Opportunities for Children in Urban Spaces in Gujarat

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1. Background

Gujarat is one of the top three urbanized states in India, with more than nine million children aged 0-19 years living in urban areas (Census, 2011). Such a high number requires an in-depth situational analysis and additional focus on urban children as a specific group. Urban development is different from rural development needing different strategies, more innovations and partnerships and a more targeted approach to reach out to vulnerable populations. This in turn requires a greater understanding of the inequalities and contexualities of urban areas. This is especially vital in the context of urban poor children and girls as it is easy to overlook their deprivations in the midst of the growing city dynamics. This brief aims to bring to focus the status of urban children in Gujarat on various child survival, development and protection parameters. It looks at the UNICEF focus areas of neo-natal mortality, stunting, all children in school and learning, Open defecation free Gujarat and child protection; as well as highlights the emerging vulnerabilities to urban children due to climate change and urbanization risks.

2. Situation of Urban Children in Gujarat and Critical Concern Areas

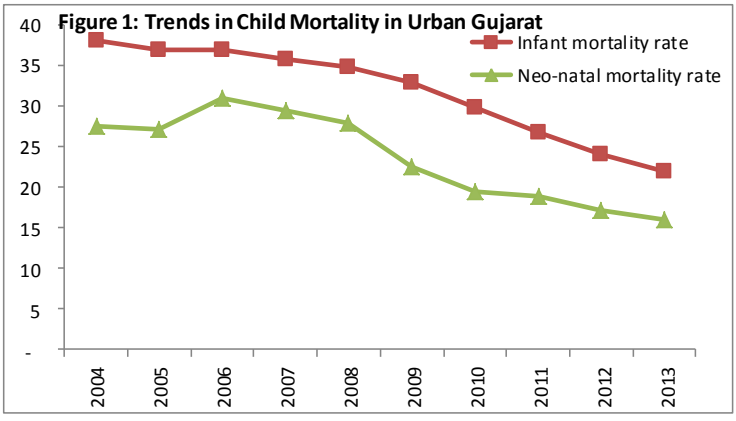
2.1. Child Survival and Development

At an aggregate level urban children in Gujarat have a consistently better status compared to the rural counterparts. There has been a decline in Infant Mortality Rate (23), with the gender gap also reducing by 16 points. The Neo-natal Mortality Rate has also reduced to 16 and is now much nearer to the SDG target of 12. (figure 1) The most alarming child survival indicator in urban Gujarat however, is the child sex ratio, which although improving is still very low at 852.

The prevalence of stunting (36.4%) and underweight (30.4%) children in urban Gujarat has also reduced significantly over the years although wasting (17.1%) is still a matter of concern having increased slightly over the years. In terms of absolute values, however stunting continues to be a concern and is much higher than the desired less than 10 percent status. Gender disparities in these parameters are not known but could be considerably higher, especially given the high anemia levels (38%) in school girls and low BMI (6%) in adolescent girls. An important achievement in case of urban Gujarat has been the decline in open defecation rates (6%) as also increasing coverage of water supply and drainage facilities. These would also contribute further to reducing wasting.

Children in urban areas in Gujarat also seem to have crossed the accessibility barriers to school enrollment with 3.13 million in primary and 1.2 million in secondary schools. The gross and net attendance rates are also high and the gender parity in enrollment and attendance also has been achieved. However, while the literacy rate among the adolescents is high at 94%, it is unfortunate to have 0.28 million illiterate adolescents in urban areas even in this age and time (Census, 2011).

Table 1 (annex 1) highlights the considerably better situation of urban children in Gujarat. However, what is a matter of concern is that more than half a million (7%



of the urban children in Gujarat) could be living in slums[1] and a much higher number would be living in slum like conditions. The situation of these children, most of who belong to poor families, is often hidden in urban aggregates. Various researches at National level point to the fact that the situation of the urban poor in terms of health and nutrition indicators can often be at par or even worse than that of rural counterparts and often the IMR and NMR as well as the prevalence of stunting and wasting among urban children is very high in the lowest quintile of the population ((Agarwal & Sangar, 2005; Agarwal, et al, 2007; NUHM Framework for implementation; Kumar and Singh, 2013). Unfortunately there is lack of data to understand and map the intra-urban disparities at the state level. However some local researches have clearly identified the gaps in health care parameters and care seeking behaviour among slum dwellers and poor children in various cities of Gujarat. (Patel et al, 2015; Kadri, et al, 2010; Sharma, Desai and Kavishkar, 2009; Yadav, et al, 2006; Nimbalkar, et al, 2013). Thus while overall the state may be faring well on child indicators in urban areas, the situation of the urban poor children is a matter of grave concern and needs special focus.

2.2. Child Protection

Another important concern area for Gujarat is the matter of child abuse. Data recently released by the National Crime Records Bureau (NCRB, 2014) highlights more than 70% rise in rape and abduction of minors. Earlier too, the 2007 MWCD report on child abuse had highlighted that 68.5% children in Gujarat have faced physical abuse, with younger children (5-12 years) and girls facing more abuse. Gujarat also showed high levels of corporal punishment with the incidence of corporal punishment reported from the Municipal/Zila Parishad Schools was second highest in the country at 41.5%. Girls and boys both had also reported a high level of sexual abuse at 63% and 37% respectively. The other worry for the Gujarat is: 113 cases of child abandonment in 2013. This is a rise of 43% from 79 reported in 2012. In absolute numbers, the state ranks fourth nationally in child abandonment.

There is also then the issue of child labourers. NSSO, 2012 data claims Gujarat to be having one of the highest incidence on child labour in urban areas at 2.2%. Media report quote a figure of around 32,000 child labourers in urban areas in 2009-10 (based on Rajya Sabha Questions). However, Census 2011, itself has revealed that more than 70,000 children in the age group of 5 to 14 years and 0.3 million children in age group 15-19 years were working as main workers (more than 6 months a year) in urban area. More than one third of the younger children and almost of quarter of these adolescents are from Ahmedabad.

Another vulnerable category is that of street children. While data on street children is not available, a study by ASAG in 2006 on street children in Ahmedabad revealed that while street children worked as labourers many of them had sometime got an option to reconnect to schooling but due to various reasons preferred to drop out. The reason for this needs to be probed more and efforts to reconnect street children with the education system needs to be strengthened. The study also highlighted other needs of street children: night shelter (61.8%), clothes (38.2%), medical treatment (26.5%), toilet and bathroom (23.5%), education (20.6%), food (11.8%) regular employment (5.9%), financial assistance (2.9%) and other services (20.6%). Street children also report maximum abuse. In Gujarat 56% of the boys and 80% of the girl street children reported physical abuse; although sexual assault reported in Gujarat was very less.

[1] Assumed on the basis of census 2011 data that almost 0.2 million from among 2.8 million of the children in the age group 0-6 years live in slums.

Unfortunately, separate data on urban areas is not available for child protection issue, but general opinion suggests that the situation is as worse in urban areas with the urban poor, particularly girls and those from scheduled tribes and scheduled castes being more vulnerable.

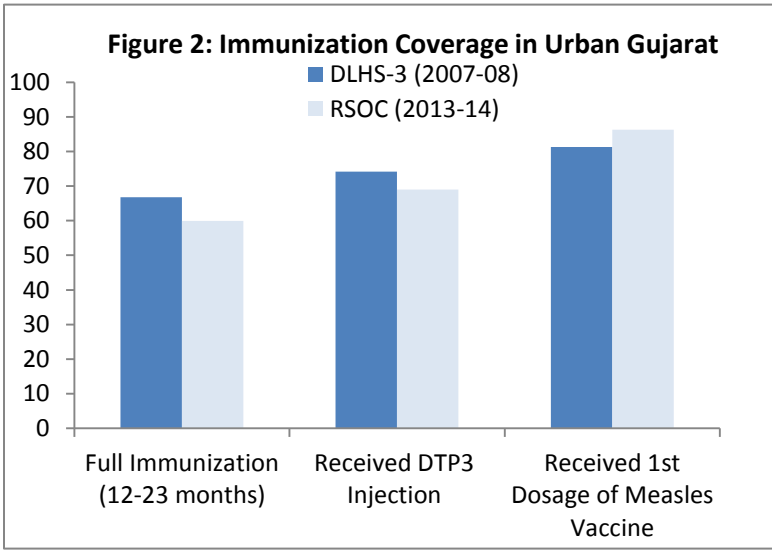
3. Policy Enablers and Intervention Gaps

3.1. Reducing Infant and Neo natal Mortality

Infant and neonatal mortality rates are reducing but are still behind the desired Sustainable Development Goal (SDG) indicators of child survival. This and the need to reduce intra-urban disparities, points to the need to assess the policy focus on reducing IMR and NNMR. An analysis of the various intervention determinants for reducing IMR and NNMR in Gujarat, shows that while the situation with regards to Ante-Natal checkups (ANC) and Institutional Deliveries has improved in urban areas, full immunization among urban children is a major challenge and the coverage has infact declined between DLHS (2007-08) and RSoC (2013-14). (figure 2) The probable cause behind this is the shift of public health focus and resources to rural areas post the launching of the National Rural Health Mission (NRHM) in 2005. While NRHM did have a focus to cover urban primary health care concerns especially reproductive and child health, gaps remained in implementation due to urban local bodies/towns not being the planning unit under NRHM, limited support for urban primary health care infrastructure and lack of standard norms and guidelines for urban health care. This added with lack of staff sensitivity and capacities to reach out to the urban poor, has led to a huge deficit in urban public primary health care system (also putting further burden on the tertiary system- thereby shifting people to private affordable yet less equipped service providers). The lack of focus is also reflected in the budgets. A review of the regional PIP of Ahmedabad region for 2013-14 shows that out of the 763 million only around 97 million has been approved for Urban RCH and Urban Institutional Deliveries. (Regional PIP 2013-14).

Again while municipal bodies and state governments continued to focus on urban health service delivery, the balance is highly tilted towards curative care rather than preventive and promotive care which is at the core for reducing IMR and NNMR.

The National Urban Health Mission has recognized these gaps in reaching out to urban areas especially the poor and has developed a framework with focus on urban planning and localized norms as well as creating a cadre of link workers (Urban ASHAs) and community based organisations (Mahila Arogya Samities). However, there needs to be a focused review and support for enabling this, in absence of which city plans may continue to focus on infrastructure creation, something which municipal bodies are more used to doing. (see Ahmedabad Health Action Plan). There is an urgent need to look at urban health systems from a service delivery perspective rather than service availability and infrastructure development perspective with a strong focus on mapping vulnerable populations and targeted service delivery in those areas. Also there needs to be a stronger focus on awareness, persuasion and behaviour change initiatives at the community level especially for ensuring full



immunization and reducing immunization drop outs.

Another emerging challenge for child survival in urban areas is the increasing vector borne diseases (malaria and dengue), ambient air pollution and heat waves. Studies (Azhar, et al, 2014; Kakkad, et al 2014) have shown a strong link between heat waves in Ahmedabad and increasing neo-natal morbidity and mortality. Also ambient air pollution has been recognized as a significant determinant for under-5 child mortality and child health (Lim, et al, 2012; WHO, 2014; Ghosh and Mukherjee 2010; TERI, 2015). Looking at these indicators as a part of survival and development of urban children should not only be a critical part of urban infrastructure planning but also of health planning.

In addition, it is also important to track and understand the changing morbidity patterns of urban children. All these facts actually point to the need for integrating the disease control and child survival indicators as part of urban development and infrastructure planning and having an integrated approach to urban child health.

The 3000 crores being allocated for urban health (under GSY) should in addition to infrastructure development also focus on community outreach activities, particularly immunization, nutrition awareness and hygiene education. These are important for improving the indicators on infant and child mortality as well as on stunting and wasting.

3.2. Reducing Malnutrition

The tracking of the determinants of malnutrition, very clearly highlight the reasons for high stunting and wasting in urban areas. While there is some improvements in infant and young children feeding practices like breastfeeding within one hour and exclusive breastfeeding for 5 months. However, the proportion of children given complementary food is still only 45.5%, almost at par with rural figures. The proportion of children aged 6-23 months who had a minimum dietary diversity has also gone down. This lack of improvement in infant and young child feeding practices is also associated with the lack of community outreach and awareness focus in the urban public health system.

In addition there are other socio-economic parameters. Although urban Gujarat has shown an improvement moving from severe food insecurity to moderate food insecurity zone, the fact remains that with inflation, urban food security is an issue, especially for the poor. The lack of proper coverage of Integrated Child Development Services (ICDS) network in urban areas further impairs the access to children form the poor communities to better nutrition services.

In Gujarat inspite of the high rate of urbanization, out of the total 336 sanctioned AWC blocks (by end Dec 2012), only 23 were urban blocks. Further, state evaluation studies also show that a significant number of 6 months to 3 years age group (74%) and 3 to 6 years age group (69%) children; adolescent girls (79%) as well as pregnant (91%) and lactating mothers (93%) in urban areas received less services from Anganwadis in Gujarat compared to their rural counter parts. Only 64% of urban anganwadis celebrated NHED. (Patel, et al, Review of ICDS in Gujarat, 2012-13).

The current focus on universalization of ICDS is thus a welcome step in the direction of promoting access of urban poor children to better nutrition services. However, only setting up on infrastructure will not be enough, it would also be important to build capacities of the ICDS workers on the issues of urban children, develop urban specific communication strategies to reach out to children in slums and most importantly map out service areas and create entitlements keeping in mind the mobility of the urban slum population.

Creating a system for identification and tracking of severely and acute malnourished children among urban poor is especially essential as urban poor are

most likely to suffer from stunting and underweight. Government of Gujarat also has specific supplementary nutrition programmes like Balbhog, Extruded Fortified Blended Premix, Nutri Candy, Demonstrative Feeding, Breakfast by SHGs, Hot Cooked after noon Meal, Third Meal, Doodh SanjeevaniYojana, Fruit through MatruMandal, Sukhadi (THR). However the outreach of these schemes in urban areas is not known. Most of these, however, by design are more suited to meet the needs of rural areas and hence need to be specifically focused on urban poor.

In addition, given the need to focus on girls and adolescents, other GoG programmes like SABLA and Mamta Taruni which are being implemented in rural areas under ICDS should also be extended to urban areas. The linkage of ICDS with health programmes especially Vit A and IFA supplementation also needs to be strengthened in urban areas as currently the coverage as per RSoC is only 53.6% and 8% respectively, even lower than that of rural areas.

Further as discussed by researchers (Vasaria, nd) urban malnutrition in Gujarat is much beyond socio-economic factors and needs interventions beyond ICDS. Thus it is also important that a holistic urban nutrition programme is designed which looks at innovation communication practices to improve eating habits of families as well as works to enable better access to public distribution system (especially ensuring access to pulses); promote urban agriculture as part of an integrated urban health programme. The school health programme functioning very effectively in urban areas needs to be tapped into being converted into a strong school health and nutrition programme.

3.3. Open Defecation Free Gujarat

Having better water and sanitation facility could significantly lower child morbidity, and should receive greater emphasis in urban planning and infrastructure development. The Government already has a major emphasis on open defecation free Gujarat as a part of its Swachh Bharat initiative. Both Census 2011 and NSSO 2012 surveys reveal that only 6 to 7 % households in urban Gujarat do not have access to individual latrines. However, it is important to reach the last mile in order to ensure ODF cities. This particularly requires high mobilization and there is the need to allocate specific budgets for the same. Sanitation needs to move much beyond only provision of latrines to having better drainage facilities, solid waste management and a lot of behaviour change in order to achieve the desired health outcomes. The current focus, while appreciable continues to be on constructing initiatives. In 2016-17, the state government made a provision of Rs 200 crore under the total allotment of Rs 1025 crore for water and underground drainage in urban areas under Swachhata Mission.

3.4. All Children in School and Learning

The high enrollment in Gujarat can be attributed to the fact that there is a high level of accessibility of schools in urban areas with more than 92% people reporting primary schools at a distance of less than one km; 81% reporting upper primary schools within one km and 73% reporting secondary schools within less than one km (another 23% report within one to two kms). Interestingly, at all levels of education the enrollment is higher in private aided schools, followed by government schools and then private un-aided schools. The move towards private education is also visible in the high average expenditure on education; around Rs.10,561 for primary; Rs. 9974 for upper primary; Rs. 14158 for secondary and Rs. 24848 for higher secondary. This data also probably hides the intra-urban inequalities in spending on education, and it is important to understand the status of urban poor in terms of spending on education and the quality of education they receive. The trend is particularly important to look at in urban context as we can see that rural students now surpassing urban students in pass out ratios. In the recently (May 2016) declared

results of class XII board examinations held by Gujarat Secondary and Higher Secondary Education Board (GSHSEB) Ahmedabad city posted 87.71% clearing their exams, while in Ahmedabad rural 90.08% students passed. There is an urgent need to focus on quality control in private schools especially those which target the poor and marginalized communities, with most students who are first generation learners.

Further, it is also important to provide special incentives to urban poor children in line with that of rural poor. Currently that is not the case as NSSO 64th round on education expenditure in 2007-08, shows that rural students benefit much more from educational incentives like text books, scholarships, etc as compared to their urban counterparts, and girls benefit more than boys in urban areas. Even though SSA has made special 'Provisions for Urban Deprived Children', an assessment of the SSA-RTE budget 2014-15, shows zero allocation under this head. There is no allocation even for transport facilities, which is a major issue in urban areas. Not much from data but from anecdotal evidence shows the problem of transportation in urban areas for children. While most states provide free transport to students, the lack of quality public transport especially during peak hours, often hinder students from benefitting. Urban transport policies need to look into the transport needs of students particularly those from economically poor backgrounds and those in resettlement colonies, which result in the increase in commutation of the children and could also lead to increase drop out or reduced attendance especially for girls. In fact the whole urban resettlement programme, particularly in Ahmedabad (BRTS and Riverfront) needs to be studies from the perspective of children's and girl's child education to incorporate the learnings into other infrastructure projects such as SMART cities and Housing for All.

The focus on urban mobility, especially BRTS, in cities also needs to consider the accessibility of children especially those from economically backward communities and their needs of "transport for education". Another major issue related to transport is to also look at the increasing incidences of road accidents and the safety of children, especially as we built high speed corridors and dedicated bus lanes, without focus on pedestrian crossing systems.

Another important aspect in urban areas is the successful implementation of Right to Education (RTE) especially enrolling of students from weaker sections in high end private schools. Despite of there being a High Court directive on the issue, various reports show low enrollment. In Gujarat, according to data for 2014-15, against 96,870 seats reserved in private un-aided schools only 6,762 were filled. (State of the Nation, RTE Section 12(1)(c)). It is important to support civil society groups for increasing advocacy on RTE compliance in urban areas. The 300 crore under Education (under GSY) which is meant on schemes like Kanya Kelavani in urban areas, also needs to consider the issue of implementing RTE and enabling the reach of girls under RTE enrollment.

There are also doubts regarding the ability of the children thus enrolled to cope with the other children from better off backgrounds particularly those who have had experience of kinder-garden, etc. Towards this strengthening Early Childhood Education systems in urban areas needs to be focused on. The wide opportunity of existing CSR groups in urban areas and the availability of educated young volunteers in cities need to be tapped in for this.

Focus on quality ECCE becomes more important in urban areas as child care in emerges as a major focus areas and there are National level Crèche Schemes for the children of working mothers and the focus on converting AWCs into Day Care centres. This would also have a strong nutritional impact, as in urban areas children (especially from poor families) whose mothers are also earning fare

better on nutritional indicators. Thus Day care and ECCE support is required for health and education agenda.

3.5. Child Protection

Integrated Child Protection Scheme (ICPS) scheme has been effectively initiated in Gujarat. However, data on outreach and outcomes especially in terms of urban areas in not available. Discussions with Childline services has, however revealed the beginning of effective implementation of the scheme in Ahmedabad. It is also important to strengthen the current child helpline services, particularly with back and forth infrastructure support services as part of the ICPS in urban areas (non- Ahmedabad based). The current budgetary allocations under the scheme seem to be adequate at 476.4 million for 2014-15, including 9 million for establishing six new open shelters in urban and semi urban areas. The actual expenditure made and the results thereof need to be examined in detail. It is also important to note here that almost 40% of this amount is towards service delivery of the scheme including setting up of the SCPS, DCPS and SARA. Thus the actual amount towards maintenance of the infrastructure may not be so high.

The current focus of ICPS also seems more on rehabilitation rather than prevention activities, which is important in urban context. Also missing in the link is to focus on involving urban communities especially women and other young children from better off backgrounds in the process, which can also help improve overall child participation in governance.

3.6. Resilient Cities

One of the critical urban SDG 11 focuses on resilient and sustainable cities. Urban development is already the focus area of Government of Gujarat, which is already spending huge amounts of money on urban development projects. The annual budget for urban development and housing in 2016-17 is around 11256 crores. It is important to ensure that these investments are child friendly and facilitate the growth and development on children especially the urban poor. While the construction of schools and other infrastructure will have a positive impact on children, a very critical areas affecting children in urban areas is the lack of open spaces and community parks. This scheme could look into these aspects from a children's perspective. Some of the possible examples of local/neighbourhood level open spaces include- Tot-lots/ play areas; Joggers Park; Pocket Parks; Collective Gardens; Dedicated Gardens; Ponds & small woodlands; Play Areas and Local Nature Reserves. Examples of Community Open Spaces include- Municipal gardens with variety of activities (paid and unpaid); Urban Canals & Waterways; Green Networks; Landmarks and heritage parks; Local Lakes; Sport Centres/ tennis courts/ football fields; Maidans; etc. As of now, neither the government nor civil society is focusing intensively on these. These urban open spaces would have a huge bearing on the quality of life of the children and hence needs to be a part of the child centric policy advocacy especially as Gujarat's urban development moves into establishing SMART cities and Mission cities.

There is also a huge focus on slum development as part of the Mukhya Mantri Gruh Yojana. With the State government allocating 594 crores in the annual budget 2016-17, this sector is expected to be a major focus of urban development in Gujarat and would also have a direct impact on the lives of the urban poor. However, there is a need to analyse these projects and designs from the perspective of children- the associated risks of being resettled or moving into high rises. There is also the need to look at building material and designs to prevent morbidity from heat stress and vector borne diseases. Another important area is the management of open spaces in these housing localities, and making them accessible to children. These have to be ensured in the initial stages itself, else there could be a high risk to these converting into gamblers' dens or garbage piles. Both of this would

have a high impact on safety of girls as well as on children's health. All the above issues are also applicable to the Garib Samruddhi Yojana (GSY) under which the state plans to allocate 13,000 crores for integrated service delivery for urban poor.

3.7. Urban Governance

A critical limitation of the urban development programmes, however is that at the city level, various departments are engaged in municipal service delivery, mostly in isolation or with minimal coordination with other relevant departments. For example under the 500 NOC scheme of AMC for accessing water and sanitation facilities, the application of an urban slum dweller is dealt by six different departments. Also most often these are lacking in inter-departmental coordination. Further there are gaps in human resources both in terms of staff availability with many positions being vacant as well as skills and capacities of the service providers (UMC, 2015). UMC also conducted a Training Needs Assessment of Surat Municipal Corporation in 2008. It was found that although SMC has been very pro-active in undertaking administrative reforms and capacity enhancement for its employees, there were a lot of gaps in terms of undertaking holistic and focused trainings. Also trainings of participatory and sensitive issues like child development, protection and gender were hardly covered. The maximum trainings across classes were provided in the area of legal procedures, followed by computer applications. 12% have received training on disaster management , 7% trained on efficient functioning and management of the organization and only two officials received training on water supply management. Even cross –sectoral training for efficient coordination was not provided. It was also observed that the total expenditure on staff training is mere 0.01% of the total revenue expenditure. Such a situation added to limited sensitivity of the staff and even less understanding of the nature of urban growth and child friendly systems further inhibits the targeting of the issues urban children.

4. Proposed strategies for UNICEF

Based on the above assessment, Table 2 (annex 2) summarizes the key focus areas and various policy enablers and gaps in urban Gujarat from child development perspective. UNICEF needs a multi-pronged strategy to work in urban areas: Evidence Gathering for Policy Advocacy and Piloting of innovative child friendly initiatives to feed into programmes. In addition, communication and especially innovative communication not only to increase awareness but also to increase child participation in governance is also being suggested. (see table 3, annex 3)

Rapid urbanization and a policy focus on urban growth in Gujarat, calls for the need to understand the issues of urban children and their interrelations with urban development policies and programmes. Urban aggregates can be very misleading and put the children from these sections at risk of being ignored by the public sector as the city grows closer to meet its targets of human development. Unfortunately, there is little segregated data available on the urban poor in Gujarat, except for some research papers in Ahmedabad and Surat. One of the critical intervention points thus required is evidence gathering on urban children, particularly the poor.

Furthermore, while efforts need to be made to ensure the last mile reach of existing child survival and development interventions to the urban poor, there is also the need to look at new emerging issues particularly in relation to environment, climate change and technological advancements. At the same time, as the government programmes move at a fast pace on creating urban infrastructure it is important to look at them from a child friendly lens to enable our cities to be safer and better places for our children. This needs to be done on an immediate basis, so as to provide inputs into current policies rather than advocacy for retrofitting at a later stage. This should be made an important focus of the evidence gathering portfolio.

Also important in the process is to look at access to technology as an opportunity for increasing the awareness of the children and improving communication to understand the needs and concerns of the children. Currently many development programmes are using mobile technology to create awareness on various issues. In urban areas, it would be useful to create a system to enable children to talk about their issues, seek feedback and engage in various constructive discussions. Platforms such as Mobile Vaani, used in Jharkhand and Madhya Pradesh need to be explored for Gujarat too. Using Big-data analytics, this information can also be better analyzed to understand the concerns and aspirations of the urban children both middle income and the poor. This use of technology for communication can in fact become the stepping stone in improving children's participation in urban governance. With use of IVR and SMS based mobile technology, games and apps; and photo mapping on GIS; children's views can be collated at the city level to derive their vision of the city. These can also be used to map the friendliness of a city for its children by developing a child friendly city-index.

A lot of issues related to urban development like public transport, waste management, water logging and drainage management, green space management can be made child friendly by inviting children to report on the current status of this infrastructure and how the improved infrastructure is benefitting or not benefitting them. Examples elsewhere in the world of having health museums, child observatories, child health workers, etc, need to be piloted in the state so as to demonstrate models for future interventions.

Last but not the least, urban development has large budgets, however software initiatives can be lost in these huge infrastructure projects. It is being recommended to work hand in hand with municipal corporations and private sector (through CSRs or in PPP mode) to ensure construction activities being managed by them while UNICEF focuses on building knowledge and outreach. Partnerships are the key to any successful urban development project. Any project in urban areas should be multi-disciplinary project having the local municipal corporation, a research partner, an implementation NGO, a communication partner and a CSR partner on board.

UNICEF is already working very closely in collaboration with the Government of Gujarat-Department of Health, Education, Labour, Social Justice and Empowerment and Women and Child Development. It would be good to take this partnership further at local level to municipal corporations particularly the four major cities Ahmedabad, Vadodara, Surat and Rajkot. This would not only enable reaching out to a larger number of urban children but would also enable influencing the urban development agenda to focus on children especially those from vulnerable backgrounds. Many of the issues and services which would be focused by UNICEF in urban areas, fall more under the purview of the Municipal Corporations and hence a partnership at that level would be very fruitful.

Further, looking into the large need for evidence on urban children, particularly the most vulnerable from point of view of gender, caste, class or residence, there would be the need to strengthen partnerships with research/academic institutions like Indian Institute of Public Health; Indian Institute of Management (Ahmedabad); Centre for Environment and Planning (CEPT) and Centre for Social Studies (Surat). The last one would particularly help look into matters of Surat and other urban areas of South Gujarat, which can bring in a more tribal focus.

A critical intervention partnership would be with local NGOs for strengthening the capacities of the Urban Health Centers, ICDS implementation as well as implementation of Right to Education. While UNICEF already has partner NGOs in many of these areas, it would be required to strengthen these partnerships through more urban based pilot projects. At the same time, it is also proposed that UNICEF also partners with other NGOs working in urban areas, particularly those working on urban planning, infrastructure development, budgeting and communication. Working in partnership mode on urban development projects with different NGOs bringing in different skills would have a larger impact on the desired indicators than working individually given the complicated nature of urban development.

Given the scope of CSR involvement in urban development in Gujarat, a very strong partnership should be explored with the Gujarat Chambers of Commerce in the major cities. It could be suggested to have a small center based within one of these, to pursue the children's agenda in all CSR activities. This center could also help channelize funds for the child development activities particularly those related to construction like water and sanitation, community parks and gardens, infrastructure upgrading of UHCs, etc; while UNICEF supports the software activities. In addition, partnerships with CSR groups like Deutsche bank and Bank of America, which are particularly interested in adolescent girls can also be explored. Dasra, already a UNICEF partner at the national level, can also be involved for extending CSR partnerships.

ANNEXURE 1

Table 1: Situation Urban Children in Gujarat

Indicator	Status	Source and Year
Child Population (0-19 years) in million	9.1	Census 2011
Child Population (0-6 years)	2.8	Census 2011
Adolescent Population (10-19 years)	4.8	Census 2011
Girls	4.1	Census 2011
Scheduled Castes	0.66	Census 2011
Scheduled Tribes	0.36	Census 2011
Infant Mortality Rate	23	SRS 2014
Neo Natal Mortality Rate	16	SRS 2014
Post Natal Mortality Rate	6	SRS 2014
Received at least one Ante-natal check-up (ANC)	90.1	RSoC 2013-14
Received three or more Ante-natal (ANC) check-up	79.0	RSoC 2013-14
Institutional delivery	89.8	RSoC 2013-14
Home delivery by Skilled Birth Attendant (SBA)	90.6	RSoC 2013-14
Births with weight < 2500 gms	19.7	RSoC 2013-14
Full immunisation (12-23 months)	59.9	RSoC 2013-14
Received DPT3 injection (12-23 months)	69.0	RSoC 2013-14
Recived 1st dose of measles vaccine (12-23 months)	86.3	RSoC 2013-14
Had diarrhoea in 15 days prior to survey (0-59 months)	6.8	RSoC 2013-14
Suffering from diarrhoea and for whom advise or treatment was sought (0-59 months)	87.2	RSoC 2013-14
Currently married women aged 20-24, married before 18 years	12.6	RSoC 2013-14
Households practicing Open defecation	12.2	RSoC 2013-14
Stunting	36.4	RSoC 2013-14
Wasting	17.1	RSoC 2013-14
Under-weight	30.4	RSoC 2013-14
BF within 1 hr	43.4	RSoC 2013-14
Exclusive BF (0-5 months)	74.6	RSoC 2013-14
Children 6-8 months given complimentary food	45.5	RSoC 2013-14
Minimum Frequency of feeding (Children 6-23 months)	32.1	RSoC 2013-14
Minimum Dietary Diversity in children (6-23 months)	23.8	RSoC 2013-14
Vit- A in the last 6 months	53.6	RSoC 2013-14
IFA in the last six months	8.0	RSoC 2013-14
Deworming in the last 6 months	102	RSoC 2013-14
Girls 15-19 with BMI<18.5	5.8	RSoC 2013-14
HH Using of iodized salt	88.2	RSoC 2013-14 RSoC 2013-14
HH without latrines	6	NSSO, 2016

ANNEXURE 2

Table 2: Key Concerns and Policy Environment for Child Development in Gujarat

Priority Concerns	Emerging Concerns	Urban Vulnerability Narrative	Policy Enablers
➢ High Neo-natal and Infant Mortality Rate ➢ Low Full Immunization Coverage ➢ High absolute stunting and underweight children ➢ Increasing wasting prevalence ➢ Learning levels of school children ➢ Physical and Sexual Abuse ➢ Child abandonment ➢ Child labour	➢ Improper infant and young children feeding practices ➢ Food insecurity and nutrition patterns within the home ➢ Incidence of malaria and vector borne diseases ➢ Mortality and morbidity due to heat waves ➢ Ambient air pollution and respiratory tract infections	➢ Paradox on poverty amidst plenty ➢ High intra-urban disparities ➢ Availability not equal to Accessibility ➢ Focus on infrastructure development not service delivery ➢ Focus on economic infrastructure vs social infrastructure development ➢ Socio-cultural parameters equally important determinant ➢ High need for change in attitude, behaviours and practices	➢ Economically growing state with vision for urban development ➢ Huge investments in urban infrastructure development ➢ Pro-active State Government with focus on innovations ➢ Pro-active municipal bodies which manage the urban service deliveries ➢ Local planning and development allows for addressing local needs ➢ Launching of new urban social sector programmes like National Urban Health Mission. ➢ Moving from severe food insecure to moderate food insecure state ➢ Good School and Tertiary health care network ➢ High rate of water and sanitation coverage and increased focus and investment on affordable housing ➢ Many innovative programmes already being implemented in rural areas ➢ Gender parity in many issues ➢ Active civil society ➢ Opportunity to tap into CSR programmes
Vulnerable Populations ➢ Girls ➢ Urban Poor, particularly those living in slums Street Children		**Policy Risks** ➢ More focus on economic and transport infrastructure than social infrastructure ➢ Move from Public Service Provisioning to Private Service Provisioning with Financing Support ➢ Investment plans made with high dependency of private investment Very low urban investment in community outreach ➢ Multiple agencies less coordination ➢ Limited staff capacities and low sensitivity particularly for issues of urban poor ➢ Concentration in cities, leading to neglect of fringes/peri-urban areas ➢ Lack of child friendly and resilience planning ➢ Environmental degradation	

ANNEXURE 3

Table 3 Suggested Strategies for UNICEF in urban areas

Communication for Development	Policy Advocacy and Programme Strengthening
➢ Increased awareness on health, hygiene and nutrition ➢ Confidence building in public health systems in urban areas ➢ Enabling children to children outreach and learning through mobile technology; games and apps; photo mapping ➢ Citizen awareness on open spaces for children and child friendly infrastructure	➢ Strengthening urban health and community outreach programmes ➢ Working with MAS, USHA and Local Women's Groups for child survival and nutrition gains ➢ Developing an urban early childhood education programme and support to civil society for increased enrollment under RTE ➢ Enabling child friendly designing in housing and transport policies and programmes ➢ Urban Open Spaces as an issue of Child Rights
Research and Evidence Gathering	**Innovative Projects**
➢ Status paper on intra-urban inequalities and child development indicators in Gujarat ➢ Understanding the issues of children in smaller cities and towns ➢ Changing morbidity patterns among children in cities ➢ Impact on education and health of children in urban resettlement colonies ➢ Influence of social media and impact of cyber abuse on child development	➢ Health museums for increasing awareness on child health indicators ➢ Developing child friendly designs for affordable housing projects ➢ School Children lead water, sanitation and vector observatory ➢ Urban agriculture for slums to enable better nutrition ➢ Children's Report Card on SMART Cities