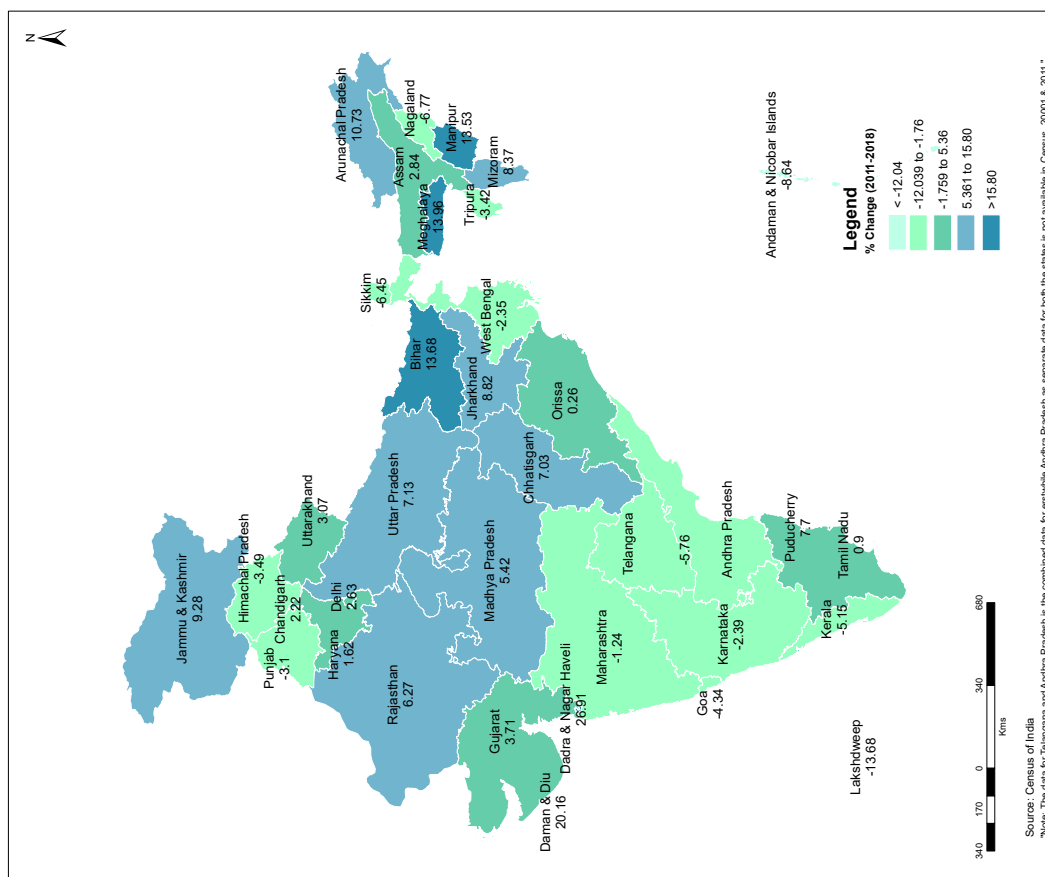
- * **Children (0-18 years) = 39 per cent of total population of India**
- * **Urban children (0-18 years) = 34 per cent of total urban population**
- * **Children (0-5 years) = 29 per cent of total population of children**
- * **Children (0-5 years) = 28.5 per cent of total population of urban children**

Map 2.3: Children population projection for India

2001 - 2011

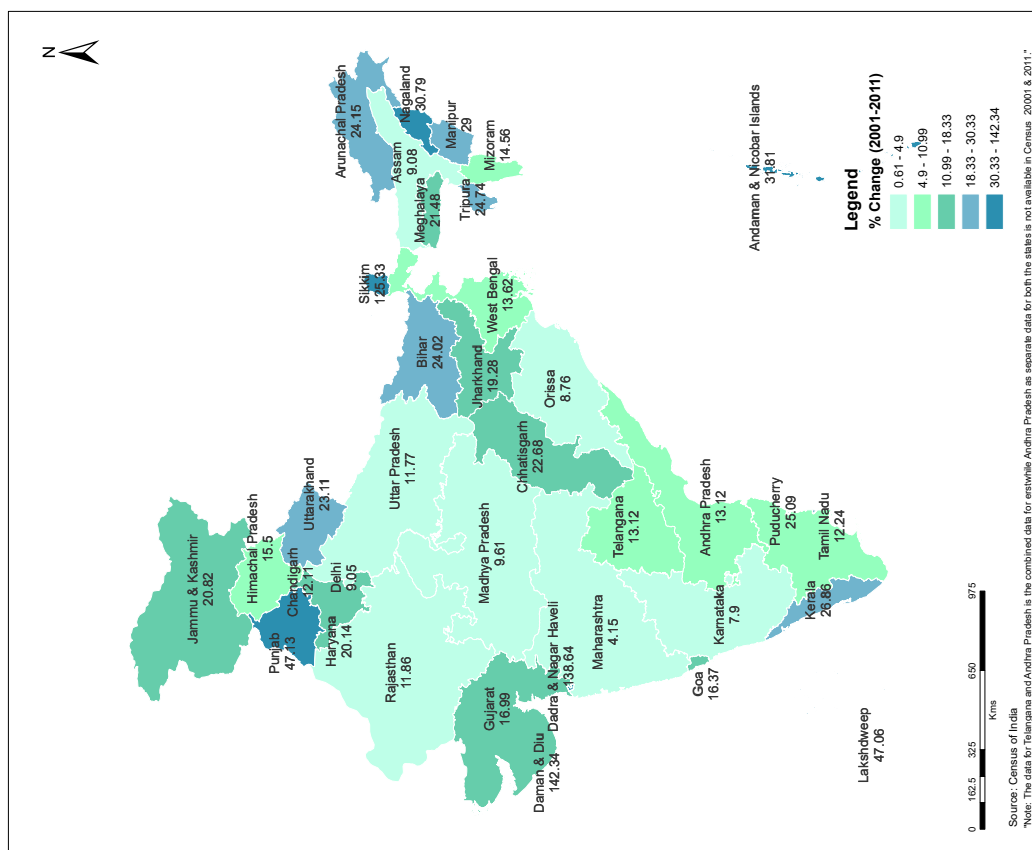


2011 - 2018

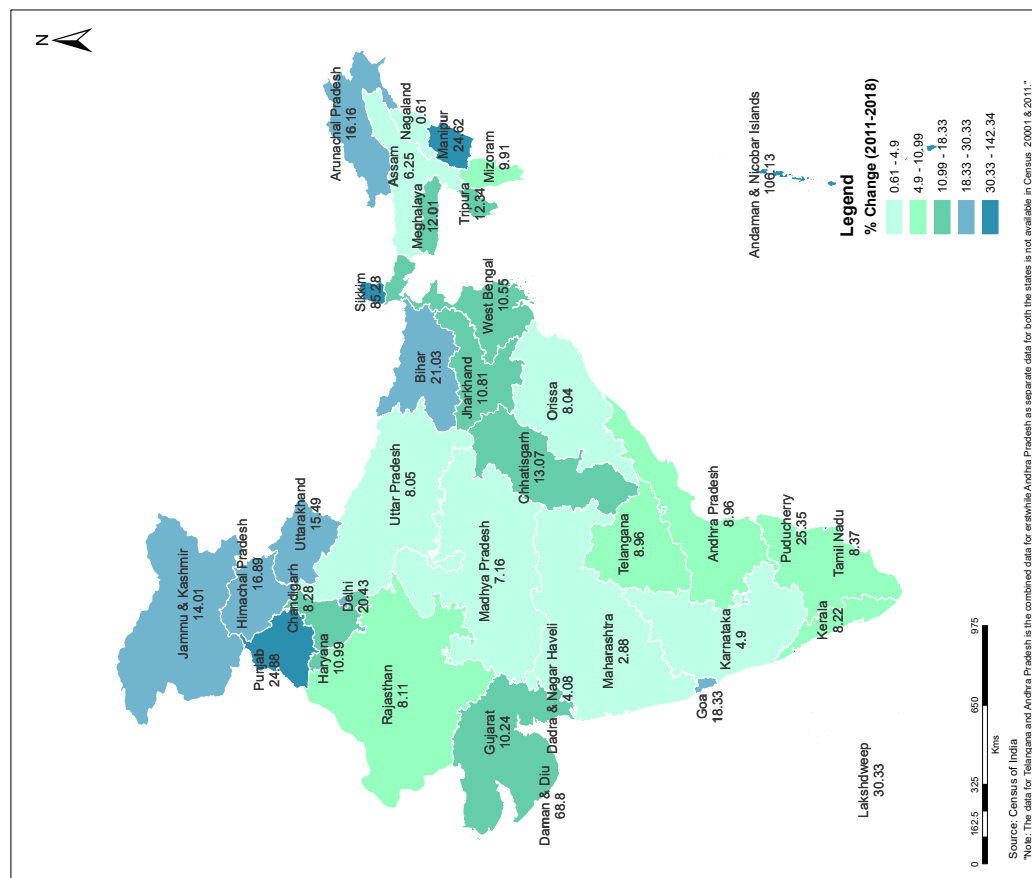


Map 2.4: Children population projection for Urban India

2001-2011

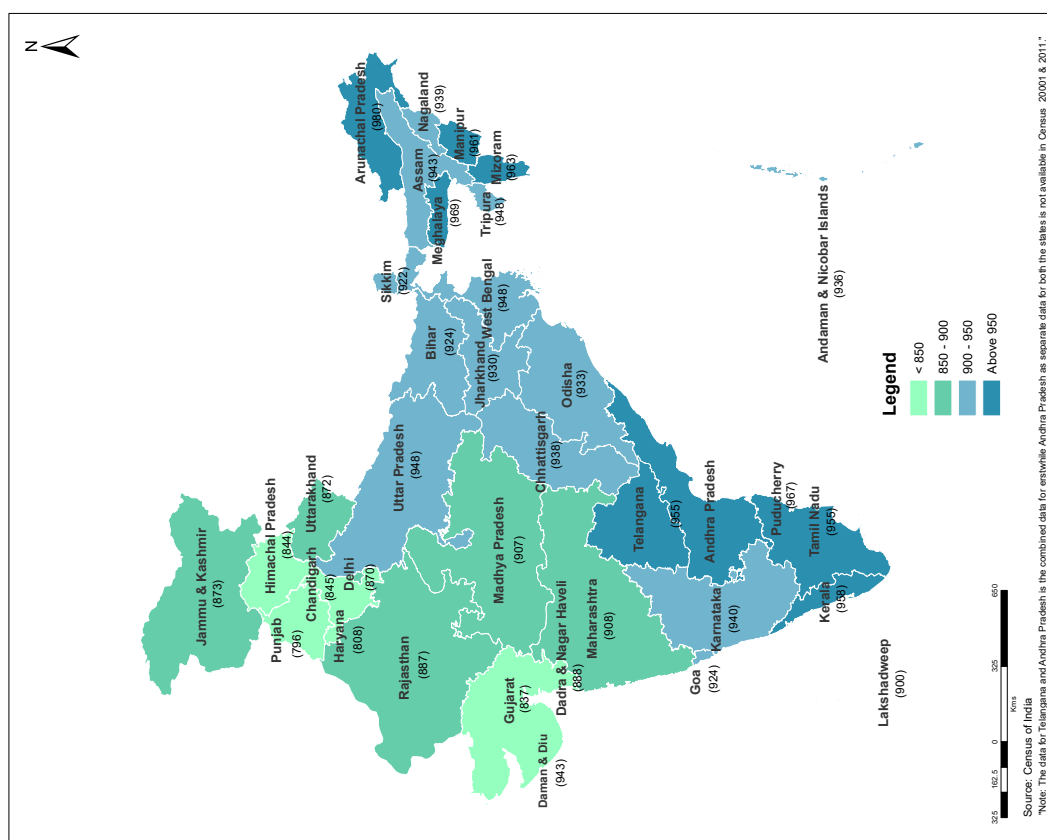


2011-2018

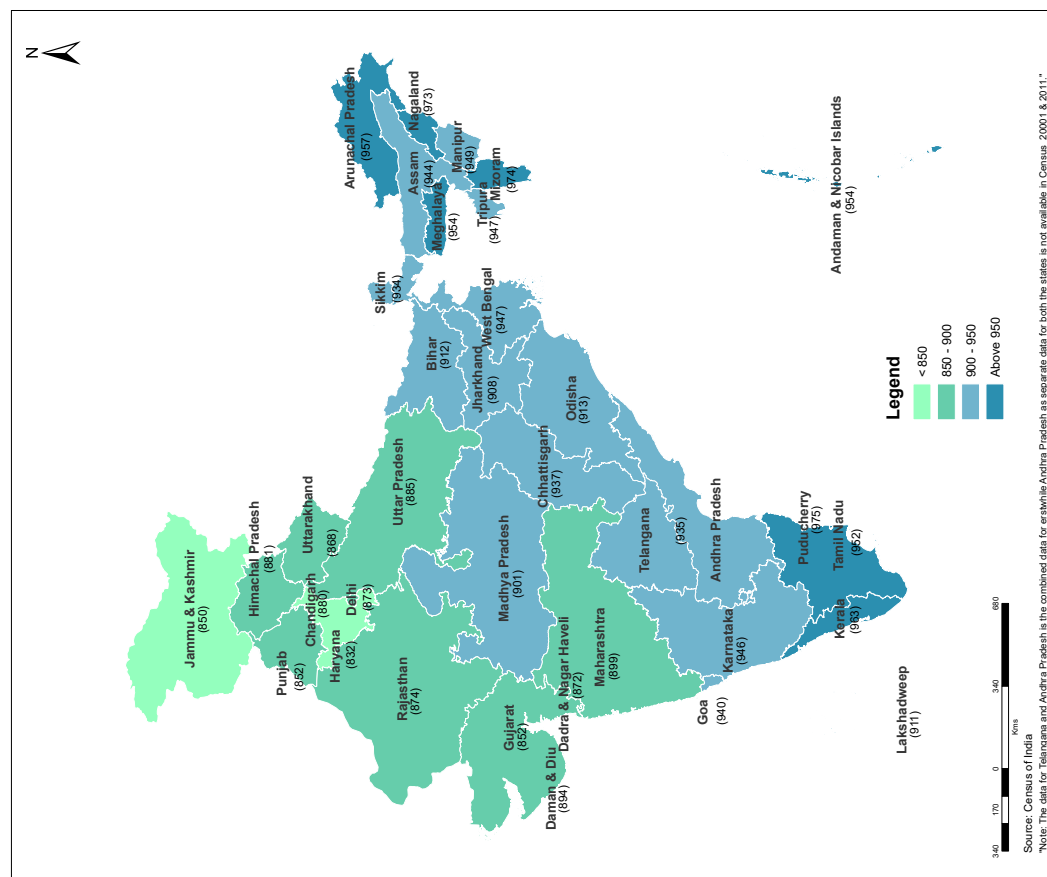


Map 2.5: Child sex ratio for India

2001



2011



2.3 Birth registration of urban children

Birth registration of a child with civil authority to have an official identity is not only important for vital statistics but also facilitates opportunities for a child to access education and healthcare besides prevention of exploitation. NFHS-4 provides information on birth registration of children and Fig 2.2 shows that only 88.8 per cent of urban children under five years of age have had their births registered. States like Bihar (64.5 per cent), Uttar Pradesh (67.9 per cent), Manipur (74.8 per cent) and Jharkhand (77.7 per cent) have lower birth registration than the national average for urban areas. All the Union Territories and states in South India have 90 per cent of births registered.

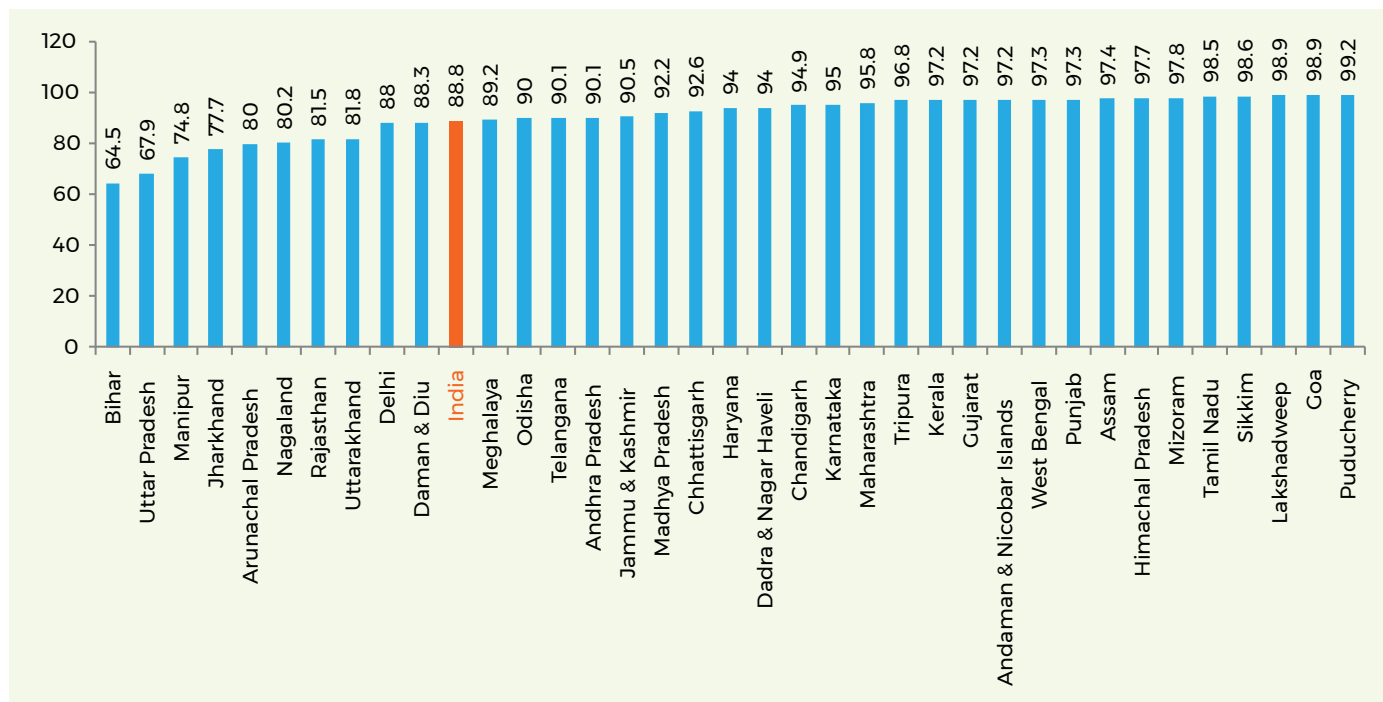
2.4 Vulnerable children

Mainstream approaches to development often view all children in urban areas as a homogeneous group and use statistical aggregates to determine resource allocation and programming actions. An equity-focused approach is needed to direct solutions precisely to those children who are hardest to reach.¹⁰ It is estimated that about 40 per cent of children in India

are vulnerable or live in difficult circumstances which includes children living in slums, homeless children, child labourers among others.

The following section gives an overview of different forms of vulnerabilities affecting children in urban India i.e., children without family support, children forced into labour or those abused/trafficked, children on the streets, children affected by substance abuse, by armed conflict/civil unrest/natural calamity etc. Survival, growth, development and protection of these children; therefore, needs priority focus and attention.¹¹ Every disadvantaged child bears witness to a moral offence: the failure to secure rights to survive, thrive and participate in society; and every excluded child represents a missed opportunity-because when the city fails to extend to the children the services and protection that would enable them to develop as productive and creative individuals, it loses the social, cultural and economic contributions they could have made.¹² Urban local governments in India need to ensure that marginalised children in urban centres receive greater attention in terms of making provisions for them in the city plan.

Fig 2.2. Birth registration of children under age 5 years in urban India, 2015-16



Source: National Family Health Survey (NFHS) 4



2.4.1 Population of children in slums

The Census of India defines a slum as a residential area where dwelling units are unfit for human habitation owing to dilapidation, overcrowding, faulty arrangements and design of such buildings, narrow or faulty arrangements of streets, lack of ventilation, light or sanitation facilities, or any combination of these factors detrimental to safety and health. Around 65.5 million people in urban India live in slums and constitute 17.4 per cent of the urban population. Children of 0-6 years of age group constitute 12.3 per cent of the total slum population. A significant number of urban children (8.1 million) and their family reside in unplanned and deprived areas.

The Census of India only enumerates the population of children in the age group of 0-6 years living in slums. The lack of data on children in other age groups up to 18 years of age living in slums is a major limitation of this study. As per Census 2011, 18.7 per cent of total urban children in the 0-6 years age group reside in slums. These children are the hardest hit by the urban living conditions. Andhra Pradesh has the highest percentage

(38.4 per cent) of children in the age bracket of 0-6 years living in slums, followed by Chhattisgarh (34.5 per cent) and Madhya Pradesh (31 per cent).

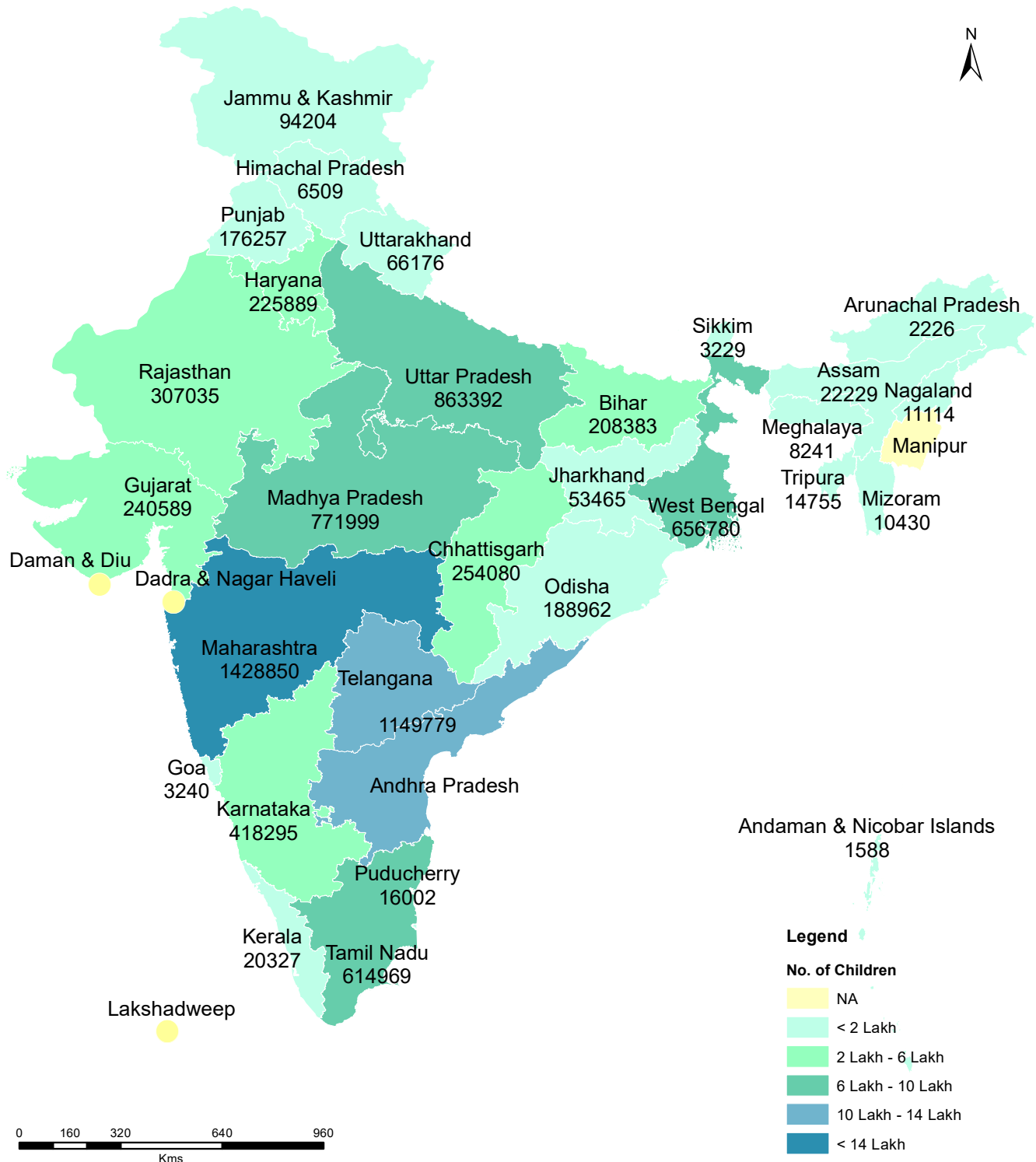
2.4.2 Children living on streets or houseless children

ChildLine India, which operates India's child helpline service (1098), under the Ministry of Women and Child Development's support, has identified three categories of children on streets:

1. Children who live on streets with their family and often engage in paid or unpaid work;
2. Children who live on streets by themselves but have family ties
3. Children who have no ties with families including runaways, orphans and refugees.

However, no government data sets, except the Census have captured the three categories of street children at either national, state or city level. Even the Census provides data in the form of enumerated houseless

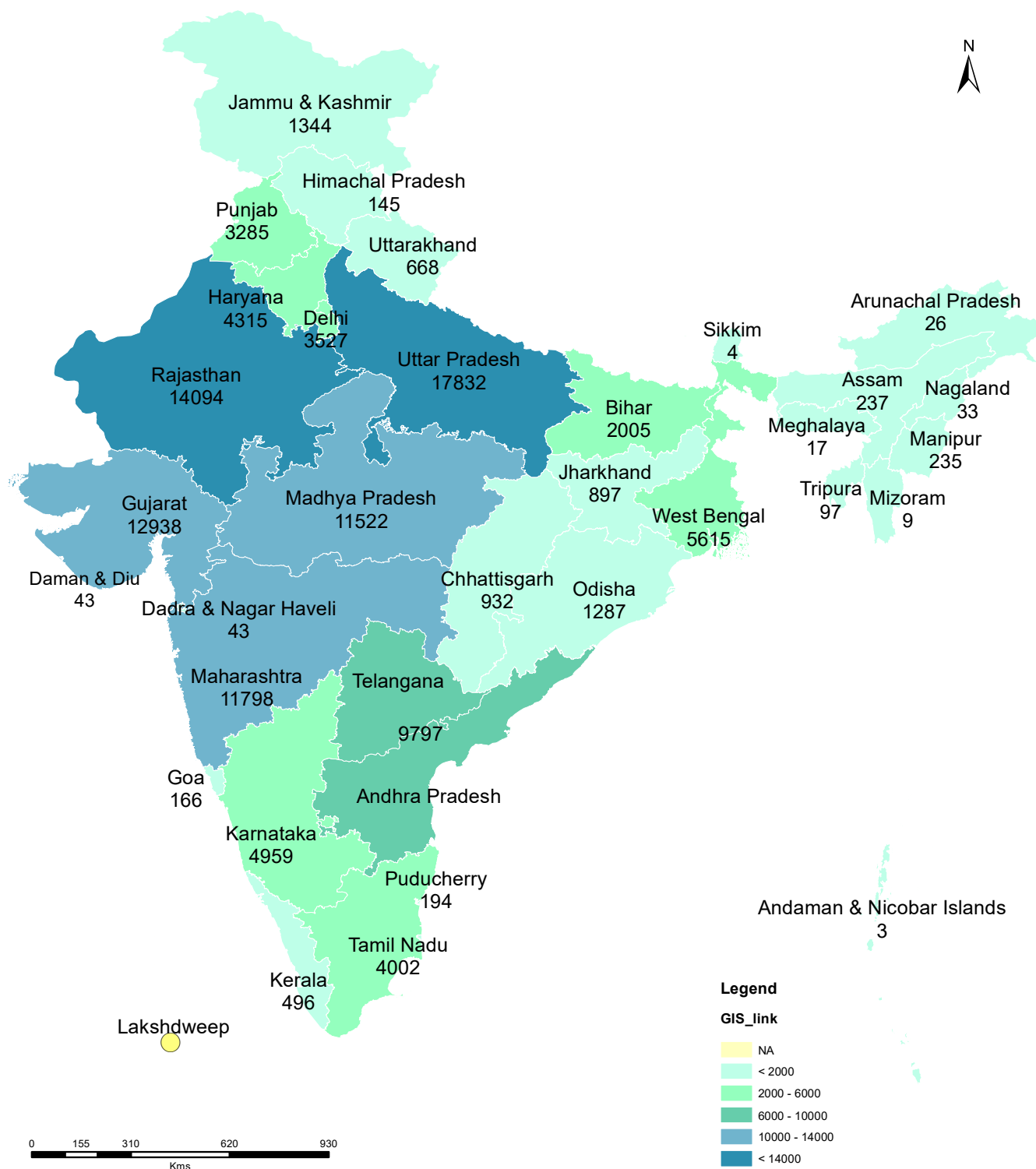
Map 2.6: Population of children living in urban slums



Source: Census of India, 2011

"Note: The data for Telangana and Andhra Pradesh is the combined data for erstwhile Andhra Pradesh as separate data for both the states is not available in Census 2011."

Map 2.7: Homeless children in urban areas (0-6 years)



Source: Census of India, 2011

"Note: The data for Telangana and Andhra Pradesh is the combined data for erstwhile Andhra Pradesh as separate data for both the states is not available in Census 2011."

children living on the side of the road, pavements, under flyovers etc.¹³ Some NGOs have data on street children in particular cities, but there exists no mechanism of regular updating of this data, or of authenticating it.

Children resort to living and working on the streets for various reasons such as violence or abuse at home or in the neighbourhood, and poverty. While abuse, conflict or neglect can happen in any family home, children whose poverty and marginalisation leave them with little choice often take to the street as the best available option for escape. Living on the street exposes them to violence and harsh living conditions. Children's gender, age, ethnicity and disability status influence the extent and type of violence they experience and the coping mechanisms they develop.¹⁴ As per the 2011 Census, India has 1.77 million homeless people out of which 0.27 million (15.3 per cent) are children in 0–6 years age group. 0.94 million (52.9 per cent) homeless people reside in urban areas out of which 0.11 million are children in 0–6 years age group (Table 2.4 & Map 2.7). These children constitute 41.7 per cent of the total homeless children population in India and 12 per cent of the total urban homeless population. However, there is no available official estimate of the total number of homeless children in the 0–18 years age group living in urban areas.

A 2016 five-city census survey and in-depth study¹⁵ by Save the Children, an international NGO, reveals that children on streets constitute 0.5 per cent of the studied cities (Hyderabad, Lucknow, Mughal Sarai, Kolkata-Howrah and Patna) total population, and more than a quarter (26.2 per cent) of these children were in the age group of 0–6 years. While a majority of the children (46 per cent) were reported to be living with their families with one of the reasons being a lack of access to affordable housing, a significant proportion of the children (87 per cent in Hyderabad and 70.2 per cent in Patna) were found to be involved in some sort of occupation.

In consonance with previous studies, children without families, the most vulnerable of the group, constituted 6 per cent of the total street children population of the five cities. In terms of human development indicators, nearly 62 per cent of the children on streets were illiterate in these cities. As regards basic nutrition, one-fourth of the surveyed children had to skip a meal in the previous week due to a lack of money to buy food.

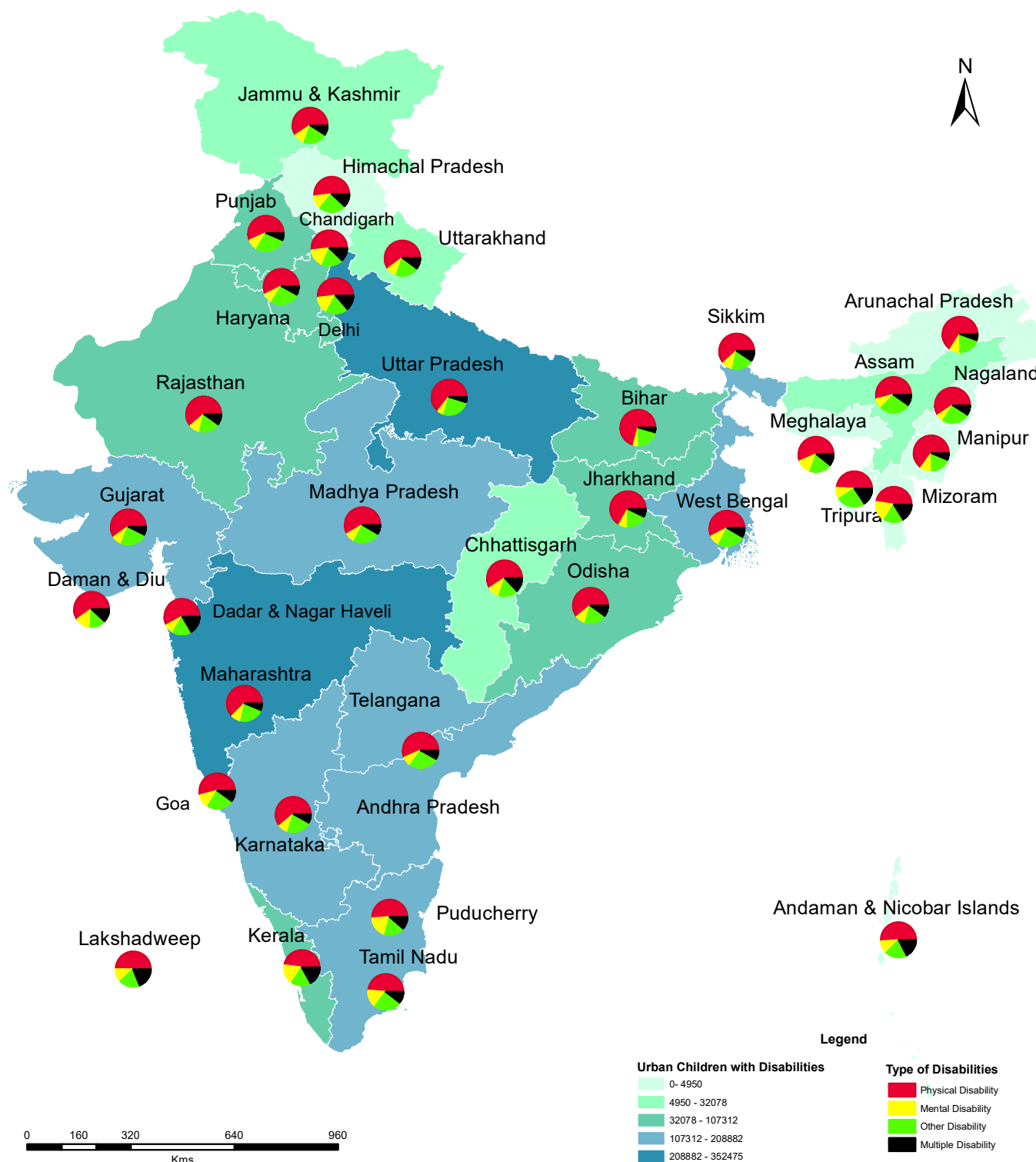
2.4.3 Migrant children

According to the data from NSS-64th Round, about 13.5 per cent of children 6–14 years and 20.47 per cent of children 15–18 years are identified as migrants.¹⁶ This data included both national and international migrant children. However, the share of international migrant children is minimal. Table 2.5, shows that the highest percentage of migrant children in the 15–18-year age group are reported in Sikkim (55.5 per cent), Chandigarh (47.9 per cent) and Himachal Pradesh (35.8 per cent) among others. The most common reasons for migration among this group are parents' migration; employment; and education.

Women and children are the most invisible and vulnerable among internal migrants. Migrant children face disruption of regular schooling, adversely affecting the country's human capital and contributing towards inter-generational transmission of poverty. A study conducted by Aide et Action in worksites of seven cities of India, points out that migrant children often live in deplorable conditions at worksites. As per the startling data revealed by the study, 90 per cent migrant children did not have access to ICDS and anganwadi services at worksites, while 65 per cent suffered from various communicable diseases. Also, 80 per cent children did not have access to education and 40 per cent worked as child labour.¹⁷

As per UNICEF's State of the World's Children Report 2012, most child migrants move with their families, accompanying parents or caregivers who seek employment or opportunity in cities. There are several factors that induce or influence the migration pattern of children. For many, migration is an attempt to secure a better life, whether in terms of economic or educational opportunities, or simply to escape poverty. Others relocate because of family circumstances, such as the loss of a parent, or to escape conflict or natural disasters and the upheaval and food shortages that accompany them. Be it forced or voluntary, with adult caregivers or alone, migration entails risks that require age-appropriate measures to protect the children involved.¹⁸ Given the high volume of migration of children to urban areas, cities need to provide basic services to migrant workers, their families and especially for migrant children.

Map 2.8: Percentage of urban children with disability (0-19 years)



2.4.4 Identity proof of children

As per SDG 16.9, all signatory states must aim to provide legal identity to all its citizens, including ensuring their birth registration. The UIDAI has introduced a Baal-Aadhaar card¹⁹ for children below five years for which the child's birth certificate and Aadhaar card of one of the parents are required. Based on data available till 30 April 2018, a total of 5,86,92,234 Aadhaar cards were assigned to children up to the age of 5 and 28,35,77,470 Aadhaar cards to children in the age group of 5-17. States in the north-east region of India, Delhi, Rajasthan and Odisha show a relatively lower assignment of Aadhaar, vis-à-vis the states' size. Rural-urban classification or socio-economic factors are not yet covered, but some reports show that migrant children living in slums still don't have the Aadhaar card.²⁰ Any family with children without documents of proof of identity and address cannot open bank accounts or get admission for children in any schools, or even get entitlement certificates like those of 'caste', 'minority' and 'poverty line' etc. With respect to children on streets, the India Exclusion Report, 2016²¹ states that there are no formal procedures to identify and thereby locate and rescue these children which excludes them from policies on basic necessities and urban welfare.

2.5 Children with disability

The discourse on disability and disability enumeration has leapt significantly ahead of the present Census data available on it. The Census 2011, with the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 as its basis, defines disability in eight broad categories: disability in seeing, in hearing, in speech, in movement, mental retardation, mental illness, multiple disability and as any other category. On this basis, India has 7.86 million children with some disability in the age group of 0-19 years, and 2.04 million children with disability in 0-6 years' age group. Of these, 2.27 million children and 0.59 million children, respectively, are located in urban areas.

Among children with disability (0-19 years) in urban areas, about 22.1 per cent have disability in hearing; 19.2 per cent have some kind of disability of sight; 8.7 per cent have disability in speech; and 10 per cent have disability in movement as shown in Table 2.6 & Map 2.8.

A similar pattern is found among children with disability in 0-6 years age group (Table 2.7 & Map 2.9): 25 per cent have disability in hearing and 21.4 per cent of the children have disability in seeing. It is important to point that nearly 30 per cent of the 0-6-year-old children have some disability other than the ones listed by the Census.

While the Rights of Persons with Disabilities (RPwD) Act, 2016 positively distinguishes between intellectual disability, mental illness, autism spectrum disorder and certain learning disabilities, the previous act did not do so. The latest data of the 2011 Census provides information only on broad categories of mental illness (a person taking medicines or treatment or has obsessive compulsive behaviour or has difficulty in social interactions and adaptability) and mental retardation (a person has lack of understanding as compared to his/her group, is unable to communicate and has difficulty in doing daily activities). Of these, the latter i.e., mental retardation is more prevalent in children of all age groups as seen in Map 2.8.

In spite of the existence of laws and regulations for the provision and promotion of safe mobility of persons with certain disabilities, Indian cities lack universal accessibility infrastructure, leading to the exclusion of children with disabilities and their families from regular urban life. Though the existing architectural guidelines like the National Building Code, Building Byelaws etc. have norms to make public places and buildings accessible to all, there is no comprehensive policy to make the city as a whole more accessible for the differently-abled. Still, accessibility is a significant component of the RPwD Act. Chapter VIII of the Act states the roles of appropriate governments in the provision of accessible transport, information and communication and technology, consumer goods, including physical infrastructure and other facilities, in both urban and rural areas.²²

The Government of India has initiated the Accessible India Campaign (Sugamya Bharat Abhiyan) for achieving universal accessibility for Persons with Disabilities (PwDs).²³ It becomes imperative for Indian cities to adopt appropriate strategies to ensure equal opportunity to all children, especially those with disability.



2.6 Conclusion

This chapter highlights the demography of different groups of urban children using available data. However, the limitations of data are that Census doesn't cover the parent's background characteristics, or the reasons behind migration and homelessness of families and children, which limits the analysis. NSSO provides in-depth information but it is based on sample survey. Further, the official definitions may not recognize certain vulnerable children as a separate target group. For example, Census defines only mental illness and mental retardation but the scope needs to be widened considerably to classify different types of disabilities and social disorders as in the RPWD Act of 2016 in order to understand specific provisions for each group. It is also imperative that data be collected under separate categories for different age groups of children as a number of learning disorders and physical disabilities can be corrected to a great extent in early childhood

through therapy and exercises

In addition to this, disaggregated data by age (0-18 years) and sex of different groups like migrants and homeless are absent. A number of problems faced by children can be pointed out by data. However, if the data is not disaggregated, issues get lost within the statistical averages that conceal the inequalities existing within the urban setting and it appears by analysis of such data that an 18-year-old and a 3-year-old have the same issues. In the absence of accurate information in most cities, development and resource allocation are done on the basis of overall city level statistical averages. Therefore, the essential prerequisite to make a city child-friendly is to create and make available disaggregated database of children in the city which is an essential step towards formulation of broad policy actions and strategies to reach excluded children and foster equity in urban settings driven by disparity.

Status of Health and Nutrition

A number of aspects shape the lives of children in urban areas including parents' socio-economic background, living conditions, relationship between parents, awareness/education level of family etc.; all of which indirectly affect the health and nutritional status of children. Factors such as access to early childcare and health care facilities and balanced nutrition are essential for the positive development of children. This chapter looks at the status of health and nutrition of children in urban settings. In addition, maternal health indicators, which have a direct impact on health of children, are also analysed.

Maternal and child health status in urban India

In 1992-93, the Ministry of Health and Family Welfare (MoHFW) introduced the Child Survival and Safe Motherhood Programme to primarily implement "enhance child survival, prevent maternal mortality

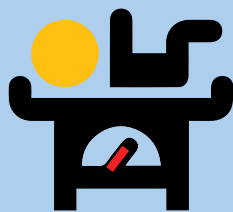
and morbidity" among other delivery services-related interventions.²⁴ According to the Human Development Report, the maternal mortality ratio in India decreased from 200 deaths per 1,00,000 live births in 2010 to 174 per 1,00,000 live births during 2015; the MMR was 600 deaths per 1,00,000 live births in 1990.²⁵ The latest Sample Registration System (SRS) data, for 2011-13, reveals that the overall MMR stands at 167 per 1,00,000 live births with the highest mortality figure reported from Assam (300) followed by Uttar Pradesh and Uttarakhand (285) and Rajasthan. Less than 100 maternal deaths per 1,00,000 live births have been reported from the states of Kerala, Maharashtra, Tamil Nadu and Andhra Pradesh.

3.1 Maternal health status in urban India

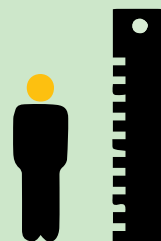
This sub-section constitutes information on maternal care and health during the prenatal, delivery, and postnatal



50 out of 1000 live births do not complete their first year of life



Half of the children (48%) under the age of five are chronically malnourished.



More than one third of the world's children who are wasted live in India

periods of pregnancy. Complete antenatal care (ANC) includes at least four antenatal check-ups, at least one tetanus toxoid (TT) injection, and consumption of iron folic tablets or syrup for 100 or more days for the most recent birth. Under the provisions of the Integrated Child Development Services (ICDS) programme, pregnant women and nursing mothers can avail food supplements, medical check-ups, and health and nutrition education services at the local Anganwadi Centres (AWC) in both urban and rural areas, apart from young children's development services. The Table 3.1 shows that greater than 60 per cent of the mothers from the states/UTs of Andaman & Nicobar Islands, Lakshadweep and Goa have reported availing of complete antenatal care whereas Arunachal Pradesh (3.9 per cent), Nagaland (4.9 per cent), Bihar (6.6 per cent) and Tripura (9.8 per cent) have the lowest reported proportions. Among the mothers who did not receive any antenatal care in urban areas, the family's disallowance and lack of awareness, including the woman's herself, stood out as major reasons (in 62.8 per cent of the surveyed cases) for the situation, as per the NFHS-4.

As regards delivery services, the percentage of institutional births, which have an impact on reducing maternal morbidity and mortality, is higher in urban areas in comparison to rural areas,²⁶ but institutional births in public facilities are still low in urban India. They range from 91.6 per cent in Andaman & Nicobar Islands, 81.4 per cent in Jammu & Kashmir to 27.1 per cent in Telangana and 28.2 per cent in Gujarat. Thus,

the overall institutional delivery rate at 88.7 per cent reflects the urban population's relative dependence on private healthcare. Regarding mothers who received postnatal care from skilled health personnel within 2 days of delivery, Lakshadweep and Goa (93 per cent), Chandigarh (89.2 per cent) and Puducherry (88.3 per cent) are good performing states whereas Nagaland (36.3 per cent) and Arunachal Pradesh (37.8 per cent) fall at the other end of the spectrum. Data on numbers of persons trained to be a mid-wife or a 'dai' is scant. It is important to understand that assisted home births are as successful as hospital births, provided all ante-natal and post-natal medical issues are taken care of and all such births are registered through due process. Proper hygienic conditions under skilled birth attendant are essential during delivery of child at home. According to NFHS-4, 4.3 per cent of home deliveries are conducted by skilled health personnel in India but only 3 per cent in urban areas. In addition, 6 per cent of live births in urban areas and 13 per cent in rural areas are assisted by traditional birth attendants (TBA) or dais. Based on other studies, home births were frequent among urban poor which emphasises the need for trained dais and it was also observed that training of traditional birth attendants had significant positive impact on deliveries conducted at home.²⁷

It is interesting to observe that the proportion of births delivered by caesarean (C) section has doubled since the NFHS-3 and the rate of C-section is higher in urban than in rural areas as shown in Table 3.1. When

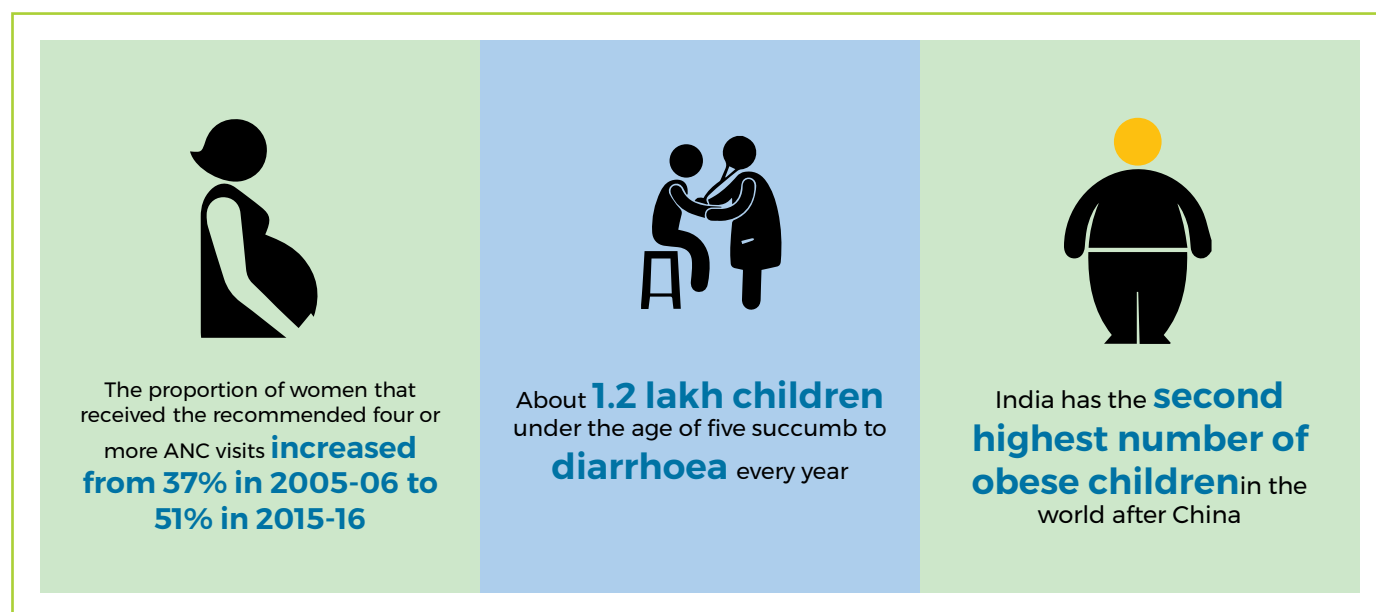
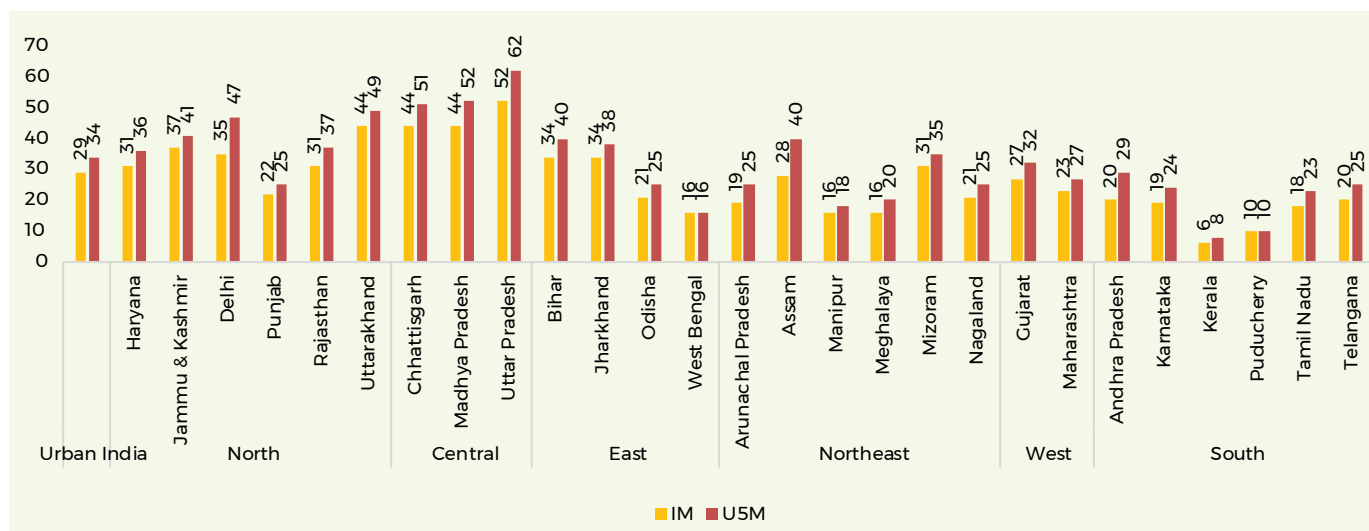


Fig 3.1. Early childhood mortality in urban India, 2015-16



Source: National Family Health Survey (NFHS) 4

not medically needed, a C-section can be a risk to the mother. Data shows mothers from different states who have delivered through C-section, with highest numbers from Telangana (63.2 per cent), Jammu and Kashmir (53.1 per cent) and Andhra Pradesh (48.4 per cent). According to one report²⁸, Telangana's C-section deliveries rate stood at 74.9 per cent against the 10-15 per cent benchmark recognized by the WHO. Some of the identified reasons behind this trend include choice of an auspicious time, the fear of labour pain etc., on the side of the family; and surgical targets, higher fee for hospitals, more number of days for recuperation in hospital etc., on the side of the service providers/doctors/hospitals. Such a trend is found more in private hospitals than in public health care facilities.

Ensuring children's right to life requires early preventive action and recognition of the fact that most child deaths are in fact preventable. A continuum of care is needed, across the life cycle linking the family, community, *anganwadis*, health centres and facilities converging health and child care services.²⁹

3.2 Infant Mortality Rate (IMR)

Infant Mortality Rate is defined as infant (a child less than one year of age) deaths per thousand live births. The probability of mortality is very high in the first few hours, days and weeks of a child being born. The reasons for infant deaths at the earlier and later stages of infancy

differ to a certain extent. Hence, infant deaths are carefully grouped in three categories according to the age of death:

- Early neonatal death: death occurring before completing 7 days of life
- Neonatal death: death occurring before completing four weeks of life.
- Post-neonatal death: death occurring between 28 and 365 days.

These three factors taken together constitute the Infant Mortality Rate. Early neonatal mortality rate (number of infant deaths less than 7 days of life per 1000 live births) forms an important component of the infant mortality rate. The identified causes of neo-natal deaths are perinatal asphyxia, pre-maturity and ARI whereas diarrheal disease and respiratory infections are the major causes of post-neonatal deaths.³⁰ A number of post neonatal deaths are also attributed to faulty feeding practices, poor hygiene, communicable diseases related to the digestive system such as diarrhoea and enteritis and diseases related to the respiratory system such as bronchitis and pneumonia.³¹ According to the NFHS-4, IMR at the national level is 41 and varies from 46 in rural areas to 29 in urban areas.³² As shown in the Fig 3.1, Uttar Pradesh (52), Madhya Pradesh (44), Chhattisgarh (44), Uttarakhand (44) have the highest IMR whereas Kerala (6) has the lowest IMR. Based on regions, the northern and central regions have reported higher IMR. IMR for female

infants is higher than male infants across all states.

According to SRS 2016 report,³³ IMR at the national level declined to 34 in 2016 from 37 in 2015. The maximum IMR has been observed in Madhya Pradesh (47 per thousand live births) and minimum in Kerala (10 per thousand live births). For urban areas, maximum IMR is recorded in Uttar Pradesh (34) and Odisha (34) whereas minimum in Kerala (10). At the national level, neo-natal mortality is 24 and ranges from 27 in rural areas to 14 in urban areas. Among the urban areas, neo-natal mortality ranges from 24 in Uttarakhand to 4 in Kerala. Despite of several initiatives by government, one in every 29 children at national level, one in every 26 in rural areas and one in every 43 in urban areas still die within one year of their birth.

3.2.1 Under five Mortality Rate (U5MR)

The Under-five Mortality Rate (U5MR) is the probability (expressed as a rate per 1000 live births) of a child born in a specified year dying before reaching the age of five. NFHS-4 shows U5MR at the national level is 50 and ranges from 34 in urban areas to 56 in rural areas. The states of Uttar Pradesh, Madhya Pradesh, Chhattisgarh report the highest mortality rates greater than 50 per thousand live births. Fig 3.2 indicates boys are more likely to die than girls and the gap is more pronounced

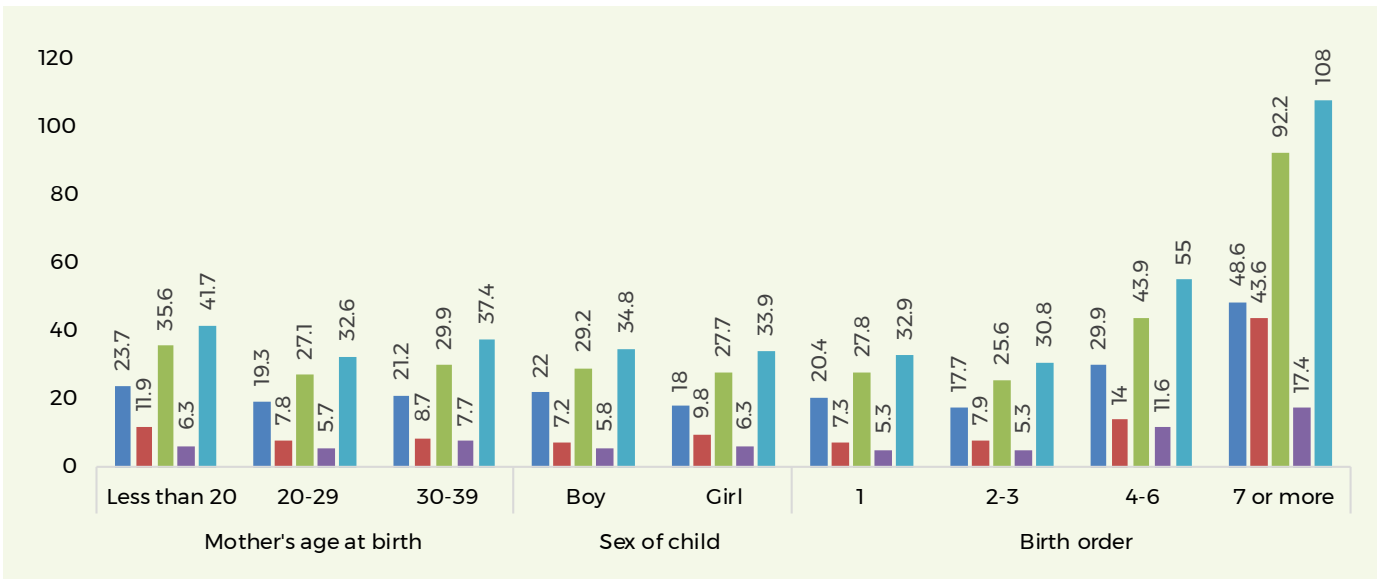
in the neonatal period. Also, the higher the birth order of a child and lower the age of the mother at the time of birth, the more is the likelihood of under-five mortality. The reported causes of U5 mortality are pneumonia, diarrhoeal diseases and non-communicable diseases including ischemic heart disease.³⁴

The SRS report (2016) estimates the under-five mortality rate at national level to be 39 and it varies from 43 in rural areas to 25 in urban areas.³⁵ Among the bigger states, the urban under-5 mortality rate varies from 10 in Kerala to 38 in Odisha. All the bigger states have higher U5MR for females (27) than that for males (24) but variation is noticeable in states like Bihar where U5MR for females is 41 whereas for males is 29.

3.2.2 Death rate for children in age group of 5-14 years

As the NFHS does not cover the death rates of young adults, the SRS 2016 Reports have been used for this section. At the national level, the death rate for children in the age group of 5-14 years is estimated to be 0.6 while the death rate for urban areas is 0.3. Among the bigger states/UT's, the lowest two death rates are registered in Karnataka (0.0) and Andhra Pradesh (0.1) and the highest are registered for Chhattisgarh (1.2). As can be seen in the Fig 3.3, the gender gap is noticeable

Fig. 3.2 Mortality rates according to demographic characteristics in Urban India, 2015-16



Source: National Family Health Survey (NFHS) 4

Map 3.1: Nutritional Status of Children and Micronutrient Deficiencies among children under 5 years

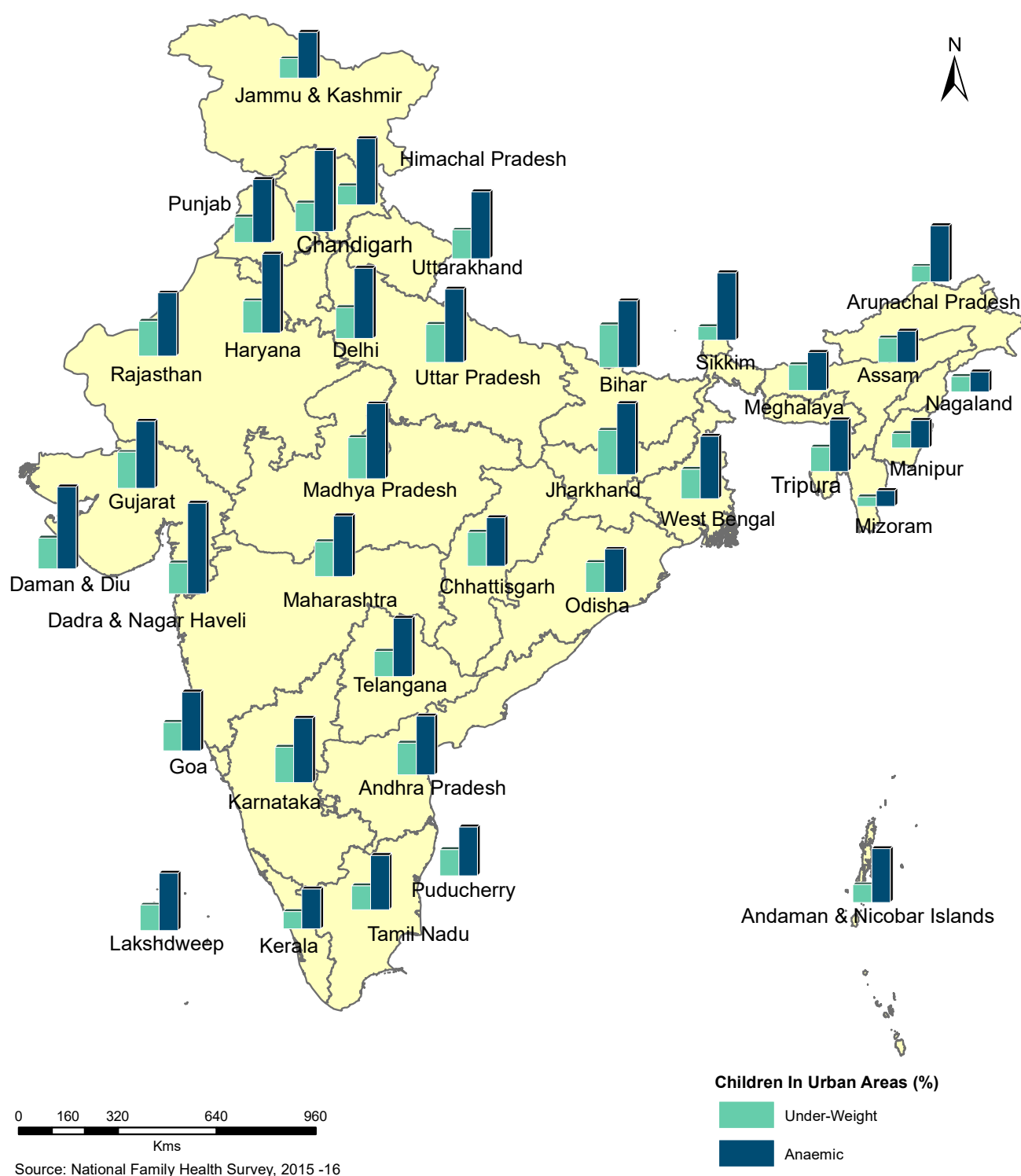
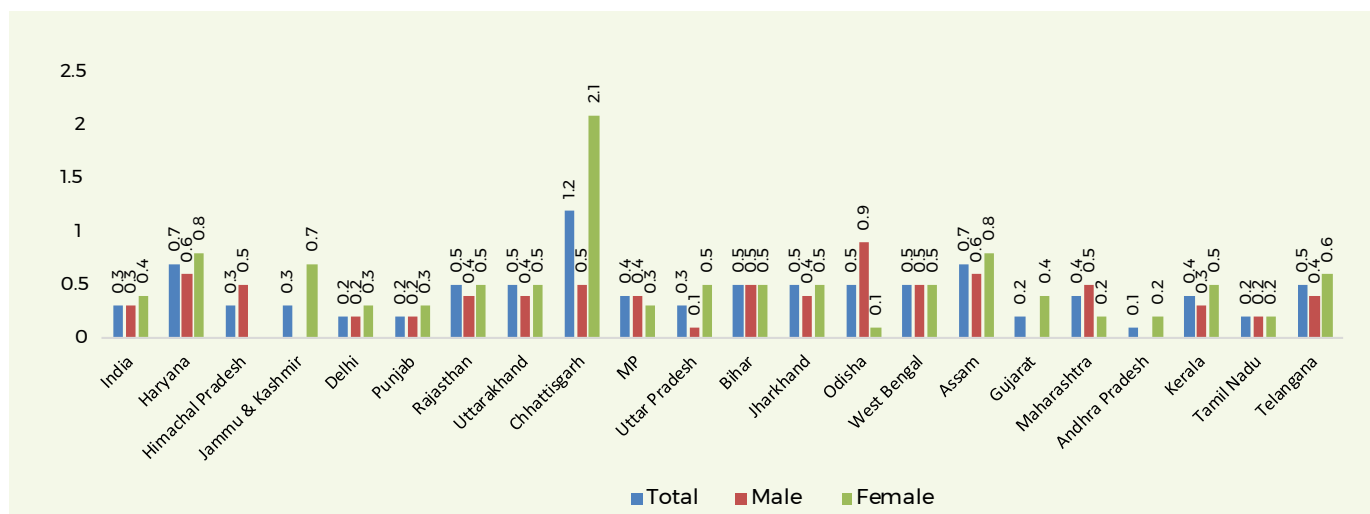


Fig 3.3. Death rate for children 5-14 years in Urban India, 2016



Source: Sample Registration System, 2016

for the states of Chhattisgarh, Odisha and Jammu & Kashmir.

3.3 Immunisation of children between 12-23 months of life

Immunization of children is essential to avert neonatal, infant and child mortality from preventable diseases. Complete immunization includes six vaccines - BCG, three doses of OPV and DPT and one dose of measles. According to the NFHS-4, the difference between rural and urban immunisation is quite minimal - 63.9 per cent of urban children received all vaccinations compared to 61.3 per cent of rural children. However, overall figures still show low levels of immunisation. The complete coverage of immunisation among children of 12-23 months of age is higher in states like Punjab (88.7 per cent), Chhattisgarh (84.9 per cent) and Kerala (82.2 per cent). The North-East states recorded the lowest percentages- Nagaland (41.6 per cent), Arunachal Pradesh (44.2 per cent) and Mizoram (49.8 per cent) as is seen in Table 3.2. Irrespective of place of residence, the status of complete immunization is significantly impacted by mother's education, economic status of family, and the birth order of children.³⁶

The Government of India conducted a coverage evaluation survey in 2009 with UNICEF, which revealed the immunisation coverage rates for each type of vaccination, on the basis of either the Immunisation

Card or recall by mother. The analysis of vaccine specific data indicated a higher coverage of each type of vaccine in urban areas than in rural areas. At the national level, 61 per cent of the children aged 12 to 23 months had received full immunisation. The coverage of immunisation was higher in urban areas (67.4 per cent) compared to that in the rural areas (58.5 per cent). The most important concern that was brought to the fore was that nearly 8 per cent children did not receive even a single vaccine. Another concern highlighted by the survey was the correlation between the birth order of the child and immunization. While 67.4 per cent of first birth order children had received full immunization, only 40.4 per cent in the category of birth order 4 and above had received full immunisation.

The full immunisation coverage of children aged 12 to 23 months was reported highest in Goa (87.9 per cent), followed by Punjab (83.6 per cent) and Kerala (81.5 per cent). The full immunisation coverage is lowest in Arunachal Pradesh (24.8 per cent) and Nagaland (27.8 per cent). The economic condition of the family has a direct and huge impact on the status of immunisation of children and so does the mother's education or awareness. About 75.5 per cent of children belonging to the highest wealth index group are fully immunized while only 47.3 per cent from the lowest quartile are fully immunised.

3.4. Curative treatment for



KANAK TIWARI

urban children

Onset of diseases and delay in seeking treatment for curative diseases also creates a risk factor for mortality. Diarrhoeal disease, is the second leading cause of deaths and leading cause of malnutrition in children under the age of five³⁷ despite Oral Rehydration Salt (ORS) being widely available as a cost-effective treatment against diarrhoea. Table 3.2 shows, the per cent of children for whom medical advice is taken from health care facility is highest in West Bengal (82.6 per cent), Punjab (86.2 per cent), Delhi (81.4 per cent). Use of ORS for diarrhoea treatment ranges from 77.6 per cent in Meghalaya to 76.6 per cent in Arunachal Pradesh and 76.3 per cent in Mizoram.

Similarly, the percentage of children who are taken to a health care facility for curative measures against fever or ARI is considerably higher in Delhi, Punjab, Rajasthan, West Bengal, Kerala, Punjab, and Meghalaya than in other states. Urban areas are better in terms of availability of health care facilities but delay in treatment of childhood diseases is still one of the primary reasons behind risk of death to children.³⁸

3.5 Nutritional Status of Children and Micronutrient Deficiencies

Adequate amount of food is essential for development of a child and thus proper feeding of children for the first two years of their lives is essential. Table 3.3 highlights the feeding practice for infants and nutritional status of

children under five years of age.

According to WHO guidelines,³⁹ it is recommended that initiation of breastfeeding within the first hour of life; exclusive breastfeeding i.e. only breast milk not even water and, breastfeeding on demand are essential interventions for safe survival of infants. Breastmilk provides all nutrients and promotes sensory and cognitive development of infants and protect against chronic and infectious diseases. In the first six months of life, every child must be exclusively breastfed.

Exclusive breastfeeding is surprisingly low in India. The states of Meghalaya (34.7 per cent), Uttar Pradesh (35.6 per cent), Nagaland (41.1 per cent) and Haryana (46.6 per cent) have very low nursing statistics; whereas Manipur (78.9 per cent), Chhattisgarh (73.7 per cent), Telangana (68 per cent) and Jammu and Kashmir (67.9 per cent) are the states with higher rates of exclusive breastfeeding practice. One of the reasons for such low rates is insufficient milk supply for which human milk bank is an alternative.

Both UNICEF and WHO stated that “human milk from other sources should be the first alternative when it is not possible for the mother to breastfeed”.⁴⁰ In India, MoHFW launched the first government run National Human Milk Bank at Lady Hardinge Medical College named Vatsalya.⁴¹ Currently, the central government is in the process of initiating milk banks in India, but state level information is not available. However, a number of non-governmental organizations have initiated facilities for donating, banking and receiving human milk in a few cities such as Surat, Mumbai and Delhi. Nutritional status of children is represented by the three most frequently used anthropometric indicators exhibited by children-stunting, being underweight, and wasting. They are defined as low height as per age; low weight as per age; and low weight as per height respectively. High levels of undernutrition in children and women constitute a major threat to their survival and development. Globally, one-third of child deaths are attributable to underlying maternal and child undernutrition, suggesting that the relationship between nutrition and infection is bi-directional. Through precipitating disease and speeding its progression, malnutrition contributes towards infant, child and maternal morbidity and mortality.

Some common childhood illnesses like diarrhoea, pneumonia, as well as measles are leading causes of death in children under five years. Frequent episodes of diarrhoea are often responsible for malnutrition among children, leading to stunted growth. Similarly, malaria contributes to increased anaemia among children.

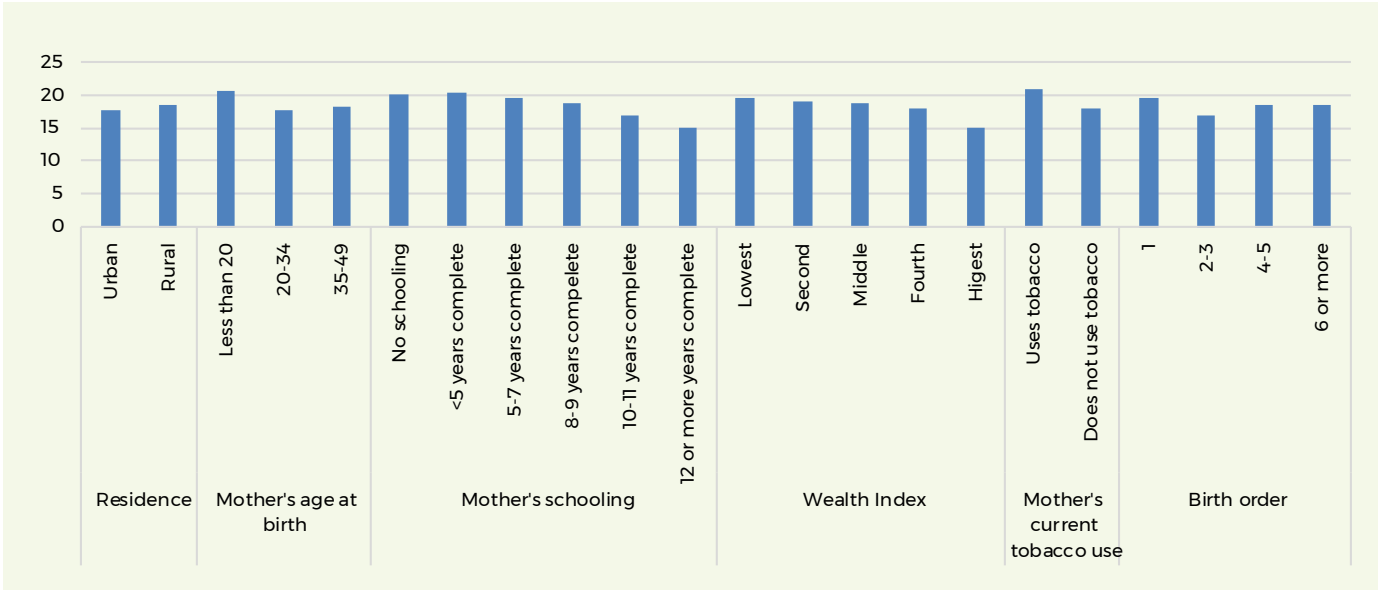
The percentage of children below five years classified as malnourished according to these anthropometric indices of nutritional status is indicative of the significant malnourishment among Indian children. Almost half of the children under the age of five (48 per cent) are chronically malnourished. In other words, they are too short for their age or stunted. Acute malnutrition, as evidenced by wasting, results in a child being too thin for his or her height. One out of every five children in India under the age of five is wasted. About 43 per cent of children under age five years are underweight for their age. In developing countries, under-five mortality is largely a result of infectious diseases and neonatal deaths, most of which are exacerbated by undernutrition. Undernutrition is an important factor that contributes to the death of children in India. For malnourished children, the mortality risk associated with respiratory infections, diarrhoea, malaria, measles, and other infectious diseases is higher. More than half (54 per cent) of all deaths before age five years in India are related to malnutrition. Because of its extensive

prevalence in India, mild to moderate malnutrition contributes to more deaths (43 per cent) than severe malnutrition (11 per cent).⁴²

Stunting, wasting, and being underweight are determined through physical examination. Children whose height-for-age or weight-for-height or weight-for-age is below minus two standard deviations (-2 SD) from the median of the reference population are considered stunted, wasted and underweight respectively, and are chronically malnourished. Children below minus three standard deviations (-3 SD) from the median of the reference population are considered to be severely suffering from the condition being determined.

Stunting reflects failure to receive adequate nutrition over a long period of time. Height-for-age, therefore, represents the long-term effects of malnutrition in a population and does not vary according to recent dietary intake. Wasting (low weight-for-height) on the other hand, describes the current nutritional status and failure to receive adequate nutrition or an episode of illness in the period immediately preceding the survey and may be enumerated as such. Being underweight (low weight-for-age): is a composite index of height-for-age and weight-for-height. It takes into account both acute and chronic malnutrition.

Fig. 3.4. Percentage distribution of births with a reported birth weight less than 2.5 kg, India 2015-16



Source: National Family Health Survey (NFHS) 4

Regarding nutritional status of children up to 5 years of age (Table 3.3), the states of Bihar (39.8 per cent), Uttar Pradesh (37.9 per cent), Madhya Pradesh (37.5 per cent) and Meghalaya (36.5 per cent) reported highest proportions of stunted children in urban areas. Wasting is most common in Goa (27.7 per cent), Jharkhand (26.8 per cent), Puducherry (26.1 per cent) and Maharashtra (24.9 per cent). The proportion of children who are underweight ranges from 39.3 per cent in Jharkhand, to 37.5 per cent in Bihar, 36.5 per cent in Madhya Pradesh and 33.7 per cent in Uttar Pradesh. In comparison, the prevalence of underweight children, stunting, wasting and Severe Acute Malnutrition (SAM) is much lower in children in urban areas than those in rural areas. Children in rural areas are almost 40 per cent more likely to be underweight than children in urban areas. The prevalence of stunting is 28 per cent higher in rural areas than in urban areas.⁴⁰ However, undernutrition is widespread in urban areas. About 40 per cent of children in 0-6 age group in urban areas are stunted, one-third are underweight, and 17 per cent are wasted. Among the three measures of nutritional status, the differential in prevalence between urban and rural areas is most prominent in terms of the prevalence of underweight children.

Micronutrient deficiencies need to be prevented across

the life cycle of children and for women, especially during pregnancy as adverse consequences occur due to iron and iodine deficiencies, which include still-births, abortions, congenital malformations, pre-term and low birth weight babies etc. Currently, 58.5 per cent children in India and 56 per cent of urban children are anaemic. The prevalence of anaemia among children in urban areas is high in Dadra & Nagar Haveli (80.1 per cent), Daman & Diu (72.5 per cent), Chandigarh (71.6 per cent), Haryana (69.6 per cent) and Madhya Pradesh (66.3 per cent) (Map 3.1).

3.6 Maternal and child health status in slums

Table 3.4 indicates that all maternal and child health indicators are better in non-slum areas than in slum areas. Regarding safe survival interventions for mothers, the percentage of those who received complete antenatal care is lower in slums of cities like Hyderabad (28.6 per cent), Nagpur (17.4 per cent) and Delhi (13.9 per cent) in comparison to other areas in the same cities - Hyderabad (41.4 per cent), Nagpur (39.8 per cent) and Delhi (34.7 per cent). The level of postnatal care is similar for slums and non-slum areas of all cities except Delhi. In relation to child health, IMR varies from 27-71 per 1,000 live births in slums in different cities across



India. However, for cities like Kolkata, Mumbai and Hyderabad, IMR is noticeably higher in non-slum areas than in slums. The proportion of slum children who have received complete immunization is observed to be above 80 per cent only in Chennai. Regarding curative treatment against ARI, fever and diarrhoea, majority of the children in slums were taken to a health facility or health provider for treatment.

3.6.1 Nutritional status and Micronutrient Deficiencies among children in slums

NFHS-3 shows that there is a strong inverse relationship between under-nutrition in children and the level of wealth of the households that they live in. Six out of 10 children living in the poorest households (households in the lowest wealth quantile) are stunted and almost as many are underweight. However, even in the wealthiest households (households in the highest wealth quantile), one-quarter of children are stunted, and one-fifth are underweight.

It is indeed alarming that the percentage of children in the age group of 0-59 months that are underweight and stunted is highest among the urban poor and is in fact higher than the overall rural figures. The problem of under-nutrition 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 informal settlements and the NFHS-3 is the only source that highlights the nutritional and micro-nutritional differences of children living in slums and non-slum areas (in 8 cities of India: Chennai, Delhi, Hyderabad, Kolkata, Meerut, Mumbai and Nagpur).

In urban areas, the scenario of under-nutrition is quite grave and more so for children coming from poor households. As seen in Table 3.5, the percentage of stunted children is highest in slums of Delhi (50.9 per cent), followed by Nagpur (47.5 per cent) and Mumbai (47.4 per cent). The percentage of wasted is highest among slum children in Indore (34 per cent), Chennai (22.8 per cent), and Nagpur (18.1 per cent). In Indore, 49.6 per cent of slum children are underweight, followed by Nagpur (41.7 per cent) and Mumbai (36.1 per cent). Findings regarding prevalence of anaemia in children in the cities also indicate that the percentage of anaemic children in the 6-59 months age group is also higher



in the poorest urban quartile (households belonging to the lowest wealth quartile on the sample) and slum areas as compared to non-slum areas. In Chennai, the anaemia prevalence rate in the poorest quartile is noted to be as high as 83 per cent. The prevalence of anaemia, i.e. haemoglobin levels less than 11 g per decilitre, among slum children between 6-59 months old slum children is reported to be over 70 per cent in cities like Delhi, Nagpur and Chennai. An analysis of undernutrition data of the eight cities also shows that the poorest quantile has the worst underweight and stunting status as compared to the rest of the urban population.⁴³

3.7 Impact of water and sanitation on health of children⁴³

Improved sources of safe drinking water and toilets protect against outside contamination and save human lives from diseases like cholera, typhoid, diarrhoea and infection due to intestinal parasitic worms among others.⁴⁴ In addition, severe diarrhoea is also responsible for malnutrition among infants and children⁴⁵. The NFHS-4 report⁴⁶ reveals that majority of urban households (91 per cent) have access to an improved source of drinking water. However, individual toilets are rare and shared toilet facilities are common in urban areas (15 per cent). In association with childhood morbidity, the prevalence of diarrhoea is higher in those households which have either shared toilets or non-improved toilets and unsafe sources of drinking water.

Unsafe disposal of children's stools can spread disease,

especially diarrhoeal disease, because of direct contact with the stools or through animal transmission. As per NFHS-4, safe disposal of children's stools is more likely in urban households (61 per cent) than in rural households (26 per cent). The low level of mother's education, figuring in the lowest two quartiles of the wealth index and non-access to improved toilet facilities are the identified factors for unsafe disposal of children's stools.

A household's source of drinking water is often linked to its socio-economic status. Poor households are more likely to obtain their drinking water from untreated or contaminated water sources such as surface water, rivers, uncovered wells, tube wells, etc. The risks of food contamination, diarrhoeal disease and malnutrition are higher when a household does not have access to an improved water source. Infants and young children from households that do not have access to an improved water source are at a greater risk of being malnourished than those from households with an improved water source. The NFHS-3 reveals that these children, who drink water from a non-improved water source are much more likely to be underweight and wasted than children with access to an improved water source. However, the level of stunting does not vary by water source. This may be related to the fact that stunting is an indicator of the long term effects of malnutrition and it does not vary according to recent dietary intake or diarrhoeal disease. Combine different water sources into improved and unimproved sources masks the distinctions between individual water sources. For all three measures of the nutritional status of children, nutritional deficiencies are most prevalent in households that obtain their drinking water from wells, tube wells, and surface water, much less prevalent in households that use piped water and least prevalent in households that use bottled water or water from a tanker.

3.8 Low birth weight

Birth weight is an important indicator for measuring the health condition of a child at birth. Weak, undernourished and anaemic women give birth to children with low birth weight, hence illustrating the relationship between maternal health and child health. The NFHS-4 indicates that 18.2 per cent of the babies born in India have low birth weight i.e. less than 2.5 Kg (Fig 3.4). Rural-urban differential is minimal; low birth

weight was reported for 17.6 per cent of urban children in comparison to 18.5 per cent of rural children. Based on mother's background characteristics, her low age at birth, low level of education, figuring at the bottom of the wealth index and lifestyle choices like consuming tobacco are significantly associated with low birth weight of a child at national level (Urban statistics are currently unavailable).

3.9 Conclusion

A major limitation with the type of data available concerning the health and nutrition status of urban children is the lack of data for all identified groups of children in Chapter 2 Demography including child labour and orphans in relation to their age and sex of children. Based on data sources, the health and nutrition related data available in the NFHS, which is based on sample survey, covers only children in 0-6 years age group. The lack or absence of data on children beyond this age group (7-18 years) has resulted in gross under documentation and analysis of the issues faced by children in this age group. Furthermore, health and nutritional status of children living in informal settlements are covered only in NFHS-3. Additionally, there is a lack of data on the prevalence of vector-borne diseases like dengue, chikungunya; communicable diseases; lifestyle diseases like childhood obesity among urban children. The increasing childhood morbidities like asthma, bronchitis, mental illness and type-2 diabetes among others are still analysed in micro-studies in cities. Additionally, while information on HIV, diabetes, asthma, tuberculosis is provided for men and women in the 15-49 age group, there is no exclusive data on children and specifically children in urban areas.

It is a well-known fact that availability of and physical proximity to a service does not guarantee access. Regarding under-five mortality, the number of deaths reported within health care institutions or the number of children who have received medical treatment before death are not yet covered. Data shows that urban children are also severely malnourished, but large-scale sample survey doesn't cover the proportion recovered from malnourished status. Therefore, it is essential that sample survey must add new headings in their questionnaires based on reporting of new prevalence of diseases according to place of residence.

Living Conditions

This chapter critically analyses the conditions of the built environment such as state of housing, access to safe drinking water and improved sanitation facilities, access to play areas and living arrangement of children, all factors which have an impact on the physical and mental health of children. Thus, improving children's living conditions by addressing and tackling these issues present an essential contribution towards the creation of child-friendly cities.

4.1 Built environment and condition of housing in urban areas

Inadequate living conditions are among the most pervasive violations of the rights of children. A healthy environment promotes social interaction, limits psychological stress and bolsters health. The 2011 Census data on condition of housing shows that 68.4 per cent of urban households are reported to be living in good condition, whereas nearly one-third of the urban

households (28.7 per cent) still occupy houses that are unliveable or dilapidated (2.9 per cent) (Table 4.1 & Fig 4.1). These conditions have been assigned to a house based on the respondent's perception. Lakshadweep has the maximum percentage of urban houses (85.2 per cent) in good condition and Odisha has the minimum percentage (51.5 per cent) of urban houses in good condition. The percentage of houses in good condition is below the national average of 68.4 per cent in 16 states, these include Madhya Pradesh, NCT of Delhi, Daman & Diu, Chhattisgarh, Tripura, Manipur, Haryana, Nagaland, Jharkhand, Assam, Arunachal Pradesh, West Bengal, Punjab, Uttar Pradesh, Bihar and Odisha.

Evidence shows that adequate (in terms of infrastructure and services) housing can protect children and families living in dense urban areas from communicable and chronic diseases as well as injuries and accidents. Lack of ventilation, overcrowding and inadequate natural light are common in the homes of the urban poor and



90% of households use an **improved** source of **drinking water**

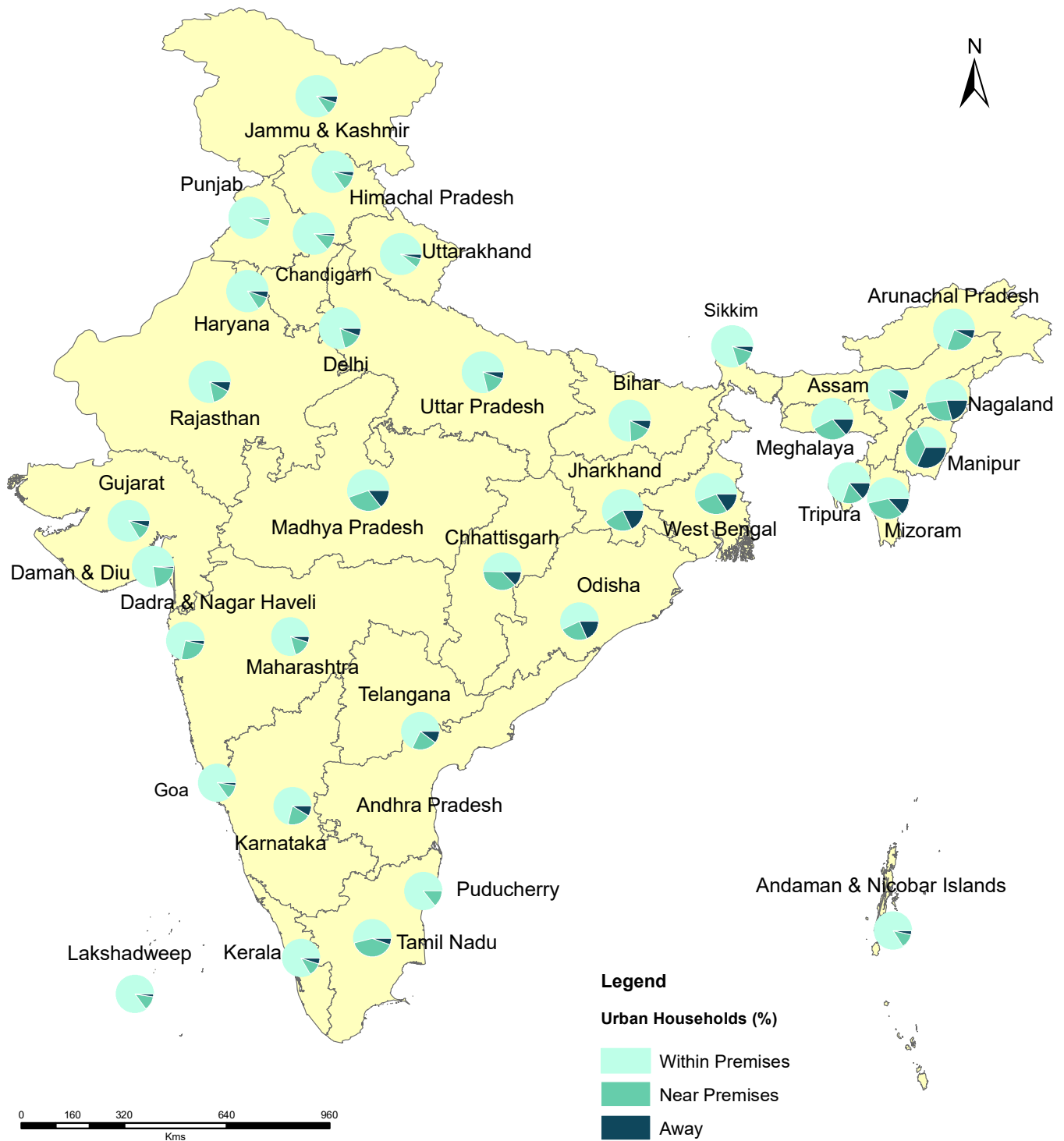


10.1% of children less than 15 years age practice **open defecation**



Only **36 %** of young children's stools are **disposed off safely**

Map 4.1: Percentage of households having access to drinking water facility in urban areas



are responsible for infectious diseases, fire hazards and physical injuries as well.⁴⁷ Table 4.1 on slums present a grim picture of the condition of housing in slum areas in Indian cities. About 58.4 per cent of houses are identified as good, 37.6 per cent as liveable and 4.03 per cent as dilapidated. Mizoram (80.2 per cent) and Sikkim (77.3 per cent) have the maximum percentages of slum houses in good condition whereas Chandigarh (6 per cent) and Delhi (31.7 per cent) have the minimum percentages. Slum houses identified as dilapidated are much more noticeable in Chandigarh (72.2 per cent) and Assam (10.5 per cent).

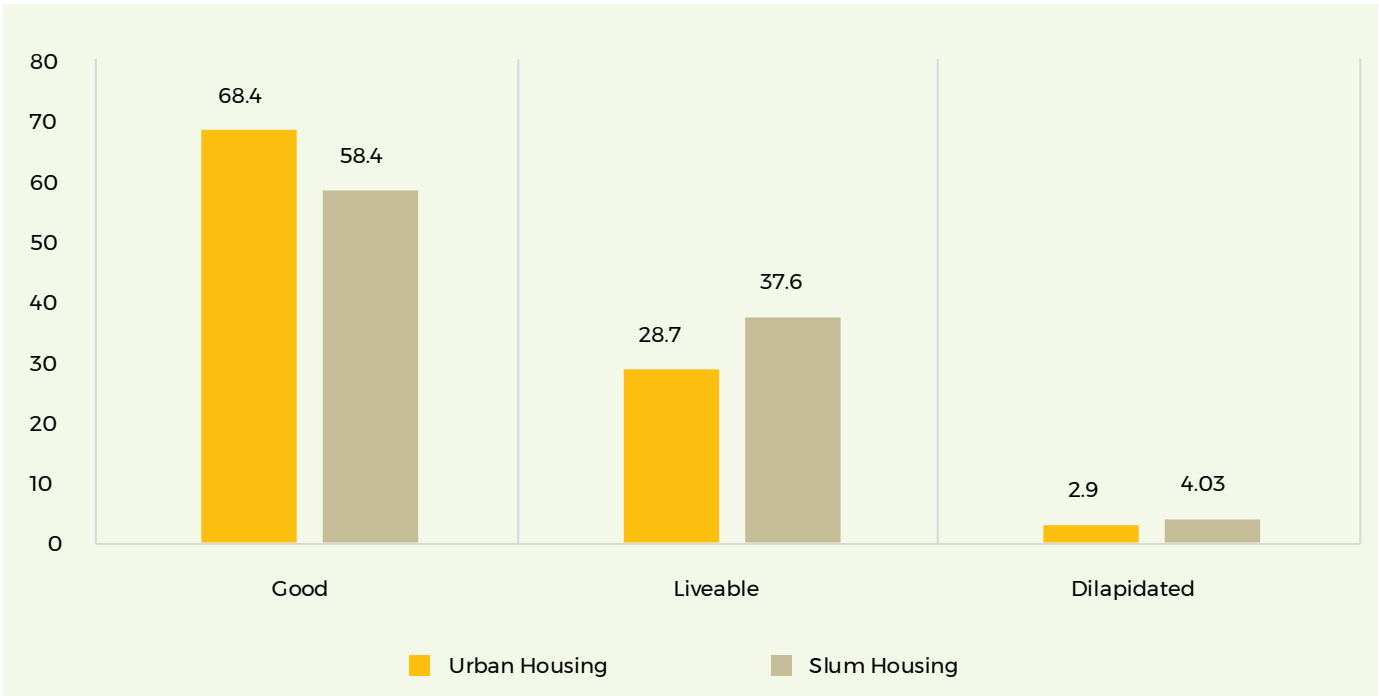
4.2 Access to water and sanitation facilities in urban areas

The challenge of sanitation in Indian cities is acute, setting forth another vicious trail of events for the poor. The poor quality of sanitation leads to disease, which then requires monetary expenditure and wage loss for treatment. With poor sanitation facilities available at household level, a large number of the urban poor in cities still depend on public toilets. To make matters worse, several public toilets do not have water supply

while the outlets of many others with water supply are not connected to the city's sewerage system. Environmental and health implications of the lack of drinking water and sanitation facilities are a major cause for concern in Indian cities. A study by the Ministry of Urban Development, Government of India (2009) noted that the health of 23 million children below the age of 14 in urban India is at risk because of poor sanitation and 8 million children due to poor water supply.⁴⁸ The poor quality of water further aggravates the situation and forces families to subsequently spend large sums of money on treatment of water-borne diseases, further adding to their financial burden. It is estimated that the lack of waste water treatment leads to over USD 15 billion being spent in treating water-borne diseases in India.⁴⁹ According to the Ministry of Health and Family Welfare, more than INR 12 billion is spent every year on illnesses resulting from poor sanitation.⁵⁰ The cost in terms of Disability Adjusted Life Years (DALY)⁵¹ of diarrhoeal diseases for children from poor sanitation is estimated at INR 500 crore.

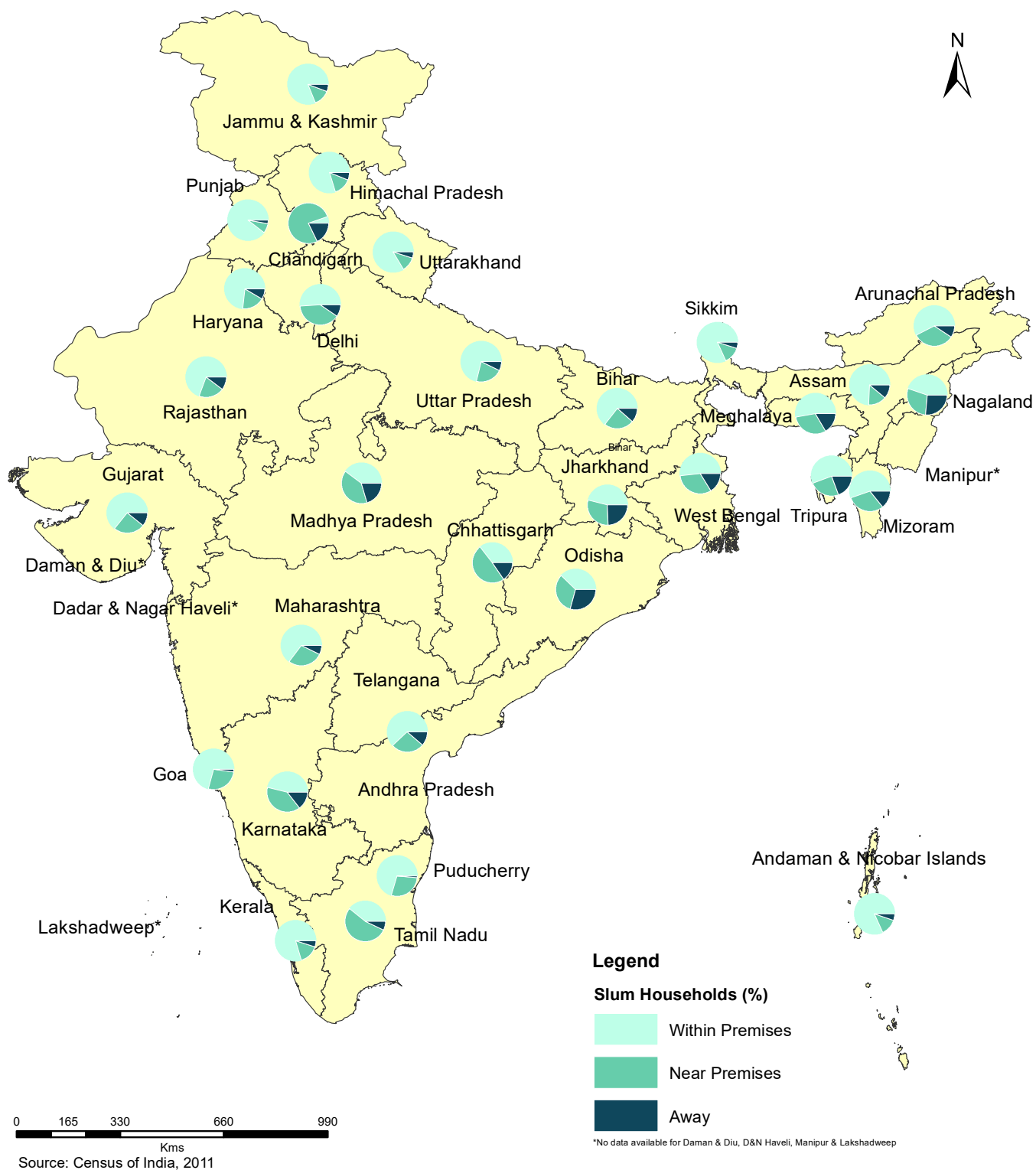
The cost as per DALY per person due to poor sanitation is estimated at INR 5,400 while that due to poor hygiene

Fig 4.1. Percentage of houses as per condition of housing, India



Source: Census of India, 2011

Map 4.2: Percentage of households having access to drinking water facility in slums



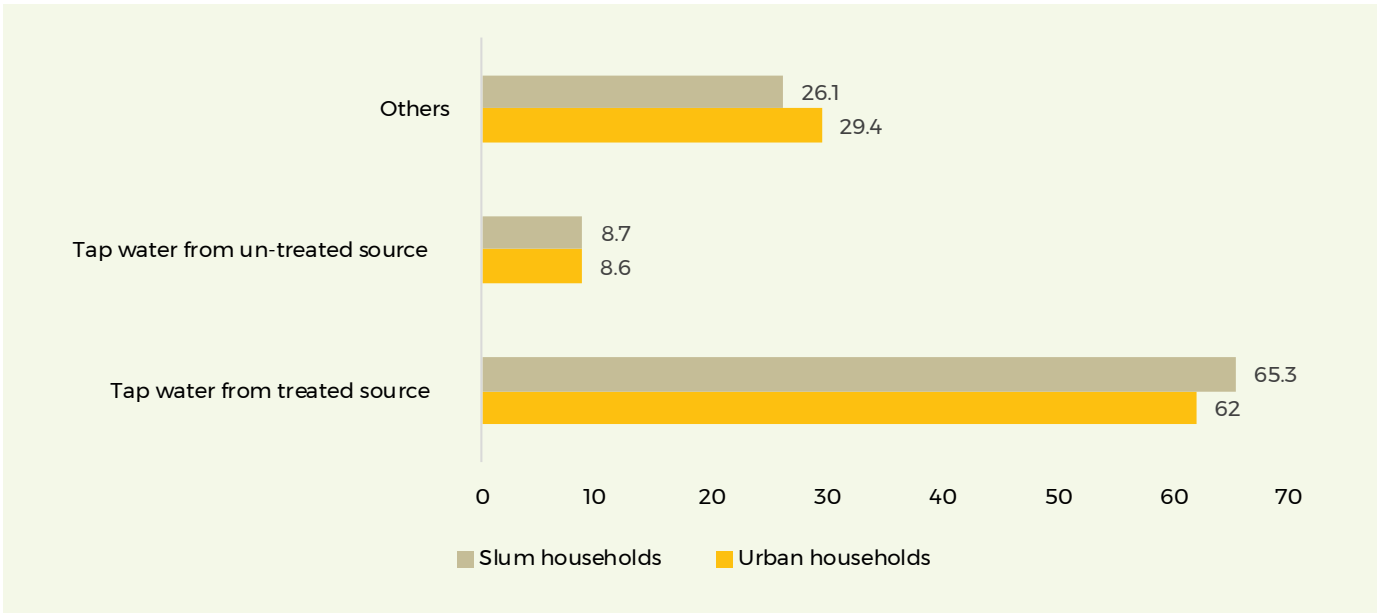
practices stands at INR 900. A study by the Water and Sanitation Program (WSP 2010) of the World Bank using data for 2006 shows that the per capita economic cost of inadequate sanitation, including mortality impact in India, is INR 2,180. The study observes that when mortality impact is excluded, the economic impact for the poorest 20 per cent of urban households is the highest.⁵²

Water, Sanitation and Hygiene (WASH) also has a direct impact on the health and education of children. 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, when facilities are provided. There is a growing evidence of the link between the linear growth of children and household sanitation practices and infections.⁵³ 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 both in terms of quantity and quality and poor use of toilets are increasingly recognised as contributing causes of undernutrition. Ignorance about the importance of washing hands with soap and water after defecation, prior to cooking or prior to feeding is a significant contributor of undernutrition in children and poor access to water, sanitation facilities and

poor personal hygiene practices lead to an increased transmission of infection. The poor and insanitary physical environment in which urban-deprived children live and their lack of or limited access to basic services such as water and sanitation has a direct impact on their health. Studies show that children living in slums are 1.3 times more likely to suffer from diarrhoea than in non-slum areas.⁵⁴

Water and sanitation are crucial for a child’s survival, health, nourishment and overall development. The section on the health and nutrition status of urban children in the preceding chapter has made apparent the various health issues faced by children in urban areas due to lack of drinking water and sanitation facilities. The UN Convention on the Rights of the Child, under Article 24, commits state parties to ensure the highest attainable standard of health for every child. This includes providing clean drinking water and eliminating the dangers of environmental pollution. Unsafe water, poor sanitation and unhygienic conditions claim many lives each year. Without sufficient access to safe drinking water and an adequate water supply for basic hygiene, children’s health suffers. Thus, improving access to basic services remains vital for reducing child mortality and morbidity.⁵⁵

Fig 4.2. Percentage of households as per source of drinking water, India



Source: Census of India, 2011

4.2.1 Access to safe water supply

The 2011 Census reveals that 62 per cent of households have access to piped water supply from treated sources whereas 8.6 per cent have access to piped water supply from untreated sources (Table 4.2 & Fig 4.2). The remaining 29.4 per cent of urban households are not connected by a networked water supply system and depend mainly on other sources like wells, hand-pumps, tube-wells, etc. Chandigarh has the highest percentage (93.8 per cent) of urban households with access to tap water from treated source and Nagaland has the lowest percentage (6 per cent).

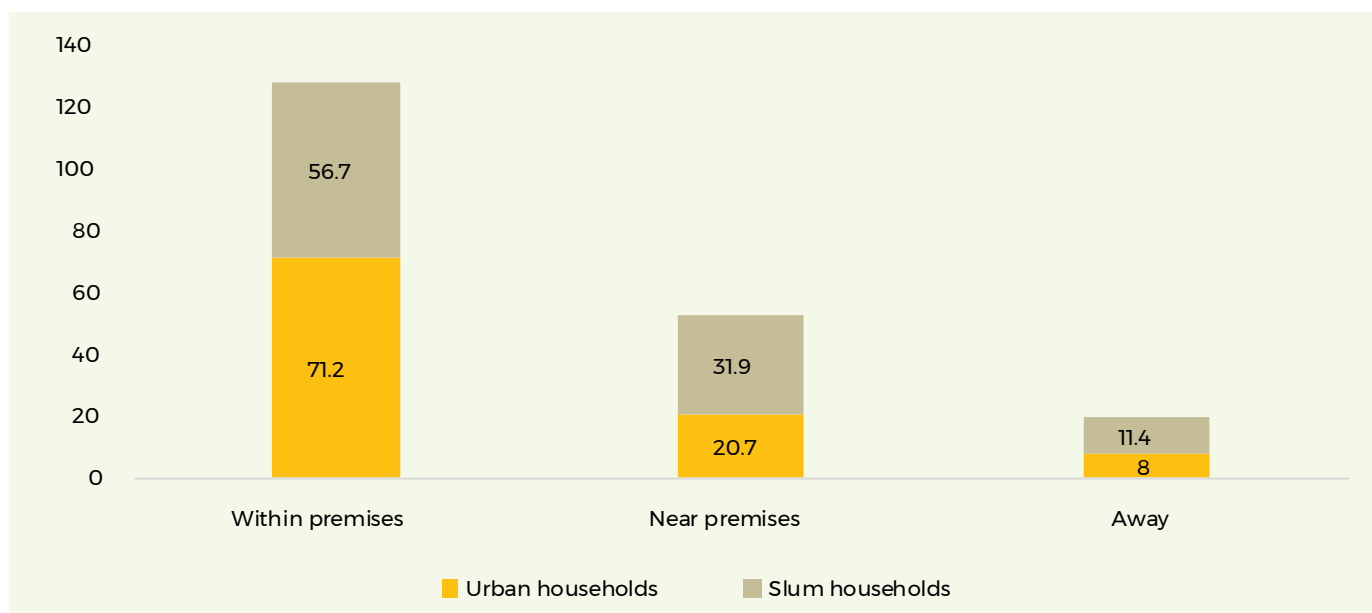
The problem of access to drinking water is more acute in slums, where only 65.3 per cent of households have access to water from treated sources while 8.7 per cent of households have accessed water from untreated water sources (Table 4.2). States like Goa (93.6 per cent), Himachal Pradesh (92.5 per cent) and Maharashtra (86.6 per cent) are better in terms of access of households to treated tap water while households located in Nagaland (4.1 per cent), Arunachal Pradesh (11.1 per cent) and Bihar (11.7 per cent) are at the bottom of the table in this respect.

Apart from access to drinking water, another crucial

issue for urban households is the location of water sources. Access to an improved water source does not always guarantee the availability of water within or near the premises or of adequate quantity. When the water source is not located within the house, the women and the children have to engage in sourcing the water. Children, in particular, have to compromise their time for study and play as they have to spend considerable time to source water for household use. This is especially true in the poorest urban districts where adequate amount of water is not available, or the source of water is far away (more than 100 m away from premises, in urban areas, according to the 2011 Census). Many people are forced to walk to collect water from other neighbourhoods or to buy water from private vendors. It is common for the urban poor to pay up to 50 times more for a litre of water than their richer neighbours, who have access to the water mains.⁵⁶

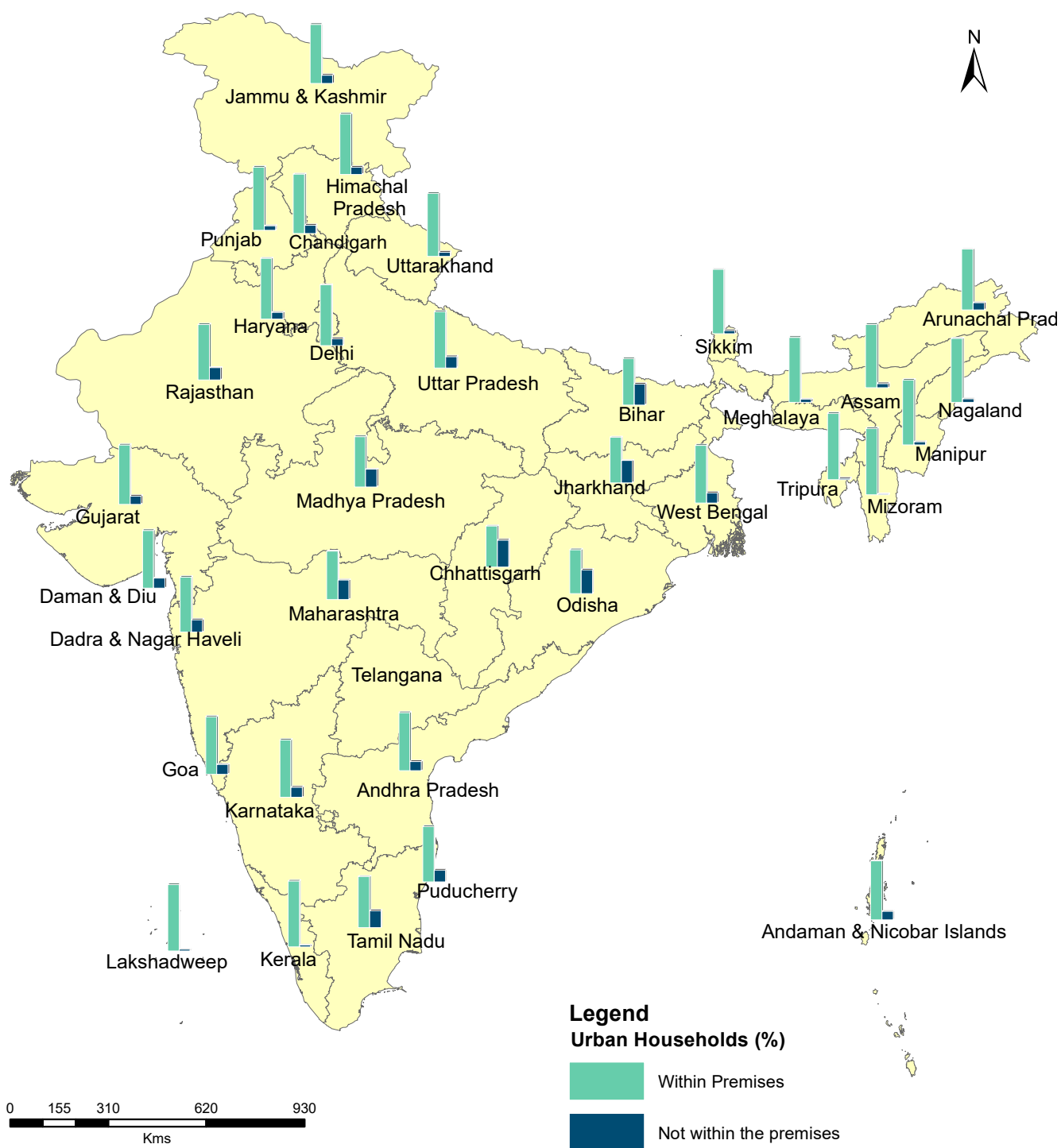
About 71.2 per cent urban households have drinking water sources within their premises, 20.7 per cent of urban households have the water source near their houses (within a 100 m range) and 8 per cent of urban households have the water source located away from their houses (Fig 4.3). Highest percentage of urban households in Punjab (92.7 per cent) have a drinking

Fig. 4.3. Percentage of households as per location of source of drinking water, India



Source: Census of India, 2011

Map 4.3: Percentage of households having access to toilet facilities in urban areas



water source located within the premises while Manipur has the lowest percentage of urban households (31.8 per cent) that have the drinking water source located within their premises (Table 4.3 & Map 4.1).

Among slum households, 56.7 per cent have access to a drinking water sources within their premises, 31.9 per cent have the water source near their premises, and 11.4 per cent have the water source located away from their houses (Table 4.3 & Map 4.2). Punjab has the highest percentage of slum households (89.2 per cent) that have a drinking water source located within the premises whereas the proportion is below 40 per cent in Chhattisgarh and Odisha. On comparing the total urban households with slum households again, we find that Chandigarh and NCT of Delhi again report the greatest disparities, followed by Karnataka. For example, in Chandigarh, while 86.2 per cent of total urban households have access to a water source within their premises, only 5.6 per cent of the slum households have that access. The gap between urban and slum households for the same is 28 per cent and 24.5 per cent for NCT of Delhi and Karnataka, respectively.

4.2.2 Access to sanitation facilities

About 81.4 per cent of urban households have toilets located within their premises however, only 32.7 per cent of households are connected to piped sewer systems.

Of the 18.6 per cent (14.7 million) urban households that do not have toilets within their premise, about 6 per cent use public toilets and 12.6 per cent resort to open defecation (Table 4.4). Lack of sanitation facilities is a major issue in slum areas where 66 per cent of slum households have toilets located within their premise (Map 4.3 & 4.4) whereas 34 per cent slum households do not have toilets within their premises (Table 4.5 & Fig 4.4). Chhattisgarh has the maximum percentage (34.4 per cent) of urban households and Odisha (48.3 per cent) reports the maximum percentage of slum households that resort to open defecation.

Based on the Swachhta Status Report 2016-Urban,⁵⁷ overall 10.1 per cent of children less than 15 years were resorting to open defecation whereas 42 per cent of children were using community or public toilets. The proportion for open defecation is highest in the states of Jharkhand (31.5 per cent), Bihar (16.1 per cent) and Odisha (16.1 per cent). Use of public/community toilets by children whose households did not have a toilet facility was higher than 95 per cent in Delhi, Meghalaya and Nagaland (Table 4.7). According to the Swachh Survekshan Report,⁵⁸ which covered 500 cities, 118 cities have been identified as open defecation free and 404 cities have substantially clean residential areas. Among cities, Indore was the cleanest city in India and Chandigarh was the cleanest Union Territory.

Fig 4.4. Percentage of households as per access to sanitation facilities, India



Source: Census of India, 2011

4.3 Drainage

Proper drainage and water management are essential for body health and for preventing other environmental risks such as flood, mudflow, etc.⁵⁹ It has been estimated that each individual generates about 15-20 litres sullage per day⁶⁰ and thus households should be well connected with sewerage system. According to statistics as Table 4.6 & Fig 4.5 indicates, only 44.9 per cent of households in urban areas have covered drainage, and this number dips further for slum households to 36.9 per cent. In urban areas, households with open drainage and no drainage are highest in the North-Eastern states, with Nagaland reporting the greatest proportion connected to an open drain (67.9 per cent) and the highest proportion of unconnected households being reported from Manipur (64.4 per cent). For slums, the highest percentage of households connected to an open drain is reported in Nagaland (80 per cent) followed by Uttar Pradesh (70.7 per cent) whereas Arunachal Pradesh (62.3 per cent) and Odisha (53.9 per cent) have inadequate drainage.

4.4 Status of WASH in schools in India

School WASH infrastructure is as important a component of liveability as is the condition in the neighbourhood. Water and sanitation facilities that are available in the area greatly influence the WASH facilities in the school which, in turn, influence the attendance levels and performance of students.

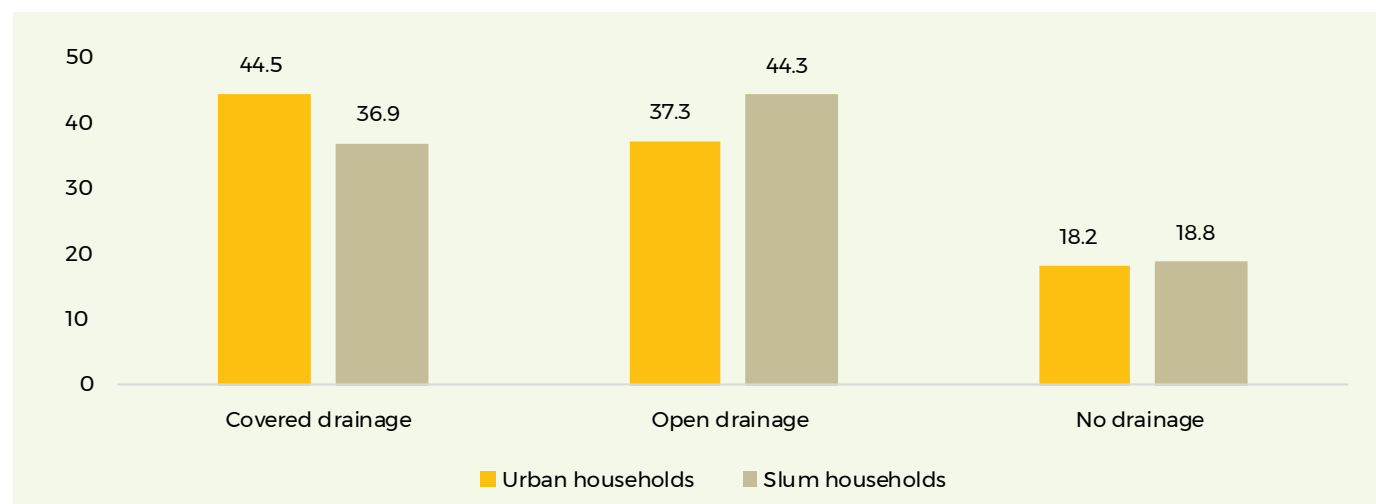
According to District Information System for Education (DISE) developed by NUEPA⁶¹, during the year 2015-16, 97 per cent of schools had separate toilet facilities for boys and 97.5 per cent of schools had separate toilet facilities for girls. With an increase from 83% primary schools having separate facilities in 2014-15 to 97% in 2015-16, great improvement has been observed in the provision of separate toilet facilities for girls and boys, throughout the nation. However, according to a study conducted by GIZ, it was observed that sanitation facilities in schools of select cities were in a poor condition. Problems associated with no ventilation, no water and electricity supply, lack of child accessible latches, hand-wash facilities among others were reported. In addition, school authorities were unaware about schools' wastewater disposal mechanisms, broken waste-water pipes and lack of maintenance of septic tanks.

According to another report,⁶² pre-cast toilets have met the quick needs in schools and have improved sanitation conditions in urban areas. Regarding water facility, consumers of piped water in three months missed 3.1 school days on an average whereas consumers of tank water missed 2.9 and urban safe water enterprises (USWEs) missed 2.7 school days.

4.4.1 Availability of water and sanitation facilities in school

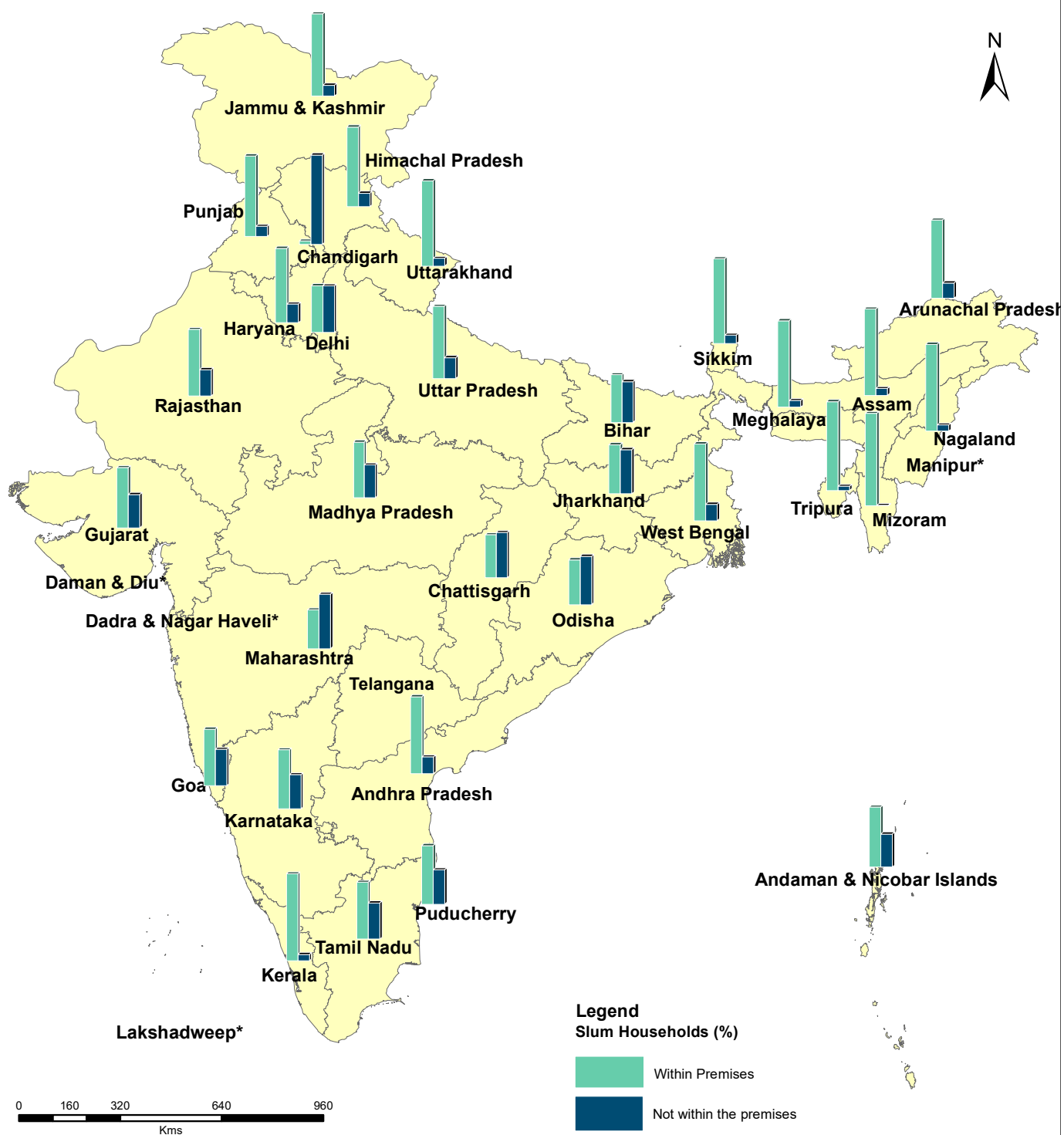
The number of schools having drinking water facilities

Fig 4.5. Percentage of households as per access to drainage facilities, India



Source: Census of India, 2011

Map 4.4: Percentage of households having access to toilet facilities in slums



Source: Census of India, 2011

"Note: The data for Telangana and Andhra Pradesh is the combined data for erstwhile Andhra Pradesh as separate data for both the states is not available in Census 2011."

has increased from nearly 0.9 million (83 per cent) in 2005-06 to 1.36 million (95 per cent) in 2012-13. As many as 193 million children in schools have access to drinking water facilities; however, 5 million (5 per cent) children still did not have access to this facility in the year 2012-13.

The number of schools having separate toilet facilities for girls has increased from 0.4 million (37 per cent) in 2005-06 to 1.24 million (88 per cent) in 2012-13. However, the functionality of toilets and maintenance is a matter of concern. In all, more than 89 million girls in schools have access to toilet facilities but 7 million (7 per cent) girls still lack access to separate toilets. About 23 million (22 per cent) boys still lack access to separate toilet facilities. There is not much variation between the status of WASH in rural and urban schools.

The Ministry of Human Resource Development (MHRD) launched the 'Swachh Bharat Swachh Vidyalaya' (SBSV) initiative in 2014. Under this, an award called the 'Swachh Vidyalaya Puraskar', was announced in 2017, for which government, government aided, or private

schools located in both urban and rural areas could register and be evaluated for provision of water, toilet and handwashing facilities among others.

Some idea about facilities available in schools may be gathered from the data present in the 2017-18 progress summary report of the award.⁶³ However, it is important to note that the number of schools that have registered in proportion to total number of schools is different in every state. Less than 1% of schools have registered for the award from the states of Manipur, Jammu and Kashmir, Arunachal Pradesh, Meghalaya and West Bengal.

However, the data is not differentiated for urban and rural schools. Among the registered schools, those in Punjab (60.06 per cent), Dadra and Nagar Haveli (58.27 per cent), Kerala (54.76 per cent) and Manipur (51.52 per cent) score very low on provision of drinking water. Provision of toilets and handwashing facilities was low in Punjab (57.45 per cent and 56.04 per cent respectively), Dadra & Nagar Haveli (both 55.91 per cent), Kerala (52.96 per cent and 51.84 per cent respectively) and Manipur (both 51.52 per cent).



4.4.2 Functionality of water and sanitation facilities in schools

While 95 per cent schools have drinking water facilities, they are functional in only 85 per cent. Functional water facilities are present in more than 90 per cent schools in 13 states/UTs, while they are present in less than 65 per cent schools in four states/UTs-Arunachal Pradesh, Manipur, Meghalaya and Tripura. Functionality of girl's toilets remains a major challenge: 25 per cent of schools still have non-functional toilets. Andhra Pradesh, Odisha and J&K have less than 40 per cent of schools with functional girl's toilets.

4.4.3 Accessibility of school-going children to water and sanitation facilities

Although the availability of drinking water stands at 95 per cent in schools across India, a total of 5.23 million children (2.6 per cent of total enrolment) do not have access to drinking water facilities in schools. Four states (Andhra Pradesh, Assam, Bihar and Rajasthan) account for more than 50 per cent of children without access to drinking water facilities in schools. Improving access to boy's toilets in four states (Andhra Pradesh, Madhya Pradesh, Odisha and West Bengal) would reduce the

gap by 50 per cent. Similarly, improving the access to girl's toilets in five states (Andhra Pradesh, Assam, Bihar, Odisha and West Bengal) would reduce the gap by 60 per cent.

4.5 Access to play spaces

Play, both spontaneous and organised, is an important component of healthy development. When children play, they reap the benefits of physical exercise, develop advanced motor skills and find relief from stress and anxiety. Play also promotes children's cognition, creativity and socialisation. The World Health Organisation (WHO) recommends at least one hour of daily physical activity for children aged 5-17. However, the current urban scenario has led to deprivation of such play experiences for children due to factors such as lack of accessibility to playgrounds, lack of availability of play grounds in the vicinity of housing areas, safety issues and lack of proper play equipment. Also, the increasing need for parking facilities has eventually reduced children's play areas by substantially reducing the open areas within neighbourhoods. Traditionally, neighbourhood streets were versatile spaces that served as play areas for children and public spaces





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for adults; these have now become congested with vehicular movement and parking.

Studies show that a lack of physical activity adversely affects the health of children. An annual School Health and Fitness survey done by EduSports⁶⁴ covering 1,02,838 students across 252 schools in 86 cities in 26 states reveals that 2 in 3 kids aged 7-18 years don't have a healthy Body Mass Index (BMI) and 1 in 3 kids have inadequate lower body strength. Based on the sex of the child, 40 per cent of the boys have a healthy BMI as compared to 38 per cent for girls. Geographically, a greater proportion of children (71 per cent) are reported to have an unhealthy BMI from central India as compared to the other regions (Fig 4.6).

In addition, an earlier report⁶⁵ also revealed that schools which provide 3 or more physical education classes have children with better BMI and fitness parameters measure in terms of sprint capacity, flexibility, lower and body strength and abdominal strength (Fig 4.7). Furthermore, the report⁶⁶ also reveals that non-metros score higher than metros in terms of BMI levels and fitness parameters (Fig 4.8). Children in non-metros demonstrated better flexibility (75 per cent in non-

metros and 70 per cent in metros), had good upper body strength (64 per cent in non-metros and 61 per cent in metros) and a marginally better overall BMI score (61 per cent in non-metros and 60 per cent in metros).

Furthermore, the NFHS-4 reports a greater proportion of overweight or obese men (26.6 per cent) and women (31.4 per cent) in urban areas as compared to the men (14.3 per cent) and women (15.1 per cent) in rural areas. Also, 4.2 per cent of women and 4.8 per cent of men in the age group of 15-19 years have a BMI equal to or above 25, i.e., they are either overweight or obese. A systemic review was conducted to measure the prevalence of childhood overweight and obesity⁶⁷ and revealed that prevalence of overweight children among 0-18 years increased from 9.7 per cent in 2001 to 13.9 per cent in 2010 and the proportion was higher in northern than in the southern regions.

Facilitating play can counteract increasing rates of obesity and overweight among children, which are related not only to changes in diet but also to a sedentary lifestyle reinforced by the loss of recreational opportunities. Lack of open and safe space to play has

a dual disadvantage. Firstly, it indirectly encourages the usage of more sedentary activities such as television and video games, which in turn leads to higher occurrences of obesity and diminished social skills amongst children. Secondly, children who do not have access to such expensive technological facilities are deprived of play activities as a whole. Cities need to create better opportunities for children to participate in physical activities by providing safe and accessible spaces for recreation and design neighbourhoods, streets and outdoor spaces that encourage active transportation, including walking and cycling.⁶⁸

4.6 Living arrangement of children

According to the NFHS-4, 87.5 per cent of children in urban areas live with both of their parents, 9.4 per cent of the children live with one parent and a 3.1 per cent are not living with either parent. Based on studies,^{69 70} it is observed that orphanages are not well managed in terms of infrastructure. Surprisingly, no state level data is available on unregistered homes, availability of basic infrastructure in registered homes: neither on health condition nor on other components like safety and security, educational status.

4.7 Conclusion

It is a well-known fact that significant proportions of the built environment in Indian cities are unfit for children, especially those disadvantaged or disabled, but evidence for focused intervention is lacking. In order to achieve such comprehensive evidence, it is necessary to collect data and evidence from specific settings. When considering the extent of child friendliness of surroundings, it is first important to have an understanding of the conditions of the households/dwelling units itself. Factors such as lighting, ventilation, adherence to fire and safety standards, etc. all are essential in contributing to a positive environment for a child to grow up in. Unfortunately, due to the unauthorised nature of many of the dwelling units in India, these aspects are often neglected, which in turn negatively impacts the growth and development of children.

Indian cities comprise of an average of 40 per cent of unauthorised settlements and colonies, including slum areas that are most often than not lacking in basic amenities and adequate space for facilities. This general lacuna of planning also results in a specific lack of planning for children per se. Thus, there is an urgent need to not only collect data on such settlements but also to map these areas. GIS can be used as a tool to map different co-related layers of data for every city so that multiple urban issues can be viewed in conjunction. Aspects such as disaster risks, air pollution and water logging etc., can be mapped to overlap with locations of dense settlements or schools and parks (and other areas frequented by children). Such intersecting information would help inform planning and decision-making. Filling such data gaps in more focused contexts such as neighbourhoods will only lead to a better understanding of larger city dynamics.

One such dynamic to focus on is mobility for children in cities. Lack of access to public transport systems, poorly designed traffic crossings and streets in cities has immensely restricted the mobility of children, hindering safe and independent movement. This threat only amplifies for children with disability. Obtaining data on mobility needs and living conditions for children, including those with disability, will consequently contribute to creating more inclusive urban environments.

Although data is available on the condition of housing and supporting infrastructure like water supply and sanitation, little data is available concerning the impact of living conditions on urban children or those deprived of facilities. Very few studies have been conducted to observe the association between poor sewerage systems and the prevalence of diarrhoea or other water-borne, water-washed and water-based diseases.⁷¹ Additionally, studies to observe vulnerability due to flooding caused by blocked drainage at the city level are limited. Therefore, to make cities child friendly, it is essential to generate data on living conditions in relation to children so that accurate statistics can then be used for formulation of necessary interventions.

Educational Status of Children

Literacy and education of children are important for self-development and are also directly associated with the socio-economic development of the country, and these linkages have been firmly recognized around the world. Awareness about the benefits and importance of education on the part of parents is critical in this regard. Furthermore, there is clear generational continuity in attainment of education. Following the previous chapter's discussion on WASH infrastructure in educational institutions, it is important to understand that attainment of education by every child is directly connected with the school environment. This is where the concept of child-friendly schools comes in. This concept aims to democratise education by creating school spaces that are "physically safe (and accessible), emotionally secure and psychologically enabling" for every student.⁷² This 'safe space' is not limited to the boundaries of the school and apply to factors such as safety in transport to school or walking to school and urban planning needs to take this into account.

Furthermore, higher educational achievement of both female and male are significantly associated with better maternal and child health, nutritional status, increase in work force participation rate in formal activities among other factors. Having basic amenities like WASH also improves student retention rates, performance, etc and reduces absenteeism. The following section discusses the educational status of urban children using census data and other reports.

5.1 Educational status of urban children (5-18 years and 6-14 age groups)

As per 2011 Census of India, 77 per cent of children in the age group of 5-18 years in urban India have access to educational institutions (Table 5.1). The highest proportion of male and female children who were attending educational institutions was reported from Lakshadweep (89 per cent) and Kerala (88.4 per cent).



77 % of children in the age group of 5-18 years in urban India **have access** to educational institutions

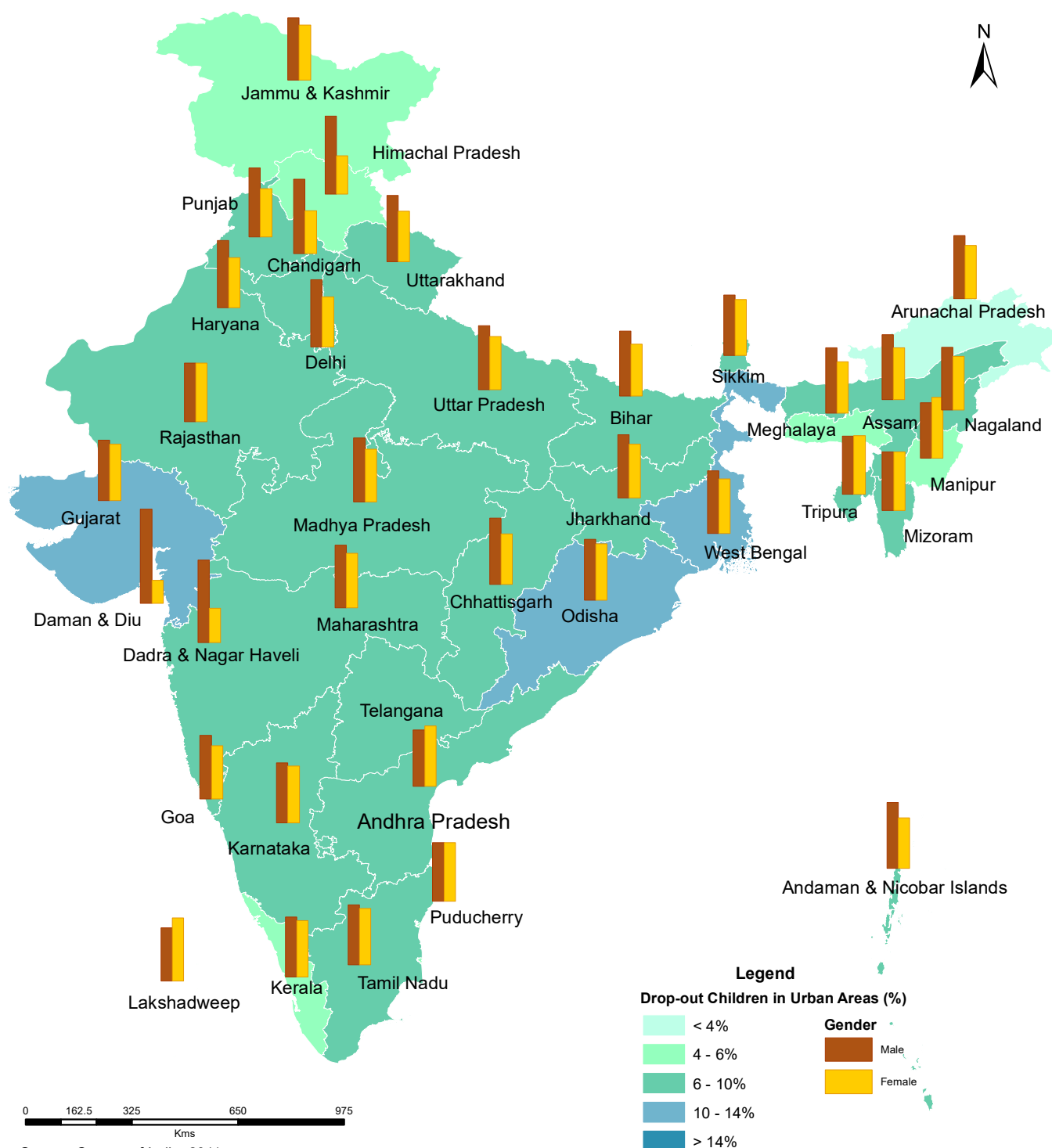


23% of adolescent girls drop out due to lack of toilets in school



34% of children with **disabilities** in the age group of 5-18 years **do not have access** to educational institutions

Map 5.1: Percentage of drop-out children (5-18 years) in urban areas



Source: Census of India, 2011

"Note: The data for Telangana and Andhra Pradesh is the combined data for erstwhile Andhra Pradesh as separate data for both the states is not available in Census 2011."

The states/UTs of Daman and Diu and Uttar Pradesh show the lowest numbers (62.4 per cent and 67 per cent, respectively).

With regard to urban children who have not attended educational institutions, Table 5.1 indicates that 23 per cent of urban children in the age group of 5-18 years are out of school. Out of this 9.1 per cent of children have attended school before but have dropped out, and 13.93 per cent of children have never attended school. The number of male dropouts (9.16 per cent) were slightly higher than female dropouts (9 per cent) (Map 5.1). However, the proportion of female children who had never attended any educational institute ever was relatively higher (Map 5.2). Daman and Diu (2 per cent), Gujarat (13.3 per cent) and West Bengal (12.7 per cent) have the highest proportion of children who dropped out of school after some time whereas Uttar Pradesh (23.6 per cent), Bihar (21.7 per cent) and Rajasthan (16.7 per cent) have a significant number of children who have never attended any educational institute (Map 5.3).

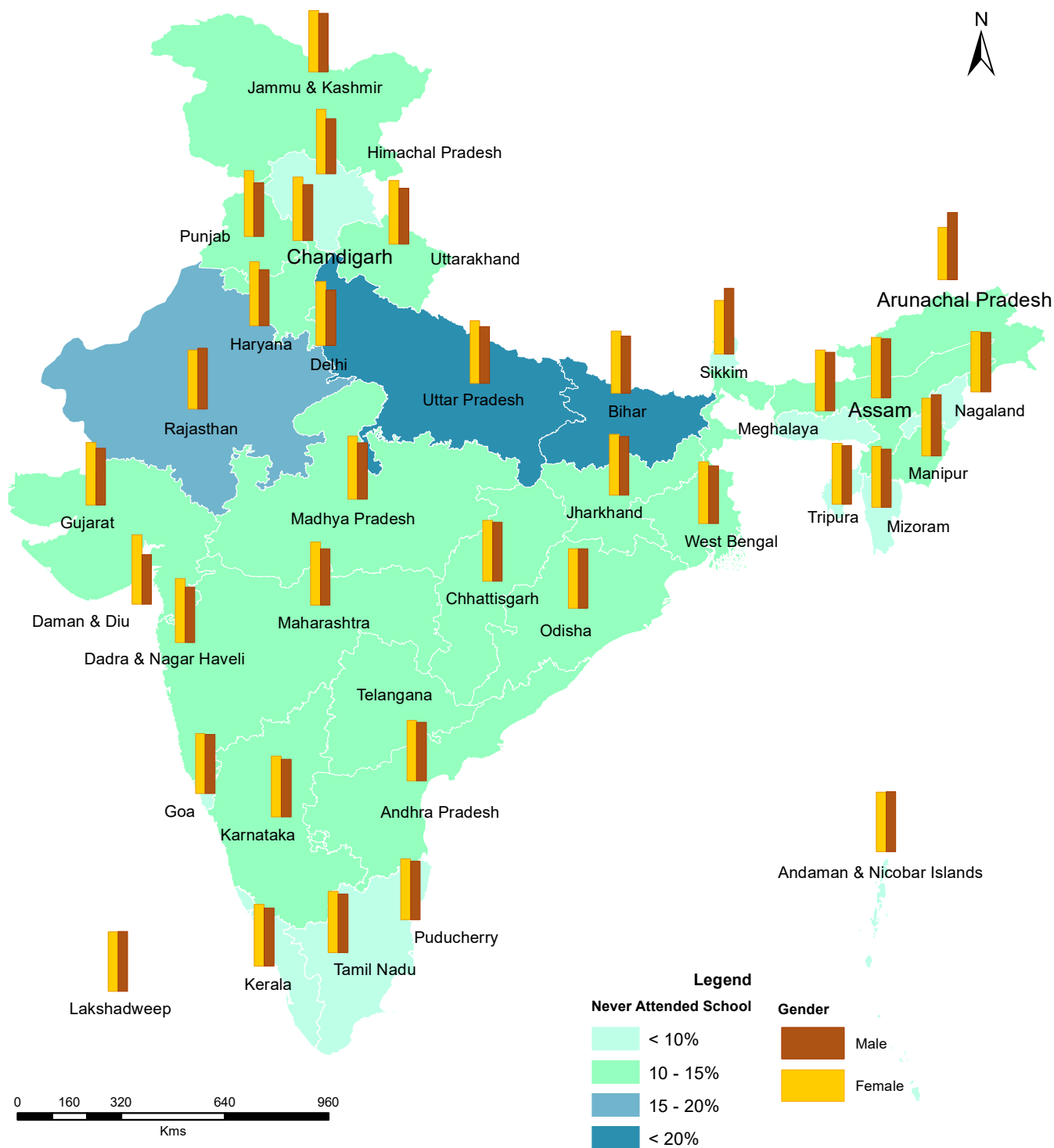
In 2009, the Right to Education Act (RTE) was enacted according to which the provision of free and compulsory education for children in the age group 6-14 years was made. Table 5.3 shows that 11.7 per cent of 6-14-year-old children have never attended any educational

institutions whereas 3.8 per cent of children have attended before but dropped out of it later. There is a marginal difference between male and female children who have not attended any educational institution. The highest proportion of children who have never attended an institution is reported from Uttar Pradesh (22.1 per cent), Bihar (19.4 per cent) and Rajasthan (14.5 per cent) whereas Gujarat (5.9 per cent), West Bengal (5.6 per cent) and Odisha (5.0 per cent) report the highest proportion of children who dropped out of formal education.

Another sample survey estimates of out-of-school children done by the Social & Rural Research Institute in 2014 reveals that approximately 2.97 per cent of children in the age group of 6-13 years are out of school in India. A higher proportion of females (3.23 per cent) are out of school than males (2.77 per cent). At the national level, a higher proportion of children are out of school in rural areas (3.13 per cent) as compared to urban areas (2.54 per cent). Odisha has the highest percentage (6.10 per cent) of children out of school in the 6-13 years age group and Uttarakhand has the highest percentage (15.64 per cent) of out of school children in urban areas. A majority of children who are out of school have never been enrolled in any school even though the Right to Education (RTE) is in place. Others have dropped out after successfully completing



Map 5.2: Percentage of urban children (5-18 years) who have never attended school



some class. Maximum drop-outs in this age group are after the second standard.⁷³

Considering social groups, 47.9 per cent of the out-of-school children in urban India belonged to the OBC category. This was followed by children of the SC (27.3 per cent), others (18.8 per cent) and ST (6.1 per cent) categories. In addition, 4.34 per cent of Muslim children in urban were out of school in comparison with children of the Hindu (1.95 per cent) and Christian (1.06 per cent) community. The report also reveals that poverty or economic constraints are one of the main reasons for dropping out of school. In urban areas, a higher proportion of the children (28.67 per cent) are out of school because of poverty or economic reasons as compared to rural areas (22.33 per cent). A gender-wise disaggregation of the reasons reveals that a higher proportion of girls are out of school as they are engaged in domestic work or are involved in taking care of the younger children. A marginally higher proportion of boys are also out of school as compared to girls as they work to supplement household income.

An estimated 28.07 per cent of children with special needs are out of school and the percentages are higher for children with mental disability (35.97 per cent) and speech disability (34.82 per cent).

Out of the total children living in slums in the urban areas, 2.38 per cent are out of school. Slums from the states of Uttarakhand (20.34 per cent), Punjab (13.25 per cent), Bihar (11.71 per cent), Assam (8.08 per cent), Madhya Pradesh (7.46 per cent), Andaman and Nicobar Islands (6.16 per cent), NCT of Delhi (5.79 per cent), Odisha (4.05 per cent), and West Bengal (3.13 per cent) report a higher proportion of children to be out of school than the national average of 2.38 per cent. With 2.70 per cent female children from slums not attending school, the proportion of out of school females within slum areas is higher than males (2.14 per cent).⁷⁴

5.2 Educational status of children with disability (5-18 years)

As per the 2011 Census, only 65.9 per cent of children with disabilities in the age group of 5-18 years in urban areas have been reported to have access to educational institutions (Table 5.2). In fact, the difference between

the total number of children attending educational institutions in urban areas and children with disabilities was greater than 5 per cent for any state/UT and was more than 20 per cent in the case of Mizoram, Nagaland, NCT of Delhi, Daman & Diu and Puducherry, closely followed by Sikkim and Meghalaya. This information reflects the disparity in education access in a large number of UTs and states in the North-Eastern region of India, calling for a greater provision of necessary facilities and removal of barriers to access.

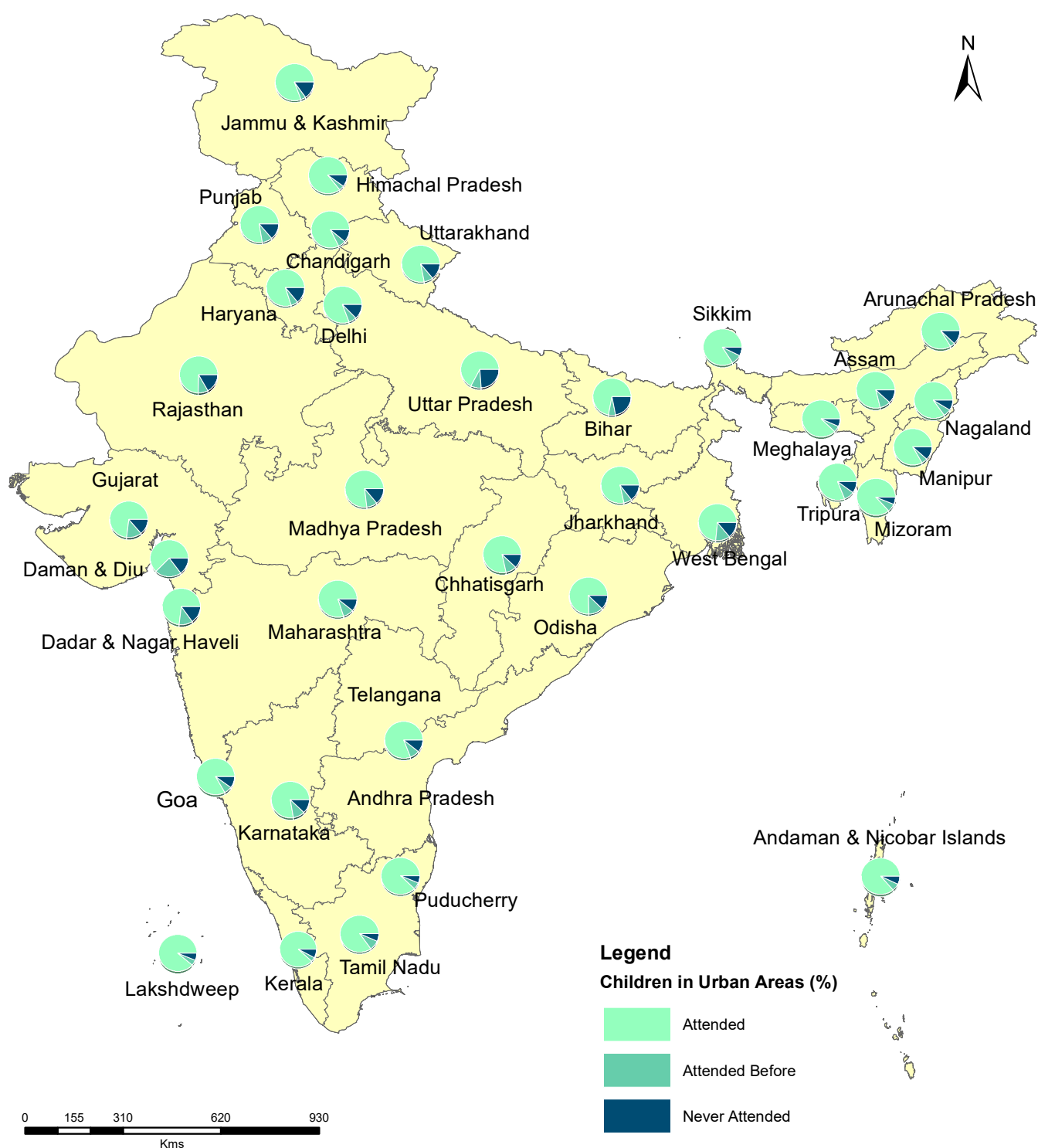
The overall access to education rate was above 75 per cent only in the state of Kerala (76.4 per cent), followed by Goa (74.7 per cent), whereas less than 60 per cent of children with disabilities have been reported to attend educational institutions in Daman and Diu (41.4 per cent), NCT Delhi (59 per cent) and Uttar Pradesh. The percentage of females attending educational institutions in this age group stood at 66.1 per cent which was marginally higher than the percentage of males (65.6 per cent).

Regarding children with disabilities in urban areas who have not attended educational institutions, Table 5.2 indicates that 34.1 per cent of them in the age group of 5-18 years are out of school. Daman and Diu (22.5 per cent), Gujarat (12.8 per cent) and West Bengal (12.7 per cent) have reported the highest proportion of children who dropped out of school after some time. Furthermore, those who have never attended any educational institution ever are reported with the highest proportion in the states of Bihar (36.1 per cent), Punjab (32.9 per cent) and Uttar Pradesh (31.6 per cent).

5.3 Urban Literacy rate of children 7-18 years

Literacy rate is an important indicator of human development and is defined as the “number of literate persons above 7 years per 100 persons”. The Fig 5.1 shows the total urban literacy rate is 91.3 per cent, and that there is a minimal difference between the male and female statistics. But the intersectionality may be understood by acknowledging that the literacy rate among female Dalits in Bihar is only 38 per cent. The highest literacy rate among children 7-18 years old is observed in Kerala (98 per cent) and the lowest is in Uttar Pradesh (81.5 per cent). Majority of Indian states

Map 5.3: Percentage of children (5-18 years) in urban areas who have and who have not attended educational institutions



Source: Census of India, 2011

"Note: The data for Telangana and Andhra Pradesh is the combined data for erstwhile Andhra Pradesh as separate data for both the states is not available in Census 2011."

and UTs have achieved an above 91 per cent literacy rate, but states such as Uttar Pradesh, Bihar, Arunachal Pradesh, Rajasthan and Jammu and Kashmir report literacy rates below the national average (Table 5.4). India devotes nearly 10.5 per cent of its expenditure on education, but there is inter-regional disparity. While Kerala spends around \$685 (INR 49700) per pupil per year, Bihar comparatively incurs only \$100 (INR 7255).⁷⁵

5.4 Early childhood education (ECE)

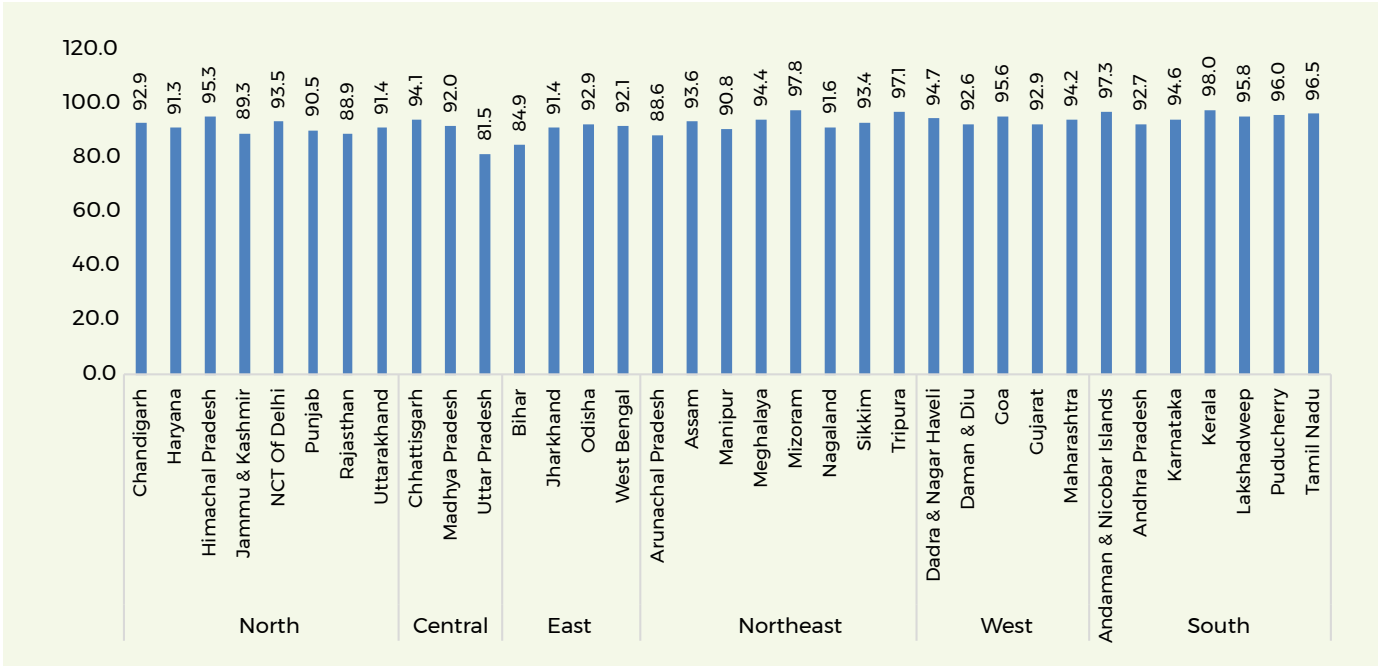
Children who do not get a healthy child care environment in the earliest years of their lives, often face lifelong developmental delays and deficits. ECE programmes give emphasis to pre-school education of children in the 3–6 years age group in India and has been positively associated with school attendance rates, retention and learning of children. However, ECE is not recognized as a compulsory provision of RTE, although states are advised to provide free pre-school education for children above 3 years in age.⁷⁶

ECE is provided through the public, private and non-governmental sectors in India. The public provision is supervised by the Ministry of Women and Child Development (MWCD) which is responsible for

initiating the Integrated Child Development Services (ICDS) programme through Anganwadi Centres (AWCs) throughout the country. In urban areas, 755 ICDS projects and 1,17,411 AWCs have been recorded. Maharashtra (104) has the highest number of urban ICDS projects followed by Delhi (92) and West Bengal (76).⁷⁷ Additionally, the Rajiv Gandhi National Crèche Scheme was initiated with a similar aim to provide early education and care to children of working women. Under this scheme, a total of 21,021 crèches are functional out of which 2,321 are located in Madhya Pradesh, 1,859 in Andhra Pradesh, 1,845 in Maharashtra and 1,724 in Uttar Pradesh.⁷⁸

According to data by UNESCO,⁷⁹ the Gross Enrolment Ratio (GER) for pre-primary education in India has steadily increased over the last twenty years, with the current GER touching a figure of 55 per cent. However, it is not clear how this has been calculated since real time data on population of 3 to 6-year old's is not available. This, however, does seem reliable as the World Development Indicators⁸⁰ also put the GER for pre-primary at around 53.8 per cent for 2008. Importantly, it also brings to light the significant enrolment gap and the need to continue enrolment efforts.⁸¹

Fig 5.1 Urban literacy rate in population 7-18 years



The private sector is another provider of early childcare and education. Playschools and day-care centres are mushrooming at a fast pace in all big and small cities. While guidelines such as the National ECCE Policy 2013,⁸² the Regulatory Guidelines for Private Play Schools by NCPCR⁸³ and the draft Guidelines for Quality Early Education by NCERT⁸⁴ are currently in place, there are no established mechanisms for enforcement and monitoring & evaluation, with the exception of government *anganwadis*. These general guidelines are not binding, and the implementation depends on the owner of the institution. Additionally, space requirements for ECE institutions are not specifically allocated in urban masterplans, often resulting in cramped environments which are not beneficial for promoting a healthy growing environment for a child. The absence of space allocation and population minimums also reduces chances of equitable access by all children in a city. The situation is compounded by the lack of data available on ECE facilities and programmes.

The quality of education offered by private stakeholders tends to range widely. Some of these pre-schools are more of 'teaching shops' that do not respect/regard the developmental needs of children. In some cases, the quality offered can often be counterproductive to children's development and may even be described as 'mis-education'.⁸⁵ Further, the schools vary considerably in size, facilities, play areas, staff and have students from different income groups. Any data collected on ECE programmes thus needs to take this diversity into account.

5.5 Conclusion

This section highlights the limitation of Census data in terms of studying these factors in conjunction with statistics of access to education. From a data perspective, it is essential to know the reasons behind children never attending any educational institutions or those who have dropped out in urban areas. The Census

neither covers any reasons nor provides information on infrastructural facilities in schools, types of schools in urban areas, number of children in vocational institutions among others.

Despite the clear significance of early education in the overall development of a child, there is little data on ECE programmes, especially in urban settings. Furthermore, it is important to recognize the multitude of private ECE setups currently in place, ranging from small one room play schools to larger institutes backed by private secondary educational institutions. Data, when available, is scattered across multiple sources which are not always consistent, and there is also very little analysis. Any planning for expanding and improving ECCE services for children is therefore limited by this inadequacy of data, which if available, could have helped to draw up a comprehensive profile of this sub-stage of education in India and understand its gaps and challenges. Guidelines and regulations need to factor in spatial considerations so as to provide a healthy learning environment for children of all ages.

The Ministry of Human Resource Development and the National Informatics Centre (NIC) has come up with an online service that maps schools across India through a web-based GIS system. In this application, base map services like street maps, and high-resolution satellite images are available for better understanding of the topography/ terrain of the location.⁸⁶ The service lists over 80% of the schools from most of the states with the exception of Karnataka, Bihar, Sikkim, Meghalaya, Nagaland and Manipur where 50-80% of the data has been listed, Uttar Pradesh where 20-50% of the data has been listed and Jammu and Kashmir for which no data is available.⁸⁷ However, this valuable data source is not utilised to its fullest extent due to lack of awareness about its existence. Further, although data on individual schools is accessible, it is not easy to collate data to undertake any state or national level analysis.

Safety and Security

An important consideration for child-friendly cities is provision of a safe and secure environment for children. This includes both physical and mental well-being and must be perceived as such not only by adults but also by children themselves. Barriers in the built environment prevent safe access to facilities for children, primarily schooling and public spaces, and thereby negating the feeling of being secure. Increased road traffic, for example, has reduced children's independent mobility which in turn affects their health and development. Polluted and overcrowded urban areas provide little room for learning, play and recreation. Moreover, girls as well as children with disability are more vulnerable and feel more unsafe in using the public realm actively. This fear hampers their right to the city. Therefore, urban planning needs to incorporate safe public infrastructure and transport, green spaces, effective policing, disaster risk reduction along with active community engagement.

6A Socio-economic factors

The security blanket required by a child gets eroded for a number of reasons in urban settings. Protection of children from violence, exploitation and different forms of abuse such as physical and sexual exploitation, trafficking, child labour and practices like child marriage are essential to reducing vulnerability. The age of a child has been defined to be below 18 years as per the Juvenile Justice (Care and Protection of Children) Act, 2000. Thus, this report has taken into account offences committed on a victim under the age of 18 years as crime against children for the purpose of analysis. This section highlights some of the phenomena that shape the lives of children in urban areas, from the condition of the built environment to the impact of urban poverty on their engagement in paid work. In addition, children are impacted by the condition of infrastructure and public transport.



In urban India, **7.8 %** of children aged 5-14 years have lost their life due to **motor vehicle accidents**

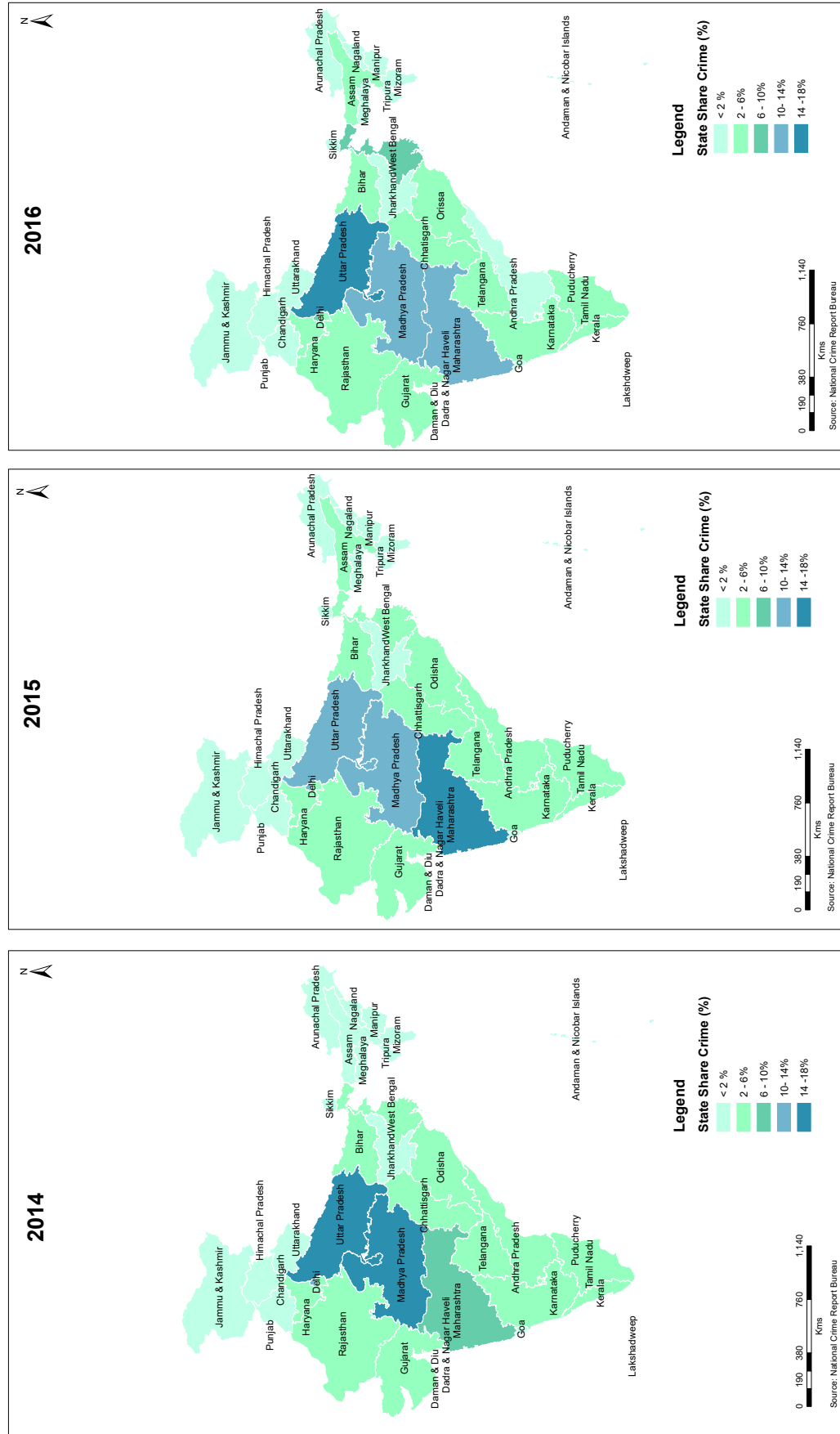


10.1 million children in the age group of 5-14 years work as marginal and main workers



Most recorded **crimes against children** are kidnapping (52.3%) & sexual offences (34.4%)

Map 6.1. Percentage state share of crime against children



6A.1 Traffic accidents and injuries

Road traffic injuries claim a disproportionate number of young lives in India. A report on the causes of death⁸⁸ highlighted that 7.8 per cent of youth aged 5-14 years have lost their lives due to motor vehicle accidents in urban areas (Fig 6.1). The highest percentage of deaths is recorded among urban young adults aged 15-29 years (15.3 per cent) is due to accidents (Fig 6.2). As per a report on road accidents,⁸⁹ about 4,80,652 accidents were recorded in 2016 which led to 1,50,785 deaths. Among cities, 7,486 accidents were recorded in Chennai followed by 7,375 accidents in Delhi. Bengaluru, Indore and Kolkata are the other top cities. Statistics from the NCRB showed that almost 43 children die in road accidents across the country each day and children below the age of 18 years dying in road accidents make up 10.5 per cent of all fatalities.⁹⁰

A study done by the Centre for Science and Environment, New Delhi on road accident risk and accident hotspots in Delhi revealed that about 16 people die and 58 are injured every hour due to road accidents, a death equivalent to wiping out about 40 per cent of the population of a small nation like Maldives in a year. As per this study, Delhi has the highest number of fatal road accidents among all cities, with five deaths per day. Eleven per cent of the global road injury deaths occur annually in India. Over the last two decades, while the total number of accidents and injuries data shows only a small downward dip, there has been a sharp increase in fatalities. The proportion of fatal accidents in total road accidents is up from 18 per cent in 2003 to 25 per cent in 2012. The impact of this harsh fate falls on the considerably large number of people walking and cycling on the city's roads, as well as those who use public transport.⁹¹ Apart from road safety, the lack of safe transport to school is a major concern for children in urban areas. Cramped autos, vans, taxis and buses ferrying students squeezed into the vehicle along with their school bags is a common sight in Indian cities. In small cities, unsafe rural transport vehicles (RTV) are used to transport children. The most common violations are overloading, over-speeding, reckless driving by the bus driver etc. Children living in urban poor communities are exposed to heightened risk as they have to walk through insecure areas to reach school. Schools on their own often have set policies in place for bus drivers, female attendants in the bus, information about the driver, etc. Some states such as Telengana⁹² and Delhi have issued

orders in this regard. While the Supreme Court has laid down guidelines in 1997 for school bus operations across the country, what is lacking, however, is an updated central level guideline which is actively enforced.⁹³

Most streets in Indian cities are by and large designed around the scale of an able adult and give priority to automobiles. The lack of pedestrian facilities such as properly designed foot paths, pedestrian crossings, street lights, adequate shading, etc., have deprived children of, especially those with disabilities, the opportunity to experience the urban environment safely. With automobiles dominating streets, it has become increasingly risky for children to bike, walk or play outside. In order to be child-friendly, it is imperative for cities to be designed in a way that minimises risk to children.

6A.2 Crime against children

Offences against children are multifarious- physical and mental abuse, trafficking and exploitation for labour, sexual abuse, among others. As per the Crime in India-2016 Compendium,⁹⁴ released by National Crime Records Bureau (NCRB), Ministry of Home Affairs, Government of India, a total of 1,06,958 crime incidences against children were reported in the country during 2016 as compared to 89,423 cases during 2014. States like West Bengal, Assam and Maharashtra show an increase in crimes against children from 2014 to 2016. Major notified crimes against children were kidnapping and abduction (52.3 per cent) and sexual offences cases (34.4 per cent). Uttar Pradesh accounted for the highest percentage of total crimes committed against children (15.3 per cent) in the country followed by Maharashtra (13.6 per cent) and Madhya Pradesh (12.9 per cent) (Map 6.1). In addition, 1,11,569 children aged below 18 years were reported missing (Table 6.1), numbers are higher for girls (70,394) than boys (41,175) and the highest proportion was recorded in West Bengal (16,881 children), Delhi (14,661 children), Madhya Pradesh (12,068 children) and Maharashtra (9982) (Map 6.2). The data on missing children was published for the first time in the 2016 NCRB report.

Statistics on cities showed that overall 19,081 crime cases against children were registered and maximum cases were reported from Delhi (7,392 cases), Mumbai (3,400 cases), Bengaluru (1,333 cases) and Pune (1,180 cases) (Table 6.2). About 67.7 per cent of cases were



of kidnapping and abduction while 24.2 per cent of the cases were sexual offences. Regarding number of victims below 18 years who were trafficked, the highest were from West Bengal (3,113), Rajasthan (2,519), Uttar Pradesh (822) and Gujarat (485). Other crimes like foeticide, infanticide and use of children for pornography are negligible; which could also be a result of incidents not being reported due to the societal pressures.

A survey conducted in New Delhi by the International Centre for Research on Women (ICRW) found that only 5 per cent of respondents said they felt “safe” or “very safe” in New Delhi’s public spaces and 73 per cent of respondents said that women and girls faced sexual aggression in their own neighbourhoods.⁹⁵ Further a report by Save the Children, WINGS 2018,⁹⁶ found that girls across urban centres travelling in public transport gave the highest sense of risk perception as 47 per cent of respondents said they feared for their safety. Nearly three in five girls feel unsafe in situations where the public space is overcrowded, while 53 per cent feel unsafe when there is inadequate lighting. The study, with an urban sample of 30 cities of varying sample, stated that spaces perceived as being unsafe included narrow bylanes of the neighbourhood, or near the school/work place, the road to the school/college/ local market, public transport, the local market itself and cinema halls. The frequency of interaction in these public spaces is inescapable, thereby heightening the everyday fear girls must go through.

The concept of a public space has now expanded to include cyber space as well. According the WINGS 2018 report,⁹⁷ nearly 1 in 10 girls who use social media shared incidents of harassment in cyber space. Further, they

were unaware of basic safeguards and firewalls. Both of these combines to reinforce the fragility of the situation. Cyber-crime like online sexual exploitation and cyber bullying are reported by the NCRB. However, no details or statistics related to children in urban areas are available in the NCRB report. According to one survey, 30 per cent of Indian children who were accessing the internet had experienced some form of cyber harm like cyber stalking, bullying, hacking or defamation.⁹⁸ It was also revealed that out of the 12 countries where the survey was conducted, Indian children faced the greatest risk combination of high access to internet services and low resilience.

6A.3 Drug addiction

There is very little documentation of drug users and drug abuse in relation to age and gender at both the country and state levels. Based on review of existing literature, it was observed that drug abuse among children and adolescents is higher than the general population. According to a report, 63 per cent of patients coming for treatment had been introduced to drugs at an age below 15 years, and alcohol, opium, cannabis, heroin and propoxyphene are most common drugs being abused by children.⁹⁹ In Delhi’s streets itself, as per the 2016 survey conducted jointly by the Women and Child Development Department and AIIMS in 2016, there are 70,000 addicts and their initiation into drugs happens as early as age nine.¹⁰⁰

Data collected by the National Commission for Protection of Child Rights from 135 cities in 27 states¹⁰¹ the data revealed that 85 per cent of the urban street children were into substance abuse and 58.8 per

cent among them were out of school. Regarding the substances, children were mostly addicted to tobacco, alcohol, inhalants and cannabis. In 2006, a study conducted by Plan India¹⁰² on children at railway platforms, found that Ganja and Smack were common among children. According to another report,¹⁰³ drug addiction was not limited to street children only as addiction was common among public school children and drugs were easily available at neighbourhood shops. Given the nature of the problem, easily accessible and affordable rehabilitation centres are far and in between. Specific allocation for de-addiction centres are undertaken on an ad hoc basis, and where available found to be understaffed and unequipped.¹⁰⁴

6A.4 Child labour in urban India

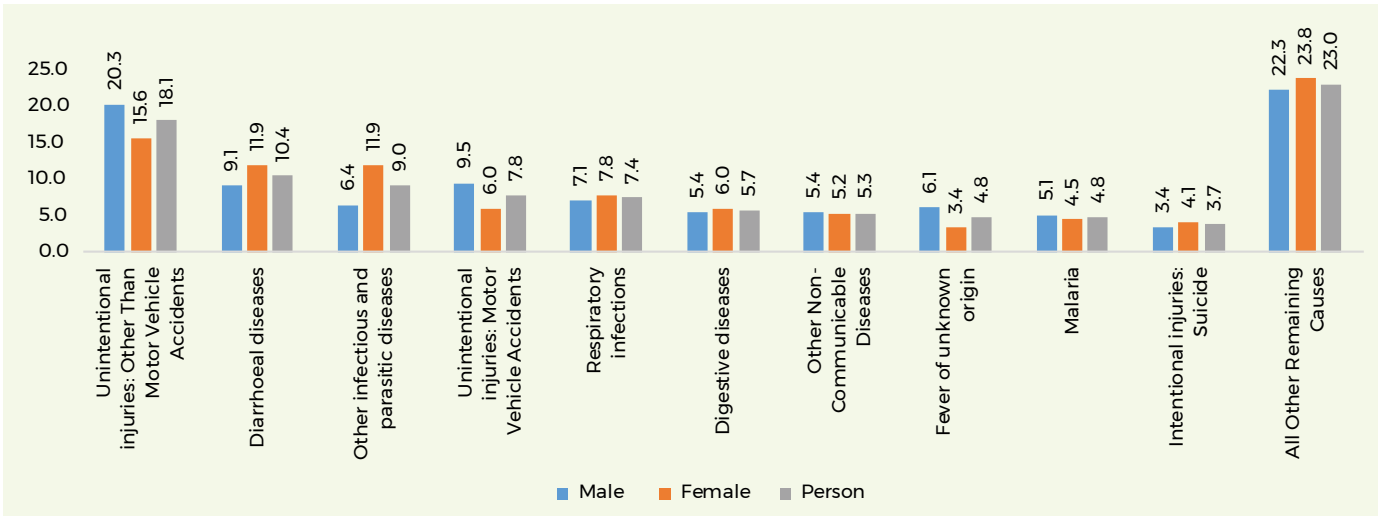
Child labour is largely defined as the engagement of children in economic activity full-time or on a part-time basis. In India, a number of legislations prohibit and criminalize child labour, including a comprehensive National Child Labour Policy Scheme. However, according to the official estimates of the Census 2011, at least 10.1 million children in the age group of 5-14 years were working children (marginal and main workers combined). Furthermore, one-fourth of the child workers belonged to the tender age group of 5-9 years.

While agriculture, small-scale industries, shops, activities on the streets, and domestic work is where most children are engaged, household chores, care of

younger children and/or fetching of water by walking long distances may also keep children (especially girl children) away from their recognised rightful environments i.e. educational institutions and play spaces. According to Save the Children,¹⁰⁵ the garment industry, firework industry and brick kilns are other areas where child labour is common. According to UNICEF¹⁰⁶, children are also engaged in match box and brass and lock-making factories, in embroidery, rag-picking, beedi-rolling, in the carpet-making industry, in mining and stone quarrying, and tea gardens amongst others. Girl children make up 56 per cent of the children who are involved in labour as per the Census. In fact, as per Child Rights and You (CRY), child labour in urban areas has increased by 53 per cent between 2001 and 2011.¹⁰⁷ In the same time period, child labour has increased by 240 per cent for girl children and by 154 per cent for boys in the 5-9 years age group.

Child labour may include “work that deprives children of their childhood, their potential and their dignity, and that is harmful to physical and mental development”.¹⁰⁸ The NSS (the 68th round is considered for this report) and Census classify worker data as per age. Table 6.3 shows work that the participation rate of children aged 7-14 years is higher in West Bengal (7.98 per cent) followed by Uttar Pradesh (2.79 per cent) and Odisha (2.41 per cent). Similarly, the work participation rate is above 20 per cent in West Bengal (22.27 per cent) and Uttar Pradesh (22.6 per cent) within the 15-18-year-old age group and it is between 15 and 20 per cent in

Fig 6.1. Causes of Death in age 5-14 years in Urban Areas, 2010-2013



Source: Cause of Death Statistics, 2010-13

the states of Rajasthan (17.05 per cent), Gujarat (16.7 per cent), Chhattisgarh (15.71 per cent), Punjab (15.52 per cent) and Odisha (15.35 per cent). According to an ILO report, child labour has come down by 2.6 million children between 2001 and 2011 Census. The decline is visible in rural areas whereas in urban areas, child labour has increased from 1.3 to 2 million between Census 2001 and 2011¹⁰⁹ and their demand is high in menial jobs.

6A.5 Marriage before attaining the legal age

Socio-economic factors are often cited as the drivers for the continuing trend of early marriages with low income groups being more conservative about the education and employment of girls. About one in five parents believe that it is better to get daughters married early rather than take the risk of something happening with her on her way to school/work/any public space. Correspondingly, over 80 per cent of girls in urban areas felt that girls who get married at an early age are forced to forfeit many of their aspirations and dreams they had for themselves.¹¹⁰

Table 6.4 shows data for urban India on males who were married before the age of 21 years and females who were married before completing the age of 18 years. The proportion of boys (1.7 per cent) married before attaining the legal age is higher than girls (1.43 per cent). It is in Rajasthan (2.6 per cent), Daman and Diu (3.22 per cent), Gujarat (2.52 per cent) and Dadra and Nagar Haveli (2.26 per cent) where the percentage of boys married before 21 years is the highest. But the fall in the number of children who were married is greater for boys, coming

down from around 10 per cent to 2.5 per cent, as compared to that for girls, from Census 2001 to 2011. For girls, the proportion is higher in Arunachal Pradesh (2.54 per cent), Bihar and Nagaland share same percentage (1.79 per cent) and Meghalaya and Uttar Pradesh (1.76 per cent). Clearly, underage marriage still persists in India which limits the education levels of children, their participation in skilled labour force and has a negative impact on their physical and mental health.

There is no central Act making the registration of marriages compulsory but individual states such as Bengal and Punjab have laws for compulsory recording.¹¹¹ Moreover, marriage registration rates are low in the country and a bill to amend the Registration of Births and Deaths Act, 1969, suitably to include compulsory registration of marriage has lapsed in Parliament, despite the backing of the Law Commission of India. The low marriage registration rate also hides the extent of underage marriages which are never registered. A centralized database for marriage registration records is still in the making.¹¹²

Conclusion

From 1953 onward, the NCRB has provided statistics on crimes including crime trends for all states and union territories. With time, the Bureau statistics have incorporated various heads and they provide several reports on crime statistics, accidental deaths, among others, giving due emphasis to children living in metropolitan cities. Data is disaggregated as per age for road accident injuries and deaths. However, data on injuries to children with disabilities during road accidents, mode of transport during accidents and proportion of male and female injured during accidents is missing.

The Census naturally classifies data on marital status as per age, but data on socio-economic background characteristics of persons married before attaining the legal age are essential for any safe or protective interventions, which are absent.

Child labour is an important issue in India as children are the cheap labour sources who are migrated or migrate themselves to urban areas due to poverty, lack of livelihood options, sometimes migrating along with their families in the event of conflicts or trafficked for



work. The barriers associated with child labour data are that the location and type of the work have changed from formal to informal work like home-based work. Thus, it's difficult to interpret whether data source covers children involved in domestic and/or home-based jobs in urban areas.

A number of policies are in place to ensure safety and security of children such as the National Policy on Child Labour (1987), the Juvenile Justice (Care and Protection of Children) Act, 2015, the Prohibition of Child Marriage Act (2006) and the Right to Act (2009). However, there is no substance abuse policy available and data on incidence of drug abuse among children and injectable drug users (IDU) are also lacking.¹¹³ To fill this gap, the Integrated Child Protection Scheme (ICPS) was introduced in 2009 by the Government of India through the service delivery structures under the scheme at state and district levels. To help children in distress, a telephone helpline - Childline - was launched by the Ministry of Women and Child Development. Operated by Childline India Foundation, it is India's first 24-hour, toll free, phone outreach service for children. The Childline receives an average of two million calls in a year, mostly from children wanting to be rescued from their place of work.¹¹⁴

6B Environment, Climate Change and Natural Disasters

Increasing urban population, high density and expansion of informal settlements have been observed in the last many years. It is expected that in a few decades from now the urban population in India will almost be the same as rural.¹¹⁵ Simultaneously, impacts of climate change are also noticeable in Indian cities, particularly Tier-II cities. Women, children and the elderly population who lack safeguards and inadequate care are vulnerable to seasonal flooding, heat waves, air and water pollution and other extreme weather events. The most affected are low-income households which enhances the vulnerability of children in these households. This section highlights the several problems that children face in association with environment, climate change and natural disasters.

6B.1 Climate change and disasters

Various studies have been conducted on the impact of

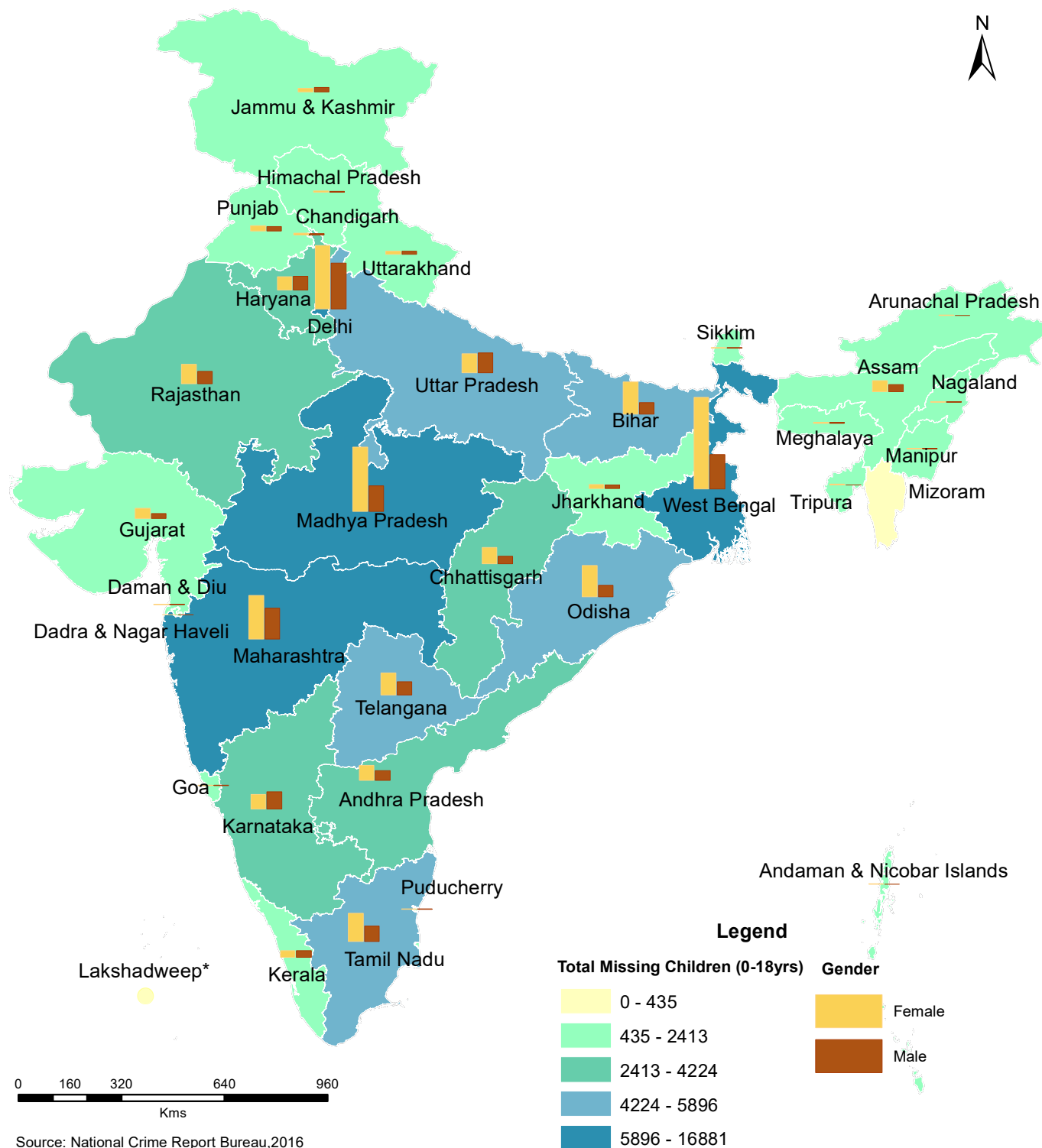
climate change and natural disasters and the results only confirm the vulnerability of women and children. For example, a study conducted on flood related mortality in Nepal revealed that the death rate of children was twice that of adults and the likelihood of pre-school girls dying was five times more than that of adult men.¹¹⁶

A Gorakhpur Environmental Action Group (GEAG) and UNICEF joint report with case studies of five Indian cities,¹¹⁷ stated that access to schools and safe places for shelter was difficult for children during heavy snowfall in Shimla. In addition, open defecation practices in informal settlements caused *E. coli* contamination in drinking water due to which skin diseases among children were high. Incidence of water and vector borne diseases among children was on the rise in all the five cities – Shimla, Indore, Grapkhpur, Panjim and Guwahati – due to poor sewerage and sanitation. The study noted that the efficiency of any urban system depends on the availability of infrastructure and services to support its population; almost all Indian cities face serious deficiencies in infrastructure and lifeline services.

The All India Disaster Mitigation Institute conducted a study to observe the impact of heat waves on vulnerable communities in Ahmedabad.¹¹⁸ The study highlighted that heat waves indirectly affected the livelihood of people while directly affecting the health of adult and children who were exposed to the sun. High incidence of sweating, weakness, heat strokes, heat rashes and cramps were reported. Also, it was revealed that the combination of hot days during summer and warm nights caused high mortality with slums being the most vulnerable to heat waves.¹¹⁹

For children in Indian cities, natural disasters are a near certain death warrant. In the face of a disaster, children are among the most vulnerable and susceptible to injury and death. Based on 2016 government data, about 107 towns and cities are considered to be in earthquake prone areas.¹²⁰ Among the global cities facing the highest climate change risk in the coming decades, Indian metropolis Kolkata is ranked 7th, Mumbai 8th and Delhi 20th.¹²¹ More than 50 per cent of those affected by natural disasters worldwide are children. Between 2000 and 2009, 8.45 million children under five years of age were affected by disasters in India, every year.¹²² During the unexpected floods that affected Kashmir in

Map 6.2: Number of missing children in India



September 2014, around 10 million people experienced large-scale inundation, which included about 4.25 million children. The flood indirectly affected around 3.43 million children and severely impacted approximately 0.82 million children.¹²³ The 2015 Chennai floods exposed fatal flaws in the city administration: the complete lack of ward-level data on vulnerable populations such as children, pregnant women, senior citizens. Such data was essential to locating households with vulnerable people to expedite the rescue and relief operation.¹²⁴

In 2017, a four-storey building with a nursery school collapsed during heavy rainfall in Mumbai. Though there were no loss of lives, the incident indicated that disaster management is an important dimension for minimising the greater risk to children, women, persons with disabilities and the elderly.

Another major aspect of disaster risk reduction is designing safe schools. Currently there are guidelines in place such as the National Disaster Management Guidelines-School Safety Policy published by the National Disaster Management Authority and the Manual on Safety and Security of Children in Schools developed by the National Commission for Protection of Child Rights. However, in recent years, schools in India have witnessed many catastrophic incidents: a fire led to the deaths of over 400 people, about half of them students, at a school's prize giving ceremony in Dabwali, Haryana in 1995; in 2001, a total of 31 teachers died and 95 were injured, while 971 students perished and 1,051 were injured in the Bhuj earthquake, Gujarat. Formal education was disrupted due to widespread damage to physical infrastructure. Many of the buildings collapsed and many others were declared unfit for use. Many of these buildings were poorly constructed, lacked earthquake resistant features and lacked maintenance. A fire at the Lord Krishna School in Kumbakonam, Tamil Nadu, took the lives of 94 children in 2004.¹²⁵

In India, where schools are often unprepared to respond to emergencies, attention needs to be accorded and support given to the efforts targeting school children and youth with the aim of making them aware of the threat of hazards and of the need and possibility of being better prepared for disasters. In this regard, the Government of India has approved a National School Safety Programme-a Demonstration Project which shall be implemented by the National Disaster Management

Authority (NDMA) in partnership with the Ministry of Human Resource Development (MHRD), State/UT Governments, national and international agencies in 43 districts of 22 states and UTs of the country falling in seismic zones IV & V.¹²⁶ This programme is being implemented in 8600 schools in 43 districts of 22 states, i.e. Jammu & Kashmir, Haryana, Meghalaya, Manipur, Himachal Pradesh, Gujarat, Assam, Nagaland, Punjab, Chandigarh, Rajasthan, Arunachal Pradesh, Sikkim, Delhi, Tripura, Uttarakhand, Bihar, Mizoram, Andaman & Nicobar, West Bengal, Uttar Pradesh and Maharashtra. This is a demonstration project to promote a culture of safety in schools by initiating policy level changes, capacity building of officials, teachers, students and other stake holders by undertaking information, education and communication activities, promoting non-structural mitigation measures and demonstrating structural initiatives in a few schools.¹²⁷

6B.2 Air Pollution

The environment is one of the most critical contributors to the global with 16.5 percent of deaths in children under five years recorded in 2012 and 15.5 percent in 2015. Further, more than 50 percent of lower respiratory infections in children under five years was found in low and middle-income countries.¹²⁸ More than three million children under five years die each year from environment-related causes and conditions¹²⁹ of which 5,70,000 children die from respiratory infections due to toxic air.¹³⁰ Air pollution is a major environment-related health threat to children and a risk factor for both acute and chronic respiratory diseases.¹³¹ Millions of children living in the world's largest cities, particularly in developing countries, are exposed to life-threatening air pollution two to eight times above the maximum World Health Organization (WHO) guidelines.

Air pollution consists of ambient (outdoor) air pollution and household (indoor) air pollution. Outdoor air pollution originates from natural and anthropogenic sources. Human activities that are major sources of outdoor air pollution include, fuel combustion from motor vehicles, heat and power generation, industrial facilities and municipal and agricultural waste sites amongst others.¹³² While outdoor pollutants are known risk factors for respiratory infections, indoor air pollution from solid fuels is one of the major contributors to the global burden of disease. According to a report, indoor



air pollution due to unclean cooking fuels such as coal, cow dung and crop residue increases the likelihood of stunting among children.¹³³ Close to half of deaths due to pneumonia among children under 5 years of age are caused by particulate matter (soot) inhaled from household air pollution.¹³⁴ According to WHO estimates, about 5 lakh deaths in India alone are due to unclean cooking fuels.¹³⁵ Thus, emphasis has been given to build separate kitchens for cooking or have sufficient ventilation within a house.

In 2012, ambient air pollution was responsible for 3 million deaths worldwide, and 1,69,250 deaths of children under five. In 2012, household air pollution was responsible for 4.3 million deaths worldwide, which includes 531,190 deaths of children under five from lower respiratory infections. Acute lower respiratory infections, in particular pneumonia, continue to be the biggest killer of young children and this burden is experienced most by children in low-and middle-income countries.¹³⁶

Recently, the Ministry of Environment, Forests and Climate Change stated air pollution to be one of the aggravating factors for many respiratory ailments and cardiovascular diseases. As per the data shared by the Ministry, more than 35,000 people have died due to Acute Respiratory Infections (ARI) across India in close to 10 years starting from 2006 to 2015. More than 26 million cases were reported every year during this period and 34.8 million cases came to light in 2014, which means more than 95,000 Indians of all ages report Acute Respiratory Infections (ARI) every day. Studies reveal that West Bengal reported the maximum number of ARI deaths, followed by Andhra Pradesh (along with Telangana), Uttar Pradesh, Madhya Pradesh,

Karnataka and Delhi. These states/UTs also reported a relatively higher number of ARI cases. International studies have been indicating that India's air pollution could be exacting a far higher toll in human lives.

Similarly, findings of the 2013 'Global Burden of Disease' (GBD) report noted that about 9,20,000 premature deaths occurred in India due to household air pollution and 5,90,000 premature deaths due to ambient air pollution in 2013. It ranked air pollution as one of the top 10 killers in the world.^{137 138} A study on ambient air quality, respiratory symptoms and lung function of children in Delhi done by the Central Pollution Control Board emphasises that children are more susceptible to environmental pollutants than the adults. To substantiate this fact, the study lists the following factors to explain the higher vulnerability of children to air pollution:¹³⁹

- Children generally spend more time and are also more active outdoors than adults. They are active outdoors during midday when air pollution levels tend to be higher.
- Children have significantly higher oxygen demands so their respiration rates are higher, and they inhale more air per unit of body weight than adults. Because of their smaller stature their breathing zone is lower, so they inhale air loaded with more particles.
- The diameter of their air passages is smaller and therefore more likely to be affected by inflammation produced by air pollution.
- Children's lungs are still developing and hence are more vulnerable to airborne particulates or pollutants.
- The efficiency of the detoxification system of the body develops in a time-dependent pattern. This in part accounts for the increased susceptibility of children at critical points of time.
- Children's immune system is immature and hence less active against inhaled pathogens.

Damage to the respiratory system in children can be devastating and permanent and the adverse effects of air pollution may be obvious in adult life owing to the long latent periods for several chronic diseases. Acute lower respiratory infection in childhood has been related to chronic cough in young adults, adult mortality from bronchitis and reduced lung function and increased bronchial reactivity. Malnourished children are more prone to bronchitis and pneumonia than normal-weight well-nourished children.¹⁴⁰

As per a study conducted by HEAL Foundation and Breathe Blue in 2015, more than one-third of school children in four big cities of India suffer from reduced lung capacity, with Delhi showing the worst results. The results of the study show the alarming impact of air pollution on the health of kids in urban India. In the survey, 2,373 children in Delhi, Mumbai, Bengaluru and Kolkata underwent a Lung Health Screening Test (LHST). The test determines how much air the lungs can hold, how quickly air can move in and out of the lungs, and how well the lungs take oxygen in and remove carbon dioxide out from the body. The test can detect lung diseases and measure the severity of lung problems. Poor results in LHST mean compromised lung function and high possibilities of contracting pulmonary diseases. Of the 735 students who took the test in Delhi, 40 per cent were found to have reduced good lung capacity. This meant that 4 out of every 10 children screened in Delhi failed the test. Children in the other three cities surveyed were only marginally better off. In Bengaluru, 36 per cent were found to have reduced lung capacity, followed by 35 per cent in Kolkata¹⁴¹ and 27 per cent in Mumbai. The worst affected are children who commute in open vehicles like autos, rickshaws etc. as they are more exposed to dust particles in the air. In Delhi alone, about 92 per cent children travelling in open vehicles fared 'poor' against 8 per cent who used closed vehicles such as cabs and buses. Similar trends were noticed in Mumbai (open: 79 per cent, closed: 21 per cent), Bengaluru (open: 86 per cent, closed: 14 per cent) and Kolkata (open: 65 per cent, closed: 35 per cent).¹⁴²

Based on a UNICEF report,¹⁴³ 17 million infants under one year of age were at the risk of brain damage who lived in areas where outdoor pollution was six times higher than international limits. The majority of the number of babies—more than 12 million—were from South Asian countries. It was also highlighted that inhaling air pollutants during pregnancy can affect the development of a foetus's brain.

While most Indian cities have taken certain steps to control ambient air pollution, e.g., the introduction of compressed natural gas (CNG) for auto-rickshaws in Delhi, phasing out of older vehicles that do not comply with emission norms across cities, and placing greater emphasis on mass transit, pollution levels especially the level of suspended particles—a significant threat

to health—continue to be dangerously high in many cities.¹⁴⁴ On a national level, the Central Pollution Control Board under the Ministry of Environment, Forest and Climate Change is currently executing a nation-wide programme of ambient air quality monitoring known as the National Air Quality Monitoring Programme (NAMP). Under N.A.M.P., four air pollutants viz., Sulphur Dioxide (SO₂), Oxides of Nitrogen as NO₂, Respirable Suspended Particulate Matter (RSPM / PM₁₀) and Fine Particulate Matter (PM_{2.5}) have been identified for regular monitoring at all the locations.¹⁴⁵

To specifically tackle indoor air pollution, the Ministry of Petroleum & Natural Gas has launched a scheme named Pradhan Mantri Ujjwala Yojana to provide LPG connections to women from Below Poverty Line (BPL) households, since the poor have limited access to cooking gas. Currently, the spread of LPG cylinders in the urban and semi-urban areas has been mostly in middle class and affluent households.¹⁴⁶ According to the NFHS-4 report¹⁴⁷, 21.7 per cent of urban households still use cooking fuels other than LPG/natural gas, with cheaper fuels such as dung, crop residue, coal/charcoal being the other available options.¹⁴⁸

Conclusion

A majority of the disaster risk reduction programmes in urban areas still do not specify the particular risks faced by children, specially the vulnerable sections. All the above information was based on news and micro-studies conducted in different places. Therefore, the primary need is to have a data base in association with environmental factors which gives information on the number of children affected during natural calamities, enumeration of the children injured and who died, including other details.

Children's issues need to be recognised and mainstreamed in climate change and disaster related policies and programmes. Urban decision making and governance on issues such as land use and air quality can have direct and adverse effects on the lives of both current and future generations of children. Therefore, by providing infrastructure and facilities for the most sensitive and vulnerable sections, cities can actually usher in greater opportunities across multiple demographic segments.

Policies and Frameworks

To improve the living conditions of all children and foster their rights, efforts to enhance the status of education, health and nutrition indicators must be backed by planning and policy vision. This chapter identifies broad policy actions and legislative frameworks that have been prepared and are being implemented to improve the urban realities that confront children. The initiatives showcased illustrate that it is possible to fulfil commitments to children—but only if all children receive due attention and investment.

7.1 International Initiatives

7.1.1 United Nations Convention on the Rights of the Child (UNCRC)¹⁴⁹

The UNCRC was the first international treaty to state the full range of civil, political, economic, social and cultural rights belonging to children. The convention was signed and ratified by India in 1992. Legally binding on state parties, the convention details universally recognised norms and standards concerning the protection and promotion of the rights of children—everywhere and at all times. The Convention emphasizes the correlation and interdependence of children's human rights. Across its 54 articles and two Optional Protocols, it establishes a new vision for children—one that combines a right to protection through the state, parents and relevant institutions with the recognition that the child is a holder of participatory rights and freedoms. This broad adoption demonstrates a common political will to protect and ensure children's rights, as well as a recognition that children in all countries, living in exceptionally difficult conditions, need special consideration. The values of the UNCRC stem from the Geneva Declaration of the Rights of the Child (1924), the Universal Declaration of Human Rights (1948), and the Declaration of the Rights of the Child (1959).⁹³ The Convention has changed the way children are viewed

and treated—i.e. as human beings with a distinct set of rights instead of as passive objects that require care and charity. The four core principles of the UNCRC—nondiscrimination; the best interests of the child; the right to life, survival and development; and respect for the views of the child—apply to all actions concerning children.

7.1.2 Child-friendly Cities Initiative (CFCI)¹⁵⁰

The Child-friendly Cities Initiative, launched by UNICEF and the United Nations Human Settlements Programme (UN-Habitat) in 1996, is the first multi-stakeholder partnership to put children at the centre of the urban agenda. Coinciding with increasing decentralisation and as part of efforts to strengthen governance, CFCI taps into the wider acceptance of community participation in decision-making to promote local accountability for children's rights.

The Child-friendly Cities approach has been adapted for diverse contexts: while in high-income countries, the focus has been largely on urban planning, safe and green environments and child participation, low-income countries have tended to prioritise service delivery in health, nutrition, education and child protection. In essence, cities aspiring to be 'child-friendly' commit to implementing the principles of the Convention on the Rights of the Child through inclusion of a strong participatory approach and mainstreaming of children's rights in budgets and policies. Tracking improvements in child well-being over time is an important component of the initiative. It has become apparent that traditional assessment methods are not always sufficient to reveal the extent of differences in child well-being across neighbourhoods within a city. Rigorous monitoring and evaluation, with children and communities playing a greater part in collection

and ownership of data, are necessary to ensure equitable progress. To address these needs, the Child-friendly Cities and Communities Research Initiative led to the development of a set of indicators and tools to assemble a wider range of disaggregated data, enabling more meaningful community engagement in local planning processes. The methodology is based on the experience of nine countries representing a variety of geographic, socio-economic and cultural contexts: Brazil, the Dominican Republic, France, Italy, Jordan, Morocco, the Philippines, Spain and the Sudan.

7.2 Constitutional Provisions¹⁵¹

The Constitution of India encompasses a majority of the UNCRC rights under its Fundamental Rights and Directive Principles, although it was written 40 years before the UNCRC. Constitutional guarantees directly relevant to children are mentioned in Table 7.1.

7.3 Relevant National Policy Frameworks

7.3.1 The National Policy for Children, 2013¹⁵²

The National Policy for Children was initiated in 1974 to identify and promote the needs and rights of children in India. The goal of the policy is to ensure the implementation of the UN Declaration of Rights as well as the constitutional provisions for children. It specifies the services the state should provide, before

Table 7.1: Constitutional Provisions

Article No.	Provision/Right
14	Right to equality
15	Right against discrimination
21	Right to personal liberty and due process of law
21 (a)	Right to free and compulsory elementary education for all children in the 6-14-year age group
23	Right to being protected from being trafficked and forced into bonded labour
24	Right to be protected from any hazardous employment till the age of 14 years
29	Right of minorities for protection of their interests
39 (e)	Right to be protected from being abused and forced by economic necessity to enter occupations unsuited to their age or strength
39 (f)	Right to equal opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity, and guaranteed protection of childhood and youth against exploitation and against moral and material abandonment
45	Provide early childhood care and education to all children until they complete the age of six years
46	Protect the weaker sections of the people from social injustice and all forms of exploitation
47	Right to nutrition and standard of living and improved public health



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and after birth and throughout a child's period of growth. The National Policy for Children 2013 adheres to the Constitutional mandate and guiding principles of the United Nations Convention of the Rights of the Child (UNCRC) and identifies the rights of children under 4 key priority areas, namely, Survival, Health and Nutrition, Education and Development, Protection and Participation.

7.3.2 The National Plan of

Action for Children, 2016¹⁵³

The National Plan of Action (NPA) for Children was initially formulated in 1992, following which India ratified the UNCRC. An updated Plan was subsequently adopted by the Government of India in 2005. The NPA has a significant number of key focus areas, such as:

- Complete abolition of female foeticide, female infanticide and child marriage. Ensuring the survival, development and protection of the girl child,
- Addressing and upholding the rights of children in difficult circumstances,
- Securing legal and social protection from all kinds of abuse, exploitation and neglect for all children

The NPA 2016 builds on such features and identifies objectives, sub-objectives, strategies and action points

under each key priority area defined in the National Policy for Children, 2013. It aims at purposeful convergence and strong coordination across different sectors and level of governance. It proposes comprehensive and actionable implementation, monitoring and evaluation framework through the establishment of National Coordination and Action Group for Children (NCAG) to be headed by the Minister for Women and Child Development.

7.3.3 National Charter for Children, 2003¹⁵⁴

The National Charter for Children, 2003 highlights the constitutional provisions towards the cause of children and the role of civil society, communities and families and their obligations in fulfilling children's basic needs.

- Seeks to secure for every child their inherent right to a healthy and happy childhood,
- Aims to address the root causes that negate the healthy growth and development of children,
- Attempts to awaken the conscience of the community in the wider societal context to protect children from all forms of abuse, while strengthening the family, society and the Nation.
- Provides that the State and community shall undertake all possible measures to ensure and protect the survival, life and liberty of all children.



7.3.4 National Health Policy, 2002¹⁵⁵

The main objective of the National Health Policy (NHP), 2002 is to achieve an acceptable standard of good health amongst the general population of the country. It built upon the National Health Policy of 2000. NHP-2002 aims to increase access to the decentralized public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure of existing institutions. Importantly, it seeks to ensure more equitable access to health services across India. Under this aim, a special focus is placed on children, women and socially disadvantaged sections of society. The NHP-2002 also specifies the goal of universal immunisation of children against all major preventable diseases. It envisages giving priority to school health programmes which aim at preventive-health education, providing regular health check-ups, and promotion of health-seeking behaviour among children.

7.3.5 National Nutrition Policy, 1993¹⁵⁶

The National Nutrition Policy, 1993 was introduced to combat the problem of undernutrition through the utilisation of direct (short term) and indirect (long term) interventions in the area of food production and distribution, health and family welfare, education, rural and urban development, woman and child development, etc.

7.3.6 National Policy on Child Labour, 1987¹⁵⁷

This policy contains the action plan for tackling child labour focusing on convergence of general development programmes for benefiting children wherever possible, and project-based interventions for the welfare of working children in areas of high concentration of child labour. The legislative framework is provided the Child Labour Act, 1986. A recent amendment in 2016, however, allowed child labour in “family or family enterprises” and reduced the list of hazardous occupations for children from 83 to include just three activities – mining, explosives, and occupations mentioned in the Factory Act.¹⁵⁸

7.3.7 National Policy on Education, 1986¹⁵⁹

The National Policy on Education (NPE), 1986 called for a ‘special emphasis on the removal of disparities

and to equalize educational opportunity, especially for Indian women, Scheduled Tribes (ST) and Scheduled Caste (SC) communities. To achieve these, the policy suggested expanding scholarships, adult education, recruitment of more teachers from SC communities, provision of incentives for poor families to send their children to school regularly, amongst other features. The NPE supported a ‘child-centered approach’ in primary education and launched ‘Operation Blackboard’ to improve primary schools nationwide.¹⁶⁰

7.3.8 Early Childhood Care and Education Policy (ECCE), 2013

The ECCE policy lays down certain conditions that must be followed by day cares and pre-schools. As per the policy, a maximum of 30 children may be accommodated in a classroom measuring 35 sq. m. Additionally, outdoor space of 30 sq. m and a separate area for cooking nutritional meals should be provided by all private and public preschools. The Ministry of Women and Child Development also published the National Early Childhood Care and Education (ECCE) Framework which detailed the implementation level details for ECCE institutions to follow.¹⁶¹

7.3.9 The Rights of Persons with Disabilities Act, 2016¹⁶²

Passed by the Indian Parliament to fulfill its obligations with the United Nations Convention on the Rights of Persons with Disabilities, the Act specifies that the government will take measures to ensure that women and children with disabilities enjoy their rights equally with others. With respect to children with disabilities, The Act states the duties of educational institutions (accessibility of facilities, individual attention, accessible transportation facilities, provision of attendants, etc), suggests measures that the Government should take to promote and facilitate inclusive education (conduction of survey for school going children in every five years for identifying children with disabilities, establishment of adequate number of teacher training institutions/ resource centers, provision of specialized books/learning materials, provision of scholarships to students with benchmark disability, etc) and addresses the matter of social security (provide support to women with disability and their children).

7.4 Guidelines and Schemes

There are provisions pertaining specifically to children in some of the guidelines and schemes notified by the Government. These range from green play spaces and day cares to safety concerns. Key provisions pertaining to children in urban areas are listed in Table 7.2.

7.4.1 Twelfth Five-Year Plan (2012-2017)

The most recent five-year plan specified the following key monitorable targets focused specifically on women and children –

- Reduce IMR to 25 and MMR to 1 per 1000 live births
- Improve child-sex ratio (0–6 years) to 950 by the end of the plan
- Reduce undernutrition among children aged 0–3 years to half of the NFHS-3 levels by the end of the plan
- Ensure that children receive a protective environment.

The plan envisaged engendering development and making it child-centric. The key strategy for children

is to fulfil the rights of children of survival, protection, participation and development.

1. Child Survival and Development
 - a. Restructured ICDS programme with revision of cost norms, strengthening of civil society partnerships, repositioning of anganwadis as 'Bal Vikas Kendra's', focusing on children under 3, strengthening early childhood care and education, 5 per cent anganwadi's-cum-creches, provision for additional anganwadi workers in 200 high burden districts, addition of innovative component of 'Sneha Shivirs'
 - b. Formulation of National Policy on Early Childhood Care and Education with curriculum framework and standards
 - c. Revision of National Policy for Children
2. Protection and Child Rights
 - a. Focused interventions to improve the Child Sex Ratio
 - b. Development and implementation of National, State and District Plan of Actions for children



Table 7.2 Guidelines and Schemes

Name of Guideline	Focus Areas	Some Specific Provisions
The Urban and Regional Development Plans Formulation and Implementation (URDPFI) Guidelines, 2014 ¹⁶⁷	<ul style="list-style-type: none"> Public health Safety and security Transport and mobility Living conditions Infrastructure Open Spaces Disaster management 	<ul style="list-style-type: none"> Encourages the use of non-motorized transportation Planning and provisions for barrier free built environments Provision of nursing homes, child welfare and maternity centres Provision of children's parks and other green spaces Guidelines for ecological, disaster resilient construction
Urban Greening Guidelines, 2014 ¹⁶⁸	<ul style="list-style-type: none"> Urban green spaces Safe play areas Child friendly planning 	<ul style="list-style-type: none"> Specify totlots as the lowest level in hierarchy of green areas, planned for a population of 2,500 as play-areas for children with an area of 125 sqm
National Urban Livelihoods Mission (NULM), 2013 ¹⁶⁹	<ul style="list-style-type: none"> Housing Infrastructure 	<ul style="list-style-type: none"> Enable poor to access gainful self-employment and skilled wage employment opportunities Provision of shelter equipped with essential services to the urban homeless in a phased manner Address livelihood concerns of urban street vendors through facilitating access to suitable spaces, institutional credit, social security, etc.
School Safety Guidelines by National Disaster Management Authority (NDMA) 2014 ¹⁷⁰	<ul style="list-style-type: none"> Safe schools Disaster resilience 	<ul style="list-style-type: none"> Integration of school safety in a more inclusive and holistic manner in the national policy sphere Capacity building of children, teachers, school personnel, state and district education machinery on school safety and disaster preparedness Anchoring/implementing child centered community-based disaster risk reduction in the local context Mainstreaming risk and safety education in the school curriculum
Integrated Child Development Services (ICDS) Guidelines for Early Childhood Care, 2017 ¹⁷¹	<ul style="list-style-type: none"> Development, welfare, and protection of the mother and child in the 0-6 age group Public health Living conditions Nutrition 	<ul style="list-style-type: none"> Offering of immunisation, health checkups and referral services Supplementary nutrition to children below 6 years, pregnant and lactating mothers (P&LM) by anganwadi workers and helpers Under the revised Nutritional and Feeding norms which have been made effective from February 2009, State Governments/ UT's have been requested to provide 300 days of supplementary food to the beneficiaries in a year Financial Norms of Supplementary Nutrition were revised, with effect from 22nd October 2012, and were to be rolled out in a phased manner under the restructured ICDS
The Rajiv Gandhi National Creche Scheme for the Children of Working Mothers, 2015 ¹⁷²	<ul style="list-style-type: none"> Early education Health 	<ul style="list-style-type: none"> Package of - Daycare facilities, including sleeping facilities Early stimulation for children below 3 years and pre-school education for children in the 3-6-year old age group, Supplementary nutrition (to be locally sourced) Growth monitoring Health check-ups and immunisation procedures
Central Board of Secondary Education (CBSE) Affiliation Byelaws ¹⁷³	<ul style="list-style-type: none"> Education School safety WASH facilities Infrastructure 	<ul style="list-style-type: none"> Every school should organize at least one-week training programme for teachers every year in association with any teachers training institute recognised by the State or Central Government or by any agency identified by the Board The school should observe prescription form the municipal authority/ district/collectorate/transport department regarding drinking water, fire safety and transport precautions in the school Specifications of class size, required facilities (libraries, science labs, rooms for extracurricular activities)
Guidelines and Space Standards for Barrier Free Built Environment for Disabled and Elderly Persons, 1998 ¹⁷⁴	<ul style="list-style-type: none"> Infrastructure 	<ul style="list-style-type: none"> In the buildings meant for the pre-dominant use of the children, it will be necessary to suitably alter the height of the handrail and other fittings, fixtures, etc.

Name of Guideline	Focus Areas	Some Specific Provisions
National Guidelines on Infant and Young Feeding, 2004 ¹⁷⁵	<ul style="list-style-type: none"> • Nutrition 	<ul style="list-style-type: none"> • Initiation of breastfeeding immediately after birth, preferably within one hour. • Exclusive breastfeeding for the first six months i.e., the infants receive only breast milk and nothing else - no other milk, food, drink or water • Appropriate and adequate complementary feeding from six months of age while continuing breastfeeding • Continued breastfeeding upto the age of two years or beyond.
National Commission for Protection of Child rights (NCPCR) Guidelines, 2007	<ul style="list-style-type: none"> • The Manual on Safety and Security of Children in Schools, 2017¹⁷⁶ • Education • School safety • Infrastructure 	<ul style="list-style-type: none"> • Physical safety addressing school buildings, fire safety management, earthquake management, flood/cyclone/landslide management, electric safety, safety from constructional hazards, safety in the playground and sports activities, water safety, laboratory safety, transport management and safety • Emotional and personal safety addressing trauma management safety of the children with disabilities, health, sanitation and hygiene, safety of children against sexual abuse, social and emotional safety, cyber safety
	<ul style="list-style-type: none"> • Guidelines for Organizing Child friendly Melas and Large Gatherings¹⁷⁷ • Public spaces • Safety and Security 	<ul style="list-style-type: none"> • A child rights corner with different stalls on different schemes of the Government • A child rights desk for information • Provision of a child tracking wrist band with telephone numbers so that children do not go missing • Volunteers with bright jackets to trace children without child tracking wrist bands and give support. Volunteers could be students who are trained by ChildLine • Safe drinking water facilities • Safe toilet facilities • Emergency response and disaster management
Integrated Child Development Scheme (ICDS), 1975 ¹⁷⁸	<ul style="list-style-type: none"> • Nutrition • Education 	<ul style="list-style-type: none"> • Aims to reduce infant mortality child malnutrition and to provide pre-school education • Provides health services (supplementary nutrition, immunisations, health check-ups, referral services) to children under the age of 6 and pregnant or lactating mothers • Under this scheme, children in the 3-6 years age group should be able to access pre-school, non-formal education, and women and adolescent girls (in the 15-45 years age group) should be able to access nutrition and health education
Mid-Day Meal Scheme, 1995 ¹⁷⁹	<ul style="list-style-type: none"> • Nutrition • Education 	<ul style="list-style-type: none"> • Improve the effectiveness of primary education by improving the nutritional status of children thereby reducing malnutrition. • Attract children from disadvantaged sections, especially girls from Dalits and Adivasi tribes to school, thereby increasing attendance, reducing dropout rates & promoting women empowerment through literacy. • Promote a feeling of oneness and secularism amongst various different religions and cultures
Janani Suraksha Yojana, 2005 ¹⁸⁰	<ul style="list-style-type: none"> • Health 	<ul style="list-style-type: none"> • Aims to reduce maternal and neonatal mortality through promotion of institutional delivery among poor pregnant woman • Provides a grading scale of assistance for financial assistance, based on the categorization of States as well as whether the beneficiary was from a rural or urban area
Sarva Shiksha Abhiyan, 2000 ¹⁸¹	<ul style="list-style-type: none"> • Education • Infrastructure 	<ul style="list-style-type: none"> • Aim is for universalizing elementary education, goals include universal access and retention, bridging of gender and social category gaps in education and enhancement of learning levels of children • Provision of interventions such as building of school infrastructure, provisioning for teachers, periodic teacher training and academic resources support. • Provision of educational resources such as libraries, computers, textbooks, etc

Name of Guideline	Focus Areas	Some Specific Provisions
Kishori Shakti Yojana, 2000 ¹⁸²	<ul style="list-style-type: none"> • Nutrition 	<ul style="list-style-type: none"> • Broad objective is to nutritional, health and development status of adolescent girls • Promote awareness of health, hygiene, nutrition and family care • Help adolescent girls gain a better understanding of their social environments
National Child Labour Project, 1987	<ul style="list-style-type: none"> • Safety and Security • Education 	<ul style="list-style-type: none"> • To eliminate all forms of child labour through • Identification and withdrawal of all children in the Project Area from child labour, • Preparing children withdrawn from work for mainstream education along with vocational training • Ensuring convergence of services provided by different government departments/agencies for the benefit of child and their family • To contribute to the withdrawal of all adolescent workers from Hazardous Occupations/ Processes and their Skilling and integration in appropriate occupations through • Identification and withdrawal of all adolescent workers from hazardous occupations / processes, • Facilitating vocational training opportunities for such adolescents through existing scheme of skill developments • Raising awareness amongst stakeholders and target communities, and orientation of NCLP and other functionaries on the issues of 'Child Labour' and 'employment of adolescent workers in hazardous occupations/processes'; and • Creation of a Child Labour Monitoring, Tracking and Reporting System.
Integrated Child Protection Scheme (ICPS), 2009 ¹⁸³	<ul style="list-style-type: none"> • Safety and Security 	<ul style="list-style-type: none"> • Objectives of the ICPS include: • To institutionalize essential services and strengthen structures • To enhance capacities at all systems and persons involved in service delivery • To create database and knowledge base for child protection services • To strengthen child protection at family and community level • To coordinate and network with government institutions and non-government institutions to ensure effective implementation of the scheme • To raise public awareness about child rights, child vulnerability and child protection services.

- c. Harmonization of child related legislative provisions and child-sensitive jurisprudence
- d. Ending all forms of child labour
- e. Addressing emerging needs of vulnerable children and children of excluded socio-religious community groups

Special attention has been given to the care and protection of the girl child by making Child Sex Ratio a monitorable target. Further, the introduction of the 'Dhana Laxmi' scheme (a girl child incentive scheme), SABLA scheme for empowerment of girls, District Plan of Action for the girl child, and the provision of quality education for girls reaffirms the importance placed on the girl child.

7.5 Key National Urban Missions^{163 164}

The centrality of children to urban planning is recognised by the Government and is reflected in the framework of

several urban missions launched by it. Some of the key missions and schemes are listed below. (Table 7.3)

7.6 Conclusion

Though India has a robust legislative and policy framework for securing child rights and fostering development of children, there is a need for significant improvement in the living condition of children in urban areas. To achieve this, children's rights have to be seen in conjunction with the barriers they face in the urban environment. Only when physical planning and design of built environment is responsive to the needs of children, can it facilitate protection of children's rights. This is mainly due to the fact that the existing policies and legislative framework primarily focus on child rights and social aspects of children's development such as health and education but have not given much significance to their living conditions and urban environments.

Table 7.3: Urban Programmes and Initiatives under current Government

Name	Provisions and Objectives
Smart Cities Mission, 2015	<ul style="list-style-type: none"> • The Mission statements and guidelines state: • Recognition of children as stakeholders in the urban development framework. • Creation of walkable localities: Inclusion of pedestrian friendly pathways, encouragement of non-motorised transport (e.g. walking and cycling); creation or refurbishment of the road network not only for vehicles and public transport, but also for pedestrians and cyclists; provision of necessary administrative services within walking or cycling distance; attention to reducing congestion, air pollution and resource depletion. • Preservation and development of open spaces: development of parks, playgrounds, and recreational spaces in order to enhance the quality of life of citizens, reducing the urban heat effects in areas and promoting eco-balance; encroachment-free public areas, ensuring safety of citizens especially children, women and elderly. • Housing and inclusiveness: This includes expansion of housing opportunities for all.
Atal Mission for Urban Rejuvenation and Transformation (AMRUT), 2015	<ul style="list-style-type: none"> • Enhancement of living conditions of children by improving basic infrastructure services • Enhancement of amenity value of cities by creation and upgradation of green spaces, parks and recreation centres, especially for children • Development of at least one children's park every year and the formulation of a mechanism for maintenance of parks, playgrounds and recreational areas relying on People Public Private Partnership (PPPP) mode • Significant focus on children's health - establishment of pollution monitoring system, including Air Quality Monitoring
Swachh Bharat (Clean India) Mission, 2014	<ul style="list-style-type: none"> • Aims to improve living conditions of children • Aims to make the country open-defecation free • Improving access to better sanitation facilities at both homes and schools
National Nutrition Mission (POSHAN Abhiyan), 2017	<ul style="list-style-type: none"> • Aim to attain proper nutritional status among children from 0-6 years, adolescent girls, pregnant women and lactating mothers Reduce stunting, under-nutrition, and anaemia among young children, women, and adolescent girls; • Lowering of low birth weight by at least 2% per annum.
Samagra Shiksha Scheme, 2018 ¹⁸⁴	<ul style="list-style-type: none"> • Provision of quality education • Enhancing learning outcomes of students • Bridging social and gender gaps in social education • Provision of annual grant of Rs.5000 to Rs.20000 for strengthening libraries in schools under the programme
Khelo India School Games, 2018 ¹⁸⁵	<ul style="list-style-type: none"> • Annual national level, multidisciplinary grassroot games for school kids under the age of 17. • Aim to revive sports culture in India • To build a strong foundation for all sports in India • Providing financial support to talented youth
The National Programme on School Standards and Evaluation (NPSSE/'Shaala Siddhi'), 2016 ¹⁸⁶	<ul style="list-style-type: none"> • Aims to enable schools to evaluate their performance in a more focused and strategic manner and facilitate them to make professional judgments for improvement. • Establishment of agreed set of standards • Provide guidelines to schools for self-evaluation
Beti Bachao, Beti Padhao, 2015 ¹⁸⁷	<ul style="list-style-type: none"> • Prevention of gender biased sex selective elimination • Ensuring survival & protection of the girl child • Ensuring education and participation of the girl child
Mission Indradhanush, 2014 ¹⁸⁸	<ul style="list-style-type: none"> • Aims to cover all children by 2020 who are either unvaccinated, or are partially vaccinated against vaccine preventable diseases • Provision of special immunisation campaigns. (for example, in urban slums, construction sites) • Free vaccines to all children to protect them against Tuberculosis, Diphtheria, Pertussis, Tetanus, Polio, Hepatitis B, Pneumonia and Meningitis amongst others

Name	Provisions and Objectives
National Urban Health Mission, 2013 ¹⁸⁹	<ul style="list-style-type: none"> • Need based city specific urban health care system to meet the diverse health care needs of the urban poor and other vulnerable sections – including street children • Institutional mechanism and management systems to meet the health-related challenges of a rapidly growing urban population • Partnership with community and local bodies for a more proactive involvement in planning implementation, and monitoring of health activities • Availability of resources for providing essential primary health care to urban poor • Partnerships with NGOs, for profit and not for profit health service providers and other stakeholders
Pradhan Mantri Ujjwala Yojana, 2016 ¹⁹⁰	<ul style="list-style-type: none"> • Provide LPG connections to women from households below the poverty line
Unique Identification Authority of India (UIDAI), 2016 ¹⁹¹	<ul style="list-style-type: none"> • UIDAI was created with the objective to issue Unique Identification numbers (UID), named as “Aadhaar”, to all residents of India that • is robust enough to eliminate duplicate and fake identities • can be verified and authenticated in an easy, cost-effective way • Regarding children, the UIDAI provides special coloured Aadhar cards for children aged below five years, with a mandatory biometric update at the age of 15

Though the current state of development of Indian cities clearly shows that urban life can be harsh towards the most sensitive and vulnerable inhabitants i.e. children, it need not continue to be the same. The current urban development agenda in the country provides a great opportunity for creation of better cities for children. Child-friendly city planning is not just a munificent concept but is actually feasible and pragmatic. Countries such as Canada, New Zealand and Finland all have policies in place which encourage child friendly practices.¹⁶⁵ In Canada, the Child and Youth Friendly City Strategy was adopted in 2010 following a consultative process that involved children, youth, parents, municipal staff and a range of community stakeholders. In Edmonton, Canada, The Child Friendly Edmonton City Council Initiative aims to make the city-more child-friendly by making it safe, accessible, well-designed with services fit for children and where children and youth are listened to, treated with respect, and valued for their individual contributions. A similar consultative process with 6000 children and young people also led to the city of Auckland in New Zealand adopting the ‘I am Auckland – The Children and Young People’s Strategic Action Plan’.¹⁶⁶

In India itself, a desire to create more child friendly

urban environments is clearly present. This has been proven by Bhubaneswar city which showcased a vision to become a child-friendly city and thereby won the national ‘Smart Cities Challenge’, topping the list of 20 Smart Cities under the Smart City Mission of Ministry of Urban Development, Government of India. Another city, Pune, which is also part of the top 20 selected Smart Cities, has envisioned the creation of a safe city for children in its Smart City proposal. Cities like these have highlighted the fact that it’s essential to put children at the heart of the planning and decision-making framework to develop more livable cities. Urban areas offer great potential and opportunities to secure children’s rights and accelerate progress towards the Sustainable Development Goals (SDGs).

Cities need to look beyond the broad statistical averages and address the specific needs of children belonging to different age groups or strata—the differently-abled, homeless, children living in slums, migrant children etc. to improve living conditions for all children. Stakeholders from all walks of urban life need to make collective efforts and pool resources and energies to create better cities for children—ultimately making cities better for everyone.



8. SDGs and Children

8.1 SDGs and Children

The Sustainable Development Goals (SDGs), laid out in the 2030 Agenda for Sustainable Development, reflect a globally agreed plan of action to protect and promote the planet and its people while ensuring prosperity and peace for all by the year 2030.¹⁹² The SDGs build on the Millennium Development Goals (MDGs), which in September 2000 rallied the world around a common 15-year agenda to tackle the indignity of poverty. The new SDGs, and the broader sustainability agenda, go much further than the MDGs, addressing the root causes of poverty and the universal need for development that works for all people.¹⁹³

India's national development goals mirror the focus of the SDGs. Programmes such as the Pradhan Mantri Awas Yojana (PMAY), Pradhan Mantri Ujjwala Yojana, Beti Bachao Beti Padhao, Integrated Child Development Services (ICDS), etc. all further the implementation of that component of SDG agenda which responds directly to well-being of children and families. Additionally, the Indian Parliament has also organized several forums such as the South Asian Speakers' Summit in February 2017, and SDG related insights were provided to the Members of Parliament through the Speaker's Research Initiative, which also held workshops to discuss the same.^{194,195}

The SDGs are universal in scope, and their call to leave no one behind puts the world's most vulnerable and marginalized people – including children – at the top of the agenda. While the goals focused on sustainable development, they are inseparably linked to human rights generally, and the rights of children specifically. Children are at the centre of all the SDGs, whether these are related to poverty, hunger, health, education, gender equality or climate change.

8.2 Children in Sustainable Development Goals – Goals, Indicators and Gaps



The 2030 Agenda includes 17 Global Goals addressing the social, economic and environmental dimensions of sustainable development. Attached to these Goals are 169 concrete targets measured by 230 specific indicators of which 50 are directly related to children, as stated by UNICEF¹⁹⁶. While the targets are fixed, the starting points are different for different countries. It is important to know where have we reached and where we want to be. The baseline data on each of the targets is the starting point to formulate relevant and pointed policies and schemes to achieve the respective targets. An in-depth analysis of existing national data to determine the baseline and identify data gaps is imperative to localise the SDGs.

The following table presents a rapid review of targets and indicators of SDGs that are relevant to children as well as the gaps in the data to measure the progress and effectively plan to realize these targets.





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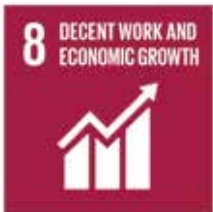
Table 8.1: Rapid review of Indicators related to Children and SDGs and data availability



Priority Targets ¹⁹⁷ for children	Selected Indicators to measure progress	Availability of Data ○ No Data ○ Insufficient Data ○ Data Available	Data Sources Available	India towards achieving specific goals (NITI Aayog) ¹⁹⁸
No poverty  4/6 Targets	<ul style="list-style-type: none">- Proportion of population living in households with access to basic services- Children living below national poverty line- Children living in households in extreme poverty- Poverty headcount ratio at \$1.25/day (%)- Number of deaths, missing persons and directly affected persons attributed to disasters per 100,000 population- Proportion of total government spending on essential services (education, health and social protection)	<div></div> <div></div> <div></div> <div></div> <div></div> <div></div>	<ul style="list-style-type: none">• NSS (Different Rounds)• 2011 Census	Key Schemes and Programs <ul style="list-style-type: none">- National Urban Livelihoods Mission (NULM)- National Social Assistance Programme (NSAP)- Mahatma Gandhi National Rural Employment Guarantee Act (MNREGA)- National Social Assistance Programme (NSAP)- Pradhan Mantri Jan Dhan Yojana (PMJDY)- Housing for All by 2022- The National Disaster Management Plan, 2016
Remarks: <ul style="list-style-type: none">• Population of children living in slum areas is taken as a proxy indicator, but this number does not necessarily correspond to actual number of children living Below Poverty Line.• Any data on BPL households provides a guesstimate of number of children, and not the actual picture.• There is no disaggregated data on number of children or families affected by recent major disasters in the country.				Steps Taken: <ul style="list-style-type: none">- Past Poverty Reduction- Anti-Poverty Programmes- Strengthening Social Safety Nets- Ensuring Access to Basic Services- Promoting Resilience against Disasters
Zero Hunger  3/8 Targets	<ul style="list-style-type: none">- Prevalence of undernourishment (%)- Prevalence of underweight children under 5 years of age (%)- Prevalence of stunting, under-5s (%)- Prevalence of wasting, under-5s (%)- Prevalence of Micronutrient deficiencies in children as compared to the overall disease burden (%)- Prevalence of moderate or severe food insecurity in the population, based on the Food Insecurity Experience Scale (FIES)(Global indicator)	<div></div> <div></div> <div></div> <div></div> <div></div> <div></div>	<ul style="list-style-type: none">• NFHS 2015-16• Annual Health Survey report• Evaluation Report on Integrated Child Development Services (ICDS) released in March 2011 by Planning Commission (covering 300 ICDS projects)	Key Schemes and Programs <ul style="list-style-type: none">- Integrated Child Development Scheme (ICDS)- National Food Security Mission (NFSM)- Mid-Day Meal Scheme- Public Distribution System (PDS)- Krishonnati Yojna- National Nutrition Mission (POSHAN Abhiyan), 2017- National action plan on Climate Change
Remarks: <ul style="list-style-type: none">• Data on availability of food to families all year round is not directly available.• No data is available on number of children receiving exclusive breastfeeding for first 6 months, important for the reduction of nutritional deficiencies in infants.				Steps Taken: <ul style="list-style-type: none">- Access to Nutritious Food- Sustainable and Adaptive Agriculture- Agricultural Productivity and Farmers' Income


Priority Targets ¹⁹⁷ for children	Selected Indicators to measure progress	Availability of Data ● No Data ● Insufficient Data ● Data Available	Data Sources Available	India towards achieving specific goals (NITI Aayog) ¹⁹⁸
<div>Good health and well-being</div> <div><div>3</div><div>GOOD HEALTH AND WELL-BEING</div><div></div></div> <div>11/13 Targets</div>	- Population coverage of essential health services (%)		<ul style="list-style-type: none">NFHS 2015-16SRSIndian TB Report 2018-Annual Status ReportAnnual HIV Sentinel SurveillanceCauses of Death Statistics 2010-13Global Adult Tobacco Survey: Fact Sheet 2009-10HMIS Monthly data2017 Health SDG Profile: India by WHO	Key Schemes and Programs <ul style="list-style-type: none">National Health Mission (NHM)Pradhan Mantri Swasthya Suraksha Yojana (PMSSY)Rashtriya Swasthya Bima YojnaCommunicable diseases: Integrated Disease Surveillance Project, National Vector Borne Disease Control ProgramNon-communicable diseases, trauma and injuries: National Iodine Deficiency Disorders Control Programme, National Mental Health Programme (NMHP), National Programme for Prevention and Control of Deafness (NPPCD), Universal Immunisation Programme (UIP), National Programme for Control of Blindness(NPCB) and the Pulse Polio programmeMission Indradhanush, 2014Rashtriya Bal Swasthya KaryakramNational Urban Health Mission (NUHM)Janani Suraksha YojanaRevised National Tuberculosis Control Program (RNTCP)Pradhan Mantri Suraksha Bima Yojana (Include 18-70 years)
	- Health facilities with essential medicines and life saving commodities (%)			
	- Maternal mortality ratio (per 100,000 live births)			
	- Neonatal mortality (per 1000 live births)			
	- Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods (%)			
	- Births attended by skilled health personnel (%)			
	- Under-5 mortality (per 1000 live births)			
	- Vaccination coverage of children between 12-23 months (%)			
	- Death rate from CDs (per 100,000)			
	- Death rate from NCDs (per 100,000)			
	- Incidence of tuberculosis (per 100,000)			
	- Number of new HIV infections per 1000 uninfected population by age, sex			
	- Prevalence of obesity in children (%)			
	- Death rate from household and ambient pollution (per 100,000)			
	- Death rate due to road traffic injuries			
	- Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)			
Remarks: <ul style="list-style-type: none">Prevalence of Acute Respiratory Illness (ARI) among children under 5 years is available in NFHS 2015-16, however direct data on number of deaths reported due to air pollution (including cases due to harmful effects on brain and nervous system) is not available.Aggregated data on communicable and non-communicable diseases does not provide information distributed across different age groups.			Steps Taken: <ul style="list-style-type: none">Improving the health status of women and childrenPreventing Communicable DiseasesReducing the Burden of Non-Communicable DiseasesEnsuring access to basic health facilities for all	

Priority Targets ¹⁹⁷ for children	Selected Indicators to measure progress	Availability of Data ○ No Data ● Insufficient Data ○ Data Available	Data Sources Available	India towards achieving specific goals (NITI Aayog) ¹⁹⁸
Quality Education  5/10 Targets	<ul style="list-style-type: none"> - Literacy rate of 7-18 years - Proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being, by gender - Net Enrolment Ratio (NER) at Primary/ Upper-Primary/ Secondary/ Senior Secondary levels - Children who have attended or not attended educational institutions by gender(%) - Children who have dropped-out of educational institutions by gender (%) - Children with disabilities (5-18years) who have and who have not attended educational institutions - Proportion of schools with access to: (a) electricity; (b) Internet for pedagogical purposes; (c) computers for pedagogical purposes; (d) adapted infrastructure and materials for students with disabilities; (e) basic drinking water; (f) single-sex basic sanitation facilities; and (g) basic handwashing facilities (as per the WASH indicator definitions) - Total public expenditure on education as a percentage of GDP 	<div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div>	<ul style="list-style-type: none"> • Census 2011 • DISE report • Anganwadi (AWCs) data • ASER (Rural) 2017 	Key Schemes and Programs <ul style="list-style-type: none"> - Sarva Shiksha Abhiyan - Integrated Child Development Scheme (ICDS) - Infrastructure Development of Minority Institutes (IDMI) - Mahila Samakhya, Prarambhik Shiksha Kosh - Rashtriya Madhyamik Shiksha Abhiyan (RMSA) - Inclusive Education for Disabled at Secondary Stage (IEDSS) - Saakshar Bharat - Special assistance to tribal sub-plan and umbrella scheme for education of scheduled tribes (ST) children - Swachh Vidyalaya under Swachh Bharat Mission - National Bal Swachhta Mission
	Remarks: <ul style="list-style-type: none"> • There is no disaggregated data available on early childhood (0-6) education to measure effective learning for all. • AWCs provide information on children achieving non-formal preprimary education, but there is no data available on the children using private play schools or not enrolled in any of the early childhood centres. • In Urban areas, it is also important to collect disaggregated information on proportion of children availing financial subsidies and scholarships, thus providing a measure of the progress towards the goal. • There is no data to measure the quality of education such as proportion of children at the end of lower secondary achieving at least minimum proficiency level in reading/ mathematics. 			Steps taken: <ul style="list-style-type: none"> - Budget for Children - Improvement in number of schools with toilets - Mahila Shakti Kendras in all Anganwadi Centres

Priority Targets ¹⁹⁷ for children	Selected Indicators to measure progress	Availability of Data ● No Data ● Insufficient Data ● Data Available	Data Sources Available	India towards achieving specific goals (NITI Aayog) ¹⁹⁸
<div><div>5 GENDER EQUALITY</div><div></div></div> <div>5/9 Targets</div>	- Literacy rate in female (as compared to % male)		<ul style="list-style-type: none">• NFHS• Census 2011• NSS• NCRB• NCPCR	Key Schemes and Programs <ul style="list-style-type: none">- Beti Bachao Beti Padhao- Maternity Benefit Programme- Nirbhaya- Kishori Shakti Yojana- National Mission for Empowerment of Women (NMEW)- Ujjawala: Prevention of trafficking and commercial sexual exploitation- Women Helpline Scheme
	- Child Sex Ratio			
	- Women aged 20-24 years married before 18 years (%)			
	- Female labor force participation (15-18 years) (% male)			
	- Gender wage gap (15-18 years) (% male wage)			
	- Proportion of time spent on unpaid domestic and care work, by sex, age and location (%)			
	- Households having access to clean fuels (%)			
	- Households having access to improved sanitation (%)			
	- Households having access to improved water (%)			
	- Proportion of trafficking of girl children to total children trafficked during the calendar year(%)			
	- Proportion of cases reported under the Prohibition of Child Marriage Act (early marriage of children below 18 years of age) total crime against children (%)			
	- Proportion of crime reported against girls to total crime reported against children in the country during the calendar year (%)			
	Remarks: <ul style="list-style-type: none">• Disaggregated data on the percentage reduction of reported crimes against children based on age and gender is not directly available for urban areas.• There is no data accounting the hours spent by children on the unpaid domestic work and care.		Steps Taken: <ul style="list-style-type: none">- Addressing discrimination against women- Increasing access to employment- Strengthening Social Protection and Security	

Priority Targets ¹⁹⁷ for children	Selected Indicators to measure progress	Availability of Data ● No Data ● Insufficient Data ● Data Available	Data Sources Available	India towards achieving specific goals (NITI Aayog) ¹⁹⁸
Clean water and sanitation 	- Proportion of population using safely managed drinking water services(%)		<ul style="list-style-type: none">2011 CensusSwachhta Status Report, 2016Swachh Survekshan Report, 2017Swachh Vidyalaya Puraskar, 2017-18	Key Schemes and Programs <ul style="list-style-type: none">- AMRUT- Housing for All- SBM (urban and rural)- National Water Mission- Jal Kranti Abhiyan
	- Proportion of the population using (a) safely managed sanitation services and (b) a hand-washing facility with soap and water (%)			
	- Per capita availability of water (m3/ person)			
	3/8 Targets	Remarks: <ul style="list-style-type: none">• Age-wise disaggregated data on open defecation is required at local level (city/village) using primary survey• Disposal of faecal waste for infants and very young children is not taken into account and it ends up in the form of soiled diapers and nappies in regular municipal solid waste.• Data is not available on provision of child-friendly toilets in community/ shared or public toilets		
Decent work and economic growth 	- Child labor (%)		<ul style="list-style-type: none">2011 CensusNSSNCRB	Key Schemes and Programs <ul style="list-style-type: none">- National Child Labour Project (NCLP)- Integrated Child Protection Scheme (ICPS)
	Remarks: <ul style="list-style-type: none">• Data on Proportion of youth (15-18 years) enrolled in vocational training centres and skill development centres is not available.			
1/12 Targets				

Priority Targets ¹⁹⁷ for children	Selected Indicators to measure progress	Availability of Data ● No Data ● Insufficient Data ● Data Available	Data Sources Available	India towards achieving specific goals (NITI Aayog) ¹⁹⁸
Sustainable cities and resilient communities  6/10 Targets	- Proportion of urban population living in slums, informal settlements or inadequate housing(%)		<ul style="list-style-type: none">2011 CensusSlum Compendium	Key Schemes and Programs: <ul style="list-style-type: none">Smart Cities MissionHousing for AllNational Mission of Sustainable HabitatUrban Greening GuidelinesNational Solar Mission
	- Proportion of population that has convenient access to public transport, by sex, age and persons with disabilities			
	- Number of deaths, missing persons and persons affected by disaster (per 100,000 people)			
	- Proportion of urban solid waste regularly collected and with adequate final discharge out of total urban solid waste generated, by cities(%)			
	- Average share of the built-up area of cities that is open space for public use for all, by sex, age and persons with disabilities (%)			
	Remarks: <ul style="list-style-type: none">There is no direct data available on the share of open space for public use for urban areas pertaining to the user's age, sex or abilities.There is scarcity of data on whether living conditions follow existing planning norms/standards, such as habitable space for a particular family size, adequate ventilation etc.			
Climate action  2/5 Targets	- Number of States that have integrated climate mitigation and adaption in education curricula and outreach programs			Key Schemes and Programs: <ul style="list-style-type: none">National Action Plan on Climate ChangeNational Solar MissionNational Mission on Strategic Knowledge for Climate ChangeNational Water MissionNational Mission for Green IndiaNational Mission for Enhanced Energy Efficiency
	- Annual mean levels of fine particulate matter (e.g. PM2.5 and PM10) in cities (population weighted)			
	- Number of deaths, missing children and children affected by climate induced disaster per 100,000 people			
	Remarks: <ul style="list-style-type: none">Insufficient data is available on population affected by climate change induced disasters.Data on air pollution is insufficient as very few monitoring stations have been set up; most of these manually operated.			

Priority Targets ¹⁹⁷ for children	Selected Indicators to measure progress	Availability of Data ○ No Data ● Insufficient Data ○ Data Available	Data Sources Available	India towards achieving specific goals (NITI Aayog) ¹⁹⁸
Peace, justice and strong institutions  2/12 Targets	- Conflict-related deaths per 100,000 population, by sex, age and cause		• NFHS 2015-16 • RSOC 2013-14	Key Schemes and Programs: - Integrated Child Protection Scheme (ICPS) - Unique Identification Authority of India
	- Proportion of population that feel safe walking alone around the area they live			
	- Proportion of children subjected to physical, psychological or sexual violence in the last year			
	- Proportion of children aged 1-17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month			
	- Proportion of children under 5 years of age whose births have been registered with a civil authority, by age			
	Remarks: • No mechanisms exist to collect data on points 2,3,4 above • Age- disaggregated data is not available for conflict related deaths such as in riots, war etc.			

(*This table is not a exhaustive list of all indicators or relevant schemes and programmes - the intent is to point some major data gaps identified during the study)

8.3 Comparative assessment of countries in South Asia

To analyse SDGs, a dashboard has been developed by UNICEF comprising 99 indicators¹⁹⁹ of which 83 are included in the global index and an additional 16 indicators are used for OECD countries to measure the “progress for every child in the SDG era”. Different agencies are responsible for different global SDGs in terms of generating, analysing and using data. For example, UNICEF is responsible for 8 global SDGs and using select indicators, an online dashboard has been prepared to perform a comparative assessment. According to this assessment²⁰⁰, most of the South Asian countries need ‘acceleration’ in ensuring every child survives and thrives, lives in a clean and safe environment, and is protected from violence and exploitation. All South Asian countries have insufficient trend data or no data in indicators for the categories, ‘every child learns’ and ‘every child has a fair chance in life’.

An analysis of this dashboard reveals the areas in which India needs to start collecting data:

- Early childhood education including attendance, levels of education, qualitative assessments for math, language etc., learning material, access of family to learning, and enrolment for pre-primary students.
- Early childhood care facilities including developmental milestones in learning and psychological well-being of children
- Children's access to WASH facilities in schools and care centres
- Children living below national poverty line
- Children covered by social-protection systems
- Maternal health especially post-natal care
- Child mortality related to micro-nutrient deficiencies
- HIV-AIDS including, pregnant women with HIV, numbers, gender and age of HIV+ve children
- Incidents of psychological aggression and physical punishment towards children even by care-givers

In some areas, although data is available, the trends are unclear and cycles of data collection need to be established to understand any improvement or decline. Some of these are:

- Children aged 5-17 engaged in child labour

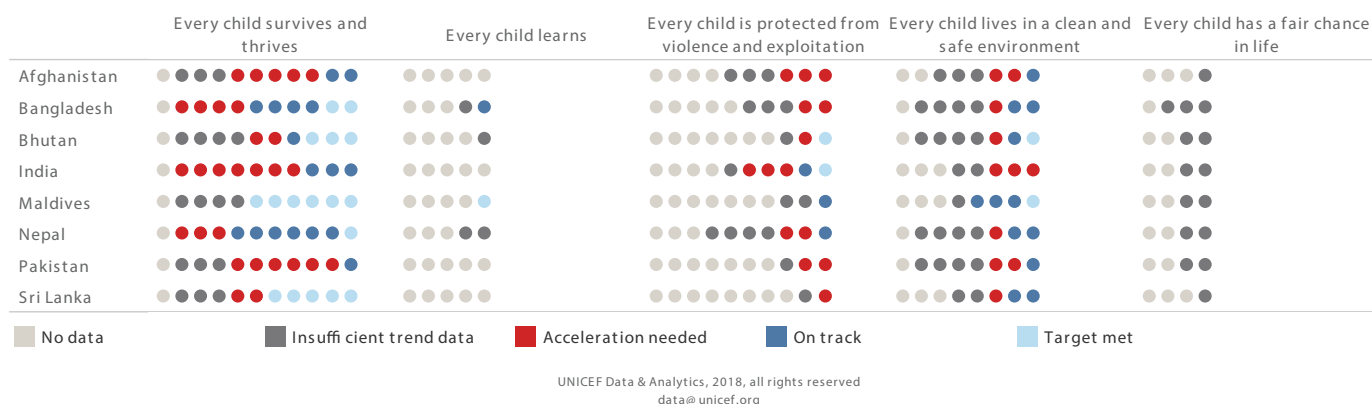


Figure 1 UNICEF Dashboard for assessing progress for every child

- Child mortality rate attributed to household and ambient air pollution
- Use of clean fuels and technology at household level
- Children living in households in extreme poverty

8.4 Conclusion

This chapter provides an overview of SDGs in relation to targets, data source and schemes/missions being implemented in India towards achieving the SDG targets. For a precise tracking of the progress of children specific targets in SDGs, it is important to focus on:

- 1. Early Childhood:** In Indian context, early childhood has been an understated area for development. The data collection at the national level does not cover any of the specific datasets required to project the gaps in the initiative and infrastructure for the age group of 0-6 years. The 'dependent' status of infants and young children enhances their vulnerability. It is thus important to bring the various aspects of their health, nutrition, education and multiple vulnerabilities within the ambit of government's policy initiatives and planning frameworks, for which, data is the first vital step.
- 2. Families:** Census takes into account household level information in terms of access to physical infrastructure and housing. In addition to this, it is important to record the socio economic status of families, which can be used to derive a number of data points related to children. For instance, a family's income and awareness levels of individual members can indicate their capacity to spend on health, nutrition and education of children. Such

information can provide clear action agenda for the government policies and programs.

- 3. Mothers:** There is an absolute lack of data linked to the health and awareness of pregnant women and lactating mothers. With SDGs giving utmost importance to empowering women, there is a lot of scope for the cities and countries to delve deeper into creating a data inventory relating to mothers' health, nutrition and education etc.; benefits of which would spread to children also.
- 4. Gender:** Gender considerations are spread across almost all SDG targets relevant for children. Disaggregation of data on the basis of gender and age becomes an important aspect to mainstream the specific needs of both girls and boys into government's initiatives.

It is also essential to map data to create geographical interlinkages with socio-economic development. This can provide an overall understanding of the gaps and provisions at the national, state and city level, leading to policy prioritization on the basis of not only the relevant issues but also on the locations and respective contexts.

Tracking the progress of various schemes and programs being implemented can also provide an idea of how far are we from the various SDG targets. Baseline is a crucial exercise to be carried out at the commencement of any scheme. This would help in establishing reliable trends and actually measure the impact of a particular scheme. With the 'urban agenda' being a focus area of the national government, Indian cities have a great opportunity to utilize multiple schemes to establish baselines and monitor progress on a number of aspects aligned to the SDGs.



Way forward

At times, even the best intentioned urban policies and plans appear inadequate due to lack of focus, which is a consequence of data scarcity. Data driven policy making helps to manage risks and promote progress in the right directions, and make informed decisions. Lack of data results from the absence of comprehensive data management frameworks, which makes tracking of progress difficult. In such cases, impacts of schemes and plans cannot be measured accurately and projections are mostly reliant on conjecture and assumptions.

India has adequate statistical capacities unlike some other developing countries. However, India needs to expand and renew existing data sets, collect disaggregated data, adapt data sets according to changing needs of society, and adopt new techniques for data collation and analysis. Equipped with multi-layered data analysis, an overall strengthening of policies is likely to take place. All such efforts especially towards making children visible in data and policies, would be an investment in the human capital of our cities.

This Baseline Study has pointed out issues related to data scarcity and reliability in every chapter. It is imperative that data be used as an instrument to recognise real issues faced by children in cities, and estimate resources required to overcome these challenges. Baseline studies are important in establishing priority areas by assimilating data from different sources and co-relating varied data sets to produce a quantitative situation analysis. In this context, this Baseline Study has utilized various available data sources such as the Census, National Sample Survey (NSS), National Family Health Survey (NFHS), National Crime Report Bureau (NCRB) among others to understand the status of urban children in India under the broad themes of demography, health and wellbeing, living conditions,

safety and security etc. However, this study is by no means a complete analysis of the current status of children in urban India as: (i) a lot of required data is not available as it is never collected, and (ii) data that is available presents challenges of reliability and timeliness. For creating a logical blueprint of a sustainable, safe and bright future for children in cities, we need data that is:

Disaggregated: Disaggregated data helps to identify vulnerable groups that need special attention. Data of children available at national level is not broken down into smaller subpopulations such as children of different ages, with disabilities, street children, orphans etc.; for example data of children with disabilities is only for a specific age group and 'type' of disability is a very broad classification, reducing the chances of policy focus. In fact, data on early childhood is completely missing in India, and this has been a major hindrance in recording any progress on the related SDG targets. Data needs to be disaggregated for age, gender, geographic location, abilities, economic, social and cultural background etc.; and this needs to be designed into the data collection and survey processes of authentic government sources like the Census. At city level, master plans and other city plans need to look at provisions for children with different needs rather than treating more than a third of the city population as a homogenous group.

Standardised: Standardised definitions of terms that are internationally comparable must be used. The lack of this is the reason that India has not been able to record progress under a number of targets under SDGs. For example, Census of India 2011 defines slums as "compact areas of at least 300 population or 60-70 households of poorly built congested tenements in unhygienic environment usually with inadequate infrastructure and lacking in proper sanitary and drinking water

facilities²⁰¹ whereas NSS²⁰² considers slums as “compact areas of at least 20 households”. Due to these disparities in definitions, the calculations of number of people living in slums vary; and not all people living in slums are poor – so how to calculate poverty? To mention another issue, children with special needs is a category very loosely defined, with no acknowledgement of differences between mental disabilities and social behaviour issues. Besides definitions, standardization of data sets is also important. While data from one source is for the age group 0-5 years, another source would be for 0-6 years, while yet another source would give data for 4-9 years.

Updated: For SDGs, new data sets are required to measure the progress on various targets. For example, SDG Goal 3 emphasises on “prevention and treatment of substance abuse, including narcotic drug and harmful use of alcohol”. However, no reliable data set is available for number of children between 0-18 years using drugs or with alcohol addiction. Only for metro cities like Delhi, these data sets are available through a one-time survey, and show alarming levels of substance abuse among children as young as 8-10 years; but at national level, these numbers are missing. Additionally, new indicators such as number of deaths and illnesses from hazardous chemicals as well as air, water and soil pollution and contamination should be included in data collection under NFHS.

Timely and regularly monitored: Census collects data every 10 years and data processing takes several years due to which statistics on population groups like children, migrants, slum dwellers and homeless are hardly helpful for implementing strategies for such groups. Besides the Census, which is the most reliable data set in India, timely data should be available from regular monitoring of programmes and schemes. While Indian government has initiated several programmes and schemes for children, it is essential to have better monitoring tools and feedback systems than those existing now. For example, under ISDSS²⁰³ project by NIUA it was observed that data on Anganwadi centres (AWCs) annual evaluation was available online but it became impossible to map these aanganwadis as in many cases, the given latitude and longitude did not correspond to any proper location on ground; making it impossible to measure the geographical coverage. Therefore, regular monitoring of complete datasets for

measuring the impact of programmes and schemes in India is essential. In addition, a proposed feedback system for online database is useful for system enhancement and decision making²⁰⁴.

Open Source: User-centered data culture needs to evolve, which involves high data literacy, data sharing and data use. With different organizations opening up their data repositories and analysis to the public domain, new studies would look to different analyses rather than duplicating efforts already made. This will also result in a culture of ownership for the open source data and a quest for being the best in terms of data reliability or authenticity.

Available, converged and co-related: Government data from different departments under different ministries and schemes is generated on a regular basis but hardly used by researchers. The main reasons are lack of awareness and the procedural issues regarding permission to use government data. A national data repository and various state and city level repositories must be set up so that data from all departments and schemes can be available on one common server, at a cost if any. In this context, Gujarat has created an online depository of data collected from various departments for village-level quantitative analysis.²⁰⁵

Technology-enabled: Unbundling Big Data, using mobiles and internet for surveys are also essential. Countries like Indonesia, Peru, Kenya and Rwanda have made much progress toward technology enabled data and India also needs to innovate in areas of data collection and analysis for improving data exchange and usability²⁰⁶. To mention a few of the many examples of readily available but hardly used data – data of trips, trip lengths and routes from taxi services such as Uber and Ola, children using play zones and related costs from user card chips, Google maps and Google Street View for studying spatial aspects of crime in terms of when, where and why crime occurs etc. Such data would definitely reduce costs and time involved in traditional data collection methods like surveys and systematic observation²⁰⁷. A systematic process needs to be devised for this otherwise these data sets can be overwhelming in volume, variety and velocity (the 3 Vs of Big Data).

Mapped: The general images that come to mind when



speaking of 'data' are of numbers and spread sheets. Spatially mapped, this data can do wonders for any city. To mention an example here - data on street children in a city was collected zone wise and aggregated at city level but the strategy to rehabilitate them seemed very general. Once it was mapped and co-related with other elements of the map, their precise locations could be identified (e.g. near railway stations), and land or buildings that could be used for child care institutions for such children could also be identified at walking distances. GIS is an important tool for mapping and analysing multi-layered data, and understanding data spatially makes decisions not only focussed but sensitive to different contexts.

To recognize children as stakeholders in our policies and plans, we need to first identify them as citizens

with specific needs. This Baseline is just a small step towards doing this. The study hopes to mainstream the idea that while planning a city, one third of its population is getting ignored in the current system. We hope that every city would create similar baselines not only for status of children but all different stakeholders by devising means to disaggregate information and creating holistic data management frameworks. While the first step is acknowledgement of the need for such frameworks, it would need evolving governance and institutional frameworks towards a data environment where information to make informed decisions is not only being produced but is accessible to policy makers and planners. For city plans to be inclusive both in letter and spirit and for our cities to be truly responsive to families and children, their starting point is a baseline- both statistical and spatial.



Annexure

Chapter 2: Demography

Table 2.1. Population of children (0-18 years) in India

State/UT	Total population of children (0-18)	Total Population of Urban children (0-18)	Percentage of children in the total population	Total Male children (0-18)	Percentage of male children (0-18)	Total Female children (0-18)	Percentage of female children (0-18)
India	472111477	128476879	39	247489356	52.4	224622121	47.6
North							
Chandigarh	348780	338132	33	192392	55.2	156388	44.8
Haryana	9727500	3147326	38.4	5353869	55	4373631	45
Himachal Pradesh	2290517	207708	33.4	1206577	52.7	1083940	47.3
Jammu & Kashmir	5272578	1174207	42	2789004	52.9	2483574	47.1
NCT of Delhi	5921350	5757301	35.3	3210942	54.2	2710408	45.8
Punjab	9371374	3362983	33.8	5174159	55.2	4197215	44.8
Rajasthan	29894376	6591705	43.6	15845710	53	14048666	47
Uttarakhand	4054494	1114529	40.2	2137408	52.7	1917086	47.3
Central							
Chhattisgarh	10335064	2149583	40.5	5248688	50.8	5086376	49.2
Madhya Pradesh	30501760	7414161	42	15947178	52.3	14554582	47.7
Uttar Pradesh	90929225	17980025	45.5	48064457	52.9	42864768	47.1
East							
Bihar	49797077	5053221	47.8	26248868	52.7	23548209	47.3
Jharkhand	14600419	3065762	44.3	7565928	51.8	7034491	48.2
Odisha	15319522	2292356	36.5	7799156	50.9	7520366	49.1
West Bengal	32120577	8685747	35.2	16511024	51.4	15609553	48.6
North East							
Arunachal Pradesh	623609	132415	45.1	315516	50.6	308093	49.4
Assam	12768623	1382701	40.9	6559738	51.4	6208885	48.6
Manipur	1098379	290061	38.5	563536	51.3	534843	48.7
Meghalaya	1447331	237829	48.8	733567	50.7	713764	49.3
Mizoram	445066	212328	40.6	226257	50.8	218809	49.2

State/ UT	Total population of children (0-18)	Total Population of Urban children (0-18)	Percentage of children in the total population	Total Male children (0-18)	Percentage of male children (0-18)	Total Female children (0-18)	Percentage of female children (0-18)
Nagaland	869237	232281	43.9	448951	51.6	420286	48.4
Sikkim	220086	50201	36	111851	50.8	108235	49.2
Tripura	1305542	275938	35.5	667426	51.1	638116	48.9
West							
Dadra & Nagar Haveli	133283	54296	38.8	71317	53.5	61966	46.5
Daman & Diu	74521	52032	30.6	42462	57	32059	43
Goa	406973	254895	27.9	210661	51.8	196312	48.2
Gujarat	22214012	8610543	36.8	11846335	53.3	10367677	46.7
Maharashtra	38488509	16282848	34.3	20396042	53	18092467	47
South							
Andaman and Nicobar Islands	119179	43623	31.3	61135	51.3	58044	48.7
Andhra Pradesh	28362506	9258181	33.5	14632580	51.6	13729926	48.4
Karnataka	20729561	7588368	33.9	10705512	51.6	10024049	48.4
Kerala	9932755	4697148	29.7	5060037	50.9	4872718	49.1
Lakshadweep	21041	16103	32.6	10521	50	10520	50
Puducherry	379568	252844	30.4	193607	51	185961	49
Tamil Nadu	21987083	10217498	30.5	11336945	51.6	10650138	48.4

Source: Census of India, 2011

Table 2.2. Percentage distribution of 0-5, 6-14 and 15-18 years among total urban population of children (0-18 years)

Age group	Total Urban population (0-18)	0 to 5		6-14		15 to 18	
State/ UT		Population	Percentage	Population	Percentage	Population	Percentage
India	128476879	36579569	28.5	62265781	48.5	29631529	23.1
North							
Chandigarh	338132	97377	28.8	160656	47.5	80099	23.7
Haryana	3147326	931406	29.6	1502884	47.8	713036	22.7
Himachal Pradesh	207708	54537	26.3	102093	49.2	51078	24.6
Jammu & Kashmir	1174207	363015	30.9	556114	47.4	255078	21.7
NCT of Delhi	5757301	1655844	28.8	2781873	48.3	1319584	22.9
Punjab	3362983	959720	28.5	1598011	47.5	805252	23.9
Rajasthan	6591705	1891939	28.7	3198995	48.5	1500771	22.8
Uttarakhand	1114529	306477	27.5	539238	48.4	268814	24.1

Age group	Total Urban population (0-18)	0 to 5		6-14		15 to 18	
State/ UT		Population	Percentage	Population	Percentage	Population	Percentage
Central							
Chhattisgarh	2149583	625744	29.1	1034341	48.1	489498	22.8
Madhya Pradesh	7414161	2098757	28.3	3611315	48.7	1704089	23
Uttar Pradesh	17980025	4793394	26.7	8822253	49.1	4364378	24.3
East							
Bihar	5053221	1452035	28.7	2565117	50.8	1036069	20.5
Jharkhand	3065762	857758	28	1506795	49.1	701209	22.9
Odisha	2292356	633441	27.6	1106474	48.3	552441	24.1
West Bengal	8685747	2338640	26.9	4240155	48.8	2106952	24.3
North East							
Arunachal Pradesh	132415	33563	25.3	65651	49.6	33201	25.1
Assam	1382701	383167	27.7	674459	48.8	325075	23.5
Manipur	290061	85881	29.6	143140	49.3	61040	21
Meghalaya	237829	66294	27.9	113067	47.5	58468	24.6
Mizoram	212328	64696	30.5	99350	46.8	48282	22.7
Nagaland	232281	61599	26.5	115399	49.7	55283	23.8
Sikkim	50201	12333	24.6	24873	49.5	12995	25.9
Tripura	275938	78865	28.6	131682	47.7	65391	23.7
West							
Dadra & Nagar Haveli	54296	19322	35.6	24498	45.1	10476	19.3
Daman & Diu	52032	16867	32.4	20842	40.1	14323	27.5
Goa	254895	77233	30.3	122058	47.9	55604	21.8
Gujarat	8610543	2513625	29.2	4134579	48.0	1962339	22.8
Maharashtra	16282848	4799499	29.5	7793237	47.9	3690112	22.7
South							
Andaman & Nicobar islands	43623	12258	28.1	21251	48.7	10114	23.2
Andhra Pradesh	9258181	2535629	27.4	4500734	48.6	2221818	24
Karnataka	7588368	2263059	29.8	3610226	47.6	1715083	22.6
Kerala	4697148	1409483	30	2287609	48.7	1000056	21.3
Lakshadweep	16103	4662	29	7787	48.4	3654	22.7
Puducherry	252844	75158	29.7	123389	48.8	54297	21.5
Tamil Nadu	10217498	3006292	29.4	4925636	48.2	2285570	22.4

Source: Census of India, 2011

Table 2.3. Population of children 0-6 years in slums of India

States/UT	Percentage of urban population living in slums	Children 0-6 years				Percentage of slum children (0-6) of total urban children (0-6)	Percentage of children (0-6) of total slum population
		Total	Female	Male	Sex Ratio		
India	17.4	8082743	3878292	4204451	922	18.7	12.3
North							
Chandigarh	9.3	14720	7023	7697	912	12.8	15.5
Haryana	18.8	225889	103765	122124	850	20.6	13.6
Himachal Pradesh	8.9	6509	3016	3493	863	10	10.6
Jammu & Kashmir	19.3	94204	43555	50649	860	22.1	14.2
Nct Of Delhi	10.9	229029	109521	119508	916	11.7	12.8
Punjab	14	176257	81476	94781	860	15.6	12.1
Rajasthan	12.1	307035	145163	161872	897	13.7	14.8
Uttarakhand	16	66176	31045	35131	884	18.1	13.6
Central							
Chhattisgarh	32	254080	123902	130178	952	34.5	13.4
Madhya Pradesh	28.3	771999	368639	403360	914	31.1	13.6
Uttar Pradesh	14	863392	406356	457036	889	15	13.8
East							
Bihar	10.5	208383	100389	107994	930	11.9	16.8
Jharkhand	4.7	53465	25762	27703	930	5.2	14.3
Odisha	22.3	188962	91411	97551	937	25.3	12.1
West Bengal	22.1	656780	319339	337441	946	23.8	10.2
Northeast							
Arunachal Pradesh	4.9	2226	1124	1102	1020	5.6	14.3
Assam	4.5	22229	10851	11378	954	4.9	11.3
Manipur*							
Meghalaya	9.6	8241	4079	4162	980	10.6	14.4
Mizoram	13.7	10430	5138	5292	971	13.9	13.3
Nagaland	14.4	11114	5545	5569	996	15.1	13.5
Sikkim	20.4	3229	1608	1621	992	21.7	10.3
Tripura	14.5	14755	7288	7467	976	15.9	10.6
West							
Dadra & Nagar Haveli*							
Daman & Diu*							
Goa	2.9	3240	1549	1691	916	3.6	12.3
Gujarat	6.5	240589	114258	126331	904	8.1	14.3
Maharashtra	23.3	1428850	685247	743603	922	25.3	12.1

States/UT	Percentage of urban population living in slums	Children 0-6 years				Percentage of slum children (0-6) of total urban children (0-6)	Percentage of children (0-6) of total slum population
		Total	Female	Male	Sex Ratio		
South							
Andaman & Nicobar Islands	9.9	1588	800	788	1015	11	11.2
Andhra Pradesh	36.1	1149779	556634	593145	938	38.4	11.3
Karnataka	13.9	418295	205367	212928	964	15.8	12.7
Kerala	1.3	20327	10056	10271	979	1.2	10.1
Lakshadweep*							
Puducherry	17	16002	7780	8222	946	18.1	11.1
Tamil Nadu	16.6	614969	300606	314363	956	17.5	10.6

Source: Census of India, 2011 *Data not available

Table 2.4. Population of homeless children (0-6 years)

State/ UT	Homeless households in India	Homeless population in India		Percentage of children (0-6) out of total homeless	Homeless households in Urban areas	Homeless population in urban areas				Percentage of urban homeless children (0-6) of total homeless children (0-6)	Percentage of children (0-6) of total urban homeless
		Total	0-6 years			Total	0-6 years	Male (0-6)	Female (0-6)		
India	449787	1773040	270605	15.3	256896	938348	112712	58708	54004	41.7	12
North											
Chandigarh	868	4139	119	2.9	867	4133	119	63	56	100	2.9
Haryana	11635	51871	10278	19.8	5864	23789	4315	2248	2067	42	18.1
Himachal Pradesh	935	4098	688	16.8	227	872	145	89	56	21.1	16.6
Jammu & Kashmir	3064	19047	2868	15.1	1623	10848	1344	716	628	46.9	12.4
NCT of Delhi	23175	47076	3594	7.6	23078	46724	3527	1774	1753	98.1	7.5
Punjab	9853	46714	8912	19.1	4422	18374	3285	1736	1549	36.9	17.9
Rajasthan	37341	181544	37568	20.7	16385	73236	14094	7279	6815	37.5	19.2
Uttarakhand	3273	11824	1524	12.9	1947	5556	668	333	335	43.8	12
Central											
Chhattisgarh	7198	24214	4455	18.4	2531	6533	932	456	476	20.9	14.3
Madhya Pradesh	37822	146435	27440	18.7	18508	66055	11522	5900	5622	42	17.4
Uttar Pradesh	72452	329125	47426	14.4	41227	180929	17832	9512	8320	37.6	9.9

State/ UT	Homeless households in India	Homeless population in India		Percentage of children (0-6) out of total homeless	Homeless households in Urban areas	Homeless population in urban areas				Percentage of urban homeless children (0-6) of total homeless children (0-6)	Percentage of children (0-6) of total urban homeless
		Total	0-6 years			Total	0-6 years	Male (0- 6)	Female (0-6)		
East											
Bihar	9818	45584	8401	18.4	3043	12591	2005	1009	996	23.9	15.9
Jharkhand	6121	23391	4360	18.6	2235	6967	897	466	431	20.6	12.9
Odisha	10334	34061	4529	13.3	4763	14053	1287	675	612	28.4	9.2
West Bengal	28647	134040	9556	7.1	21087	104967	5615	3102	2513	58.8	5.3
Northeast											
Arunachal Pradesh	314	1556	209	13.4	68	313	26	11	15	12.4	8.3
Assam	3293	12919	1816	14.1	915	2527	237	128	109	13.1	9.4
Manipur	706	3212	477	14.9	326	1331	235	117	118	49.3	17.7
Meghalaya	298	1241	228	18.4	62	177	17	4	13	7.5	9.6
Mizoram	38	152	19	12.5	24	104	9	6	3	47.4	8.7
Nagaland	220	876	135	15.4	125	344	33	16	17	24.4	9.6
Sikkim	75	277	29	10.5	13	32	4	0	4	13.8	12.5
Tripura	850	3225	358	11.1	385	1352	97	60	37	27.1	7.2
West											
Dadra & Nagar Haveli	216	1004	221	22	65	281	43	21	22	19.5	15.3
Daman & Diu	166	737	104	14.1	131	591	71	32	39	68.3	12
Goa	820	3051	346	11.3	498	1693	166	80	86	48	9.8
Gujarat	36925	144306	24920	17.3	23987	84822	12938	6706	6232	51.9	15.3
Maharashtra	57480	210908	30211	14.3	32664	111373	11798	6221	5577	39.1	10.6
South											
Andaman and Nicobar Islands	63	95	3	3.2	42	65	3	0	3	100	4.6
Andhra Pradesh	42812	145211	20750	14.3	23376	75857	9797	5021	4776	47.2	12.9
Karnataka	21425	76735	11998	15.6	10922	35473	4959	2541	2418	41.3	14
Kerala	5759	11853	880	7.4	3992	7761	496	253	243	56.4	6.4
Lakshadweep*											
Puducherry	492	1590	205	12.9	459	1508	194	94	100	94.6	12.9
Tamil Nadu	15299	50929	5978	11.7	11035	37117	4002	2039	1963	66.9	10.8

Source: Census of India, 2011 *Data not available

Table 2.5. Percentage distribution of migrant children in Urban India

States /UT	Age wise			
	0-5	6-14	15-18	0-18
India	5.70	13.55	20.47	13.06
North				
Chandigarh	10.17	5.73	47.92	17.44
Haryana	3.95	12.60	18.23	11.19
Himachal Pradesh	17.33	29.97	35.82	27.45
Jammu & Kashmir	9.90	7.52	4.97	7.45
Delhi	5.64	18.13	22.98	15.82
Punjab	5.43	8.67	20.98	11.01
Rajasthan	3.41	10.88	23.95	12.46
Uttaranchal	17.49	27.40	27.25	24.36
Central				
Chhatisgarh	13.27	22.44	27.99	21.46
Madhya Pradesh	3.83	11.84	13.85	10.13
Uttar Pradesh	4.44	9.35	14.19	9.27
East				
Bihar	3.90	15.27	28.85	15.36
Jharkhand	4.61	11.51	17.23	11.26
Orissa	6.17	17.54	24.91	16.31
West Bengal	5.19	11.58	14.98	10.59
Northeast				
Arunachal Pradesh	0.43	0.64	1.77	0.87
Assam	6.22	13.51	20.58	13.09

States /UT	Age wise			
	0-5	6-14	15-18	0-18
Manipur	1.02	1.35	1.89	1.39
Meghalaya	2.90	2.34	4.04	2.89
Mizoram	5.93	11.26	11.79	10.20
Nagaland	17.04	24.92	24.10	22.43
Sikkim	35.76	28.45	55.46	39.46
Tripura	7.61	8.10	8.04	7.94
West				
Dadra & Nagar Haveli	23.73	43.66	29.52	35.72
Daman & Diu	2.94	18.96	23.79	16.14
Goa	12.45	17.59	29.36	18.48
Gujarat	7.14	17.90	25.83	16.84
Maharashtra	6.29	15.09	25.28	15.21
South				
Andaman & Nicobar	17.67	30.83	32.20	27.66
Andhra Pradesh	8.71	20.77	25.47	18.23
Karnataka	4.76	11.69	19.81	11.50
Kerala	6.54	14.13	22.86	13.97
Lakshdweep	9.66	20.99	25.47	18.48
Pondicherry	2.02	25.21	18.17	17.85
Tamilnadu	4.41	10.07	16.62	10.01

Source: NSS 64th round (2007-08)

Table 2.6. Percentage distribution of differently abled urban children (0-19 years) as per types of disability

State/ UT	Types of disabilities								
	Total number	In seeing	In Hearing	In Speech	In Movement	Mental Retardation	Mental Illness	Any Other	Multiple Disability
India-total	7,864,636	17.9	20.3	8.7	13.3	7.6	1.7	21.9	8.6
India-urban	2,272,454	19.2	22.1	8.7	10	7.6	1.7	22.9	7.8
North									
Chandigarh	3,965	12.4	16.1	7.7	16	11.8	4.7	18.9	12.3
Haryana	52,001	12.3	30.5	4.9	9.5	6.6	2.6	25.7	8
Himachal Pradesh	3,066	14.6	22	7.9	7.3	10	2.3	23.9	12
Jammu & Kashmir	20,853	19.5	25.8	6.2	8.1	6.4	3.9	21.3	8.9
NCT of Delhi	58,986	11.4	14.7	9.2	16.5	11	4.2	19.5	13.5
Punjab	60,847	12.1	31.1	4.4	8.8	8.1	1.9	27.4	6.2
Rajasthan	93,096	23.8	18.3	7.9	11.7	7.7	2.2	18.5	9.9
Uttarakhand	15,811	15.2	25.3	7.7	11.8	6.7	2.7	20.3	10.2
Central									
Chhattisgarh	32,078	20.5	14.5	7.7	16.4	8.5	2.4	17.1	12.8
Madhya Pradesh	133,126	18.7	21	6.3	12.8	6.7	2.1	23.8	8.7
Uttar Pradesh	344,701	18.3	29.5	6.8	9.8	4.5	1.6	24.6	4.9
East									
Bihar	107,312	25.2	27.1	7.4	11.1	3.9	1.2	19.5	4.5
Jharkhand	55,937	24.3	23.6	8.1	11	5.8	1.9	17.9	7.4
Odisha	47,507	20.8	22.3	7.7	10	7.8	1.7	19.7	10.1
West Bengal	155,891	21.3	18.5	9.4	8.4	7.7	2.4	24.2	8.2
Northeast									
Arunachal Pradesh	1,664	22	30	5.8	8.1	7.1	2.3	19.2	5.5
Assam	16,133	13.4	20.4	10.5	9.8	6.9	2.1	27.2	9.7
Manipur	4,950	38.4	16.5	5.1	5.3	8.7	1.4	18.3	6.3
Meghalaya	2,245	12.9	24.2	7.6	11.8	8	5.4	19.5	10.7
Mizoram	1,593	15.4	15.4	7.8	9.2	13.2	5.2	17.6	16.2
Nagaland	1,848	12.9	28	7.6	11.1	4.7	1.8	24.8	8.9
Sikkim	447	11	30.6	10.3	9.6	6.9	3.1	19.2	9.2
Tripura	4,141	12.1	12.2	11	13.6	7.3	3.1	24.9	15.7
West									
Dadra & Nagar Haveli	465	12	23	7.7	15.3	7.1	1.7	16.6	16.6
Daman & Diu	329	17.6	17.3	10	14.9	10.3	4	14	11.9
Goa	3,538	11.9	17.2	17.9	6.8	9.4	3.4	23.5	9.9

State/ UT	Types of disabilities								
	Total number	In seeing	In Hearing	In Speech	In Movement	Mental Retardation	Mental Illness	Any Other	Multiple Disability
Gujarat	146,363	23.3	20.3	6.8	9.3	6.9	2.2	23.9	7.4
Maharashtra	352,475	21	18.8	14.6	8.3	8	1.1	22	6.2
South									
Andaman and Nicobar Islands	510	7.5	20.4	10.8	12.5	8	3.7	19.8	17.3
Andhra Pradesh	208,882	18.4	19.5	10.2	8.7	7.1	1.4	26.4	8.2
Karnataka	154,655	23.1	21.8	6.8	9.2	8.3	1	21.8	7.9
Kerala	55,728	11.4	16.5	8.5	11.6	16.5	1.3	17.3	17
Lakshadweep	304	17.4	14.5	5.6	12.5	12.2	0	18.8	19.1
Puducherry	3,565	8.6	17.6	8.6	16.2	18.6	1.2	17.9	11.3
Tamil Nadu	127,442	9.1	21	7.4	11.5	15.1	0.9	24.6	10.5

Source: Census of India, 2011

Table 2.7 . Percentage distribution of differently abled urban children (0-6 years) as per types of disability

States/UTs	Total number of urban disabled children (0-6 years)	Types of disabilities							
		In seeing	In Hearing	In Speech	In Movement	Mental Retardation	Mental Illness	Any Other	Multiple Disability
India	590584	21.42	24.93	5.4	7.08	4.69	0.83	29.39	6.25
North									
Chandigarh	897	12.49	21.63	6.69	13.04	5.69	3.46	25.08	11.93
Haryana	14176	12.48	35.25	3.1	6.32	4.02	1.12	30.76	6.94
Himachal Pradesh	701	15.83	27.67	3.57	6.13	5.56	0.71	31.67	8.84
Jammu & Kashmir	5861	20.99	32.09	3.74	6.43	4.9	1.48	23.97	6.4
Nct Of Delhi	13347	12.61	18.76	6.72	12.81	6.02	2.38	28.75	11.94
Punjab	16316	13.34	36.08	2.64	5.3	4.96	1.04	32.01	4.63
Rajasthan	24262	28.17	21.49	4.98	8.25	4.45	0.93	24.05	7.68
Uttarakhand	3682	16.43	29.03	5.73	7.44	3.8	1.2	26.94	9.42
Central									
Chhattisgarh	7711	23.19	16.07	5.54	13.8	5.15	0.87	23.12	12.27
Madhya Pradesh	34647	21.1	23.54	4.04	9.11	4.14	0.99	29.62	7.46
Uttar Pradesh	89800	20.64	32.76	4.17	5.44	2.88	0.69	29.45	3.97
East									
Bihar	30407	28.41	29.36	4.51	7.31	2.65	0.49	23.47	3.8
Jharkhand	15072	27.01	27.28	5.14	7.41	3.61	0.84	22.45	6.26

States/UTs	Total number of urban disabled children (0-6 years)	Types of disabilities							
		In seeing	In Hearing	In Speech	In Movement	Mental Retardation	Mental Illness	Any Other	Multiple Disability
Odisha	11358	22.33	24.57	5.1	8	5.49	0.77	25.29	8.45
West Bengal	38867	23.35	20.32	5.59	6.44	5.57	0.91	31.01	6.81
Northeast									
Arunachal Pradesh	385	21.3	27.01	3.64	8.83	6.49	1.3	25.97	5.45
Assam	3847	14.32	22.12	6.24	9.05	5.12	0.81	33.87	8.47
Manipur	1471	42.56	18.76	3.4	4.28	6.39	0.41	18.9	5.3
Meghalaya	500	12.6	25	5.6	13.4	4.8	2.6	25.2	10.8
Mizoram	377	17.24	16.18	6.9	9.02	7.16	1.33	27.59	14.59
Nagaland	470	12.13	36.6	3.62	8.09	4.26	0.43	25.96	8.94
Sikkim	98	11.22	35.71	4.08	6.12	3.06	1.02	26.53	12.24
Tripura	1007	7.75	12.51	6.85	13.51	4.07	0.3	43	12.02
West									
Dadra & Nagar Haveli	149	14.09	32.89	6.71	12.75	2.68	0.67	16.78	13.42
Daman & Diu	82	23.17	25.61	2.44	9.76	8.54	1.22	20.73	8.54
Goa	905	11.82	18.01	13.37	4.97	6.63	1.44	35.14	8.62
Gujarat	39701	25.52	22.62	4.18	6.61	3.57	1.37	31.03	5.11
Maharashtra	96554	23.04	20.22	8.89	6.03	4.66	0.67	31.74	4.74
South									
Andaman & Nicobar Islands	114	7.02	24.56	7.02	9.65	7.02	1.75	28.07	14.91
Andhra Pradesh	53691	20.25	21.95	5.76	6.26	4.67	0.78	33.95	6.37
Karnataka	41382	26.98	24.62	4.03	6.62	5.87	0.56	25.12	6.2
Kerala	12229	8.97	21	7.34	12.45	7.42	0.45	26.45	15.92
Lakshadweep	64	12.5	17.2	6.3	15.6	3.1	0	28.1	17.2
Puducherry	836	8.13	21.89	6.46	11.6	14.83	0.12	27.75	9.21
Tamil Nadu	29618	9.18	25.41	4.73	9.11	10.06	0.44	32.31	8.75

Source: Census of India, 2011

Annexure

Chapter 3: Status of Health and Nutrition

Table 3.1. Percentage distribution of urban women according to safe survival interventions, 2015-16

State/ UT	Mothers who had complete antenatal care	Institutional births in public facility	Births delivered by caesarean section	Mothers who received postnatal care from a doctor/nurse/LHV/ANM/mid-wife/other health personnel within 2 days of delivery
Urban	31.1	46.2	28.3	27.2
Rural	16.7	54.4	12.9	23
India	21	52.1	17.2	24.3
North				
Chandigarh	35.4	71.8	23.5	89.2
Haryana	21.4	46.3	13.6	67.4
Himachal Pradesh	49.2	69.3	29.6	83.8
Jammu & Kashmir	29.4	81.4	53.1	86.7
Delhi	37.4	56.7	23.7	62.4
Punjab	34.8	41.3	25.8	86.6
Rajasthan	17.5	57.6	16.4	71.3
Uttarakhand	15.6	42.3	19.4	66.1
Central				
Chhattisgarh	29.1	50.7	18.9	74.7
Madhya Pradesh	19.5	66.9	19.1	67.1
Uttar Pradesh	13.5	30.3	18.9	62.9
East				
Bihar	6.6	42.7	13.9	52.6
Jharkhand	17.9	36	22.4	58.3
Odisha	27.1	66.9	24.1	73.6
West Bengal	25.2	55.5	36.6	68.5
Northeast				
Arunachal Pradesh	3.9	59.5	20.1	37.8
Assam	30.4	61.7	36.9	71.5
Manipur	45.1	55.3	33	77.7
Meghalaya	38.4	53.1	20.5	76.4

State/ UT	Mothers who had complete antenatal care	Institutional births in public facility	Births delivered by caesarean section	Mothers who received postnatal care from a doctor/nurse/LHV/ANM/mid-wife/other health personnel within 2 days of delivery
Mizoram	47.9	70.2	19	77
Nagaland	4.9	40.2	12.4	36.3
Sikkim	36.7	77.5	28.8	79.3
Tripura	9.8	68.7	45.8	72.6
West				
Dadra & Nagar Haveli	23.2	55.3	26.7	62.1
Daman & Diu	26.3	43.4	14.9	63.1
Goa	64.4	57.3	33.5	93
Gujarat	39.6	28.2	27.8	67.5
Maharashtra	35.7	46.4	26.3	82
South				
Andaman & Nicobar Islands	67.3	91.6	27.4	80.8
Andhra Pradesh	45.4	34.8	48.4	84.7
Karnataka	34.9	50.2	29.2	66.7
Kerala	63.1	35.6	37.1	87.7
Lakshadweep	67.2	63.5	36.4	93
Puducherry	59.4	77.9	30.9	88.3
Tamil Nadu	46.3	58.7	36.1	74.3
Telangana	47.7	27.1	63.2	84.8

Source: National Family Health Survey (NFHS) 4

() Based on 25-49 unweighted cases * Percentage not shown; based on fewer than 25 unweighted cases

Table 3.2. Percentage distribution of urban children under five years classified according to preventive measure and curative treatment, 2015-16

State/ Uts	Complete Immunization (12-23 months)	Children with diarrhoea in the last 2 weeks who received oral rehydration salts	Children with diarrhoea in the last 2 weeks taken to a health facility	Children with fever or symptoms of ARI in the last 2 weeks preceding the survey taken to a health facility
India	62	50.6	67.9	73.2
Urban	63.9	58.5	74.1	80
Rural	61.3	47.9	65.8	70.8
North				
Chandigarh	(77.2)	*	*	*
Haryana	57	67	79.3	80.2
Himachal Pradesh	(64.8)	*	*	*
Jammu & Kashmir	81.6	68.4	75.4	85.7
Delhi	66.2	62.2	81.4	81.5
Punjab	88.7	64.9	86.2	89.7
Rajasthan	60.9	64.6	82	85.8
Uttarakhand	56.5	63.8	76.6	86.5
Central				
Chhattisgarh	84.9	68.3	77.9	78.6
Madhya Pradesh	63	62.8	71.5	79.6
Uttar Pradesh	53.6	47.4	72.7	77.6
East				
Bihar	59.7	62.1	56.3	57
Jharkhand	67	49.1	61.4	76
Odisha	75	68.6	65.8	74.3
West Bengal	77.7	69.6	82.6	78.2
Northeast				
Arunachal Pradesh	44.2	76.6	57.1	48.7
Assam	70.9	(58.7)	(57.8)	58
Manipur	74.3	60.4	37	45.6
Meghalaya	81.4	77.6	76	87.3
Mizoram	49.8	76.3	46.7	62.8
Nagaland	41.6	43.5	33.8	41.4
Sikkim	(81.4)	*	*	*
Tripura	64.2	*	*	(79.5)
West				
Dadra & Nagar Haveli	*	*	*	*
Daman & Diu	67.8	*	*	*
Goa	(87.7)	*	*	(89.1)
Gujarat	50.4	49.7	72.1	76.3
Maharashtra	55.8	63.8	75.6	87

State/ Uts	Complete Immunization (12-23 months)	Children with diarrhoea in the last 2 weeks who received oral rehydration salts	Children with diarrhoea in the last 2 weeks taken to a health facility	Children with fever or symptoms of ARI in the last 2 weeks preceding the survey taken to a health facility
South				
Andaman & Nicobar Islands	(61.8)	*	*	*
Andhra Pradesh	60.4	(54.9)	(83.2)	73.9
Karnataka	59.8	44.9	64.2	77.8
Kerala	82.2	(40.5)	(69.5)	90.2
Lakshadweep	86.1	*	*	(83)
Puducherry	93.9	(79.4)	(80.6)	77.8
Tamil Nadu	73.3	65	73.9	83.4
Telangana	67.8	61.8	79.5	82

Source: National Family Health Survey (NFHS) 4

() Based on 25-49 unweighted cases * Percentage not shown; ased on fewer than 25 unweighted cases

Annexure

Chapter 4: Living Conditions

Table 4.1 Percentage of households by condition of housing as per location

State/UT	Total no. of Urban households	Urban Households as per condition of housing			Total no. of Slum households	Slum Households as per condition of housing		
		Good	Liveable	Dilapi-dated		Good	Liveable	Dilapi-dated
India	78,865,937	68.4	28.7	2.9	13749424	58.4	37.6	4.03
North								
Chandigarh	228,276	69.9	26.6	3.5	22080	6.0	72.2	21.9
Haryana	1,751,901	62.9	33.7	3.4	325997	49.5	45.5	5.0
Himachal Pradesh	166,043	80.1	18.5	1.4	14240	73.0	24.9	2.1
Jammu & Kashmir	517,168	70.9	26.3	2.9	96990	65.1	30.9	4.0
NCT of Delhi	3,261,423	66	31.2	2.8	383609	31.7	58.5	9.8
Punjab	2,094,067	57.3	37.4	5.2	296482	42.6	48.2	9.1
Rajasthan	3,090,940	68.9	29.3	1.8	383134	56.5	40.4	3.1
Uttarakhand	592,223	74.4	23.1	2.5	89398	62.8	32.5	4.7
Central								
Chhattisgarh	1,238,738	64.2	33.1	2.6	395297	57.4	39.4	3.2
Madhya Pradesh	3,845,232	67.6	29.7	2.7	1086692	57.8	38.4	3.8
Uttar Pradesh	7,449,195	57	39.1	3.9	992728	49.5	45.5	5.0
East								
Bihar	2,013,671	53.1	40	6.9	194065	41.8	48.4	9.8
Jharkhand	1,495,642	59.9	36.3	3.7	79200	50.0	43.9	6.1
Odisha	1,517,073	51.5	42.7	5.8	350306	38.1	54.0	7.9
West Bengal	6,350,113	57.5	35.9	6.6	1393319	50.6	42.1	7.3
Northeast								
Arunachal Pradesh	65,891	58.5	38.7	2.8	4005	40.1	53.3	6.6
Assam	992,742	58.9	35.4	5.7	48122	44.7	44.8	10.5
Manipur	171,400	63.4	32.1	4.5				
Meghalaya	116,102	69.5	27.7	2.7	10936	61.1	34.7	4.2
Mizoram	116,203	73.6	24.9	1.5	16240	80.2	19.2	0.6
Nagaland	115,054	62	36.1	1.9	15268	60.0	38.2	1.8
Sikkim	35,761	80.3	18	1.8	8612	77.3	20.6	2.2

State/UT	Total no. of Urban households	Urban Households as per condition of housing			Total no. of Slum households	Slum Households as per condition of housing		
		Good	Liveable	Dilapi-dated		Good	Liveable	Dilapi-dated
Tripura	235,002	63.6	32.1	4.2	33830	53.9	40.4	5.7
West								
Dadra & Nagar Haveli	37,655	79	20.8	0.2				
Daman & Diu	47,631	65.3	34.2	0.5				
Goa	198,139	76.9	21.8	1.3	4846	54.9	42.2	3.0
Gujarat	5,416,315	76.5	22.6	0.9	360291	48.1	49.3	2.6
Maharashtra	10,813,928	73.1	25	1.9	2449530	57.9	39.2	2.9
South								
Andaman and Nicobar Islands	34,346	76.5	22.2	1.3	3053	69.6	29.5	0.9
Andhra Pradesh	6,778,225	78.9	19.6	1.5	2421268	75.0	23.2	1.8
Karnataka	5,315,715	72.4	25.7	1.9	728277	57.3	38.5	4.2
Kerala	3,620,696	72.4	23.7	3.9	54849	63.0	31.3	5.6
Lakshadweep	8,180	85.2	14.3	0.5				
Puducherry	206,143	80	18.9	1.2	35070	70.5	27.2	2.3
Tamil Nadu	8,929,104	76.4	22.4	1.2	1451690	69.2	29.1	1.7

Source: Census of India, 2011

Table 4.2. Percentage distribution of households as per main source of drinking water

State/UT	Urban households as per source of drinking water				Slum households as per source of drinking water			
	Total number of households	Tap water from treated source	Tap water from un-treated source	Others [#]	Total number of households	Tap water from treated source	Tap water from untreated source	Others [#]
India	78,865,937	62	8.6	29.4	13,749,424	65.3	8.7	26.1
North								
Chandigarh	228,276	93.8	2.9	3.2	22,080	72.5	20.6	6.8
Haryana	1,751,901	70.2	7.3	22.5	325,997	63.9	9.3	26.9
Himachal Pradesh	166,043	93.3	2.2	4.5	14,240	92.5	1.5	6
Jammu & Kashmir	517,168	70.6	17.3	12.1	96,990	63.8	27.2	9
NCT of Delhi	3,261,423	75.8	6.1	18.1	383,609	73.3	11	15.7
Punjab	2,094,067	66.1	10.4	23.6	296,482	60.4	9.4	30.2
Rajasthan	3,090,940	75.4	7.2	17.4	383,134	76	7	16.9
Uttarakhand	592,223	72.7	5.7	21.6	89,398	68.2	5.5	26.2
Central								
Chhattisgarh	1,238,738	44.2	18.2	37.5	395,297	42.6	18.3	39.2
Madhya Pradesh	3,845,232	50.6	11.6	37.8	1,086,692	48.4	12.5	39.2

State/UT	Urban households as per source of drinking water				Slum households as per source of drinking water			
	Total number of households	Tap water from treated source	Tap water from un-treated source	Others [#]	Total number of households	Tap water from treated source	Tap water from untreated source	Others [#]
Uttar Pradesh	7,449,195	44.7	6.9	48.5	992,728	38.6	6.8	54.6
East								
Bihar	2,013,671	15.1	4.9	80	194,065	11.7	3.9	84.5
Jharkhand	1,495,642	34.7	6.9	58.4	79,200	21.6	5.8	72.6
Odisha	1,517,073	42.1	5.9	52	350,306	35	5.7	59.4
West Bengal	6,350,113	50	5.7	44.4	1,393,319	55.7	7.5	36.9
Northeast								
Arunachal Pradesh	65,891	46.5	37.7	15.8	4,005	11.1	37.3	51.5
Assam	992,742	27.4	2.8	69.8	48,122	25.8	2.2	72
Manipur*	171,400	50.9	5.4	43.7				
Meghalaya	116,102	68.1	9.4	22.4	10,936	61.4	5	33.6
Mizoram	116,203	61.8	12.5	25.6	16,240	56.6	10.5	32.9
Nagaland	115,054	6	29.7	64.3	15,268	4.1	31.8	64.2
Sikkim	35,761	70	22	7.9	8,612	71.6	21	7.4
Tripura	235,002	43.5	10.5	46	33,830	48.4	10.5	41.1
West								
Dadra & Nagar Haveli*	37,655	35.7	14.7	49.7				
Daman & Diu*	47,631	48.7	23.9	27.4				
Goa	198,139	87.8	2.4	9.8	4,846	93.6	3.9	2.5
Gujarat	5,416,315	68.8	16.8	14.4	360,291	72.7	11.9	15.4
Maharashtra	10,813,928	85.7	3.4	10.9	2,449,530	86.6	3.7	9.7
South								
Andaman and Nicobar Islands	34,346	92.7	5.3	2.1	3,053	95.7	0.5	3.8
Andhra Pradesh	6,778,225	75.5	8	16.5	2,421,268	77.8	6.2	16
Karnataka	5,315,715	68.4	12	19.6	728,277	67.5	16.2	16.4
Kerala	3,620,696	30.4	4.5	65.1	54,849	53.2	4.7	42
Lakshadweep*	8,180	11.7	5.2	83.1				
Puducherry	206,143	91.8	3.6	4.6	35,070	91.1	7.1	1.7
Tamil Nadu	8,929,104	66.3	14	19.7	1,451,690	67.1	13.5	19.3

Source: Census of India, 2011

[#]Others: covered well, uncovered well, hand pump, tube well/borehole, spring, river/canal, tank/pond/lake, other sources etc.

*Data not available

**Table 4.3. Percentage distribution of households
as per location of source of drinking water**

State/UT	Urban Households				Slum households			
	Total number of households	Within premises	Near premises (≤100 m)	Away (>100 m from premises)	Total number of households	Within the premises	Near premises (≤100 m)	Away (>100 m from premises)
India	78,865,937	71.2	20.7	8	13,749,424	56.7	31.9	11.4
North								
Chandigarh	228,276	86.2	11.6	2.2	22,080	5.6	76.8	17.7
Haryana	1,751,901	83.9	11.0	5.1	325,997	73.4	18	8.6
Himachal Pradesh	166,043	84.7	11.7	3.6	14,240	79.9	14	6.1
Jammu & Kashmir	517,168	84.7	10.2	5.1	96,990	80.7	13.3	5.9
NCT of Delhi	3,261,423	78.8	15.2	6.1	383,609	50.9	39.6	9.5
Punjab	2,094,067	92.7	5.7	1.6	296,482	89.2	7.9	2.8
Rajasthan	3,090,940	78.2	14.1	7.7	383,134	69.2	20.4	10.4
Uttarakhand	592,223	88.7	7.8	3.5	89,398	83.5	11.6	4.9
Central								
Chhattisgarh	1,238,738	49.7	37.4	12.9	395,297	35.6	48.9	15.5
Madhya Pradesh	3,845,232	55.4	30.1	14.5	1,086,692	39.9	39.7	20.5
Uttar Pradesh	7,449,195	78.8	16.0	5.2	992,728	71	21.7	7.2
East								
Bihar	2,013,671	75.5	17.5	7	194,065	64.5	24.2	11.3
Jharkhand	1,495,642	59.1	23.1	17.8	79,200	46	29.6	24.4
Odisha	1,517,073	56.8	24.7	18.4	350,306	38	32.7	29.3
West Bengal	6,350,113	56.2	27.8	16.1	1,393,319	51.7	32.3	16
Northeast								
Arunachal Pradesh	65,891	69.7	23.1	7.3	4,005	57.3	33.6	9.1
Assam	992,742	78.8	12.8	8.4	48,122	74.4	14.5	11.2
Manipur*	171,400	31.8	36.2	32.1				
Meghalaya	116,102	57.7	28.4	13.9	10,936	53	30.2	16.7
Mizoram	116,203	53.5	33.2	13.3	16,240	55.3	30.5	14.2
Nagaland	115,054	52.1	27.2	20.7	15,268	45	28.7	26.4
Sikkim	35,761	79.8	15.7	4.5	8,612	82	13.2	4.8
Tripura	235,002	69.6	16.7	13.7	33,830	55.8	24.6	19.6
West								
Dadra & Nagar Haveli*	37,655	71.5	25.1	3.4				
Daman & Diu*	47,631	77.4	21.5	1.1				
Goa	198,139	85.1	12.3	2.7	4,846	70.8	27	2.1
Gujarat	5,416,315	83.7	11.5	4.8	360,291	64	25.5	10.5
Maharashtra	10,813,928	79.3	15.6	5.2	2,449,530	64.6	28.3	7.1

State/UT	Urban Households				Slum households			
	Total number of households	Within premises	Near premises (≤100 m)	Away (>100 m from premises)	Total number of households	Within the premises	Near premises (≤100 m)	Away (>100 m from premises)
South								
Andaman and Nicobar Islands	34,346	83.9	12.8	3.4	3,053	81.8	13.1	5.1
Andhra Pradesh	6,778,225	67.9	21.8	10.3	2,421,268	61.8	27	11.2
Karnataka	5,315,715	70.9	20.6	8.5	728,277	46.4	39	14.6
Kerala	3,620,696	83.3	11.5	5.2	54,849	79.4	15.6	5
Lakshadweep*	8,180	84.9	12.6	2.5				
Puducherry	206,143	85.1	14.2	0.7	35,070	70.2	28.4	1.4
Tamil Nadu	8,929,104	54	40.2	5.7	1,451,690	39.3	53.7	7

Source: Census of India, 2011

*Data not available

Table 4.4. Percentage of urban households as per access to toilet facilities

State/UT	Total number of households	Percentage of households having latrine facility within the premises					Percentage of households (HHs) not having latrine facility within the premises				
		Total	Flush/ pour flush latrine connected to			Others	Total	Proportion of HHs using public latrine of total HHs	Proportion of HHs resorting to open defecation out of total HHs	Proportion using public latrine out of total HHs not having latrine facility within premises	Proportion of HHs resorting to open defecation out of total HHs not having latrine facility within premises
			Piped sewer system	Septic tank	Other system						
India	78,865,937	81.4	32.7	38.2	1.7	8.8	18.6	6	12.6	32.3	67.7
North											
Chandigarh	228,276	87.6	85.9	0.9	0.2	0.6	12.4	9.2	3.2	13.2	86.8
Haryana	1,751,901	89.9	54.8	23.8	2	9.4	10.1	1.3	8.8	74.5	25.5
Himachal Pradesh	166,043	89.1	40.7	45.3	0.9	2.1	10.9	4	6.9	36.8	63.2
Jammu & Kashmir	517,168	87.5	25.3	37.9	5.3	18.9	12.5	1.8	10.7	14.3	85.7
NCT of Delhi	3,261,423	89.8	60.5	24.7	0.9	3.8	10.2	7.1	3	70.2	29.8
Punjab	2,094,067	93.4	63.7	19.9	1.9	7.8	6.6	0.8	5.8	12.6	87.4
Rajasthan	3,090,940	82	25.6	45.6	2.4	8.4	18	1.3	16.7	72.8	27.2
Uttarakhand	592,223	93.6	31.7	53.1	1.2	7.7	6.4	1.7	4.7	26.5	73.5
Central											
Chhattisgarh	1,238,738	60.2	9.1	48.6	1	1.5	39.8	5.4	34.4	13.5	86.5
Madhya Pradesh	3,845,232	74.2	20.2	50.1	1.2	2.7	25.8	3.3	22.5	12.8	87.2

State/UT	Total number of households	Percentage of households having latrine facility within the premises					Percentage of households (HHs) not having latrine facility within the premises				
		Total	Flush/ pour flush latrine connected to			Others	Total	Proportion of HHs using public latrine of total HHs	Proportion of HHs resorting to open defecation out of total HHs	Proportion using public latrine out of total HHs not having latrine facility within premises	Proportion of HHs resorting to open defecation out of total HHs not having latrine facility within premises
			Piped sewer system	Septic tank	Other system						
Uttar Pradesh	7,449,195	83.1	28.3	46.9	2	5.9	16.9	2.1	14.8	12.2	87.8
East											
Bihar	2,013,671	69	7.2	52.7	3.5	5.5	31	2.2	28.9	6.9	93.1
Jharkhand	1,495,642	67.2	14	49.2	1.5	2.5	32.8	1.8	31	5.6	94.4
Odisha	1,517,073	64.8	11.5	45	2.3	6	35.2	2	33.2	5.8	94.2
West Bengal	6,350,113	85	13.6	45.4	2.5	23.5	15	3.7	11.3	24.9	75.1
Northeast											
Arunachal Pradesh	65,891	89.5	13.8	53.6	7.5	14.6	10.5	3.8	6.7	35.8	64.2
Assam	992,742	93.7	15	50.3	5.8	22.7	6.3	1.3	5	20.6	79.4
Manipur	171,400	95.8	7.4	43.1	13.2	32.1	4.2	1.9	2.3	44.5	55.5
Meghalaya	116,102	95.7	9.7	68.7	4.5	12.8	4.3	1.9	2.4	43.6	56.4
Mizoram	116,203	98.5	5.1	71.3	4.4	17.7	1.5	0.6	0.9	40.6	59.4
Nagaland	115,054	94.6	4.5	67.3	7.4	15.5	5.4	3.2	2.2	58.9	41.1
Sikkim	35,761	95.2	34.4	55.7	1.8	3.3	4.8	2.6	2.2	54.6	45.4
Tripura	235,002	97.9	6.7	37.6	5.7	47.9	2.1	0.8	1.3	40.1	59.9
West											
Dadra & Nagar Haveli	37,655	81.3	8	71.7	0.5	1	18.7	7.6	11.1	40.6	59.4
Daman & Diu	47,631	85.4	6.3	77.6	0.3	1.2	14.6	10.5	4.1	71.9	28.1
Goa	198,139	85.3	18.6	59.3	2.7	4.6	14.7	5.2	9.5	35.5	64.5
Gujarat	5,416,315	87.7	60.4	24.2	0.5	2.5	12.3	3.6	8.7	29.0	71.0
Maharashtra	10,813,928	71.3	37.8	28.6	0.9	4	28.7	21	7.7	73.2	26.8
South											
Andaman and Nicobar Islands	34,346	87.1	3	83.2	0.6	0.2	12.9	5.1	7.8	39.9	60.1
Andhra Pradesh	6,778,225	86.1	33.7	44.4	1.3	6.7	13.9	2	11.9	14.1	85.9
Karnataka	5,315,715	84.9	53.3	17	1.2	13.4	15.1	4.4	10.7	28.9	71.1
Kerala	3,620,696	97.4	14.3	56.7	4.3	22.1	2.6	0.9	1.7	34.8	65.2
Lakshadweep	8,180	97.7	2.9	93.8	0.5	0.5	2.3	0.4	1.9	18.2	81.8
Puducherry	206,143	82	19.9	60.9	0.3	1	18	5.8	12.2	32.3	67.7
Tamil Nadu	8,929,104	75.1	27.4	37.9	1.1	8.7	24.9	8.6	16.2	34.8	65.2

Source: Census of India, 2011

Table 4.5. Percentage of slum households as per access to toilet facilities

State/UT	Total number of households	Percentage of households having latrine facility within the premises					Percentage of households(HHs) not having latrine facility within the premises				
		Total	Flush/ pour flush latrine connected to			Others#	Total	Proportion of HHs using public latrine out of total HHs	Proportion of HH resorting to open defecation out of total HHs	Proportion using public latrine out of total HHs not having latrine facility within premises	Proportion of HHs resort to open defecation out of total HH not having latrine facility within premises
			Piped sewer system	Septic tank	Other system						
India	13,749,424	66	24.5	31.4	1.8	8.3	34	15.1	18.9	44.4	55.6
North											
Chandigarh	22,080	3.9	1.6	1.1	0.1	1.2	96.1	76.6	19.4	79.8	20.2
Haryana	325,997	80	45.9	19.1	2.6	12.4	20	2.7	17.3	13.6	86.4
Himachal Pradesh	14,240	85.5	32.5	43.7	0.8	8.5	14.5	5.1	9.4	35.1	64.9
Jammu & Kashmir	96,990	88.2	25.9	22.4	6.9	33	11.8	2.7	9.1	23.0	77.0
NCT of Delhi	383,609	50.1	43	4	0.9	2.2	49.9	37.4	12.5	75.0	25.0
Punjab	296,482	88.7	58.3	18.5	2.4	9.5	11.3	0.8	10.5	7.4	92.6
Rajasthan	383,134	71.6	22	35.4	2.4	11.8	28.4	2.1	26.3	7.6	92.4
Uttarakhand	89,398	91.7	27.7	53.4	1.9	8.7	8.3	2.2	6.1	27.0	73.0
Central											
Chhattisgarh	395,297	48.7	3.6	42.2	1.1	1.8	51.3	9.7	41.6	18.9	81.1
Madhya Pradesh	1,086,692	62.9	13.6	44.3	1.5	3.5	37.1	5.5	31.6	14.8	85.2
Uttar Pradesh	992,728	77.5	20.5	47.4	2.7	6.8	22.5	3.8	18.8	16.7	83.3
East											
Bihar	194,065	53.8	4.4	39.7	3.6	6.1	46.2	3.7	42.5	7.9	92.1
Jharkhand	79,200	52.7	5.9	42.5	1.5	2.8	47.3	5.4	41.9	11.5	88.5
Odisha	350,306	48.1	5.4	33	2.2	7.6	51.9	3.5	48.3	6.8	93.2
West Bengal	1,393,319	82.5	14.6	42.6	3	22.3	17.5	6.4	11.1	36.4	63.6
Northeast											
Arunachal Pradesh	4,005	83.7	6	39	5.3	33.4	16.3	2.8	13.5	17.3	82.7
Assam	48,122	86.4	13.1	40.5	6.6	26.2	13.6	3.1	10.5	22.5	77.5
Manipur*											
Meghalaya	10,936	92.7	18.9	59.9	6.6	7.3	7.3	3.6	3.7	49.3	50.7
Mizoram	16,240	99.3	5	77	3.9	13.3	0.7	0.3	0.5	34.2	65.8
Nagaland	15,268	93.3	4.4	66.4	5.7	16.8	6.7	5.4	1.3	80.7	19.3
Sikkim	8,612	91	22.8	60.1	2.2	6	9	6.3	2.6	70.5	29.5
Tripura	33,830	95.4	4.3	30.5	7.9	52.7	4.6	2.6	2	56.7	43.3

State/UT	Total number of households	Percentage of households having latrine facility within the premises					Percentage of households(HHs) not having latrine facility within the premises				
		Total	Flush/ pour flush latrine connected to			Others#	Total	Proportion of HHs using public latrine out of total HHs	Proportion of HH resorting to open defecation out of total HHs	Proportion using public latrine out of total HHs not having latrine facility within premises	Proportion of HHs resort to open defecation out of total HH not having latrine facility within premises
			Piped sewer system	Septic tank	Other system						
West											
Dadra & Nagar Haveli*											
Daman & Diu*											
Goa	4,846	60.9	29.6	29.1	1.8	0.5	39.1	31.7	7.3	81.2	18.8
Gujarat	360,291	64.4	40.3	20.2	0.8	3.1	35.6	14.3	21.3	40.3	59.7
Maharashtra	2,449,530	41.6	23	13.8	1.1	3.7	58.4	48.6	9.8	83.3	16.7
South											
Andaman and Nicobar Islands	3,053	66.1	4.1	61.5	0.2	0.2	33.9	20	14	58.9	41.1
Andhra Pradesh	2,421,268	82.3	29.7	43.9	1.5	7.2	17.7	2.9	14.8	16.3	83.7
Karnataka	728,277	63.3	33.3	13.1	1.6	15.3	36.7	11.7	25	32.0	68.0
Kerala	54,849	93.2	15.6	52.1	3.8	21.7	6.8	3.5	3.3	50.9	49.1
Lakshadweep*											
Puducherry	35,070	62.8	11.5	49.4	0.5	1.4	37.2	12.3	24.9	33.1	66.9
Tamil Nadu	1,451,690	61	30.7	24.2	1	5.1	39	15.9	23.1	40.8	59.2

Source: Census of India, 2011

*Data not available

Others# Pit Latrine; Service Latrine

Table 4.6. Percentage distribution of households as per access to drainage facilities

State/UT	Urban Households				Slum households			
	Total number of households	Households as per access to drainage facilities			Total number of households	Households as per access to drainage facilities		
		Covered drainage	Open drainage	No drainage		Covered drainage	Open drainage	No drainage
India	78,865,937	44.5	37.3	18.2	13,749,424	36.9	44.3	18.8
North								
Chandigarh	228,276	87.3	8.7	4	22,080	15.6	56.8	27.6
Haryana	1,751,901	49.4	42.8	7.8	325,997	38.4	52	9.6
Himachal Pradesh	166,043	65	28.6	6.4	14,240	57.9	31.6	10.5
Jammu & Kashmir	517,168	32.7	50.4	16.9	96,990	26.9	54.2	18.9
NCT of Delhi	3,261,423	60.3	35.7	4	383,609	48.7	45.6	5.7

State/UT	Urban Households				Slum households			
	Total number of households	Households as per access to drainage facilities			Total number of households	Households as per access to drainage facilities		
		Covered drainage	Open drainage	No drainage		Covered drainage	Open drainage	No drainage
Punjab	2,094,067	57.6	33.3	9.1	296,482	49.8	38.8	11.3
Rajasthan	3,090,940	34.4	51.6	14	383,134	26.6	56.6	16.8
Uttarakhand	592,223	42.3	50.6	7.1	89,398	29.8	64.4	5.8
Central								
Chhattisgarh	1,238,738	17.5	51.4	31.1	395,297	10.2	56.8	33.1
Madhya Pradesh	3,845,232	31.9	50.4	17.7	1,086,692	20.8	57.1	22.1
Uttar Pradesh	7,449,195	32.2	61.2	6.6	992,728	21.5	70.7	7.7
East								
Bihar	2,013,671	30	41.4	28.6	194,065	19.2	39.5	41.2
Jharkhand	1,495,642	24.9	45.9	29.2	79,200	14.4	41.6	44
Odisha	1,517,073	19.9	39.2	41	350,306	9.4	36.7	53.9
West Bengal	6,350,113	24.4	42.4	33.2	1,393,319	25	43.8	31.3
Northeast								
Arunachal Pradesh	65,891	15.7	50.6	33.8	4,005	4.2	33.5	62.3
Assam	992,742	15.4	40.9	43.7	48,122	12.1	37.8	50.1
Manipur *	171,400	6	64.4	29.6				
Meghalaya	116,102	17.9	62.5	19.7	10,936	19.6	61.6	18.9
Mizoram	116,203	20.4	59.1	20.5	16,240	23.8	61.4	14.8
Nagaland	115,054	8.6	67.9	23.5	15,268	5	80	15
Sikkim	35,761	39.5	52.6	7.9	8,612	35.3	59.8	4.9
Tripura	235,002	7.3	46.2	46.6	33,830	3.9	43.3	52.8
West								
Dadra & Nagar Haveli *	37,655	47	15.7	37.3				
Daman & Diu *	47,631	46.5	30.7	22.8				
Goa	198,139	54.8	23.2	22	4,846	61.5	23.8	14.7
Gujarat	5,416,315	69.4	13.2	17.4	360,291	50.6	21.9	27.6
Maharashtra	10,813,928	62.7	28.4	8.8	2,449,530	57.4	34.8	7.7
South								
Andaman and Nicobar Islands	34,346	12.1	74	14	3,053	10.3	82.1	7.7
Andhra Pradesh	6,778,225	49.6	38.7	11.7	2,421,268	43.2	44.3	12.4
Karnataka	5,315,715	56.5	31.1	12.4	728,277	34.9	49	16.1
Kerala	3,620,696	33.5	21	45.5	54,849	31.7	30.7	37.6
Lakshadweep*	8,180	14.8	11.1	74.1				
Puducherry	206,143	32.3	50.2	17.4	35,070	20.9	53.2	25.9
Tamil Nadu	8,929,104	44.8	30.2	25.1	1,451,690	42.1	29	28.9

Source: Census of India, 2011

*Data not available

Table 4.7. Percentage of persons in respective age category as per use and non-use of toilets

Defecation	Persons in respective age category going for open defecation					Percentage of persons using community/ public toilets				
	Old (>60 years)	Adult (15-60 years)		Children (<15 years)	Total	Old (>60 years)	Adult (15-60 years)		Children (<15 years)	Total
		Male	Female				Male	Female		
India	6.5	6.6	6.5	10.1	7.5	44.3	48.6	47.9	42	46
North										
Chandigarh*										
Haryana	1.1	3	2.3	3	2.6	2.5	0.2	0.7	1.2	0.8
Himachal Pradesh	0.9	0.3	0.2	1.4	0.5	0	0	0	0	0
Jammu & Kashmir	5.4	4.5	4.5	8.1	5.6	45	37	40.8	33.2	37.5
NCT of Delhi	2.8	1.2	1.4	1.2	1.4	0	100	100	100	100
Punjab	1.9	0.8	1.2	4.1	1.8	11.5	55.2	52.5	29	41.6
Rajasthan	10	8.9	8.5	11.9	9.8	14.2	5	8.2	5.4	6.7
Uttarakhand*	0.1	0	0.3	1.3	0.5					
Central										
Chhattisgarh	9.3	8.5	9.8	10.9	9.6	5	11.2	13	13.1	11.8
Madhya Pradesh	11.7	10.7	10.8	15.6	12.2	18.7	23.5	17.2	13.6	18.3
Uttar Pradesh	5.9	5.4	5.4	8.5	6.4	69.2	76.5	75.5	71.8	74
East										
Bihar	9.8	12.4	12.3	16.1	13.4	7.7	2.6	2.7	3	3.2
Jharkhand	13.8	20.8	20	31.5	23.5	0.7	3.2	3.8	2.7	3.1
Odisha	18.3	12	11.8	16.1	13.7	3.7	7.8	7.1	4.2	6
West Bengal	5.5	6.8	6.7	11	7.5	18.7	28.1	29.9	26.8	27.6
Northeast										
Arunachal Pradesh										
Assam	0	0.4	0.4	7.7	2.1	100	95.4	97.7	88.2	94.9
Manipur	0.4	0	0.1	12.1	3.1	100	100	97.7	72.8	90.8
Meghalaya	0	0	0	2.7	0.7	0	100	100	100	100
Mizoram	0.3	0.1	0.3	1.8	0.6					
Nagaland*				1.8	0.6	100	100	100	98	99.4
Sikkim*										
Tripura*										
West										
Dadra & Nagar Haveli*										
Daman & Diu*										
Goa*										
Gujarat	2.1	2.5	2.4	4.2	2.8	37.4	48.3	25.6	14	33.3
Maharashtra	5.2	5.4	5.8	10.9	6.9	75.4	77	75.1	61.6	72

Defecation	Persons in respective age category going for open defecation					Percentage of persons using community/ public toilets				
	Old (>60 years)	Adult (15-60 years)		Children (<15 years)	Total	Old (>60 years)	Adult (15-60 years)		Children (<15 years)	Total
		Male	Female				Male	Female		
South										
Andaman and Nicobar Islands										
Andhra Pradesh	11.6	9.6	8.2	14.8	10.5	17.2	12.9	20.3	12	15.4
Karnataka	12.1	13.7	11.7	15.1	13.2	13.9	9.9	19.9	9	13.1
Kerala	0.1	0.5	0.5	3.7	1.2	90.2	63.6	65.1	68.4	68
Lakshadweep*										
Puducherry*	3.6	1.6	1.8	4.9	2.8					
Tamil Nadu	9.3	9.1	9.2	11.2	9.6	29.2	31	30.7	31.1	30.7
Telangana	1.7	1.6	2	4.4	2.4	56.7	74.2	68.2	67.2	69.4

Source: Swachhta Status Report 2016

*Results of the States/UTs with less than 20 FSUs have not been presented

Annexure

Chapter 5: Educational Status of Children

Table 5.1. Percentage of children in urban areas in school going age (5-18 years) who have and who have not attended educational institutions, 2011

State/UT	Children who have attended			Children who have not attended									
	Children (5-18 years) who have attended educational institutions out of total urban children (5-18 years)	Male who have attended educational institutions out of total urban children (5-18 years)	Female who have attended educational institutions out of total urban children (5-18 years)	Attended before					Never attended				
				Children (5-18 years) who have attended before educational institutions out of total urban children (5-18 years)	Male (5-18 years) who have attended before educational institutions out of total urban male (5-18 years)	Female (5-18 years) who have attended before educational institutions out of total urban female (5-18 years)	Male (5-18 years) who have attended before	Female (5-18 years) who have attended before	Urban Children (5-18 years) never attended educational institutions out of total urban children (5-18 years)	Male (5-18 years) never attended educational institutions out of total urban male (5-18 years)	Female (5-18 years) never attended educational institutions out of total urban female (5-18 years)	Male (5-18 years) never attended	Female (5-18 years) never attended
Urban India	77	77.1	76.8	9.1	9.2	9.0	53.2	46.8	13.9	13.7	14.2	52.0	48.0
North													
Chandigarh	82.4	82	83	6.6	7.5	5.4	63.5	36.5	11.0	10.5	11.6	53.3	46.7
Haryana	79.9	80.3	79.4	6.3	6.5	6.1	57.3	42.7	13.8	13.2	14.5	53.5	46.5
Himachal Pradesh	85.9	85.2	86.8	4.4	5.4	3.3	67.0	33.0	9.7	9.5	10.0	54.0	46.0
Jammu & Kashmir	80.8	81.4	80.2	4.3	4.3	4.3	53.1	46.9	14.9	14.3	15.5	51.1	48.9
NCT of Delhi	80.5	80.4	80.7	6.8	7.2	6.4	57.3	42.7	12.7	12.5	12.9	53.7	46.3
Punjab	77.4	77.2	77.7	9.1	9.6	8.5	58.8	41.2	13.5	13.2	13.8	54.9	45.1
Rajasthan	74.6	76.5	72.4	8.7	8.1	9.4	50.0	50.0	16.7	15.4	18.3	49.3	50.7
Uttarakhand	78.2	78.1	78.2	7.8	8.2	7.4	56.7	43.3	14.0	13.7	14.3	53.2	46.8
Central													
Chhattisgarh	78.4	77.7	79.2	9.4	10.3	8.4	56.7	43.3	12.2	12.0	12.4	50.8	49.2
Madhya Pradesh	77.1	76.8	77.4	9.4	9.7	9.0	54.9	45.1	13.6	13.5	13.6	53.0	47.0
Uttar Pradesh	67	67.1	66.8	9.3	9.6	9.1	54.7	45.3	23.7	23.3	24.1	52.5	47.5
East													
Bihar	72.1	72.2	71.9	6.2	6.5	5.9	55.6	44.4	21.7	21.3	22.2	52.0	48.0
Jharkhand	78.5	78.7	78.3	6.9	7.1	6.7	54.1	45.9	14.6	14.2	15.0	50.9	49.1
Odisha	75.4	75.8	75	12.5	12.5	12.5	52.0	48.0	12.1	11.7	12.6	50.1	49.9

West Bengal	73.5	72.9	74	12.7	13.2	12.2	53.5	46.5	13.8	13.9	13.8	51.7	48.3
Northeast													
Arunachal Pradesh	84.1	85.2	83.1	4	4.4	3.6	54.3	45.7	11.9	10.5	13.2	43.8	56.2
Assam	78.9	78.4	79.4	9.4	10.1	8.6	55.5	44.5	11.7	11.5	11.9	50.5	49.5
Manipur	83.6	84.3	82.8	5	4.8	5.3	47.6	52.4	11.4	11.0	11.8	48.6	51.4
Meghalaya	87.7	86.9	88.5	5.5	6.2	4.9	56.0	44.0	6.7	6.9	6.6	50.9	49.1
Mizoram	86.8	86.8	86.8	6.9	6.8	6.9	50.0	50.0	6.3	6.4	6.2	51.0	49.0
Nagaland	85	84.9	85.2	6.2	6.5	5.8	53.8	46.2	8.8	8.7	9.0	50.4	49.6
Sikkim	84.1	84.6	83.7	8.4	8.7	8.1	52.0	48.0	7.5	6.7	8.2	45.0	55.0
Tripura	81.2	81.4	80.9	9.1	9.0	9.4	49.9	50.1	9.7	9.7	9.7	51.0	49.0
West													
Dadra & Nagar Haveli	73.2	71.1	76	11.9	14.8	8.1	70.6	29.4	14.9	14.1	15.9	53.6	46.4
Daman & Diu	62.4	55.7	72.8	23	30.3	11.6	80.4	19.6	14.6	14.0	15.7	58.2	41.8
Goa	83.2	83.2	83.2	6.9	7.2	6.5	54.5	45.5	9.9	9.6	10.3	50.4	49.6
Gujarat	73.2	74.7	71.4	13.3	12.5	14.3	51.7	48.3	13.5	12.9	14.4	52.3	47.7
Maharashtra	80	80	79.9	9.2	9.3	9.2	53.5	46.5	10.8	10.7	10.9	52.8	47.2
South													
Andaman and Nicobar Islands	86.7	86.4	87.1	6.4	7.1	5.8	56.4	43.6	6.8	6.6	7.1	49.9	50.1
Andhra Pradesh	80.9	81.5	80.3	8.4	8.0	9.0	48.3	51.7	10.6	10.6	10.7	50.8	49.2
Karnataka	77.6	77.6	77.5	10.5	10.5	10.5	51.4	48.6	11.9	11.9	12.0	51.3	48.7
Kerala	88.4	88.3	88.5	4.1	4.2	4.1	51.5	48.5	7.5	7.6	7.4	51.4	48.6
Lakshadweep	89	89.4	88.6	4.8	4.4	5.2	45.7	54.3	6.2	6.2	6.2	49.8	50.2
Puducherry	88.4	88.6	88.3	5.5	5.4	5.6	49.9	50.1	6.1	6.1	6.1	50.9	49.1
Tamil Nadu	85.2	85.1	85.3	8.4	8.4	8.3	51.6	48.4	6.5	6.5	6.4	51.2	48.8
Telangana	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Source: Census of India, 2011

Table 5.2. Percentage of disable children in urban areas under-school going age (5-18 years) who have and who have not attended educational institutions, 2011

State/UT	Children who have attended	Attended before			Never attended		
	Children with disability (5-18 years) who have attended educational institutions out of total urban children with disability (5-18 years)	Children with disability (5-18 years) who have attended educational institutions before out of total urban children with disability (5-18 years)	Male (5-18 years) who have attended before	Female (5-18 years) who have attended before	Children (5-18 years) never attended school out of total urban children (5-18 years)	Male (5-18 years) never attended	Female (5-18 years) never attended
Urban India	65.9	9.9	56.0	44.0	24.2	56.1	43.9
North							
Chandigarh	64	6.5	61.4	38.6	29.4	58.7	41.3
Haryana	67.2	7.8	59.4	40.6	25	59.4	40.6
Himachal Pradesh	72.5	5.7	67.2	32.8	21.9	58.5	41.5
Jammu & Kashmir	66.8	4.9	58.5	41.5	28.2	56.6	43.4
NCT Of Delhi	59	8.1	60.2	39.8	32.9	59.6	40.4
Punjab	63.7	10.2	59.4	40.6	26.2	59.8	40.2
Rajasthan	60.9	8.8	56.7	43.3	30.3	57.3	42.7
Uttarakhand	64.4	8.9	60.3	39.7	26.7	57.4	42.6
Central							
Chhattisgarh	62.1	10.7	58.8	41.2	27.1	55.6	44.4
Madhya Pradesh	66	10.1	57.9	42.1	23.9	57.8	42.2
Uttar Pradesh	59.1	9.8	57.2	42.8	31.1	56.1	43.9
East							
Bihar	64.2	7.5	56.4	43.6	28.3	55.2	44.8
Jharkhand	65.9	7.8	56.8	43.2	26.3	53.5	46.5
Odisha	65.7	12.7	54.9	45.1	21.7	54.8	45.2
West Bengal	62.1	12.7	55.9	44.1	25.3	56.1	43.9
Northeast							
Arunachal Pradesh	73.8	4.2	54.4	45.6	22	54.7	45.3
Assam	62	9.9	56.9	43.1	28.1	55.2	44.8
Manipur	71.7	6	54.5	45.5	22.3	51.0	49.0
Meghalaya	68.5	7.2	61.1	38.9	24.3	50.1	49.9
Mizoram	63.1	10.1	53.1	46.9	26.9	53.8	46.2
Nagaland	61.6	6.8	57.6	42.4	31.6	54.8	45.2
Sikkim	64.2	9.7	58.8	41.2	26.1	62.0	38.0
Tripura	67.3	9.2	55.7	44.3	23.5	60.3	39.7

State/UT	Children who have attended	Attended before			Never attended		
	Children with disability (5-18 years) who have attended educational institutions out of total urban children with disability (5-18 years)	Children with disability (5-18 years) who have attended educational institutions before out of total urban children with disability (5-18 years)	Male (5-18 years) who have attended before	Female (5-18 years) who have attended before	Children (5-18 years) never attended school out of total urban children (5-18 years)	Male (5-18 years) never attended	Female (5-18 years) never attended
West							
Dadra & Nagar Haveli	64.2	8	75.0	25.0	27.8	61.2	38.8
Daman & Diu	41.4	22.5	82.1	17.9	36.1	63.3	36.7
Goa	74.7	7.4	56.0	44.0	17.9	50.0	50.0
Gujarat	65.4	12.8	54.6	45.4	21.9	56.7	43.3
Maharashtra	72	10.1	56.0	44.0	17.9	55.4	44.6
South							
Andaman & Nicobar Islands	70.6	9.4	54.1	45.9	20.1	53.2	46.8
Andhra Pradesh	69.5	9.1	52.7	47.3	21.4	53.9	46.1
Karnataka	68.9	10.9	53.5	46.5	20.1	54.3	45.7
Kerala	76.4	6.6	55.8	44.2	17	56.0	44.0
Lakshadweep	71.4	6.5	56.3	43.8	22.2	52.7	47.3
Puducherry	67.9	9.2	56.5	43.5	22.8	57.3	42.7
Tamil Nadu	67.8	10	54.6	45.4	22.2	56.1	43.9
Telangana	NA	NA	NA	NA	NA	NA	NA

Source: Census of India, 2011

Table 5.3. Percentage of children in urban areas under-school going age (6-14 years) who have and who have not attended educational institutions, 2011

State/UT	Children who have attended	Children who have not attended	
	Children (6-14 years) who have attended educational institutions out of total urban children (6-14 years)	Children (6-14 years) who have attended before educational institutions out of total urban children (6-14 years)	Children (6-14 years) who have never attended educational institutions out of total urban children (6-14 years)
Urban India	84.38	3.9	11.7
North			
Chandigarh	89.17	2.0	8.8
Haryana	85.81	2.5	11.7
Himachal Pradesh	90.53	1.6	7.9
Jammu & Kashmir	85.18	1.9	12.9
NCT of Delhi	87.40	2.4	10.2
Punjab	84.67	3.8	11.6
Rajasthan	81.95	3.5	14.5
Uttarakhand	84.95	3.1	12.0
Central			
Chhattisgarh	87.16	3.1	9.8
Madhya Pradesh	85.23	3.6	11.2
Uttar Pradesh	73.16	4.7	22.1
East			
Bihar	77.60	3.0	19.4
Jharkhand	85.13	2.7	12.2
Odisha	85.39	5.0	9.6
West Bengal	83.18	5.6	11.3
Northeast			
Arunachal Pradesh	87.60	1.9	10.5
Assam	86.59	4.0	9.5
Manipur	88.10	2.1	9.8
Meghalaya	91.90	2.3	5.8
Mizoram	93.80	1.6	4.6
Nagaland	89.16	2.9	7.9
Sikkim	90.78	3.2	6.1
Tripura	89.89	3.0	7.2
West			
Dadra & Nagar Haveli	83.22	3.3	10.9
Daman & Diu	85.82	5.2	11.6
Goa	88.93	5.9	10.8
Gujarat	83.38	3.3	7.8
Maharashtra	87.51	3.9	8.6

State/UT	Children who have attended	Children who have not attended	
	Children (6-14 years) who have attended educational institutions out of total urban children (6-14 years)	Children (6-14 years) who have attended before educational institutions out of total urban children (6-14 years)	Children (6-14 years) who have never attended educational institutions out of total urban children (6-14 years)
South			
Andaman and Nicobar Islands	92.91	2.0	5.0
Andhra Pradesh	87.26	4.0	8.8
Karnataka	86.68	4.2	9.2
Kerala	93.36	1.6	5.1
Lakshadweep	94.53	1.3	4.2
Puducherry	93.89	1.7	4.4
Tamil Nadu	92.12	3.2	4.7
Telangana	NA	NA	NA

Source: Census of India, 2011

Table 5.4. Urban literacy rate in population 7-18 years

	Literacy rate		
	Person	Males	Females
Urban India	91.3	91.7	90.8
North			
Chandigarh	92.9	93.4	92.4
Haryana	91.3	92.0	90.4
Himachal Pradesh	95.3	95.4	95.2
Jammu & Kashmir	89.3	90.3	88.2
NCT Of Delhi	93.5	93.7	93.2
Punjab	90.5	90.7	90.1
Rajasthan	88.9	90.7	86.9
Uttarakhand	91.4	91.9	90.9
Central			
Chhattisgarh	94.1	94.4	93.7
Madhya Pradesh	92.0	92.3	91.7
Uttar Pradesh	81.5	82.3	80.6
East			
Bihar	84.9	85.6	84.0
Jharkhand	91.4	92.1	90.6
Odisha	92.9	93.6	92.1
West Bengal	92.1	92.2	92.0

	Literacy rate		
	Person	Males	Females
Northeast			
Arunachal Pradesh	88.6	90.6	86.6
Assam	93.6	94.0	93.1
Manipur	90.8	91.5	90.0
Meghalaya	94.4	94.1	94.6
Mizoram	97.8	97.7	97.9
Nagaland	91.6	91.8	91.4
Sikkim	93.4	94.5	92.4
Tripura	97.1	97.1	97.1
West			
Dadra & Nagar Haveli	94.7	95.0	94.3
Daman & Diu	92.6	92.6	92.5
Goa	95.6	96.0	95.3
Gujarat	92.9	93.7	91.8
Maharashtra	94.2	94.3	94.0
South			
Andaman & Nicobar Islands	97.3	97.3	97.4
Andhra Pradesh	92.7	93.2	92.3
Karnataka	94.6	94.9	94.3
Kerala	98.0	98.0	97.9
Lakshadweep	95.8	95.9	95.6
Puducherry	96.0	96.0	96.0
Tamil Nadu	96.5	96.7	96.4
Telangana	NA	NA	NA

Source: Census of India, 2011

Annexure

Chapter 6: Safety and Security

Table 6.1. Crime Against Children (IPC + SLL)

States/UTs	Total Children Missing (2016) in India			Crime against children (IPC+SLL)		
	Female	Male	Total	2014	2015	2016
India	70394	41175	111569	89423	94172	106958
North						
Chandigarh	231	204	435	208	271	222
Haryana	1787	1788	3575	2540	3262	3099
Himachal Pradesh	158	122	280	467	477	467
Jammu & Kashmir	481	589	1070	211	308	222
Delhi UT	8536	6125	14661	9350	9489	8178
Punjab	699	591	1290	1762	1836	1843
Rajasthan	2597	1606	4203	3880	3689	4034
Uttarakhand	432	427	859	489	635	676
Central						
Chhattisgarh	2172	955	3127	4358	4469	4746
Madhya Pradesh	8622	3446	12068	15085	128659	13746
Uttar Pradesh	2529	2640	5169	14835	11420	16079
East						
Bihar	4325	1571	5896	2255	1917	3932
Jharkhand	515	493	1008	423	406	717
Odisha	4215	1576	5791	2196	2562	3286
West Bengal	12286	4595	16881	4909	4963	7004
Northeast						
Arunachal Pradesh	47	14	61	134	181	133
Assam	1474	939	2413	1385	2835	3964
Manipur	74	112	186	137	110	134
Meghalaya	100	84	184	213	257	240
Mizoram				178	186	188
Nagaland	49	28	77	25	61	78
Sikkim	93	57	150	93	64	110
Tripura	144	53	197	369	255	274

States/UTs	Total Children Missing (2016) in India			Crime against children (IPC+SLL)		
	Female	Male	Total	2014	2015	2016
West						
Dadra & Nagar Haveli	6	2	8	11	35	21
Daman & Diu	18	21	39	7	28	31
Goa	29	28	57	330	242	230
Gujarat	1342	665	2007	3219	3623	3637
Maharashtra	5827	4155	9982	8115	13921	14559
South						
Andaman & Nicobar Islands	40	13	53	50	102	86
Andhra Pradesh	2015	1309	3324	2059	1992	1847
Karnataka	1951	2273	4224	3416	3961	4455
Kerala	871	864	1735	2391	2384	2879
Lakshadweep				1	2	5
Puducherry	37	21	58	38	56	71
Tamil Nadu	3771	2030	5801	2354	2617	2856
Telangana	2921	1779	4700	1930	2697	2909

Source: National Crime Record Bureau, 2016

Table 6.2. Crime Against Children (IPC + SLL) in Metropolitan Cities

Cities	2016	Percentage city share to total crime against children
Ahmedabad (Gujarat)	481	2.52
Bengaluru(Karnataka)	1333	6.99
Chennai(Tamil Nadu)	230	1.21
Coimbatore (Tamil Nadu)	69	0.36
Delhi	7392	38.74
Ghaziabad (Uttar Pradesh)	130	0.68
Hyderabad (Telangana)	410	2.15
Indore (Madhya Pradesh)	631	3.31
Jaipur (Rajasthan)	699	3.66
Kanpur (Uttar Pradesh)	189	0.99
Kochi (Kerala)	86	0.45
Kolkata (West Bengal)	317	1.66
Kozhikode (Kerala)	92	0.48
Lucknow # (Uttar Pradesh)	956	5.01
Mumbai (Maharashtra)	3400	17.82
Nagpur (Maharashtra)	693	3.63
Patna # (Bihar)	378	1.98
Pune (Maharashtra)	1180	6.18
Surat (Gujarat)	415	2.17
	19081	

Source: National Crime Record Bureau, 2016

Table 6.3. Work participation rates as per age groups, Urban India 2011-12

States/UTs	7-14	15-18	7-18
Urban India	1.36	14.01	5.49
North			
Chandigarh	0.74	9.07	3.37
Haryana	0.23	4.34	1.57
Himachal Pradesh	0.00	8.50	3.44
Jammu & Kashmir	0.42	7.49	2.83
Delhi UT	0.11	7.14	2.24
Punjab	0.73	15.52	5.97
Rajasthan	0.75	17.05	6.91
Uttarakhand	0.56	11.19	3.48
Central			
Chhattisgarh	1.02	15.71	5.57
Madhya Pradesh	0.41	11.28	3.95
Uttar Pradesh	2.79	22.60	9.49
East			
Bihar	0.56	7.69	2.86
Jharkhand	1.19	12.47	4.56
Odisha	2.41	15.35	6.85
West Bengal	7.98	22.27	12.93
Northeast			
Arunachal Pradesh	0.05	0.92	0.34
Assam	0.80	6.51	2.65
Manipur	0.06	2.70	0.70
Meghalaya	0.50	6.00	2.60
Mizoram	0.00	9.31	2.93
Nagaland	0.00	3.85	1.52
Sikkim	1.27	10.13	3.52
Tripura	0.88	4.44	2.10
West			
Dadra & Nagar Haveli	0.00	8.69	2.05
Daman & Diu	0.41	3.02	0.93
Goa	0.52	3.03	1.29
Gujarat	1.29	16.70	6.01
Maharashtra	0.35	11.15	3.78
South			
Andaman & Nicobar Islands	0.00	4.54	1.69
Andhra Pradesh	0.59	12.09	4.45
Karnataka	0.35	10.96	3.75
Kerala	0.24	5.85	1.95

States/UTs	7-14	15-18	7-18
Lakshadweep	0.00	2.32	0.73
Puducherry	0.00	6.79	2.22
Tamil Nadu	0.19	9.87	3.14
Telangana	NA	NA	NA

Source: 68th round of NSS (2011-12)

Table 6.4. Percentage of urban children married before the legal age

	Less than 21	Less than 18	Married persons (All ages)		Married below legal age as percentage of married persons	
	Males	Females	Males	Females	Males	Females
Urban India	1591948	1327927	93377168	93181654	1.70	1.43
North						
Chandigarh	3393	1699	274020	239608	1.24	0.71
Haryana	42142	27262	2250080	2195720	1.87	1.24
Himachal Pradesh	2291	1539	187399	165614	1.22	0.93
Jammu & Kashmir	10292	8413	857672	715546	1.20	1.18
NCT of Delhi	47188	31887	4098314	3862870	1.15	0.83
Punjab	43933	28261	2687517	2592909	1.63	1.09
Rajasthan	108784	71604	4184530	4199342	2.60	1.71
Uttarakhand	8778	6785	710945	697184	1.23	0.97
Central						
Chhattisgarh	17812	13665	1407391	1399061	1.27	0.98
Madhya Pradesh	96782	69100	4785598	4804205	2.02	1.44
Uttar Pradesh	224787	172048	9711696	9800270	2.31	1.76
East						
Bihar	61591	47113	2591818	2627370	2.38	1.79
Jharkhand	35154	28269	1827420	1812788	1.92	1.56
Odisha	19475	19371	1709464	1711085	1.14	1.13
West Bengal	117854	108101	7569145	7502527	1.56	1.44
North East						
Arunachal Pradesh	1556	1624	75177	63852	2.07	2.54
Assam	12782	13654	1070253	1055882	1.19	1.29
Manipur	2664	2408	184112	186803	1.45	1.29
Meghalaya	1908	1907	113561	108103	1.68	1.76
Mizoram	1663	1274	113696	110173	1.46	1.16
Nagaland	1612	1827	114908	101959	1.40	1.79
Sikkim	589	536	38179	34723	1.54	1.54
Tripura	2639	3308	253635	249908	1.04	1.32

	Less than 21	Less than 18	Married persons (All ages)		Married below legal age as percentage of married persons	
	Males	Females	Males	Females	Males	Females
West						
Dadra & Nagar Haveli	1058	387	46745	35967	2.26	1.08
Daman & Diu	1808	327	56122	34652	3.22	0.94
Goa	3246	3038	229754	228601	1.41	1.33
Gujarat	172510	114273	6842831	6600952	2.52	1.73
Maharashtra	272116	210858	13304870	12701910	2.05	1.66
South						
Andaman & Nicobar islands	299	348	38423	35591	0.78	0.98
Andhra Pradesh	99597	111647	7049511	7288296	1.41	1.53
Karnataka	81242	91778	5829533	6021660	1.39	1.52
Kerala	17978	30969	3840224	4382367	0.47	0.71
Lakshadweep	73	124	12184	11898	0.60	1.04
Puducherry	1511	1787	211331	220786	0.71	0.81
Tamil Nadu	74841	100736	9099110	9381472	0.82	1.07
Telangana	NA	NA	NA	NA	NA	NA

Source: Census of India, 2011

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