MAPPING VULNERABILITIES OF CHILDREN OF WOMEN WORKERS IN INFORMAL SECTORS IN DELHI

Reimagining Childcare and Protection for All

A Study Conducted by Mobile Creches

Delhi Commission for Protection of Child Rights (DCPCR)

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FOREWORD

Most significant changes take place in the physical and cognitive abilities of children in their early years. The importance of the first six years, when the foundation of human life is laid, must be acknowledged by the state, society, communities and parents, who are collectively duty bound to provide young children with a caring and nurturing environment, and assist them in optimising their potential.

In urban areas, the settings and living conditions play a vital role in the care and development of young children. Amongst the most vulnerable are children whose parents work in the unorganised sector. Gravitating towards the localities that are often cramped and under-served by basic services and in perpetual need to sustain their families, parents often take up casual jobs and leave their children in the care of the elderly, older siblings, neighbours and, in exceptional situations, alone at home. Deficient and unprotected urban environments often impede the ability of these children to realise their basic rights.

Effective mechanisms need to be activated to ensure quality childcare in early childhood in order to harness the potential of the most vulnerable children. But this requires an understanding of the nuances of life in poor neighbourhoods and everyday struggles of the parents for basic sustenance, which must be factored in the design and delivery of programmes and services.

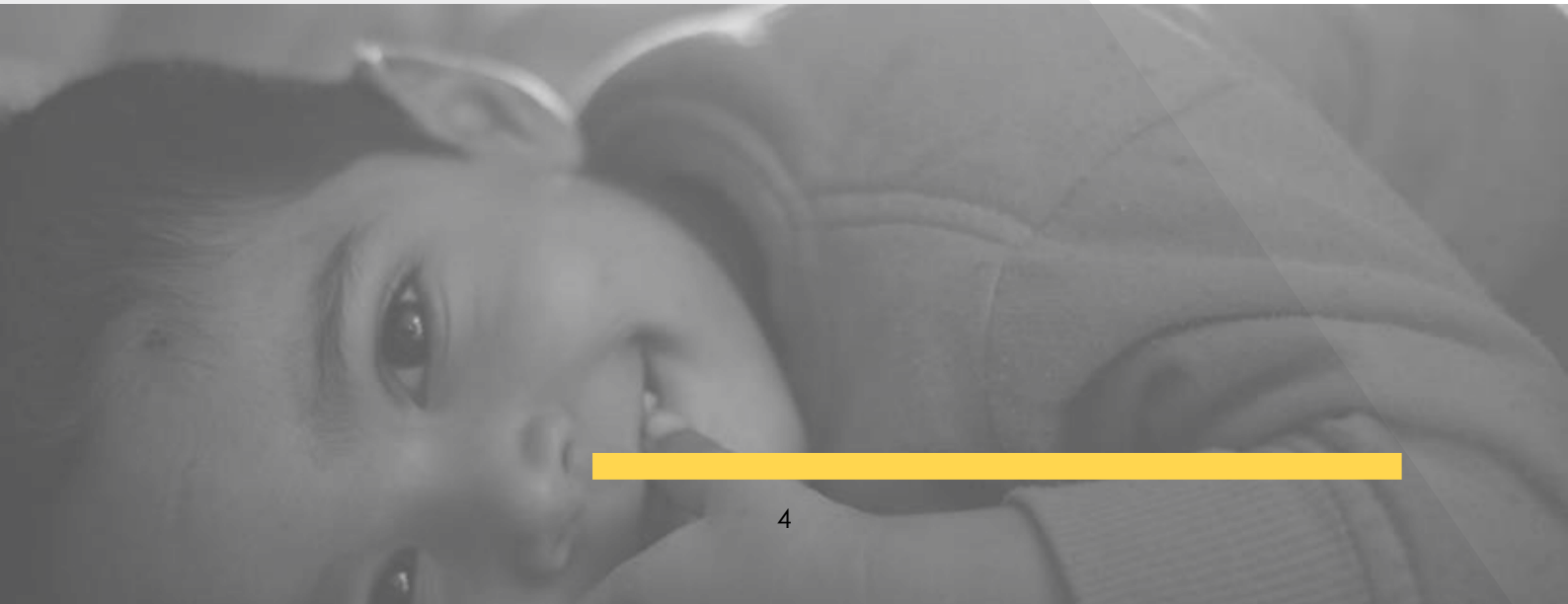
Delhi Commission for Protection of Child Rights (DCPCR) undertook this study in partnership with Mobile Creches primarily to understand the status of childcare provisions and the extent of their need in the urban slums of Delhi. It is an important step towards building evidence for advocacy for the most marginalised in urban spaces. DCPCR is grateful to Ms. Rita Singh, Member, for providing her support for this study.

The focus of the study is on J.J. or *Jhuggi Jhonpri* clusters, resettlement colonies and unauthorized colonies, which witness high number of cases of violence and abuse against children. The respondents of the study belong to five unorganised sector occupations, namely, construction work, domestic work, waste-picking, street vending and sex work. These categories were chosen because many women work in these sectors, and understanding of their lives and the impact of the nature of their work on the rights and well-being of young children could provide useful insights for policy and planning purposes.

We are confident that the perspective and information contained in this report will help in creating a consensus on the imperative of transformative change in the lives of most disadvantaged and marginalised children.

Ramesh Negi

Chairperson, DCPCR



ACKNOWLEDGEMENT

Mobile Creches appreciates the vision of the Delhi Commission for Protection of Child Rights (DCPCR) for evidence-based decision making for the most marginalised and excluded children. Its endeavour to map the vulnerabilities of children of women workers in the informal sector is expected to contribute insights to the urban planning processes amidst far-reaching changes taking place in Delhi. Inequitable socio-economic and infrastructural developments, pollution and environmental degradation have become important concerns but the implications of in-migration, growth of nuclear families and crimes against children have not received due policy attention.

Several organisations and communities contributed to this mapping exercise. We are particularly thankful to the Institute of Social Studies Trust (ISST) for leading the exercise, to Indo-Global Social Service Society (IGSSS) for technical assistance for online quantitative data collection, and to Delhi Neenv FORCES partners for their valuable contribution to the data gathering process. Without the commitment and unfailing support of our partners, this research could not be concluded. **We are immensely grateful to Ms. Rita Singh, Member, DCPCR, who provided relentless support and feedback at every stage of the process.**

We are indebted to the local communities, especially mothers and caregivers of under-six children who work in the unorganized sector. Despite the long and busy working hours, and the added responsibilities of household chores, care of children and other family members, they responded to our queries and questions with patience. Their experiences and insights made the research process worthwhile.

This report highlights the need for collective action at different level to secure the wellbeing of the young child. We hope that it would contribute to significant policy-level decisions in the interest of childcare of the under-sixes who reside in disadvantaged and vulnerable settings.

Sumitra Mishra

Executive Director, Mobile Creches

EXECUTIVE SUMMARY

Children are the foundation and future of India with inalienable rights to development, care and protection, which can be realized by ensuring for them a quality caring, nurturing and protective environment. But many children, specifically those who belong to the marginalised strata of the society, struggle every day with problems related to poverty, malnutrition, and lack of basic services. They are unable to claim their right to holistic development and remain on the margins of society and invisible on the policy agenda.

The 'Mapping Vulnerabilities of Children of Women Workers in Informal Sectors in Delhi: Reimagining Childcare and Protection for All' is an attempt to highlight the situation of the children of the marginalised communities. It identifies and assesses the care and protection mechanisms that children in the 0-6 age group, whose mothers work in Delhi's unorganized sector, are able to access to, specifically with regards to health, nutrition, learning opportunities, and a safe, secure, disease free and a nurturing environment.

Through extensive field work, using both quantitative as well as qualitative research methods, the study captured responses from 621 mothers across Delhi with at least one child under the age of six years, doing paid work in any one of the unorganized sectors, i.e., domestic work, construction work, waste picking, street vending or sex work. It used the lens of mother's paid work to understand and map the vulnerabilities of the children and causal factors.

Key findings: Casualisation of labour in the absence of a comprehensive public system for childcare and protection has detrimental effect on children, mothers and caregivers in urban areas where other support systems are limited and strained. Lack of public services and unsafe environment exacerbates the vulnerabilities of children and makes the caring and nurturing of young children more challenging for their parents. Child vulnerability could be traced to three sets of factors: (i) lack of public services; (ii) lack of health and safety related services; and (iii) informal nature of mother's paid work.

Child Vulnerability due to lack of public services:

- **Lack of safe drinking water:** The time spent by mothers or caregivers to fetch water for the household from tankers and other sources reduces the time available for childcare. Families living in the JJ clusters depend on community taps while tankers provide water once a day in places like Shahabad Dairy.
- **Lack of toilet facility:** Open defecation by children increases the risk to their health, safety and security. About 53 percent of the respondents stated that they had no choice but to let their children defecate in the open. The remaining respondents used free public toilets (27 per cent), community toilets (12 percent) and paid public toilets (8 per cent).
- **Lack of formal child protection systems and mechanisms:** Unsafe environment for children is a major concern in these communities. Women across areas like Mongolpuri, Shahabad Dairy, Rangpur Pahadi voiced their concerns regarding high incidences of kidnapping and sexual assault of young children and girls, and high drug usage and alcoholism among men and young boys.

- **Lack in quality service at Anganwadi Centre (AWC):** Children had restricted access to AWCs, which were open for short duration (about 1-2 hours), lacked drinking water, toilet and safety concerns, partly due to negligence on the part of the anganwadi worker and helper.

Child vulnerability due to lack of health, sanitation, crèches/child day-care facilities:

- **Lack of hygienic environment:** Children staying at worksites and unauthorised colonies were 70 per cent more prone to fever and diarrhoea. About 45 per cent mothers identified unhygienic environment and poor nutrition as the major cause of illnesses.
- **Lack of awareness on vaccination:** Although 87 per cent of the children were vaccinated against vector borne diseases, one in ten mothers lacked awareness of the vaccination status of their child and relied on the anganwadi worker to administer vaccines on time.
- **Lack of crèches/child day care facility:** Childcare facilities such as crèches were non-existent at almost all study sites. About 80 per cent of women left their children at home alone when they went out to work. This phenomenon was found to be highest amongst waste pickers in Rangpur Pahadi (90 per cent). The other common childcare arrangement, especially amongst construction workers (65 per cent) and street vendors (60 per cent), was to take the children with them at their workplace. Accidents occurred as mothers could not focus on their work as well as the child.

Child Vulnerability due to mother's paid work:

- **Double burden on mothers:** Multitude of responsibilities at times compromises the attention mothers can give to their young children. Children are often vulnerable to abuse and negligence as the responsibility of caregiving rests solely on the mothers (84 per cent), who are also responsible for household tasks (93 per cent). Fathers assume negligible responsibility for childcare. In view of their workload, women take on low-paid jobs with relatively flexible timings.
- **Elder sibling supporting working mother:** The older children, specifically the girl child, provide valuable support to the mother in care of younger siblings (15 per cent). But they miss school in the bargain.
- **Mothers engaged in unorganized sector**: Children's health suffers immensely when they do not receive appropriate care in time. Mothers, fearing wage cut or loss of job in the unorganised sector that does not follow any norms or standards of employment, are often unable to take leave for taking their unwell children to the government hospital for treatment. Instead, they prefer to take the child to quacks ("Bengali doctor") or private clinic hospital – options that are less time consuming but poor in quality and high in cost. About 51.6 per cent mothers stated that most of their out-of-pocket expenditure was on health and treatment, followed by nutrition of their children.

The mapping highlights the need of quality childcare mechanisms such as crèches in the vulnerable neighbourhoods or unorganized sector workplaces to ensure optimal growth and development of the young child.

ABBREVIATIONS

AWC	Anganwadi Centre
DoPT	Department of Personnel and Training
ECCD	Early Childhood Care and Development
ECCE	Early Childhood Care and Education
ECD	Early Childhood Development
FGD	Focused Group Discussion
FORCES	Forum for Crèches and Childcare Services
IGSSS	Indo-Global Social Service Society
J.J.	Jhuggi Jhonpri
JSY	Janani Suraksha Yojana
MOSPI	Ministry of Statistics and Programme Implementation
MWCD	Ministry of Women and Child Development
NCPRB	National Capital Region Planning Board
NCR	National Capital Region
NCRB	National Crime Records Bureau
NCT	National Capital Territory
NFHS	National Family Health Survey
NGO	Non-Governmental Organisation
NIUA	National Institute of Urban Affairs
NSS	National Sample Survey
NSSO	National Sample Survey Organization
OBC	Other backward Castes
PHC	Primary Health Centre
RSoC	Rapid Survey of Children
SC	Scheduled Caste
ST	Scheduled Tribe
UN	United Nations
UNDESA	United Nations Department of Economic and Social Affairs
UNICEF	United Nations Children's Fund

1. INTRODUCTION

Children are the most valuable, and yet the most vulnerable, section of the population. They are however not a homogenous group. Children in the 0-6 years age group are highly assailable (UNICEF, 2017). And many are rendered vulnerable by certain situations and attributes. The categories of children identified by UNICEF as particularly vulnerable are: children exposed to violence, children living amidst or associated with armed groups, children affected by HIV/AIDS, children without birth registration, children engaged in labour, children who are married early, children in conflict with law, children without parental care, children used for labour and/ or commercial sexual exploitation, female children subjected to genital mutilation/ cutting and trafficked children.[1] The vulnerability of children increases manifold if they belong to more than one vulnerable categories.

In India, many young children belonging to socio-economically marginalised communities experience poverty, malnutrition, socio-economic inequities, and inadequate access to basic services. These conditions render them vulnerable to communicable and non-communicable diseases and they are deprived of a caring and nurturing environment. The development, care and protection of children, thus, needs to be ensured by facilitating access to age appropriate learning, nutrition, institutional and legislative support for enabling them to gain their full potential with equal opportunities in a safe and protective environment (MOSPI, Government of India, 2018).

The tenets of Early Childhood Care and Development (ECCD) entail that every child should have the same opportunities to fully develop their potential, which is achievable only if they receive nutritious food and timely healthcare, and grow up in a caring and stimulating home environment. Socio-economic drivers such as child development and cognitive ability are more important than the biological abilities (Camargo-Figuera et al, 2014: 308) and are determined significantly by factors such as maternal education, poverty and poor home stimulation environment.[2]

Historically, children were brought into the ambit of international law and conventions at the end of the First World War. In 1924, the League of Nations adopted the Declaration of Geneva to recognize the rights of children. The process of recognition continued with United Nation Declaration of Children's Rights in 1959. In 1989, this recognition became legally binding for

1 http://www.childlineindia.org.in/vulnerable-children.htm
2 Early childhood development: new challenge for the SDG era, Comment, the Lancet, Vol. 4, December 2016, p.e873

the member countries of the United Nations with the adoption of International Convention on the Rights of Child in 1989.

Several other international and regional conventions, such as the ILO Minimum Age Convention, 1973 (Convention 138), the World Declaration on Education for all, 1990, the European Convention on the Exercise of Children's Rights, 1996, ILO Convention on the Worst Forms of Child Labour, 1999 (Convention 182), African Charter on the Rights and Welfare of the Child, 1999, and the SAARC Convention on Regional Arrangements for Promotion of Child Welfare in South Asia (2002) have sought to address additional critical aspects of child rights. It needs to be noted that this is not an exhaustive list.

India ratified Convention 182 and Convention 138 in 2017. Earlier in 1999, India had ratified the International Convention on the Rights of Child. Besides, India legally and morally recognizes the rights of children in the age group of 0-6 years in provisions of the Constitution of India. The legislation focused on freeing children from exploitation and abuses while enabling them to develop their full potential with fair access to health, education and respect. However, the child was not recognized as an independent entity with agency, and a social actor.[3]

The Constitution guarantees certain Fundamental Rights that embody basic human values that characterise a civilised and democratic society, and provides Directive Principles of State Policy that guide progressive action by the governments at the Central and State levels. They clearly refer to special provisions for children (Article 15(3)), prohibition of human trafficking, including child trafficking (Article 23), and prohibition of employment of children below the age of 14 in hazardous occupations and industries (Article 24). Articles 39(a) and (f) which direct the state policies towards securing the tender age of children, and provision of early childhood care and education for children till the age of six (Article 45) (Tarjei Havnes and Magne Mogstad, 2011).

The Integrated Child Development Scheme (ICDS), a centrally sponsored and state administered programme, covers around 38 million children through a network of almost 1.4 million anganwadis. It delivers an integrated package of services such as supplementary

3 Kumar, Dinesh, "Protection of Children's Human Rights in India". Accessed online http://www.legalserviceindia.com/legal/article-11-protection-of-childrens-human-rights-in-india.html

nutrition, immunisation, health check-up, preschool education, referral services and nutrition and health education. Early Childhood Care and Education (ECCE) is one of the components and aims at psycho-social development of children and developing school readiness.

The Government of India's National Policy for Children, 2013, has given primacy to the all-round development and protection of children. The National ECCE Policy, 2013, visualizes nurturance and promotion of holistic development and active learning capacity of all children below 6 years of age by promoting free, universal, inclusive, equitable, joyful and contextualised opportunities for laying foundation and attaining full potential. The Policy framework also includes the National Curriculum Framework and Quality Standards for ECCE.

A plethora of legislation provide for maternity entitlements but for a few sectors. They have not been able to deliver significant results because of poor implementation as a result of lack of administrative and political will, grossly inadequate funding, and other resource constraints.

Several laws in the past few decades have sought to strengthen child protection. They include: the Protection of Children from Sexual Offences Act, 2012; the Commissions for the Prohibition of Child Marriage Act, 2006; Protection of Child Rights Act, 2005; and the Immoral Traffic Prevention Act, 1986. Childline (1098), a 24-hour toll-free emergency helpline, is an important mechanism for the care and protection of children in need. The Integrated Child Protection Scheme (ICPS) seeks to bring together multiple existing child protection schemes of the MWCD under one comprehensive umbrella, and integrates additional interventions for protecting children and preventing harm. The ambition is to institutionalise essential services and strengthen structures, enhance capacities at all levels, create database and knowledge base for child protection services, and ensure appropriate inter-sectorial response at all levels.

Various non-government organisations (NGOs) have also advanced children's rights through delivery of basic services, advocacy, pilot projects for potential up scaling, community mobilisation and capacity development in the interest of implementation of public policies and programmes. Some of them who have focused on ECD have identified the operation of crèches for the underprivileged and women working in informal sector as a critical intervention. Among them, Mobile Creches and Pratham complement the provisions of the government and try to plug the gaps while SEWA Bharat implements the ICDS in Gujarat. Pratham currently operates 312 direct crèches/childcare centres in Delhi, in addition to the 150 centres it runs in partnership with the anganwadis, to serve around 10,000 children. Mobile Creches also runs crèche services, especially at construction sites in and around Delhi. A few corporate bodies also provide crèches/childcare services as part of their Corporate Social Responsibility initiatives.

ECD forms the foundation of a child's life who, in the long run, plays a critical role in sustainable development of the nation (SDGs) (Lu, Black and Richter 2016). Goals such as quality education (SDG 4, particularly 4.2 – which entails equal access of children to ECD), poverty elimination (SDG 1), Zero Hunger (SDG 2), good health and well-being (SDG 3), clean water and sanitation (SDG 6) and Proportion of children aged 5-17 years engaged in child labour (SDG 8) can contribute to reducing the vulnerability of children below the age of six. This recognition of the formative aspect of early childhood has increased emphasis on reducing risks for poor child development, which is necessary to accurately assess challenges, effectiveness of interventions, gauge progress and plan future investments (Lu, Black, Richter 2016).

Child health and nutrition data presented below in Table 1.1 shows conclusively India's progress in reducing under five mortality rate and neonatal mortality rate. From 1990 to 2017, the under 5 mortality rates declined sharply from 126 to 39. Infant mortality rate showed a similar trend with the decline from 88 deaths per 1,000 live births in 1990 to 32 in 2017 while the neonatal mortality rate was 24 deaths per 1,000 live births in 2017. Improved nutritional status is reflected in the decline in the percentage of stunted children from 62.7 per cent in 1990 to 37.9 per

cent in 2017, whereas the percentage of severely wasted children was 7.7 per cent in 2017. Meanwhile, overweight among children at 2.4 per cent in 2017 is an emerging concern.

Table 1.1: Basic indicators for children in India

S. No.	Indicator	1990	2017
1	Under 5 mortality rates (per 1,000 live births)	126	39.4
2	Infant Mortality Rate (per 1,000 live births)	88.5	32
3	Neonatal Mortality Rate	57.4	24
4	Severe Wasting	-	7.7
5	Wasting (percentage of children below 5 years)	20.3	20.8
6	Stunting (percentage of children below 5 years)	62.7	37.9
7	Underweight (percentage of children below 5 years)	55.5	36.3
8	Overweight (percentage of children below 5 years)	-	2.4

Source: Inter-agency Group for Child Mortality Estimation (IGME); UNICEF/WHO/World Bank Joint Child Malnutrition estimates, 2019.

The available data shows that the schemes and programmes launched have proved successful but there is still a long way to go. In terms of most indicators of child health and well-being, Delhi has performed better than other States. In NFHS-4 (2015-16), Delhi had Infant Mortality Rate of 31 deaths per 1,000 live births compared with 41 at the national level, stunting among children below the age of 5 years was 31.9 per cent compared with the national average of 38.4 per cent, and severe wasting among children below 5 years of age was 4.6 per cent or nearly half the national average of 7.6 per cent. However, the Urban Hunger and Malnutrition (Hungama) Report (2018) estimated that Delhi at 11.7 per cent of children aged 0-5 years had the highest percentage of severely stunted children across 10 cities where the survey was conducted.

Other than the absence of basic services and quality food and water, owing to low income levels, children are vulnerable due to the various types of mothers' work-paid and unpaid, organised and unorganised. The absence of supportive, accessible and quality childcare provisions in the neighbourhood or at the workplace is a major impediment to relational and nurturing care of children. To ignore them would be to risk overlooking what has been considered the most important and most meaningful human relationship – with benefits for both the care recipient and the carer (Lu, Black and Richter 2016). The solution for the same, as suggested by many, was providing crèche services at place of work or in the neighbourhood for the working women.

This has been supported by various committees and policy frameworks such as the Committee on the Status of Women in its landmark report, 'Towards Inequality' (1974), advocated for the provision of crèches, nurseries and labour-saving measures reduce the work load of women who are vested with the responsibilities of household chores, child and elder care, and in many cases, wage employment. The National Perspective Plan for Women, 1988, recommended the provision of crèche services universally for all women working in the organised and unorganised sectors. The National Policy for Empowerment of Women, 2001, also proposed the provision of childcare facilities at work place and education institutions, homes for the aged and differently-abled for reducing women's multiple burdens.

The Law Commission of India Report no. 259 in 2015 on ECCD and Legal Entitlements provides one of the most forceful policy articulations of the right of every child to provisioning of childcare. Furthermore, the Ministry of Women and Child Development (MWCD) drafted a New Policy on Women in 2016 which speaks of the need for measures to provide 'child/parental care services (crèches)' and 'childcare/parental leave' (Chigateri 2017).

The crèche facilities run the risk of becoming extinct as they have been neglected in the Government of India's list of priorities and receive inadequate funding. The central government has reduced its contribution to the National Crèche Scheme from 90 per cent of the costs to 60 per cent. The state governments are expected to fund a substantial portion. The crèche facilities under the scheme declined from 23,000 in 2015 to just 7,000 in 2018 which translates to around one crèche per 21,000 children which is grossly insignificant (Alexander, 2019). In Delhi, 167 crèches were run under the National Crèche Scheme by the end of 2017 (State-wise list of crèches run under RGNCS, MWCD). The *Grih Kalyan Kendra* (GKK), a registered society under the Department of Personnel and Training (DoPT) administers crèches in Samaj Sadans and Government quarters for women government employees, currently runs 11 crèches in Delhi-NCR region.

Due to paucity of crèches and day care facilities, parents are compelled to leave their children alone at home, in the care of an elder sibling, or older relatives, or neighbours. Such arrangements are neither satisfactory nor adequate for quality child care, and contribute to child malnutrition, stunting, sub-optimal cognitive development, and risks to safety and security.

1.1 Purpose of the study

This study aims at identifying the care and protection mechanisms for children in Delhi urban slums, during the early years of 0-6 particularly with regards to their health, overall development, safety and security, in relation to their mother's nature of paid work. It is based on the premise that ECCD is a social good, which sustains and reproduces society and is a critical input for socio-economic development.

Demographic snapshot: Children aged 0-6

- 164.47 million children aged 0-6 years comprise 13.6 per cent of India's total population
- Of these, 43.19 million reside in Urban areas
- 18.7 per cent of urban children aged 0-6 years reside in India
- NCT of Delhi comprises of 11.7 per cent children aged 0-6 years residing in slums.

Census 2011

A study by Delhi – FORCES (2016) found that high level of poverty coupled with limited access to public services (such as water, electricity, sanitation, housing and anganwadis), lack of education, jobs in the unorganised sector and migrant status of many families have led to deprivation of care, nourishment and health among children in urban resettlement colonies in Delhi. This study particularly used the lens of care and protection needs of children under six years of age, given the nature of their mothers' paid work. As shown later in the study, the mother continues to be the primary care giver of the family and is thus mostly involved in taking care of young children.

Delhi has the highest inflow of migrant labour today (Economic Survey of India, 2016-17) and many women from migrant families in low-income households work in informal jobs such as domestic work as it gives them ease of entry and flexibility in terms of time (Chigateri, Zaidi and Ghosh, 2016).

The idea of this study grew from the felt need of quality childcare where the women workers, who are employed in the unorganized sector, are forced to leave their children in unsafe and unhygienic environment in the absence of childcare and protection centres such as crèches at or near to their workplaces or residences and poor public services. The study has attempted to generate data on the status of child health, early education, nutrition, safety and security in relation to the engagement of their parent or caregivers in the unorganized sector. Based upon the findings, it has come up with recommendations for ensuring childcare with quality and others related actions in the interests of children and women.

1.2 Sampling

The sample consisted of working mothers engaged in waste picking, street vending, domestic and construction, and sex work. Studies have found that a large number of urban women workers are engaged in the first four occupations (Mohapatra 2012, Neetha N.). The decision to select the first four unorganized sector occupations was based on multiple factors involving discussions with FORCES partners of the Delhi chapter who work in various communities around Delhi and were able to identify the kind of informal work that women from urban poor households are involved with. Informal discussions were also held with experts in the field of ECCD, and women and work, in Delhi, who also encouraged the research team on undertaking an important and resourceful study.

A purposive random sampling technique was used to identify the respondents, and quantitative and qualitative methods were used for primary data collection. **Quantitative data was obtained through a survey of a total of 441 women respondents** meeting the following criteria:

(i) Women who have at least one child who is younger than 6 years;
(ii) Who work in any of the five identified forms of paid work; and
(iii) Who have worked in any one of these forms of paid work in the last 12 months.

A total of 13 FGDs were conducted with 156 women to elicit qualitative information. Table 1.2 shows the distribution across different occupations.

Table 1.2: Sampling framework

Type of paid work	No. of questionnaires administered	No. of FGDs
Domestic work	147	3
Construction work	81	3
Waste picking	100	2
Street vending	98	3
Sex work	15	2
Total	**441**	**13**

Source: Survey data, 2018.

The difference in numbers for data collected from the respondents across the five forms of paid work, as seen in Table 1.2, was based on the availability of respondents meeting the sampling criteria, identification of partners working with the women workers in a specified form of paid work and access of partners to the respondents.

1.3 Methodology

Mobile Creches, the Institute of Social Studies Trust (ISST) and Indo-Global Social Service Society (IGSSS) developed the survey tools jointly after extensive discussions. The draft survey form was translated from English to Hindi, pilot tested and revised before being used in the survey.

The partners in the Delhi Chapter of FORCES[4] attended a two-day workshop, which orientated them on the purpose of the study and focused on the use of various modules of the survey form and the app (designed by IGSSS) for collection of quantitative data. They conducted the survey between September and October 2018.[5] ISST analysed the quantitative and qualitative data, and used software such as STATA and Excel for quantitative data analysis and illustration of the findings through tables and figures in this report.

4 Forum for Crèches and Child Care Services (FORCES) is an all India network of 50 organisations (Trade unions, women's organizations and NGOs), individual members (including academics, lawyers and doctors), and 11 regional networks with their own membership. It is engaged in grassroots mobilization, campaigns, policy interventions and research on early childhood care and development. Mobile Creches is the current convener of Delhi FORCES.
5 As these partners have worked for long in these communities and are aware of the ground realities, their access to the respondents and the quality of data was assured.

For the qualitative analysis, ISST developed a semi-structured questionnaire for the Focused Group Discussions (FGDs). The ISST team conducted the FGDs at the sites identified by other partner organisations based on their community based work and networks. The qualitative data from the FGDs were coded as per the codes identified by the researchers after much deliberation. NVIVO software was used for data coding and analysis. The ISST researchers also reviewed secondary literature to situate the arguments in the report in a proper perspective.

1.4 Ethics and challenges

To obtain unbiased information, the researchers ensured the anonymity of women respondents at different stages of the research process. Before the survey and the FGDs, they informed the respondents about the purpose of the study and sought their consent to use their information in the research. They also took their consent before audio recordings.

Identifying women who met the three sampling criteria, as described above, within a short span of time was a major challenge for the partner organisations. Mobile Creches explored other similar organisations, but within such a short period of time, it was difficult to bring most partners on board. As these organisations spared time from their ongoing programmes, the number of respondents across different occupations varies (see Table 1.2). Nonetheless, the detailed survey data and the FGDs have strengthened the research.

Research with sex workers was especially difficult because of the sensitive nature of their work. Identifying, approaching and gathering information about their work was problematic. The survey team gained access to only 37 sex workers across two communities in Delhi. As one of the communities did not permit the survey team to carry their phones or paper, the forms were filled by recall, making the data biased. As a result, this report does not include the survey information from the 22 respondents from that community.

The survey team did not use the information obtained from this community of sex workers through 15 survey tools and one FGD on the nature of their occupation due to its sensitive nature, some contradictions and biases of the field coordinators. However, it used information on public services and childcare, which the women were more comfortable speaking about. The information they shared was validated by the partner organizers working with these communities. To protect the identity of sex workers, this report does not reveal the exact location of their residence.

1.5 Organisation of the report

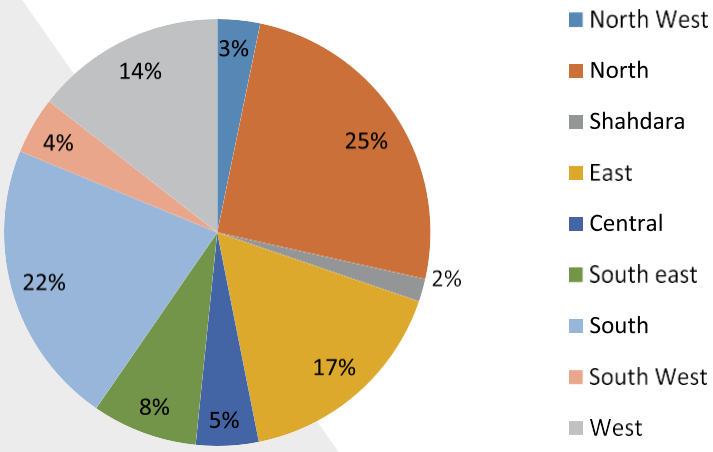
The second section provides a description of the sample characteristics and the demographic profile to establish the context of this study. The third section, based on the analysis of quantitative and qualitative data, is a discussion on the availability and access to public services and the status of health, safety and security of the children in the different areas, as well as the social organization of care, and how the nature of women's paid work affects childcare and their access to public services. The fourth and the final section concludes the report with key findings and recommendations.

2. SAMPLE CHARACTERISTICS AND DEMOGRAPHIC PROFILE

2.1 Sample characteristics

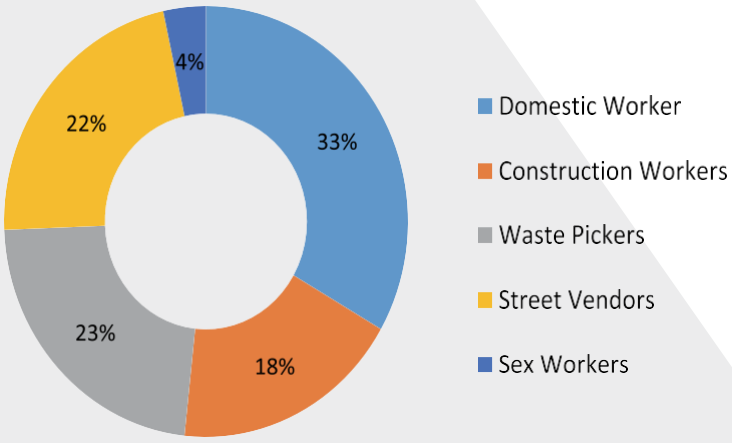
The respondents in the mapping were women workers from five informal sectors across Delhi who lived in various urban poor neighbourhoods where the FORCES – Delhi partner organisations worked. **Figure 2.1 shows that the respondents were spread across nine districts of Delhi and covered areas such as Shahabad Dairy, Holambi Kalan, Rangpur Pahadi and Sultanpuri.**

Figure 2.1: Survey respondents across districts in Delhi (%)



Source: Survey data, 2018.

Figure 2.2: Sample size across women's paid work (%)



Source: Survey data, 2018.

Domestic workers: Domestic workers formed the largest group in the study, accounting for 33 per cent of the total survey sample (see Figure 2.2). Surveys and FGDs with women working in domestic work were conducted in Dallupura (Harijan Basti), Shahabad Dairy and Mongolpuri. Most of them were part-time workers. The part-time domestic workers cleaned, washed clothes and utensils, and cooked in houses in nearby neighbourhoods while the full time workers were

engaged in childcare or eldercare. The three neighbourhoods where domestic workers were surveyed are notorious for having one of the highest crime rates in Delhi. Not surprisingly, safety and security was a major concern of the respondents.

Construction workers: Women construction workers comprised 18 per cent of the total sample. They were surveyed around Dwarka in south-west Delhi. Almost all of them had migrated with their husbands, post marriage, from Rajasthan, Madhya Pradesh, Haryana and Uttar Pradesh. They comprised of (i) those who lived in the areas and (ii) those who were brought by the *thekedaar* from their villages to work and live at the construction site temporarily. Their work was gendered in nature and comprise of tasks that are considered unskilled and which fetch lesser wages than their male counterparts. Interestingly, they had heard of women *thekedaars* but had never worked with them.

A strong sense of regional identity amongst the residents results in bias against persons from other regions (FGDs with construction workers, Dwarka, October 2018). Those living in their own or rented houses had access to water and toilets whereas those living temporarily in the tents depended on community tap water and community toilets.

Waste pickers: Women waste pickers (23 per cent of the total sample) were surveyed in Rangpur Pahadi Basti. They belonged to two categories: (i) those who worked in *godowns*, segregating waste in return for a monthly wage; and (ii) those, mostly Muslims, who assisted their husbands (who collected the waste material) in segregating the waste at their homes.

The living conditions of the waste pickers were extremely poor in terms of water, sanitation (open defecation), roads, and access to anganwadis and other crucial public services. The women reported that there was no medium of reporting the lack of services as almost all of them were tenants who could be evicted without notice.

Street vendors: Women street vendors (22 per cent of the total sample) were surveyed in Holambi Kalan, Mandavali and Jwala Nagar. They belonged to two categories of street vending: (i) *Pheri* vendors– those who hawked their wares roaming around neighbourhoods; (ii) Those who set up a stall/cart/space in a permanent or weekly market.

They and their goods are exposed to vagaries of nature as they work outside. Unless their work is located in markets, most of them do not have shelter, or running water and toilets near their workplace.[6] Some of the women complained about having to carry heavy loads to the markets or from the wholesale *mandis*. According to their accounts, the living conditions in Holambi Kalan and Mandavali are extremely poor in terms of sanitation and drinking water whereas in Jwala Nagar personal toilets are available but difficult to access despite higher rents charged by the landlords.

6 For more details, see: http://www.wiego.org/informal-economy/occupational-groups/street-vendors

Sex workers: Due to the difficulties in accessing them, sex workers comprised of only 3 per cent of the total sample. The two communities of sex workers who were part of the study were widely different in terms of how their work operated as well as their residential set ups. In both cases, the women were uncomfortable discussing their forms of work, clearly indicating that there is a sense of shame around their work and an apprehension that either they or their families may face backlash from the community or state functionaries. (See Section on ethics and challenges)

2.2 Demographic profile of respondents

Table 2.1 below shows that most of the women surveyed were in the age group of 19 – 30 years (71.4 per cent) followed by the age group of 31 – 40 years (26 per cent). The number of women below the age of 18 was insignificant, which may be a reflection of the declining practice of child marriages and/or early child births.

About 96 per cent of the women were married and the remaining were widowed, separated or divorced. In terms of education status, 40 per cent of the women surveyed had never been to school, 27 per cent had completed their primary education, and 18.3 per cent had attended junior/lower secondary school. None of the women were graduates or diploma holders. Poor educational status forces many of the urban poor women into informal forms of work, which accommodates unskilled labour but pays low wages. There are not many opportunities for these women, who lack access to information relevant for them and unable to negotiate at the level of the market and the state.

Most of the respondents were Hindus (82 per cent), followed by Muslims (15 per cent). Almost 56 per cent of the respondents belonged to the Scheduled Castes (SC), communities generally equated with landlessness, lack of equal opportunities, inter-generational poverty and the notions of 'purity and pollution'. These characteristics push members of the community into informal forms of labour, which is insecure, low-paying and often degrading. They monopolise work involving segregation of waste, which the higher castes refuse to take up.

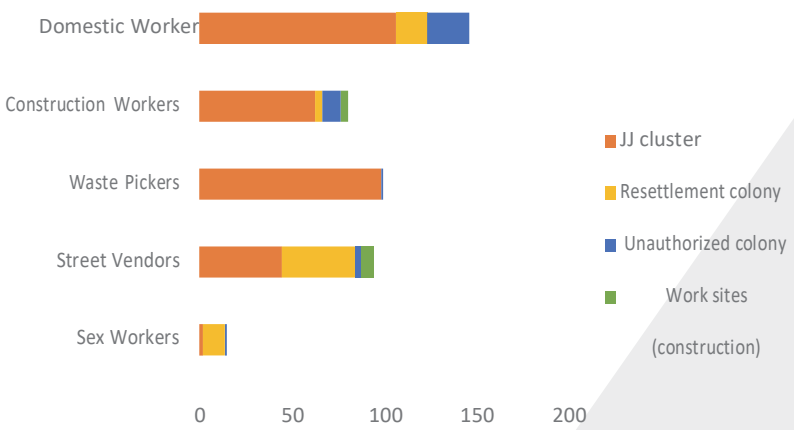
Table 2.1: Demographic profile of survey respondents

Age group	***Percentage (%)***
18 years and below	0.2
19 – 30 years	71.4
31 – 40 years	26.0
41 – 50 years	1.8
Education	***Percentage (%)***
None	40.1
Primary	27.1
Junior/lower secondary	18.3
Secondary/Higher secondary	2.58
Informal education	2.3
Marital status	***Percentage (%)***
Married	96.0
Widowed	2.4
Separated/Divorced	1.3
Religion	***Percentage (%)***
Hindu	82.3
Muslim	15
Sikh	2.2
Caste	***Percentage (%)***
General	13.8
SC	55.7
ST	13.0
OBC	6.5

Source: Survey data, 2018.

Delhi being an urban agglomeration, the housing patterns of the respondents is intrinsically linked to the availability of public services which directly affects women's ability to work and to provide care for her young child. Figure 2.3 below shows that most respondents, especially waste pickers, domestic workers, live in J.J. colonies where the quality of life is poor due to lack of vital public services.

Figure 2.3: Types of housing across women's occupations



Source: Survey data, 2018.

That a significant number of people have resided at the construction site for over five years is a matter of special concern as it exposes children to unhealthy environment and increases the risk of injury and malnourishment.

Almost 60 per cent of the respondents, who have lived in Delhi for more than five years, migrated from Uttar Pradesh (42 per cent), Bihar, Madhya Pradesh, Rajasthan and West Bengal. Yet, only around 37 per cent have been able to own houses. Among them, most have houses in resettlement colonies (56.5 per cent) followed by JJ clusters (36.4 per cent). The lives of the remaining respondents, as tenants, find their right to demand public services further curtailed owing to the fear of evictions and demolitions.

3. VULNERABILITY OF YOUNG CHILDREN IN URBAN SLUMS OF DELHI

Children's life in urban slums is generally marked by poverty, deprivation and exclusion. UNICEF's "The State of the World's Children" in 2012 on urban children highlighted the "*invisibilisation*" of children in urban slums, who are deprived of quality education, safe water, sanitation facilities, health and nutrition, care and protection – essential pre-requisites for their growth and development. Loss of opportunities to realise their potential as capable, competent and confident individuals and become responsible citizens perpetuates intergenerational transfer of socio-economic exclusion and undermines overall development of the country. Situated within this context, this section discusses the research findings related to the concerns of women working in the informal sector in urban areas regarding the well-being of their young children.

3.1 Health status of young children

There is considerable literature which shows that children are most vulnerable to malnutrition and diseases in the first six years in their lives. The study also found that young children were highly prone to contracting preventable ailments. About 78 per cent of children aged 0-6 years had been ill during the last six months of the survey, mostly with fever (63 per cent) and followed by diarrhoea (16 per cent). A Rapid Survey of Children (RSoC) in Delhi in 2013-14 had found a similar morbidity pattern among children aged 0-5 years, who had fever (7 per cent) and diarrhoea (5 per cent) in the 15 days preceding the survey. However, it needs to be noted that the survey for this study sought information about incidence of illnesses among young children in the previous six months while the RSoC sought information about illnesses in the 15 days before the date of survey.

3.1.1 Impact of the lack of public services in communities on child health

Children living in the JJ clusters are at high risk of ill-health, which is indicative of the unsanitary and unhygienic conditions arising out of absence of adequate public services such as sanitation, toilets, safe drinking water and basic housing.

In the survey, about 90 per cent of the children who had been ill resided in unauthorised colonies. Children living in unauthorised colonies or accompanying their mothers to worksites were 70 per cent more prone to fever and diarrhoea. About 45 per cent mothers identified unhygienic environment and poor nutrition as the major causes of illness but a considerable proportion of them (33 per cent) were unaware of the reasons of illness.

Several studies have related open defecation with poor public health outcomes. Agarwal (2011) had observed that 'in Delhi, among

the poorest quartile, 34 per cent did not use a flush toilet or pit latrine' and linked the poor hygienic conditions of the slum residents to higher risk of diarrhoea, typhoid, jaundice and vector-related diseases such as dengue, chikungunya and leptospirosis due to exposure to excreta (2011, p. 21). Bartlett had also (1999) emphasized the heightened vulnerabilities of children in contracting infections in situations of poor sanitation and defecation in the open (also see Brown et al, 2013). Spears et al (2013) also found a positive correlation between increase in open defecation and increase in stunting among children.

The practice of open defecation was widespread at the study sites. **About 53 per cent of the respondents defecated in the open.** Certain neighbourhoods such a Shahabad Dairy and Rangpur Pahadi were in most pitiable condition owing to lack of garbage disposal, open defecation and no proper sewage system resulting in severe water-logging putting young children at high risk of water-borne diseases (e.g., diarrhoea) and vector-borne diseases (e.g., malaria, dengue and chikungunya).

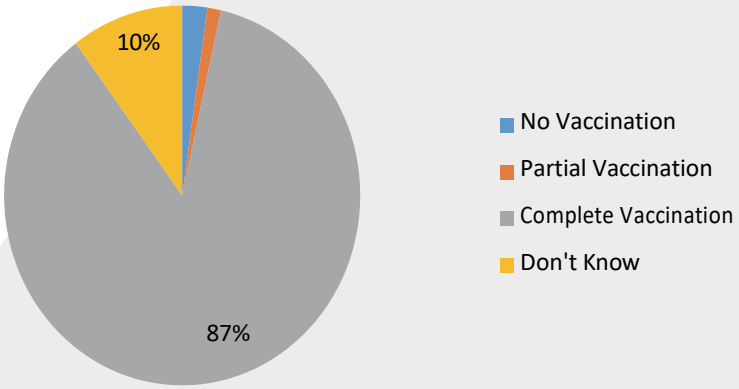
The immediate environment characterized by air and water pollution is a critical concern as a sizeable number of young children are left on the streets with minimal care in the urban slums. Many of them lack safe places for children to play outdoors (Satterthwaite 1993; Bartlett 2003), and indoor and outdoor chemical pollutants that compromise the health of children are frequently encountered in low-income urban areas (Satterthwaite 1993). Young children under the age of 6 years with underdeveloped lungs are particularly vulnerable.

Delhi is one of the most polluted cities in the world and its poorest children are the most vulnerable and bear the heaviest burden of the city's poor air quality There is an inverse relationship between socio-economic status and the pervasiveness of lung function deficits: the lower the socioeconomic status, the greater the percentage of children with reduced lung function (Slutsky, 2017).

3.1.2 Immunisation status of children below 6 years of age

According to the National Family Health Survey 4 in 2015-16, 62 per cent of the children in the age group 12-23 months were fully immunized in India, up from 44 per cent in 2005-06 (NFHS-4, 2015-16). As Figure 3.1.2 below shows, **about 87 per cent of the children across the study sites were vaccinated against vector borne diseases**, in all probability due to the fact that they resided in Delhi with relatively better immunisation delivery system.

Figure 3.1.2. Immunisation coverage of children aged 0-6 years (%)



Source: Survey data, 2018.

However, it is important to note that women are often not aware of the list of vaccinations to be administered to their children and rely mainly on the anganwadi workers to vaccinate

them on time. Every tenth woman in this study was unaware of the vaccination coverage, which increases the probability of a particular vaccine being missed.

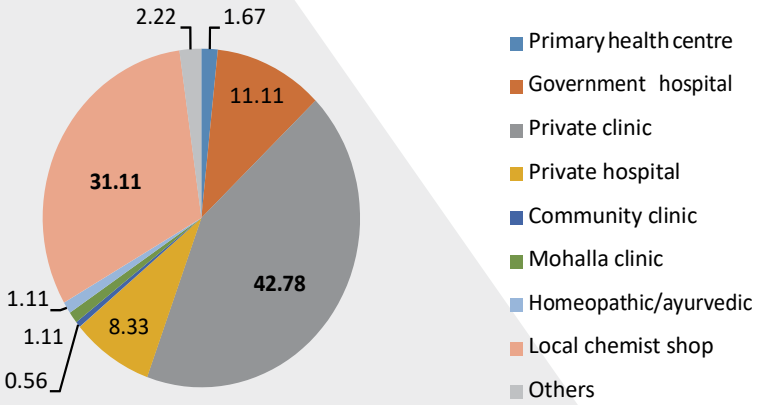
Access to anganwadi centres and government health facilities is crucial for availing essential services such as immunisation. But social discrimination acts as an important deterrent to utilisation of public services. **In this study, the proportion of children who received no vaccinations was low at two per cent. But most of them (87 per cent) belonged to Schedule Castes (SC) and Schedule Tribes (ST). Across the occupations, children of construction workers and domestic workers were more likely to receive all basic vaccinations (90 percent) in comparison with children of sex workers (19 per cent).**

A higher proportion of children received vaccination at private health facilities relative to government hospitals in this study whereas the RSoC, found that 56 per cent of children were immunized at government health facilities and 33 per cent at private health facilities in the National Capital Territory (NCT) of Delhi during 2013-14.

3.1.3 Practice of seeking medical treatment for children

The survey data shows high reliance of women workers in the informal sector on private health care providers in relation to public health sector. Only 11 per cent of women informal workers took their children to government hospitals for treatment while approximately 51 per cent respondents approached private healthcare providers.

Figure 3.1.3a Sources of medical treatment for children (%)



Source: Survey data, 2018.

Most women in the FGDs spoke about their preference for private facilities for minor illnesses of their children notwithstanding the high out-of-pocket expenses because their work does not allow them the time required to queue up at government facilities. Given their paid and unpaid responsibilities and the informal nature of their work, women find it difficult to spend too much time waiting in long queues as it means loss of earning.

However, for major illnesses some women stated that they preferred to go to the government hospitals for free of cost or subsidized services. Some women also approach quacks and traditional healers with health problems their family members, including children. Many women also referred to the attitude of health professionals at government hospitals and clinics as reasons for seeking treatment at private clinics or quacks in the neighbourhood.

> *"There are problems in going and coming [to the hospital/dispensary]. To top it all the doctors scold and do not talk properly."*
>
> FGD with domestic workers in Harijan Basti in Dallupura

"A Bengali [quack] doctor sits here; he takes 30 rupees, the doctor acts very pricey at the hospital that is why I stopped visiting the hospital."

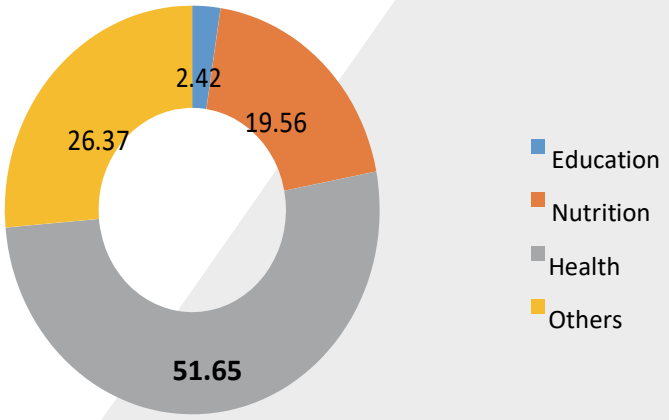
FGD with domestic workers in Shahabad Dairy.

Domestic workers and waste pickers (working in *godowns)* found it most difficult to take out time for treatment of their children as taking leaves would result in wage cut or loss of daily wage. They preferred to pay more for treatment at private hospitals or by quacks for their children's minor illnesses. A few women waste pickers who belonged to lower castes also reported that they had faced caste-based discrimination when accessing treatment at government hospital OPDs.

The out-of-pocket expenditure on health is substantial and increasing, which affects the household economy and the well-being of the family and child. Both Baru et al (2010) and Balaranjan et al (2011) have noted that growing dependence on the private sector for health services has affected the expenditures of poorer households. The 'out of pocket expenditure on health as a proportion of household expenditure is increasing for the poorest households (Balaranjan et al 2011, p. 6).

The out-of-pocket expenditure for 51.6 per cent of the respondents was primarily on health whereas 26.3 per cent spent the most on nutrition. A reverse of this situation would indicate a positive trend. The dependence on the private sector due to inadequacy of the public sector has the potential of further trapping the poor in a circle of poverty and enhancing the vulnerabilities of the child.

Figure 3.1.3b Childcare related expenditure in the last six months (%)



Source: Survey data, 2018.

3.1.4 Challenges for Institutional child delivery practices

Non-institutional deliveries of children in poor localities significantly impede maternal and child health. Agarwal (2011) noted the preference for institutional delivery of children but the percentage of births assisted by health personnel was particularly low among the poorest quartile of the urban populations in Uttar Pradesh, Delhi, Bihar and Rajasthan (p. 19). Home-based deliveries if not carried out by trained *dais* are known to lead to complications in birth, poor post-partum care and neo-natal infections, and endanger the lives of mothers and children.

In the FGDs across study sites, women expressed their preference for child birth at home with help from a mid-wife or a private doctor. They cited rude behaviour and attitude of the doctors, nurses and other staff at public hospitals and health facilities as one of the reasons against going for institutional delivery.

"No-one pays attention in government hospitals. Four women were waiting for bed in government hospitals, but there was no bed. One woman gave birth on the floor and she and her baby both died due to negligence."

FGD with Street Vendors in Mandavali.

Reported crimes against children in India have increased over the years. **According to NCRB, the total number of reported crimes against children were 106,958 in 2016 and 94,172 crimes in 2015.**
Ministry of Statistics and Programme Implementation, Government of India, 2018

The experience with the provision of maternity benefits linked to institutional delivery of the first-born child in government hospitals was mixed. In the FGDs with domestic workers in Mongolpuri and with waste pickers in Rangpur Pahadi, some women reported receiving monetary benefit of Rs. 6,000 under the Janani Suraksha Yojana (JSY) while others reported that they had filled up the required forms but had not received any money.

Clearly, child health is compromised when women are unable to access free treatment at government clinic and hospitals. Expenses on health can delay timely treatment and push the family further into poverty. Rude behaviour of hospital staff and doctors has been a recurring complaint that hinders both treatment seeking behaviour and child delivery practices.

3.2 Safety and security concerns of young children

Unsafe housing, unhygienic surroundings, high crime prone communities and the nature of paid work of their families contributes to insecurity among children in poor households and colonies. It needs to be noted that Delhi had the highest rate of crime against children in India in the NCRB report for 2016. Kidnapping and abduction were the most common complaints, followed by cases of sexual offences booked under the POCSO Act, 2012. Sexual assaults amounted to more than 18 per cent of all crimes against children (MOSPI, GOI, 2018: 54-55).

In the FGDs, women across areas like Mongolpuri, Shahabad Dairy, and Rangpur Pahadi consistently articulated their concern for children's safety due to high incidence of crimes against women and children in their neighbourhoods. They referred to several cases of kidnapping and sexual assault of young children. Most of them mentioned that drug usage and alcoholism among the men and young boys in these communities is a common phenomenon, which has made these areas unsafe and notorious.

"If you come in the evenings, you will find groups of alcoholic or drug addicted men and young boys. One cannot leave children alone even for a few minutes to go and buy vegetables from the corner of the street. There are parks but children cannot play because of these people in these parks… You can find children as young as 10 years sniffing varnish in this area."

FGDs with domestic workers in Mongolpuri. October 2018.

In areas such as Mandavali and Rangpur Pahadi, where there were no toilets and people practiced open defecation, young children were found to be more vulnerable to kidnapping, accidents and assault. **Women in Rangpur Pahadi referred to several instances of young girls being assaulted when they were on their way to the nearby forested areas to relieve themselves.**[7]

7 In August 2018, major newspapers across Delhi NCR reported the case of a nine-year old girl living in J.J. colony in Rangpur Pahadi who was sexually assaulted and dumped in a ditch in the forested area when she had gone to

"A few days back, an eight or nine years old girl who had gone to relieve herself in the forest, was raped by a group of boys who were taking drugs in the forest…The forest is a very unsafe space even in the middle of the day. We constantly look over our backs to check if there are any men around. Boys also take our photographs when we go to relieve ourselves. It is a difficult place for women and girls."

FGD with waste pickers in Rangpur Pahadi, September 2018.

Mothers also expressed concern about having to leave their children alone at home while they went out for work. Figure 3.2 below indicates that children mostly play outside the house. In Rangpur Pahadi, women feared accidents as children played on the streets. But they felt that they did not have any option. **There are no safe places, such as a crèche, where children could be placed under supervision.**

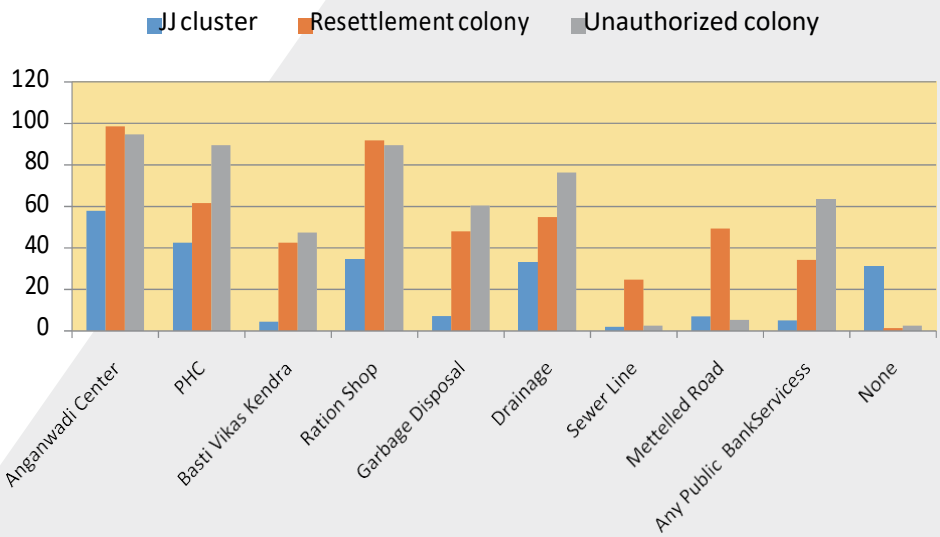
Women also experience high levels of domestic violence, which has serious effects on children's emotional well-being and development. NFHS-3 (2005-06) found that women in Delhi slums were more than twice likely to have experienced spousal violence than women in non-slum areas (2009, p.62). As the issue of domestic violence was not incorporated in the survey, its prevalence could not be quantified. But women repeatedly referred to it in the FGDs.

Children who are exposed to violence in the home are denied their right to a safe and stable home environment. A UNICEF report in 2006 had associated children's exposure to violence in the home with difficulties in learning and social skills, depression or severe anxiety, and exhibition of violent, risky or delinquent behaviour. Indeed, several studies have corroborated that children who witness domestic violence are more likely to be affected by violence as adults – either as victims or perpetrators. Domestic violence in conjunction with poverty can also lead to neglect, which is detrimental of children's well-being, safety and security.

3.3 Access to public services

Women try to strike a balance between their paid and unpaid responsibilities through negotiations of various kinds within their families, at their workplaces, and with public service providers. A number of factors determine their ability to negotiate and ensure optimal care for their children.

Figure 3.3: Access to public services across types of dwelling (%)



Source: Survey data, 2018.

relieve herself.

3.3.1 Anganwadis

The ICDS, through *anganwadis*, offers supplementary nutrition, immunisation, health check-ups, referral services for pregnant women and children aged 0 to 6 years, pre-school non-formal education for children aged 3- 6 and nutrition and health education for women aged 15-45.[8] According to the Department of Women and Child Development of the State Government of Delhi, 10,758 anganwadis catered to around 6.5 lakh children in Delhi in 2017 under the ICDS.

Many women are unaware of the existence of anganwadis in and around their homes and places of work. But there are many who are familiar with the anganwadis and their services but most of them did not consider them to be a viable alternative childcare institution. As the centres did not admit children below the age of three, the concerns of working mothers of young children were not addressed. In the FGDs, some sex workers disclosed that their children were discriminated against in the anganwadi so they preferred not to send them there. Table **3.3.1** shows that, barring domestic workers, **more than 50 per cent of the respondents stated that they had never used an anganwadi.**

Table 3.3.1: Occupation wise distribution usage of anganwadi (%)

Frequency of the use of Anganwadis	Domestic workers	Street vendors	Waste pickers	Construction workers
Always	41	13	2	10
Mostly	2	9	0	4
Never	39	50	89	65
Sometimes	17	28	9	21

Source: Survey of Mobile Creches- ISST study, 2018

In the FGDs, they revealed that they did not like using the centres because they were open for a short duration - about 1-2 hours, which did not help working mothers. It was more of a liability for them as they had to drop and pick up their children at the centre. Irregular timings of the anganwadis was a common complaint amongst the respondents in Shahabad Dairy, Harijan Basti and Mongolpuri.

Most anganwadis did not have an attached toilet facility. In case the child felt the need to go to the toilet, someone from the household was expected to come and take the child for it. Women also expressed their worries about children leaving the centre on their own. The mothers wanted more in terms of education, which is either non-existent or of poor quality. Of all the services, children seem to benefit the most from supplementary nutrition and immunisation.

> *"There is a [anganwadi] centre here but it opens at 10 am, sometimes even at 11 am and closes by 12. Children are given food and then asked to leave. Only on days when someone visits the centre, all the children are called and engaged in some activities. On other days, nothing happens."*
>
> FGD with street vendors in Holambi Kalan.

> *"Anganwadis should not just feed the children and close the centre, shouldn't there be some education and care for the children? Will I benefit if they only feed and let the children go?"*
>
> FGD with construction workers in Dwarka Sector 15A.

> *"I do not send my child to the anganwadi... Children do not like to sit there for long and leave the place. The teacher and helper at the centre do not look after them well. At*

8 For more details, see the section related to ICDS on website of the Department of Women and Child Development of the Government of Delhi. http://delhi.gov.in/wps/wcm/connect/doit_wcd/wcd/Home/Integrated+Child+Development+Services/Services+under+the+ICDS

times they do not even notice that the child has gone out. It is not safe. Also, it opens only by 10 a.m."

FGD with domestic workers in Harijan Basti.

Be it the timing of the *anganwadis*, or the quality of services provided, or the level of awareness and abilities of parents to claim their entitlements, the fact is that a large number of disadvantaged children are deprived of care and nurture. Left in the care of siblings, or alone at home with minimal supervision from the neighbours renders them vulnerable to deprivation, accidents and abuse.

Some problems with the *anganwadis* stem from the perception of poor quality of services, which to a significant extent emanates from deficit of resources. For instance, most of them are located in rented spaces, which are insufficient and ill-equipped for the programme activities.[9] Some problems emanate from the environment – they are located in poor localities that are under-served in terms of essential infrastructure and basic services.

"Many children are both unwilling and unable to access the anganwadi as the road leading to the centre is full of sludge… My son slipped and his leg got stuck in between the sewage pipes over an open drain. We were all very worried as he was hurt."

FGD with Street Vendors in Holambi Kalan.

3.3.2 Access to toilets and other sanitation facilities

Various studies have highlighted the negative impact of poor sanitation facilities on the health conditions of slum populations, particularly children. While immunisation drives may be an important way of controlling spread of infections among children, the impact of better sanitation facilities and services cannot be ignored and should be given due importance in public investments.

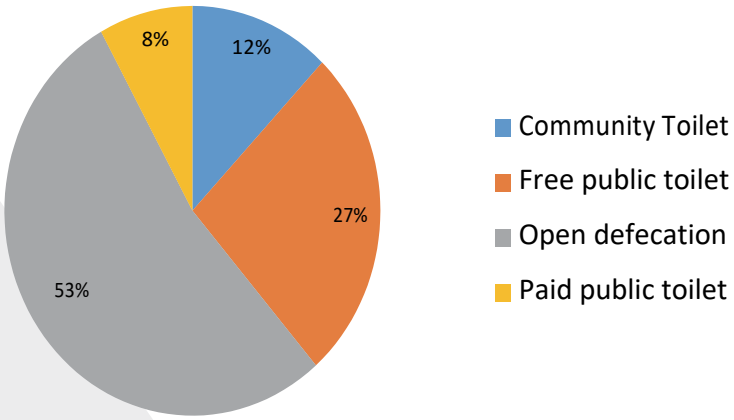
Sanitation facilities and hygiene are critical for public health, and especially the survival, health and cognitive development of children. NFHS-4 in 2015-16, reported that in India only 36 per cent of children under the age of five years who lived with their mothers had their last stools disposed off safely (MOSPI, GOI, 2018). Open defecation in urban poor areas is known to contaminate land and water, and bring in host of diseases such as jaundice, diarrhea and malaria, etc., which hamper children's overall growth and development (Agarwal 2011, Bartlett 1999). They are highly vulnerable to infections through pathogens found in human excreta and other household waste (Brown et al 2013, Jaiswal & Joon 2017, Barlett 1999, Agarwal 2011).

The living conditions in the study sites are grim as the families are amongst the poorest in Delhi, with inadequate housing, water and sanitation facilities. **Only 41 per cent of the respondents reported access to toilets inside the house. Of**

9 A CAG Performance Audit of the ICDS in 2013 reported that all anganwadis in Delhi were being run from rented spaces, which did not have enough space for the programme activities

the total 273 respondents who did not have toilet facilities, an overwhelming majority of 244 persons lived in the JJ clusters. A majority of those without household toilets, 53 per cent chose to defecate in the open, 27 per cent used free public toilet, 12 per cent used community toilet, and 8 per cent used paid public toilet.

Figure 3.3.2a. Defecation practices of households without toilets (%)



Source: Survey data, 2018.

The state of garbage disposal, drainage, and sewer lines was also abysmal. **Only 7.2 per cent and 1.9 per cent of the respondents in the J.J. clusters had garbage disposal and sewer line facilities in their areas respectively. The drainage facilities were slightly better at about 32 per cent.**

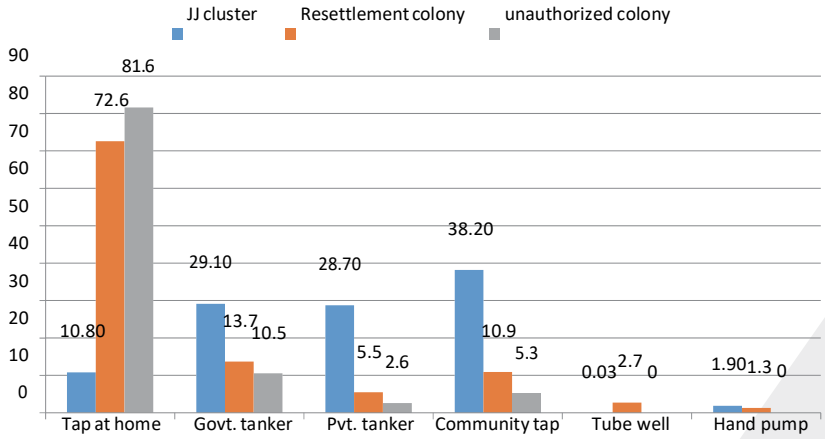
At 2.9 per cent, the resettlement colonies also performed poorly in terms of the availability of sewer lines but fared well on garbage disposal and drainage facilities in comparison. In the resettlement colonies about one fourth respondents could avail sewer line facility, while garbage disposal services and drainage facilities were available to 48 and 55 per cent of the respondents respectively.

"There is no sewer line here. Garbage floats in the open drains."
FGD with street vendors in Holambi Kalan.

3.3.3 Access to safe drinking water

While the demand for sanitation, and hygiene practices, has been influenced by socio-cultural and economic factors, universal recognition of water as a basic necessity results in better supply in response to high demand. Apart from tap water at home, tankers and public taps, which are shared by a number of households in a neighbourhood, tube wells and hand pumps are the main sources of water in the poor urban communities.

Figure 3.3.2b: Sources of water across types of dwelling (%)



Source: Survey data, 2018

The survey findings indicate that water availability is better in the resettlement and unauthorized colonies in comparison to sanitation facilities and services. However, the J.J. clusters fare poorly in terms of tap water at home and they depended on community taps for their household requirements. In some areas, the respondents in the FGDs articulated their difficulties in procuring water, especially portable drinking water. The waste pickers at Rangpur Pahadi fetch water in cans and containers from a distance. They pay for the water as well as a *rickshaw* to bring it home.

> *"There is a lot of water problem here. One canister costs Rs. 30 and lasts for a day. We cannot afford to pay so much every month."*
>
> FGD with waste pickers in Rangpur Pahadi.

> *"There is no water here. We buy water for drinking or fetch sometimes from the tankers."*
>
> FGD with street vendors in Holambi Kalan.

Poor access to water not only increases the financial burden of the family already in economic distress but also increases the work load on women and children. The task of arranging and carrying water most often than not falls upon on them (Zaidi et. al 2017). Carrying water from a distance also increases the chances of water contamination due to improper storage (Bartlett 1999). Child mortality and morbidity (diarrhoea in particular) have been associated with poor water quantity and quality, in addition to the lack of sanitation and poor hygiene (Agarwal et. al. 2005 p. 234).

3.4 Young children's vulnerability arising from women's nature of paid work

Understanding children's vulnerabilities in terms of their mother's nature of paid work was one of the main reasons for this mapping. It was found that women from low income households across the sites worked in the most low-paying, insecure work, such as domestic work, street vending, and waste picking. They offered women flexibility, which they needed to balance their responsibilities for household chores and childcare with their need to earn money. Women also undertook multiples forms of paid work in order to supplement household income. But it was evident in the FGDs that women perceived household chores and care work as their primary responsibility, which they did with negligible support from their families. This perception was substantiated in the survey.

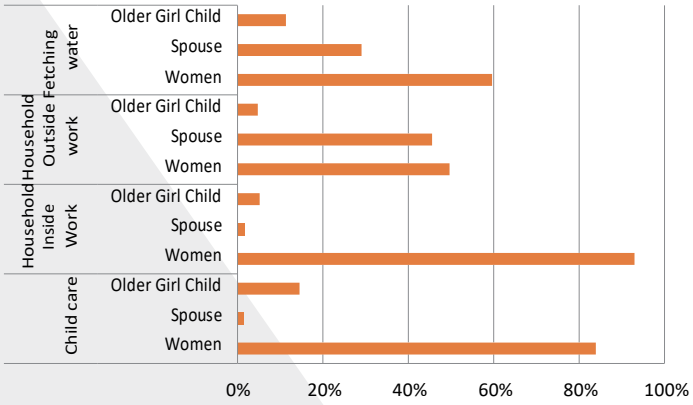
Women were primarily responsible for household tasks inside the house (93 per cent) and childcare (84 per cent). Their husbands assumed negligible responsibility for both these categories of work. During the FGDs, barring some who claimed that husbands helped them to some extent, most women responded that they received no help at all from their husbands.

"Even when we are ill, we have to do all the work [inside the house]. We take medicines and continue to work. Our husbands also say …take medicine and work….as if we are servants. We also have to look after our own children."

FGD with Domestic Workers in Shahabad Dairy, October 2018.

As most households in urban slums were nuclear in nature, childcare by grandparents and other relatives was minimal. Instead, sibling care is a common arrangement. Citing safety and security concerns, older siblings often take time off from school to look after their younger siblings while their parents go out to work. The responsibility of childcare is generally vested in the older girl child in accordance with the patriarchal social norms that weigh in favour of her future role as 'a wife and a mother' and often relegate her formal education to a secondary position when crucial decisions are taken regarding allocation of responsibilities within the household.

Figure 3.4.1: Social organisation of care



Source: Survey data, 2018

The older daughters assisted their mothers with household chores like cooking and cleaning (5 per cent), but more so with the care of younger siblings (15 per cent) and fetching water (11 per cent) (See Figure 3.4.1). In the FGDs, several women claimed that their older daughters, sometimes as old as 10 - 11 years, took care of their younger children and prepared the meals while they were at work. Older children took the younger ones to the nearby forests to relieve in areas like Shahabad Dairy, which lacks toilets.

"My husband and I have to go to work so my older girls take turns to take leave from schools to look after their younger siblings."

FGD with Domestic Workers in Mongolpuri. September 2018.

"I do not go to school every day as I have to look after my younger brother. My teacher does not say anything as she knows why I do not come every day."

A nine-year old girl in the FGD with Domestic Workers in Shahabad Dairy. October 2018.

"I worked in a factory till my first child was born. Now I work as a domestic worker in the nearby neighbourhoods. I am paid much less than what I earned in the factory. My child is very young and this work allows me to come home early to look after him."

FGD with domestic workers in Mongolpuri. October 2018.

Women often worked longer hours and at times were paid relatively well till they become pregnant. Most women stated that they took a break when their children were young and took up work, even if it was low paid, closer home with flexible timings. Lack of alternative care mechanisms in the community or at the workplace made it difficult for women to take up better jobs and resulted in inadequate care and higher risks for young children.

Almost 80 per cent of the women respondents across study sites left their children at home alone when they went out to work. This phenomenon was most common amongst waste pickers in Rangpur Pahadi (90 per cent) where their children did not attend anganwadis because they were located far from their homes. The other most common childcare arrangement, especially amongst construction workers (65 per cent) and street vendors (60 per cent), was to carry the children with them to their workplace.

Figure 3.4.2: Sector-wise childcare arrangements of working mothers (%)

Source: Survey data, 2018.

A sector-wise analysis also reflects the nature of care children receive in relation to their mothers' paid work (Figure 3.4.2). Only 4-7 per cent of domestic workers and waste pickers took their children along with them to their workplace. Domestic workers either left their children alone at home or in sibling care. About 20 per cent respondents stated that they left their child in the care of relative who lived nearby. Most waste pickers left their children at home, who play around in the streets. In contrast, most street vendors and construction workers took their children to their workplace.

Most domestic workers and waste pickers revealed that they do not take their children to work due to the objections of their employers. According to the domestic workers, the employers express their annoyance if they ever take their child to work. At times they ask them to leave the child outside or in a nearby park. Even if they allow the child to stay in the house, they do not like it when the mother looks after her child while at work. Women in such situations prefer to leave the child alone at home or in the care of older children.

The employers did not allow the waste pickers living in Rangpur Pahadi to bring their children to the godowns. This was not due to any concern for protection of children from all kinds of waste but because they do not want the work to slow down in any way. A lactating woman shared that she left her child alone at home and went home from the godown during her lunch break to feed her.

Some women sent their young children (0-6 years) with their older siblings to a nearby *balwadi* run by a non-profit organisation as they felt that children would be more secure there than on the roads. This *balwadi* was meant for children aged three years and above but, according to the staff, women often plead with them to keep their younger children as well. The rest had no choice but to leave their children behind and often alone.

In contrast, women in street vending and construction took their young children along to work. Most street vendors took their children along to the market place but some of them left their children at home but with siblings or relatives. The women construction workers usually left their children to play at the worksite in the absence of a safe space. They complained that the contractor did not permit breaks for childcare, which compromised the safety of the child in spite of the mother being nearby.

"When the child is very young, an infant, it is still easy to carry them to work. You can feed and put them to sleep. But the risk increases when they start walking. Even if we put them to sleep, the fear is always there that they might get hurt…so it is also difficult to focus on work. The contractor also scolds us for this…he gets angry that we are not doing enough and are only focused on our children…"

"My child stays with me at the worksite. He keeps playing there; eats cement and plays in the cement…We do not get any separate time to look after them. While doing our work, we have to take out the time. …make the cement mixture, give it to the Mistri and then quickly breastfeed the child. Once done, leave the child again to play and get back to work".

FGD with construction workers, Dwarka 16A. October 2018.

"My child was electrocuted as she played at the construction site for which there was no compensation."

FGD with construction workers, Dwarka. October 2018.

Street vendors, who moved with mobile carts from one place to another, stated that they made their child sit on the cart. But their children were exposed to the elements of nature and due to constant distraction they could not attend to the customers properly.

"We face several problems… in weighing the goods, attending to customers, handling a rush… It really becomes very difficult and we fear that there may be some accident."

FGD with street vendors, Jwala Nagar. October 2018.

The street vendors who set their shop outside their house every afternoon stated that they lock their children inside their house because they find it difficult to attend to customers with their children around. Construction workers and street vendors also faced problems in focusing on their work while tending to their children.

Women *pheri-valas* shared that it was difficult to carry young children along with them as they were out on the streets for long hours because of which the child also suffered. Safety of children was also of concern where the worksite and residence coincided. Women in Rangpur Pahadi shared in the FGDs that the children would play around while they segregated the waste at home, which helps them to keep an eye on their children. But it was observed that unsanitary, unhygienic and dangerous site of segregation poses high risk to the child's health and safety.

In urban slums, informal nature of paid work coupled with lack of crucial public services leaves parents fatigued and with very little time for quality childcare. But while fathers are not available for the young child, gender norms place the responsibility of childcare squarely on the mothers. The study also revealed that women from female-headed households (primarily widows, divorcees or separated women) found it especially difficult to take care of their children while they went to work.

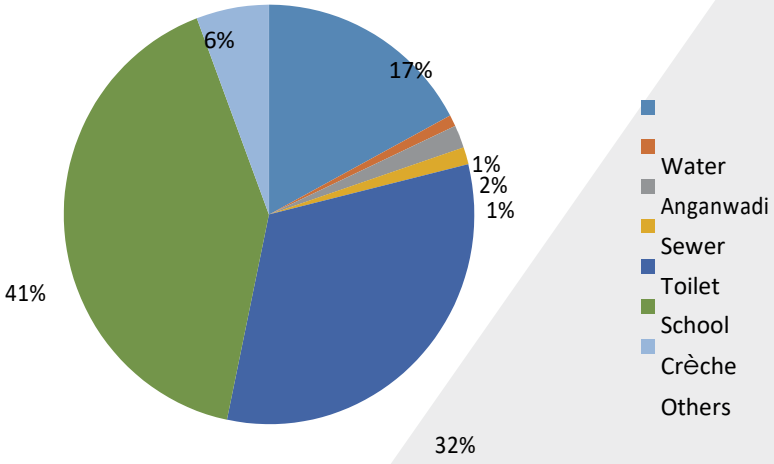
Childcare facilities such as crèche, crucial for children's development and overall well-being, were non-existent in almost all study sites. Having quality crèches in the neighbourhood or workplaces allow mothers to go for worker which involves longer hours and better pay which would further add to the growth and development of the child. Mothers fear for their children's safety at all times when they are away from home. In this study, there was only one example of a crèche which operates in a community of sex workers – a particularly vulnerable area which is a major threat to child's safety, security and health. This crèche is a nurturing and safe place for women in sex work to come and leave their children for the day or for full time and it illustrates the need for setting up day-care centres in vulnerable populations.

The informal nature of the mother's paid work contributed to children's vulnerability. Women were compelled to take up low paid informal work in order to contribute to household income.

However, deep-rooted gender norms hindered the sharing of responsibilities for household chores and childcare. They did not have access to public services and facilities for childcare, e.g., crèches in their neighbourhoods or workplaces. The excessive workload affected their ability to look after the health, nutrition and educational requirements of their children. Although they expressed their utmost concern about the safety and security of their children, they found no alternative to locking up their children in their homes or leaving them free to play in the streets where they were at high risk of accidents, violence and abuse.

When asked to list what they consider as priorities for the well-being of their young children, the women articulated the need for quality childcare, crèches and *anganwadis* as well as other public services such as water and sanitation, roads, and electricity in their neighbourhoods.

Figure 3.5: Respondents' expressed needs for children aged 0-6 years (%)



Source: Survey data, 2018.

Figure 3.5 shows that in addition to adequate public services, women across occupations and communities felt the need for quality childcare facilities in their communities so that they could leave their young children in a safe and clean place. Two in five women wanted a crèche (41 per cent) that could provide 'quality' childcare, followed by improvements in schools (32 per cent) and easy availability of water (17 per cent). While the crèche could enable them to work without worries for the safety of their children, the desire for education indicated their aspirations, and water supplies could save the time they spend to fetch or the money to buy water, especially in areas like Rangpur Pahadi and Shahabad dairy.

About 48 per cent respondents felt that crèches in the community would be very useful for the safety of young children. One in ten women also felt that community toilets were needed (10.8 per cent) because there have been several cases of sexual offences and accidents involving women and children as they went out to defecate due to lack of toilets in the community.

4. CONCLUSION

4.1 Summary

Young children in urban slums of Delhi are extremely vulnerable to neglect and abuse owing to extreme poverty coupled with lack of public services, poor housing and lack of social security. Their mothers, who are expected to provide them with care, bear the multiple burden of contributing to the household economy through low paid jobs in the informal sector while performing household chores and caring for all the family members.

The condition of anganwadis, a crucial public service for ECCD, was poor across the study sites. The mothers complained of tardiness, poor quality, difficulties in access and unhelpful attitude of the staff. They also expressed their concerns about children's safety and security due to lack of water and sanitation, and policing in their areas.

Effective and efficient provision of childcare centric public services (crèches and anganwadis) is critical for widening the scope of opportunities for young children, their families and communities. There is also a need for more research and dialogue between policymakers, academicians, social activists on childcare and protection, essential public services, rationalization of women's work, and law and order, which play an important role in early childhood development in urban settings.

4.2 Key findings

- **Sibling care was prevalent across all the study sites.** It adversely affected the education of older sisters who were usually entrusted with the responsibility of childcare. The contribution of fathers towards childcare was negligible.
- There was high prevalence of preventable ailments, especially fever and diarrhoea, among young children. **Among 78 per cent of children had fallen ill in the six months before the survey, and 90 per cent of them lived in unauthorized colonies. About 45 per cent of the mothers identified unhygienic environment and poor nutrition as the main causes of illnesses while 33 per cent were unaware.**
- **About 87 per cent of the children across the study sites were fully immunised**. However, 10 per cent of the women across the study sites were unaware of the immunisation status of their children.
- **Only 19 per cent children were immunized in one of the communities of sex workers**, probably the most vulnerable among those visited during the study due to extreme poverty, poor housing and lack of public services.
- There was heavy reliance on private medical practitioners. **About 51 per cent of the respondents sought treatment from private providers** while the others approached smaller private clinics, chemist shops, '*bengali doctors*' (quacks) and '*ojhas*'.
- In terms of out-of-pocket expenditure for the care of children, **51.6 per cent of the respondents spent most on children's health needs,** followed by food (19.6 per cent).
- Young children from the waste picking community in Rangpur Pahadi did not attend the anganwadi centre because it was far from their homes. **Barring domestic workers, more than 50 per cent of respondents of other sectors had never used an anganwadi centre**.
- Amongst the respondents whose children had access to anganwadis, most complained of tardiness in terms of opening hours, indifferent attitude of the staff, lack of toilets, and poor quality of food. **Although children in the anganwadis benefitted from supplementary nutrition and immunisation services, early childhood education was poorly implemented**.

- **Lack of other public services such as water and sanitation also had an impact on young children's health and safety**, e.g., lack of toilets in Rangpur Pahadi was associated with cases of kidnapping and assaults on children in the area.
- Untrained and unsanitary child delivery practices and/or lack of post-partum and neo natal care can be life-threatening for both the mother and child. But **many women respondents preferred home-deliveries to institutional birthing owing to the rude behaviour and attitude of the medical practitioners.**
- **Owing to non-availability of childcare centres such as crèches in the communities or workplaces, 80 per cent of the women respondents left their young children alone at home, either locked inside homes or playing on the street under minimal supervision, which increased the risk of accidents and abuse.**
- Respondents from Shahabad dairy, Mongolpuri and Rangpur Pahadi considered these areas to be unsafe for children, especially **due to high substance abuse such as drugs and alcohol**.

4.3 Recommendations

ECCD should be placed high on the policy agenda as there is evidence that deprivation and neglect during early years impede lifelong growth and development. The provision of quality childcare centres in urban poor communities with adequate financial, technical and human resources should be a priority for achieving the overall well-being of young children aged 0-6 years in disadvantaged communities. This age group has been neglected even in the Constitutional guarantee of the right to education, which is a fundamental right for the 6-14 age-group.

National and state policies and urban planning processes must recognize the unequal burden of care work, unpaid work and paid work of urban poor women and girls, and focus on the provisions for ECCD and food security. Urban plans and design must take cognizance of the needs of young children and aim to build child-friendly infrastructure, including parks and roads**. Intensive efforts are required to improve infrastructure, staff recruitment and training, nutrition, and early childhood education to make non-functioning and/or poor anganwadis across Delhi fit to serve young children**. Simultaneously, all policies and programmes aimed at children below 6 years must take into account other public services (such as water and sanitation), which are crucial for ECCD.

The scope of the Labour Code on Occupational Safety, Health and Working Conditions, which calls for the provision of crèche facilities in establishments with more than 50 women workers, should be widened to bring all women workers within its ambit for addressing childcare concerns for all mothers. Women working in the unorganized sector require a robust social security umbrella but they have been invisible on the policy agenda for long and the quantum of their work has often been underestimated. The Labour Code on Social Security hardly mentions childcare or any maternity benefits for informal workers thereby rendering women more vulnerable, and which has a negative impact on the health, nutrition, educational and safety needs of the young child.

More research and data is needed around women's concerns for childcare, the needs of young children, and the availability of public services. The areas with high rates of crime against children across Delhi should be mapped to help in building a focused strategy to address violence against children and the widespread problems of alcohol and drug abuse in the urban slums in Delhi.

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ANNEXURE I: AREAS/SECTORS OF WOMEN WORKERS FOR FGDs

The FGDs conducted across various locations and occupations by the field researchers of the Institute of Social Studies Trust (ISST) covered a range of topics, including the working conditions of women, childcare arrangements while they work, available and expected support from the family, community, market (employer) and the state, and the quality of available and expected childcare and other public services.

The FGDs were conducted with women workers from the five identified paid work: domestic work, construction work, waste pickers, street vendors and sex work in some of the areas where the survey were conducted. Some of the women who participated in the survey as well as other women in the community involved in similar or some other form of informal labour took part in the FGDs.

OCCUPATION	FGDs	DATE	AREA/LOCATION
Domestic Work	FGD 1	19-Sep-18	Dallupura
	FGD 2	03-Oct-18	Shahabad Dairy
	FGD 3	10-Oct-18	Mongolpuri
Construction Work	FGD 1	04-Oct-18	Dwarka sector 16
	FGD 2	09-Oct-18	Dwarka sector 15
	FGD 3	09-Oct-18	Dwarka sector 15
Waste Pickers	FGD 1	25-Sep-18	Rangpur Pahadi
	FGD 2	25-Sep-18	Rangpur Pahadi
Street Vendors	FGD 1	24-Sep-18	Holambi Kalan
	FGD 2	10-Oct-18	Mandavali
	FGD 3	15-Oct-18	Jwala Nagar
Sex Workers*	FGD 1	09-Oct-18	N/A
	FGD 2	22-Oct-18	N/A

* Due to ethical reasons, the location/areas where FGDs for sex workers were conducted have not been disclosed.

ANNEXURE 2: SURVEY MODULES

The survey was divided into the following ten modules, covering questions related to the household, women, their work, childcare and so on. Before the modules were developed, a master sheet listed questions about the basic information to be sought from the respondent, including her marital status, religion, caste, the place of residence, and number of children, and her consent to the use of information provided by her for the study.

Module 1. **Household-related information:** The number, gender, education, age and occupation of the family members.

Module 2. **General information:** The place and type of residence of the respondents, the length of their stay in Delhi, and availability of and accessibility to public/community services (viz., water, toilets, waste collection, and identity documents).

Module 3. **Expenditure for childcare:** The expenses incurred on the items considered most important for childcare, such as nutritious food, early childhood education, toys, and equipment.

Module 4. **Child health:** Recent illnesses of the child, causes and source of treatment, i.e., the government hospital, private hospital or clinic, and the local chemist, distance to the place of treatment, the time taken to travel, the expense incurred, and if the mother took leave from work.

Module 5. **Access to public health services:** Immunisation of children.

Module 6. **Access to ECD services:** Access to the anganwadis, the distance and quality of services, timings, and problems, if any.

Module 7. **Intra-household allocation of work:** Distribution of household work (such as childcare, household work inside the house, household work outside the house, and the fetching of water) among members, i.e., the respondent, husband, older child, in-laws, and others.

Module 8. **maternal work profile:** Various aspects of paid work of the respondent, such as distance to work, time taken, childcare facilities at the workplace, requirements of leave, and maternity benefits available, and availed of, during the previous pregnancies.

Module 9. **Child protection:** Safety, security and other concerns related to childcare, including discrimination.

Module 10. **Maternal entitlements:** Situation of care provisions and care support expected by women from the family, state, community and employer.

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GLOSSARY

Aaya	Semi-trained or untrained nurse hired for the care of children or the elderly.
Anganwadi	Childcare centre operated under the ICDS to combat hunger and malnutrition among infants and young children, pregnant and lactating women, and adolescent girls.
Balwadi	Pre-school centres run by the government or NGOs for the economically weaker sections of the society.
Bengali doctor	A local doctor without formal and recognised qualification; a quack.
Godown	A warehouse or a storage place.
Jhuggi-jhopri	A small roughly built house or shelter usually made of mud, wood or metal with thatched or tin sheet roof covering.
Mandi	A local market.
Pheri-vala	A street hawker.
Rickshaw	A three-wheeled cart drawn by one or more people.
Sangathan	A worker's union; an organisation.
Thekedaar	A person who undertakes to provide labour or materials to do a job; a contractor.