This chapter highlights health inequities in urban settings and demonstrates how aggregated data often mask substantial health inequities within urban populations – inequities that are revealed only through looking at subgroups of city dwellers according to their socioeconomic status, neighbourhood or other population characteristics. Results uncover both gaps between richest and poorest urban subgroups, and gradients in health across entire urban populations.
Most examples featured in this chapter were drawn from new analyses conducted by the World Health Organization on the nature and extent of urban health inequities. Data were extracted from reliable sources (established international organizations, or national or municipal government agencies) for which disaggregation was possible by urban/rural setting and ideally by other socioeconomic factors, such as income and education level. Data from the 2003 World Health Survey\textsuperscript{113} and the Demographic and Health Surveys (DHS)\textsuperscript{114} were used for many of the topic areas. City populations were disaggregated according to their household income and education level. Health inequities were assessed by looking at how these different subgroups varied across a range of health indicators, including disease risk factors, healthcare access and health outcomes. For selected health indicators, an additional step involved identifying specific factors that contributed to urban health inequities.

This chapter is not an exhaustive review of the World Health Organization’s new analyses on urban health inequities or of urban health inequities in general. Examples from specific countries should not be interpreted as assessments of their overall urban health equity, nor should they be taken to mean that cities in these countries have more health inequities than cities in other countries. More detailed information about the World Health Organization’s analyses and results can be found in Annex B of this report.

Health inequities between rich and poor urban populations

Urban health averages often mask wide gaps between people of different socioeconomic status. This section demonstrates that disaggregated data reveal a starkly different reality for the urban poor. Differences exist not only between richest and poorest city dwellers, but also along the continuum of entire urban populations.

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure4_1.png}
\caption{Under-five mortality rate in urban areas, by region, in 42 low- and middle-income countries}
\end{figure}

Note: These results represent averages of those countries for which urban DHS data were available for under-five mortality (Africa = 25 countries, Americas = 7 countries, Asia = 10 countries). As such, they are not representative of the regions as a whole.
POOR URBAN CHILDREN ARE AT INCREASED RISK FOR CHRONIC MALNUTRITION AND DEATH

Although child survival rates in urban areas are mostly higher than in rural areas, these averages obscure substantial inequities between different population groups. Figure 4.1 reveals that within urban areas, large inequities exist within and between regions in under-five mortality rates. Within each region, children from the poorest urban families are roughly twice as likely to die as children from the richest urban families. Between regions, mortality rates in urban areas of Africa are roughly double those of the Americas and Asia.

In each of the 42 low- and middle-income countries for which data (from 2000 onwards) are available, the poorest urban children are twice as likely as the richest urban children to die before the age of five years. The magnitude of difference varies substantially across countries, ranging from 1.3 to 15.6 times relative difference between groups. Nonetheless, the overall health penalty is clear. Across all 42 countries, the poorest urban children are the most likely to die before the age of five years.

Differences exist not only between the richest and the poorest, but also across entire urban populations. In urban areas of several exemplar countries (Figure 4.2), under-five mortality rates decline progressively as family income rises. These results indicate that efforts to reduce inequities need to address the entire population, rather than focusing only on the poorest groups.

A similar picture emerges for childhood malnutrition, which causes more than a third of all deaths during childhood. Globally, malnutrition among under-five children is less common in urban areas, compared with rural areas. Yet once again, these urban averages mask substantial differences within cities. Results from 41 low- and middle-
FIGURE 4.3
CHRONIC MALNUTRITION AMONG CHILDREN LESS THAN FIVE YEARS OF AGE, BY REGION, IN 41 LOW- AND MIDDLE-INCOME COUNTRIES

Note: These results represent averages of those countries for which urban DHS data were available (Africa = 27 countries, Americas = 7 countries, Asia = 7 countries). As such, they are not representative of the regions as a whole.


FIGURE 4.4
CHRONIC MALNUTRITION AMONG CHILDREN LESS THAN FIVE YEARS OF AGE IN URBAN AREAS OF SEVEN SELECTED COUNTRIES

Income countries for which data are available show that on average, the prevalence of stunting (see footnote i, Chapter 3, for a definition) among the poorest urban children is three times greater than among the richest urban children. Figure 4.3 displays inequities in childhood malnutrition among urban populations in Africa, the Americas and Asia. In each region, large gaps exist between the poorest fifth and richest fifth of urban populations.

It is not only the children in poor households who are prone to malnutrition. In general, the middle classes also suffer more childhood stunting than the richest families. Examples from urban areas in selected countries in Figure 4.4 reveal that the risk of chronic child malnutrition increases progressively as family income declines.

What accounts for these inequities? To help answer this question, WHO conducted additional analyses to identify factors that contribute to inequities in childhood malnutrition. Results are presented in Figure 4.5. Across urban areas of seven studied countries, inequalities in household wealth had a strong impact on inequities in child malnutrition. The contribution of household wealth to inequity in malnutrition ranged from 30% to 76% across the seven countries. Inequalities in education levels of mothers and their partners also each independently contributed to childhood malnutrition, accounting for 1% to 31%, and 8% to 18%, of malnutrition inequities, respectively. Region of residence and the child’s biological characteristics were identified as additional contributors to inequity, although their relative impact was generally less than the aforementioned factors.
FIGURE 4.6
SKILLED BIRTH ATTENDANCE COVERAGE, BY REGION, IN URBAN AREAS OF 44 LOW- AND MIDDLE-INCOME COUNTRIES

Note: These results represent averages of those countries for which urban DHS data were available (Africa = 26 countries, Americas = 7 countries, Asia = 11 countries). As such, they are not representative of the regions as a whole.


FIGURE 4.7
SKILLED BIRTH ATTENDANCE COVERAGE IN URBAN AREAS OF SEVEN SELECTED COUNTRIES

individual countries. For example, in Bangladesh, skilled birth attendance coverage is 6% among the poorest fifth of the urban population while it is more than 75% among the richest fifth. While gaps tend to be smaller in countries where urban averages are higher, inequities exist even where average coverage in urban areas is relatively high. For example, Egypt’s average skilled birth attendance coverage is 89% in urban areas, but ranges between 74% for the poorest fifth and 99% for the richest fifth.

With few exceptions, inequities in skilled birth attendance also affect the middle classes of urban areas. Women from middle-income families are less likely than those in the upper class to be attended during childbirth, but more likely than the poorest city dwellers to have access to this form of health care (Figure 4.7).

FIGURE 4.8
FACTORS THAT CONTRIBUTE TO INEQUITIES IN SKILLED BIRTH ATTENDANCE, IN URBAN AREAS OF SEVEN COUNTRIES

<p>| Contribution of key factors to socioeconomic inequalities in skilled birth attendance (percentage, %) |</p>
<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameroon</td>
<td>2004</td>
<td>Africa</td>
</tr>
<tr>
<td>Morocco</td>
<td>2003</td>
<td>Americas</td>
</tr>
<tr>
<td>Mozambique</td>
<td>2003</td>
<td>Africa</td>
</tr>
<tr>
<td>Plurinational State of Bolivia</td>
<td>2003</td>
<td>Americas</td>
</tr>
<tr>
<td>Colombia</td>
<td>2005</td>
<td>Asia</td>
</tr>
<tr>
<td>India</td>
<td>2005</td>
<td>Asia</td>
</tr>
<tr>
<td>Turkey</td>
<td>2003</td>
<td>Asia</td>
</tr>
</tbody>
</table>

Note: Other factors include mother’s age, cohabiting with partner, having a female household head, distance to health facility, and residual factors. See Annex B for more information on the analytic methods. Source: WHO calculations based on data from Demographic and Health Surveys (DHS), 2003–2005.

POOR, URBAN WOMEN HAVE LOWER SKILLED BIRTH ATTENDANCE

Professional care at birth by doctors, nurses, auxiliary nurses or other allied health professionals – skilled birth attendance – helps reduce complications during childbirth that can lead to maternal disability and death. Yet in urban areas of 44 low- and middle-income countries for which data are available, skilled birth attendance varies from a low of less than 40% to a high of 100%. The majority of the studied countries have skilled birth attendance coverage of less than 90% in the urban areas.

Figure 4.6 reveals that across the regions of Africa, the Americas and Asia, large gaps exist in skilled birth attendance between the richest and the poorest urban residents. This relationship also holds true within individual countries. For example, in Bangladesh, skilled birth attendance coverage is 6% among the poorest fifth of the urban population while it is more than 75% among the richest fifth. While gaps tend to be smaller in countries where urban averages are higher, inequities exist even where average coverage in urban areas is relatively high. For example, Egypt’s average skilled birth attendance coverage is 89% in urban areas, but ranges between 74% for the poorest fifth and 99% for the richest fifth.

With few exceptions, inequities in skilled birth attendance also affect the middle classes of urban areas. Women from middle-income families are less likely than those in the upper class to be attended during childbirth, but more likely than the poorest city dwellers to have access to this form of health care (Figure 4.7).
Neniata has nine children, and lives in a small house with seven other adults and 12 children. “My children do painting, cleaning, gardening, whatever work they can get,” she says. “They give me money when they can, but they have their own children too, so I wait my turn.” On good days, she eats a lot, but, she confides, “sometimes all we have is bread. When I get some money it usually only lasts a few days. Most of it I will spend on food. I don’t drink or gamble.”

Fifteen years ago she discovered she had diabetes, high cholesterol and high blood pressure. “I was weak and felt wobbly and dizzy.” Neniata recalls. Now, she relies on the medicine she receives for free at her monthly check-up, but she usually can’t afford to buy more when it runs out and needs to go looking for a clinic prepared to give a handout. For example, “Right now I have no medicine left. It ran out about two weeks ago.”

She can’t get insulin for free at the clinic and at US$ 6.50 a day, she can’t afford to buy it. Three years ago, this almost cost her a foot. “My foot was swollen to the knee and numb. The doctor told me they might have to amputate it. I asked him not to because I like to dance! I made him laugh. I spent two months in hospital recovering and getting insulin. I am happy I kept my foot!”

Neniata is a very humorous lady with a love for life. “Really my illness is nothing! I can’t worry too much about it. I like to smile and dance.”
As with child malnutrition, WHO conducted additional analyses on skilled birth attendance to identify factors that contribute to inequities in skilled birth attendance coverage. Results are presented in Figure 4.8. In general, results indicate that inequalities in household wealth again have a strong impact on inequities in coverage. Across the seven countries, household wealth accounted for between 34% and 58% of the inequities. Residing in different regions contributed additionally in some countries such as Cameroon (25%) and the Plurinational State of Bolivia (14%), while its contribution was negligible in India (~0%) and Morocco (3%).

The education level of the mother was another important factor: its contribution to inequities in skilled birth attendance coverage ranged from 10% in Morocco to 31% in India. The education level of the mother’s partner also played a role, especially in Morocco, where the partner’s education contributed more than the mother’s education to inequities in skilled birth attendance. Finally, the birth order of the child, while not a major factor in most countries, contributed to inequities in skilled birth attendance up to 24% in Colombia and 23% in Turkey.

THE URBAN POOR ARE AT INCREASED RISK FOR DIABETES AS COUNTRIES DEVELOP

As a country’s economy grows, the burden of noncommunicable diseases tends to shift from wealthier to poorer segments of urban populations. The specific reasons for this phenomenon are a topic of debate, but presumably are related to differential exposure to noncommunicable disease risks (for example unhealthy diet, physical inactivity, obesity and tobacco use) among different urban subgroups at different stages of a country’s economic development.

Diabetes is a case in point. Figure 4.9 shows the prevalence of self-reported diabetes among adults age 45 and older in urban areas of Bangladesh, a low-income country, by level of wealth. In this case, diabetes primarily affects the wealthier segments of the urban population. Tunisia, a middle-income country, shows a similar pattern (Figure 4.10). In contrast, Spain, a high-income country, displays a different pattern, with diabetes more evenly distributed across wealth levels (Figure 4.11).
country, shows a relatively flat distribution of diabetes across urban wealth groups (Figure 4.10). In urban areas of Spain, a high-income country, it is poorer urban residents who are most likely to have diabetes (Figure 4.11). As several factors may contribute to these differences, more detailed epidemiological analysis is required to understand trends over time and causal relationships.

**DISPARITIES IN PIPED WATER ACCESS WITHIN URBAN AREAS**

Inequities between the rich and the poor exist not only for health outcomes, but also for health determinants, such as piped water access. Piped household water connections provide running water into dwellings, plots or yards. They are considered to be the most improved drinking-water source (provided pipes are maintained properly and water quality is assured). Improvements in access to piped household water connections have been the main driver of progress in access to safe water in most regions, with growth in piped household water access twice as high as growth in other improved drinking-water sources between 1990 and 2008.115

Globally, piped water coverage among urban households is much higher than that in rural areas.115 However, substantial inequities exist between the richest and poorest urban residents in Africa, the Americas and Asia (Figure 4.12). While magnitudes vary, the same relationship holds true within each of the studied countries in these regions.

When inequities in urban access to piped water are analysed in further detail, social gradients emerge; that is, systematic increases in urban piped water access correspond to increases in urban wealth quintile. Figure 4.13 displays these gradients in seven selected countries. Among these countries, the degree of inequity is largest in Mozambique and smallest in Morocco, although gradients exist in all countries.

One important caveat to these results is that routine administrative data generally refer to

**FIGURE 4.12**

PERCENTAGE OF HOUSEHOLDS WITH ACCESS TO PIPED WATER, IN URBAN AREAS OF 44 LOW- AND MIDDLE-INCOME COUNTRIES

Notes: Data refer to the most recent data available during the period 2000–2007. Poorest and richest 20% refer to the lowest and highest urban wealth quintiles. These results represent averages of those countries for which urban DHS data were available (Africa = 27 countries, Americas = 7 countries, Asia = 10 countries). As such, they are not representative of the regions as a whole. Source: WHO calculations based on data from Demographic and Health Surveys (DHS), 2000–2007.
existing water sources, whether or not they are actually used by households. More importantly, they might not take into account those living in slums. Thus, these data might provide gross overestimates of access to piped water, especially in cities with poorly maintained water distribution systems or with large slum areas.

**SUMMARY**

This section has demonstrated that aggregated data often mask substantial health inequities within urban populations – inequities that are revealed when looking at city dwellers according to their family income or wealth level. Specifically, these analyses show that families with the lowest incomes in urban areas are most at risk for adverse health outcomes such as child malnutrition and early childhood death, have less access to health services such as skilled birth attendance, and are also disadvantaged in terms of their living conditions, such as access to piped water. Importantly, these inequities exist along a social gradient, also affecting middle class city dwellers to at least some extent. The underlying causes of these inequities in health are primarily social in nature, including household wealth, education and location of residence, which outweigh the effects of predetermined attributes such as age and gender.

**Health inequities between neighbourhoods**

Evidence in this section looks at health inequities from a geographical perspective, by comparing neighbourhoods or districts within cities. Results show that city dwellers’ odds of being healthy depend very much on their “place” within the city.
Neighbourhoods vary dramatically within most cities, and disadvantage tends to cluster within certain districts. Some have ready access to fresh food via meat and produce markets; others have only fast food or street vendors. Some have good-quality housing, green spaces and clean air; others are run down, crowded and polluted. Some have an array of health and social services within their limits; others have none. These and other factors combine to influence health on a neighbourhood-by-neighbourhood level.

Although neighbourhoods differ according to residents’ economic status, not all urban poor live in slums or areas of concentrated disadvantage, and not all people who live in slums or areas of concentrated disadvantage are poor. It is therefore useful to consider health inequities by neighbourhood, in addition to socioeconomic status, although these two factors tend to correlate with one another.

SLUM DWELLERS IN NAIROBI, KENYA, ARE THE MOST LIKELY IN THE COUNTRY TO DIE DURING EARLY CHILDHOOD

The city of Nairobi, Kenya, exemplifies rapid urbanization amidst deteriorating economic and health conditions. With an annual growth rate of 7% over the last two decades, Nairobi remains one of the fastest growing cities in Africa. Since the 1960s, Nairobi’s population has increased more than tenfold, from 293 000 in 1960 to more than 3 million in 2009.116,117 Most of the growth of the city of Nairobi is a result of rural-urban migration rather than immigration from other countries or natural increase.

On average, infant deaths in Nairobi are less common than infant deaths in rural parts of Kenya.118 Nonetheless, this urban average masks stark differences between different areas of Nairobi. Figure 4.14 reveals that slum areas of Nairobi have infant death rates that far exceed corresponding rates for the city as a whole and its high-income areas. The same picture emerges for deaths in children less than five years of age (Figure 4.15).
TUBERCULOSIS RATES DIVERGE DRAMATICALLY BY WARD IN JAPAN’S LARGEST CITIES

Urban health inequities also exist in Japan, a country known for high standards of health and social development (as indicated by its residents’ life expectancies). Data obtained from the Research Institute of Tuberculosis in Japan reveal wide disparities in tuberculosis incidence within the country’s largest cities.

Tuberculosis (TB) was highly prevalent in Japan before and immediately after the Second World War, with hundreds of thousands of people dying from the disease each year. Poverty, poor housing and overcrowded cities were the major causes at the time. Japan’s economic development in the 1960s helped to change the situation: living standards improved enormously and the government reinforced its TB control efforts. Nevertheless, TB is more common in Japan than in other developed countries.

Figure 4.16 reveals wide disparities in the number of newly notified TB cases between the largest cities in Japan. In 2006, the average number of newly notified TB cases per 100 000 urban population ranged from a low of 11.5 in Sapporo to a high of 57.0 in Osaka. The national rate for that year of 20.6 new cases per 100 000 population (including both urban and rural areas) was exceeded in 9 of the 13 cities.

This figure also shows that substantial gaps exist within cities, from ward to ward. Such large variations over small distances are a characteristic of TB in many cities around the world. In Japan, inequities were found within all of the studied cities, including Tokyo, Kawasaki and Yokohama (part of the Greater Tokyo area), and Kyoto, Nagoya and Kobe (part of, or contiguous with, the Kyoto-Osaka-Kobe metropolitan area). The cities with higher average rates tended to have wider gaps, but even cities with relatively low rates, such as Yokohama, had large disparities between the worst and best performing wards in the city.

Figure 4.16 NEWLY NOTIFIED TB CASE RATE PER 100 000 POPULATION, LARGEST CITIES IN JAPAN, 2006

Source: Research Institute of Tuberculosis, Kiyose, Japan.
Osaka had the highest rate of newly notified TB cases, as well as the largest disparities among its wards. Among its 24 wards, new TB cases ranged from 31.6 per 100,000 residents in the Tsurumi ward to 284.3 per 100,000 residents in the Nishinari ward. Nishinari is home to one of Japan's largest concentrations of day labourers, many of whom are homeless. Its extremely high TB rate probably reflects the situation among this economically and socially disadvantaged minority group.

RISK OF HOMICIDE VARIES FOURFOLD BETWEEN SUBDISTRICTS IN CAPE TOWN, SOUTH AFRICA

The following data from Cape Town, South Africa, show that disadvantaged clusters often exhibit a number of negative indicators — the subdistricts with the greatest number of homicides are also those that are the poorest, and have the largest proportion of residents who are unemployed and living in slums.

South Africa has one of the highest rates of homicide in Africa and in the world. Among South Africa’s major cities, Cape Town has the largest problem, with 63.5 homicides per 100,000 residents in 2007.

When homicide data from Cape Town were disaggregated into 11 city subdistricts, striking disparities within the city were revealed. Homicide rates ranged considerably, from a low of 33 in South Peninsula to a high of 132 in Nyanga, equivalent to four times the risk of violent death.

The two districts with the highest homicide rates, Nyanga and Khayelitsha, are also the most disadvantaged. Considerable proportions of people living in these areas live in slums, are unemployed and subsist below the poverty line. This stands in contrast to South Peninsula, which is among the most advantaged districts of the city (Figure 4.17).

HEALTH INEQUITIES BETWEEN NEIGHBOURHOODS OF NEW YORK CITY, UNITED STATES

Data from New York City, United States, reveal that poor health is concentrated in certain New York City neighbourhoods, and that the neighbourhoods with the worst health outcomes are also those that are the poorest in economic terms, and in which people are least likely to have access to essential health care. In 2001, the...
life expectancy in New York City’s poorest neighbourhoods was eight years shorter than in its wealthiest neighbourhoods.¹²¹

Figure 4.18 illustrates this phenomenon by displaying the geographical relationship between the percentage of residents living in poverty and the likelihood of dying from acquired immune deficiency syndrome (AIDS). Neighbourhoods with high concentrations of poverty (indicated by darker colours on the left map) coincide with neighbourhoods that have higher rates of AIDS deaths (indicated by darker colours on the right map). Similar relationships have been found for numerous other indicators of poor health and adverse living conditions, including rates of hospitalization, infant deaths and deaths due to diabetes.¹²¹

POOR HEALTH CONCENTRATED IN CERTAIN DISTRICTS OF PRESTON, UNITED KINGDOM

Data from Preston, United Kingdom, show a similar picture to that of New York City. Certain parts of the city (called wards) are localities of concentrated deprivation and premature death. As a growing city of around 132 000 people, and home to a university and the British aerospace industry, local leaders are now using the deprivation and health inequity data to better tailor interventions and services to communities with the greatest need.

Within Preston, life expectancy varies dramatically between the largely deprived communities and the more affluent. Men in affluent areas live 14.7 years longer than those in deprived wards. For women, life expectancy varies 10 years between wards.¹²²

The maps of Preston (Figure 4.19 on the next page) illustrate in greater detail how level of income and crime and disorder cluster into the same areas of the city. These and other indicators are combined to form an index of multiple deprivation (IMD), which is used in a standardized manner throughout the whole of England.¹²³

SUMMARY

This section has provided examples from a wide range of cities from around the world, showing that health inequities exist by neighbourhood or district. Once again, these data illustrate that while...
Urban averages give one picture, information disaggregated into neighbourhoods or districts provides a completely different view. Disaggregated data at subcity level can help identify areas and populations most in need of intervention and support.

Health inequities between subgroups of city dwellers

Beyond socioeconomic status and neighbourhood, some city dwellers have poorer health outcomes than others due to unfair marginalization and discrimination as a result of their age, gender, ethnicity, disability or other aspects of their identity. Most frequently, these factors interact to create double or triple jeopardy for certain people. A poor, immigrant woman living in a disadvantaged neighbourhood, for example, will probably experience a very different reality than a wealthy, male citizen living in an upscale part of the city. This section provides examples of different segments of the urban population having unfair differences in health status.

Poor urban women are most likely to have HIV infection

Results from the Demographic and Health Surveys (DHS) conducted in 21 selected countries, primarily in sub-Saharan Africa, show that the average HIV prevalence in urban areas is higher than in rural areas, and that women are particularly vulnerable to HIV within cities (Figure 4.20). Prevalence of HIV among urban women is 1.5 times higher than that among urban men, and 1.8 times higher than that among rural women.
"I have known for 13 years that I am HIV positive," reveals Huguette. Soon after marrying, she says, "My husband started to get sick. There was no treatment. He knew he was positive but no one would talk about it. I only discovered it when I looked in his health papers one day and it was written. I was very angry with him." She began to use condoms with him, but she tested positive. "My husband would go out with many girls and he refused to change. So I decided to leave him." Yet her family persuaded her to return and care for him in his dying days.

She got pregnant by him and gave birth to an HIV-positive baby. "Poro had TB and suffered for so long. At that time the treatment was available, but it was too expensive, almost US$ 1040 a month. It was so painful to see him suffer. He would cough all night, and there was nothing I could do. He was 5 years old when he died." Huguette remarried to a man she met at church, and lost another baby, this time a baby girl, to the virus before her own health made a turn for the worse. "I also started to become sick, and reached the last stage. I had TB, I was vomiting, coughing."

Finally, she went to the central hospital and received ARVs, which saved her life. With her supportive husband and the falling cost of ARVs, eventually made free, "I got better and better and then I had a new baby. She was born healthy and is HIV negative. I now have a newborn son as well. I am so happy. I did all the treatments to prevent them from getting HIV from me."

Now, Huguette has started her own small organization. "I advise other HIV positive people, give information, people come here to my house to talk. I also go to schools and churches to educate and tell them about HIV. I feel so happy when I help others. It feels so good to live."
Low socioeconomic status appears to further compound the problem for women living in urban areas. In 71% of the countries considered in this analysis, the poorest 40% of women in urban areas had a higher HIV prevalence than other women, who are relatively wealthier; among men, this income-based inequity was found in only 48% of the studied countries. There is an urgent need for further research to understand the urban conditions that may increase vulnerability to HIV infection among women, such as gender-related barriers in access to services, lack of access to education and economic opportunities, and violence against women and girls.

**CHAPTER SUMMARY**

This chapter has demonstrated how aggregated data often mask substantial health inequities within urban populations – inequities that are revealed when this same information is disaggregated according to defining characteristics of city dwellers, such as their socioeconomic status or place of residence. Examples in this chapter have illustrated that the urban poor suffer disproportionately from a wide range of diseases and health problems, and that disadvantage and disease tend to cluster within certain neighbourhoods of cities. Beyond socioeconomic status and neighbourhood, some city dwellers have poor health outcomes because of the way societies marginalize and discriminate against them for aspects of their identity they cannot change, such as their age, sex or disability. In every city, disaggregated data can help identify people and areas most in need of intervention and support. Once again using disaggregated urban data, the following chapter reveals that unless urgent action is taken to reduce health inequities in urban areas, many countries will not achieve the health-related MDG targets by 2015.