This chapter presents new analyses looking at health progress and projections on health-related MDGs in urban areas. It goes beyond urban averages to reveal how the richest and poorest city dwellers differ from one another in relation to MDG health targets.
From the 1990 baseline date, 2010 is 80% of the way towards the Millennium Development Goal (MDG) target date of 2015. Currently available data show that while some countries have made impressive gains in achieving health-related targets, others are falling behind.

Results reveal that at current rates of progress, many health-related MDG targets will not be achieved unless urban health inequities are addressed urgently. Current levels of urban health inequities are undermining countries’ ability to meet national targets, and preventing the realization of the international community’s vision of health and development for all.

**Introduction to the Millennium Development Goals**

In September 2000, the largest-ever gathering of heads of state and government ushered in the new millennium by adopting the United Nations Millennium Declaration. The Declaration was endorsed by 189 countries and was translated into eight Millennium Development Goals (MDGs – see Box 5.1) to be achieved by 2015.10,124

Health is at the heart of the MDGs (Figure 5.1). Achieving the health-related MDGs will not be possible without progress on poverty, food security, gender equality, wider access to education and better stewardship of the environment.

Although the MDGs are global and their related targets are set for countries as a whole, cities, as the newly dominant setting of human habitation, are essential for the realization of the MDGs. The success or failure in meeting MDG targets at global and national levels will depend to a large extent on how much is achieved within urban populations.

**Box 5.1**

**The Eight Millennium Development Goals**

- **MDG 1:** Eradicate extreme poverty and hunger
- **MDG 2:** Achieve universal primary education
- **MDG 3:** Promote gender equality and empower women
- **MDG 4:** Reduce child mortality
- **MDG 5:** Improve maternal health
- **MDG 6:** Combat HIV/AIDS, malaria and other diseases
- **MDG 7:** Ensure environmental sustainability
- **MDG 8:** Develop a global partnership for development

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*Image: UN Photo/Terry Doggett (Eastman Kodak)*
And while MDG goals and targets are not equity specific, evidence shows that failure to address the distribution of wealth undermines progress in development. Policies to promote equity, on the other hand, accelerate progress towards the MDGs.125

Projections presented in this chapter are based on observed rate of progress over the longest time period for which data are available. This form of linear projection might not be most accurate in every case, given that each country has a specific context and may be undergoing health reforms or economic growth (or crisis), which may create the conditions for better or worse performance leading to 2015. However, linear projection also has several advantages: it can be applied in a standard manner for all countries; it is dependent entirely on observable data, as opposed to arbitrarily assigned growth rates; and it is relatively simple to understand because it is based on past achieve-ments. More detailed information about the World Health Organization’s analyses and results can be found in Annex B of this report.

### MDG 1: Eradicate extreme poverty and hunger

The first MDG is to eradicate extreme poverty and hunger, both of which are determinants of health and development. The second of its two targets is to halve, between 1990 and 2015, the proportion of people who suffer from hunger. The health indicators for this target are the prevalence of underweight children (under five years of age), and the proportion of the population below the minimum level of dietary energy consumption.
Globally, the number of children younger than five years of age suffering from malnutrition, according to WHO child growth standards, declined from 1990 to 2007. But the progress is uneven, and an estimated 112 million children are underweight.

Our analysis examined the prevalence of stunted children (see footnote i, Chapter 3, for a definition), which is considered an indicator of chronic malnutrition. Figure 5.2 reveals that among urban areas of 21 countries in Africa, 6 in the Americas and 5 in Asia, the poorest 20% of urban populations in Africa have, on average, experienced an increase in childhood stunting during 2000 to 2007, compared with 1990 to 1999. In the Americas, the poorest 20% in urban areas have experienced an average reduction of 7% in childhood stunting. In all examined regions, the gap between the richest and poorest has not improved significantly over the two decades.

Linear projections indicate that in 88% of considered countries, stunting among the urban poor is unlikely to be reduced by 2015 to half of what it was nationally in the 1990s. On the other hand, the urban rich are likely to achieve this in 75% of these countries, based on current rates of progress.

Figures 5.3 and 5.4 display the prevalence of childhood stunting over time in urban areas of the Plurinational State of Bolivia and India. In both countries, large inequities exist between rich and poor urban children. However, in the Plurinational State of Bolivia, the gap between poor and rich children is widening, while in India, childhood stunting is declining in all segments of the population, resulting in a gap that is essentially unchanged over time. In urban areas of both counties, average levels of childhood stunting will not meet MDG-related targets by 2015. This is due in large part to the situation of the poorest urban children.
FIGURE 5.3
TRENDS AND PROJECTIONS TOWARDS HALVING STUNTING BY 2015 (IN RELATION TO 1990 LEVELS) IN URBAN AREAS OF THE PLURINATIONAL STATE OF BOLIVIA

Note: Projected estimates are based on the long-term annual rate of growth from the 1990s to the latest year with available data.
Source: WHO calculations based on data from Demographic and Health Surveys (DHS).

FIGURE 5.4
TRENDS AND PROJECTIONS TOWARDS HALVING STUNTING BY 2015 (IN RELATION TO 1990 LEVELS) IN URBAN AREAS OF INDIA

Note: Projected estimates are based on the long-term annual rate of growth from the 1990s to the latest year with available data.
Source: WHO calculations based on data from Demographic and Health Surveys (DHS).
MDG 4: Reduce child mortality

MDG 4 is to reduce child mortality, and its target is to reduce the under-five mortality rate by two thirds between 1990 and 2015. Under-five mortality rate is defined as the probability of dying before the age of five, expressed as the number of deaths per 1000 live births.

Globally, the number of children who die before their fifth birthday has been reduced by 27%, from 12.5 million estimated in 1990 to 8.8 million in 2008. Under-five mortality rates (number of deaths per 1000 live births) have declined in all regions of the world.¹⁹⁷

Figure 5.5 displays under-five mortality rates in urban areas of Africa, the Americas and Asia. Progress has been made in each of the three regions, in both poor and rich urban populations. Between the periods of 1990 to 1999 and 2000 to 2007, 86% of the countries studied improved their overall under-five mortality rates in urban areas. The few countries with worsened urban under-five mortality rates were all located in sub-Saharan Africa.

However, based on annual rates of progress since the 1990s, the poorest urban children in 80% of the countries studied will not achieve the target level of under-five mortality rate at the national level. This stands in contrast to the richest 20% of urban children, among whom the target is likely to be achieved in 57% of countries.

Figures 5.6 and 5.7 show trends and projections for urban areas of the Plurinational State of Bolivia and India. In both countries, progress is being made. On average, the Plurinational State of Bolivia is expected to achieve its national MDG target in its urban areas, whereas India’s urban areas will fall slightly short of its national target. Nonetheless, the poorest 20% of urban children will continue to suffer from unacceptably high mortality rates, and as a group will fall substantially short of their countries’ MDG targets. Similar results are found in many other countries.

Note: These results represent averages of those countries for which urban DHS data were available (Africa = 21 countries, Americas = 6 countries, Asia = 8 countries). As such, they are not representative of the regions as a whole.

FIGURE 5.6
TRENDS AND PROJECTIONS TOWARDS REDUCING BY TWO THIRDS UNDER-FIVE MORTALITY BY 2015 (IN RELATION TO 1990 LEVELS) IN URBAN AREAS OF THE PLURINATIONAL STATE OF BOLIVIA

Note: Projected estimates are based on the long-term annual rate of growth from the 1990s to the latest year with available data.
Source: WHO calculations based on data from Demographic and Health Surveys (DHS).

FIGURE 5.7
TRENDS AND PROJECTIONS TOWARDS REDUCING BY TWO THIRDS UNDER-FIVE MORTALITY BY 2015 (IN RELATION TO 1990 LEVELS) IN URBAN AREAS OF INDIA

Note: Projected estimates are based on the long-term annual rate of growth from the 1990s to the latest year with available data.
Source: WHO calculations based on data from Demographic and Health Surveys (DHS).
MDG 5: Improve maternal health

MDG 5 is to improve maternal health, and its target is to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio (the number of women dying as a result of pregnancy or childbirth). One of the indicators for this target is the proportion of births attended by skilled health personnel (physicians, nurses, trained midwives), which, ideally, should be 100%. The proportion of women who deliver with the assistance of a skilled health-care worker is highly associated with maternal mortality ratios.128

Around the world, the proportion of births attended by a skilled health worker improved between 1990 and 2006, though still falling short of the 100% target. Improvements were made in almost all regions, except in Europe, where coverage levels were already high in 1990.128

Figure 5.8 displays skilled birth attendance coverage rates in urban areas in Africa, the Americas and Asia. Very little progress has been made in urban areas of these regions. At current rates of progress, 78% of the studied low- and middle-income countries in Africa, the Americas and Asia will not achieve even 90% coverage of skilled birth attendance for the poorest 20% of urban women. The situation is even more dire in 38% of the same countries, where fewer than half of the poorest women in urban areas will have access to skilled birth attendance in 2015, according to current rates of progress.

Trends and projections for skilled birth attendance in urban areas of the Plurinational State of Bolivia and India are shown in Figures 5.9 and 5.10. The Plurinational State of Bolivia has made remarkable progress towards skilled birth attendance for all urban women. In India, however, inequities have remained relatively constant and are projected to continue into the future. Around half of poor urban women in this country will continue to lack access to skilled birth attendance in 2015.
FIGURE 5.9
TRENDS AND PROJECTIONS TOWARDS ACHIEVING UNIVERSAL COVERAGE FOR SKILLED BIRTH ATTENDANCE BY 2015 IN URBAN AREAS OF THE PLURINATIONAL STATE OF BOLIVIA

Note: Projected estimates are based on the long-term annual rate of growth from the 1990s to the latest year with available data.
Source: WHO calculations based on data from Demographic and Health Surveys (DHS).

FIGURE 5.10
TRENDS AND PROJECTIONS TOWARDS ACHIEVING UNIVERSAL COVERAGE FOR SKILLED BIRTH ATTENDANCE BY 2015 IN URBAN AREAS OF INDIA

Note: Projected estimates are based on the long-term annual rate of growth from the 1990s to the latest year with available data.
Source: WHO calculations based on data from Demographic and Health Surveys (DHS).
MDG 7: Ensure environmental sustainability

MDG 7 is to ensure environmental sustainability, and a key target relating to urban areas is to achieve a significant improvement in the lives of at least 100 million slum dwellers by 2020.

UN-HABITAT estimates that this target has already been exceeded by at least 2.2 times. Between 2000 and 2010, 227 million people will have moved out of slum conditions. The proportion of slum dwellers has declined in all regions of the world, from 39% in the year 2000 to an estimated 33% in 2010. Because more than 200 million urban dwellers have gained access to improved water and sanitation or to durable and less crowded housing, their prospects have improved to escape poverty, disease and illiteracy, and to lead better lives.¹

However, due to population growth the absolute number of slum dwellers has grown considerably, and will continue to rise in the near future.

FIGURE 5.11
PROPORTION OF URBAN POPULATION LIVING IN SLUM AREAS, 1990 AND 2010

UN-HABITAT estimates that the number of slum dwellers has risen from 657 million in 1990 to 767 million in 2000 and 828 million in 2010. This means that 171 million urban poor have been added to the global population of slum dwellers since 1990.\textsuperscript{1} There is therefore no room for complacency during the next decade.

In least-developed and conflict-affected countries, slum prevalence is expected to remain very high, comprising 70% of the urban population. In conflict-affected countries, the proportion of the urban population living in slums increased from 64% in 1990 to 77% in 2010.\textsuperscript{1}

Figure 5.11 displays the proportion of city dwellers estimated to be living in slums in 1990 and 2010, for various regions of the world. In 2010, the highest slum prevalence is in sub-Saharan Africa (62%), followed by Southern Asia (35%), compared to less than one third of urban residents in all other regions of the developing world. Despite the efforts of some cities and countries in sub-Saharan Africa to expand basic services and improve housing conditions in slum areas, inaction in other areas has prevented overall progress in the region. In Western Asia, the increase in the proportion of slum dwellers can be attributed largely to the conflict related deterioration of living conditions in Iraq, where the proportion of urban residents living in slum conditions has tripled from 17% in 2000 (2.9 million) to an estimated 53% in 2010 (10.7 million).\textsuperscript{1}

\textbf{CHAPTER SUMMARY}

Although the MDGs are global and their related targets are set for countries as a whole, cities – by virtue of their population sizes – are crucial parts of the equation. Results presented in this chapter show that at current rates of progress, many health-related MDG targets will not be achieved in urban populations by 2015. This will undermine countries’ ability to meet national targets, and will prevent the realization of the international community’s vision of health and development for all. Results in this chapter also revealed that the urban poor are most at risk of not achieving national MDG targets. For example, more than 80% of low- and middle-income countries studied will fail to meet MDG-related benchmarks for childhood stunting and childhood deaths among their urban poor. MDG goals and targets are not equity specific: there is no explicit requirement for achievements to be made equally in all population subgroups. Nonetheless it is generally understood that achievement of the MDGs will improve equity, and that improving equity will contribute to achievement of the MDGs. It is not too late to alter these trends. Action must be taken at street and neighbourhood levels, with municipal, provincial and national governments working in partnership with communities. Part Three of this report describes a strategy for overcoming urban health inequities and providing a better future for all city dwellers.