

# Rapid Urbanisation, Economic Growth and the Well-being of Children

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Front cover photograph: Rapid city growth. Bangladesh  
Jon Warren/World Vision.

Inside photos:

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## Foreword

An increasing proportion of the world's poor are now living in cities, and urban slums are expanding globally. This 'urbanisation of poverty' has presented international non-governmental organisations (NGOs) with a largely unexplored territory.

Children are the first victims of urban poverty. Living in overcrowded, makeshift and often transitory housing – and for some particularly unfortunate ones, being pushed onto pavements and streets – means children are often caught in a poverty trap from which it is difficult to escape. Life in a slum involves a range of risks including eviction, violence, trafficking and a violation of children's basic rights. Impoverished slum dwellers living in fragile pockets of a city suffer from poor health, as evidenced by the prevalence of stunting and underweight. Infant mortality numbers are high in slums. Inadequate nutrition, unsanitary living conditions of slums and exposure to contaminated water leave children and their families at greater risk of disease and chronic health problems.

Cities are engines of power and influence, of growth and opportunity, yet huge numbers of their citizens are not counted and remain invisible to policy makers. Most slum dwellers are unable to register their children at birth, which limits their lack of access to basic services, including quality education. Reliant on the informal economy, many poor urban households push their children into labour, not seeing the value of investing in formal education. Yet the rising powerhouse economies such as India, Brazil and China need a continuing supply of skilled workers to sustain their progress to becoming major power hubs of the 21st century.

The purpose of this paper is to explore the megatrend of urbanisation and its impact on children after, for many developing countries, a sustained period of strong economic growth. Can we say with confidence that children are better off in the urban areas of the developing world than they were two decades ago? Can we say that we are measuring with reasonable accuracy the well-being of the growing number of urban children? Is there sufficient data to inform us about the basic components of well-being at an urban level? Even more fundamentally, do our traditional concepts of child well-being adequately cover the challenges that urban children face?

This article seeks to stimulate interest and contribute to public debate on the essentials of the well-being of urban children and explore this question: Are children of slum dwellers able to benefit from their parents' migration to the city, or do they remain caught in the poverty trap inherited from their parents?

As a child-focused organisation with a commitment to responding to the most vulnerable, World Vision is keen to explore and frame its contribution to child well-being in urban contexts. Its Centre for Expertise for Urban Programming has developed a 'Cities for Children' framework, consisting of four interrelated sectoral domains that contribute to and promote just and inclusive cities where children thrive, especially the most vulnerable. Through this framework, World Vision seeks to further develop workable solutions in successful urban programming, solutions that contribute to greater impact and child well-being in cities.

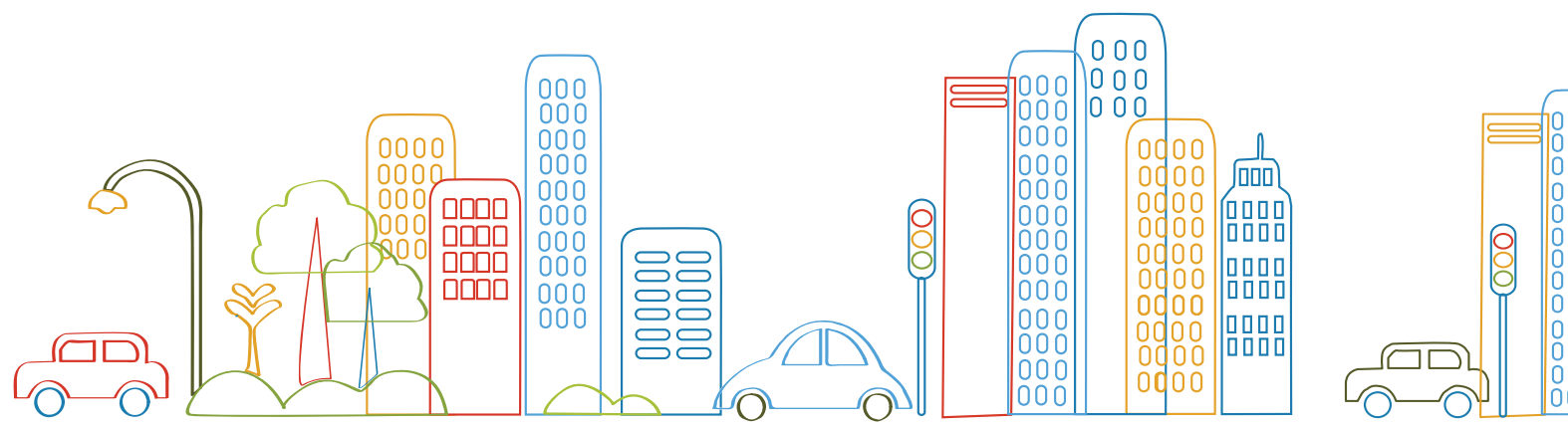
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## Introduction

Over the past two decades the world has seen urbanisation reach a scale that has permanently changed the physical, social and economic landscape of many low- and middle-income countries. In 2011 an estimated 3.63 billion people lived in cities, compared to 3.34 billion in rural areas. Of the 3.63 billion people in cities, 2.67 billion were in cities in less-developed regions. Urbanisation proceeded fastest in the developing world, growing by 3.3 per cent a year from 1970 to 2011, compared to 0.89 per cent in more developed areas.<sup>1</sup> Over the 20 years from 1990 to 2010, in 139 low- and middle-income countries, the population of small urban areas (less than one million people) grew by 65.7 per cent, large urban areas (one million or more) by 71.8 per cent, and rural areas by just 14.0 per cent.<sup>2</sup>



Slum dwellers in dense and unhygienic areas of Dhaka, Bangladesh.

The rapid urbanisation in the developing world over the past two decades occurred against a background of strong sustained economic growth in many low- and middle-income countries. The dramatic expansion of the Chinese and, to a lesser extent, Indian economies is well known. Less well known is the sustained strong growth in other parts of Asia, Africa and South America. For example, Myanmar, Cambodia, Mozambique and Angola achieved trend growth in real per capita gross domestic product (GDP) of more than five per cent a year over the two decades to 2012, while in South America, the Dominican Republic and Peru grew by more than three per cent a year over the same period.<sup>3</sup>

These megatrends of urbanisation and economic growth have generated a substantial amount of research. The aggregate impact of more than 20 years of sustained economic growth on global poverty and inequality has received considerable attention. Urbanisation in both developing and developed countries has also generated a large and diverse literature. Yet because of the scale and pace of change, and the complexity of large and rapidly growing urban environments, the impact of these trends on urban children is not well understood.

This uncertainty about the effects of these major trends on urban children has significant implications for the work of a child-focused agency such as World Vision. Designing and implementing effective programmes to reduce urban child poverty requires a good understanding of the costs and benefits of rising urbanisation and of how increased national income is affecting the lives of urban children. Does the evidence show that sustained

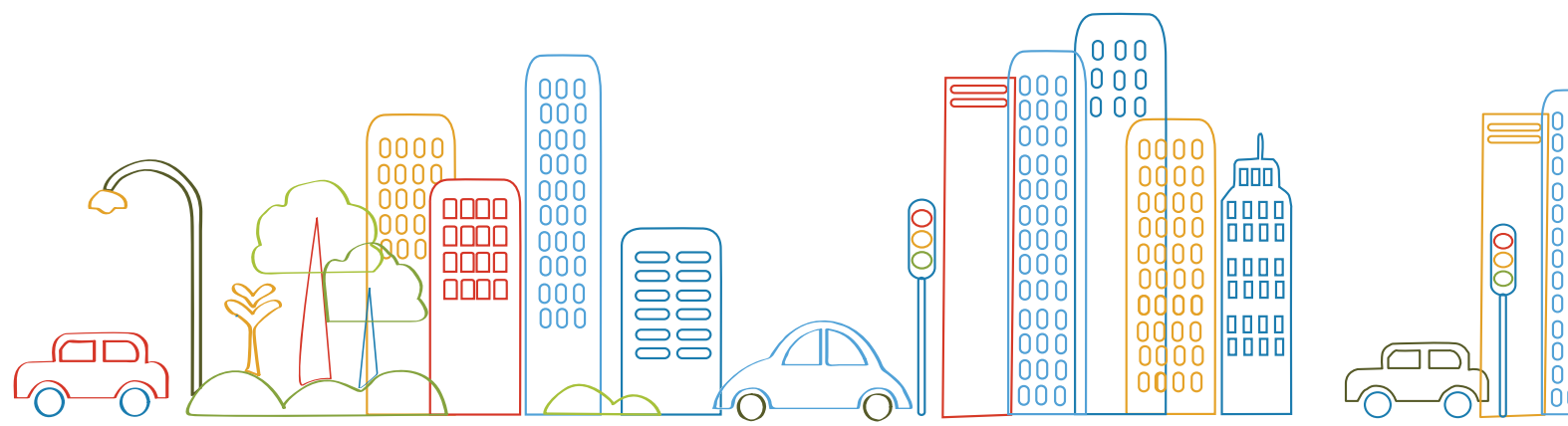


economic growth produces an aggregate improvement in child well-being? If it does, are the benefits of growth trickling down to the poorest? And even if this is the case, is it of a sufficient scale to bring about a permanent change in their welfare? More fundamentally, is the conventional view of child well-being (centred on health, nutrition and education) adequate for the complex urban environments of the 21st century?

This report looks at four aspects of these questions. We start with an overview of national income trends over the past two decades and consider their likely impacts on child poverty to see whether, at a macro level, children have generally benefitted from strong sustained economic growth. We then consider the effect of rising urbanisation on child well-being. On balance, do children benefit from greater urbanisation, or are rural environments broadly better for the health and well-being of children? The available research allows some broad conclusions to be drawn, but closer examination of even the traditional dimensions of child well-being quickly highlights a third issue – the adequacy of the available data. Much national data is not available on a rural/urban split, let alone in a form that allows changes in the well-being of poor urban children to be separately considered. Consequently, focusing on the nine countries where World Vision has urban learning centres or pilot projects, this section of the report considers gaps in both the depth and breadth of data that need to be filled to provide a fuller picture of urban child well-being. And this brings us to the fourth issue: irrespective of the quality of the available data, are the mainstream elements of child welfare sufficient to provide an adequate picture of child well-being in an urban context? New threats and opportunities in urban environments are challenging our ideas of what constitutes the well-being of urban children. Using examples of the work of World Vision and others to reduce child poverty in urban settings, we argue that NGOs are well placed to contribute to a better understanding of some of the less tangible but very important factors that influence the well-being of children in diverse and rapidly growing urban environments.



New housing development threatening slum dwellers in Phnom Penh, Cambodia.

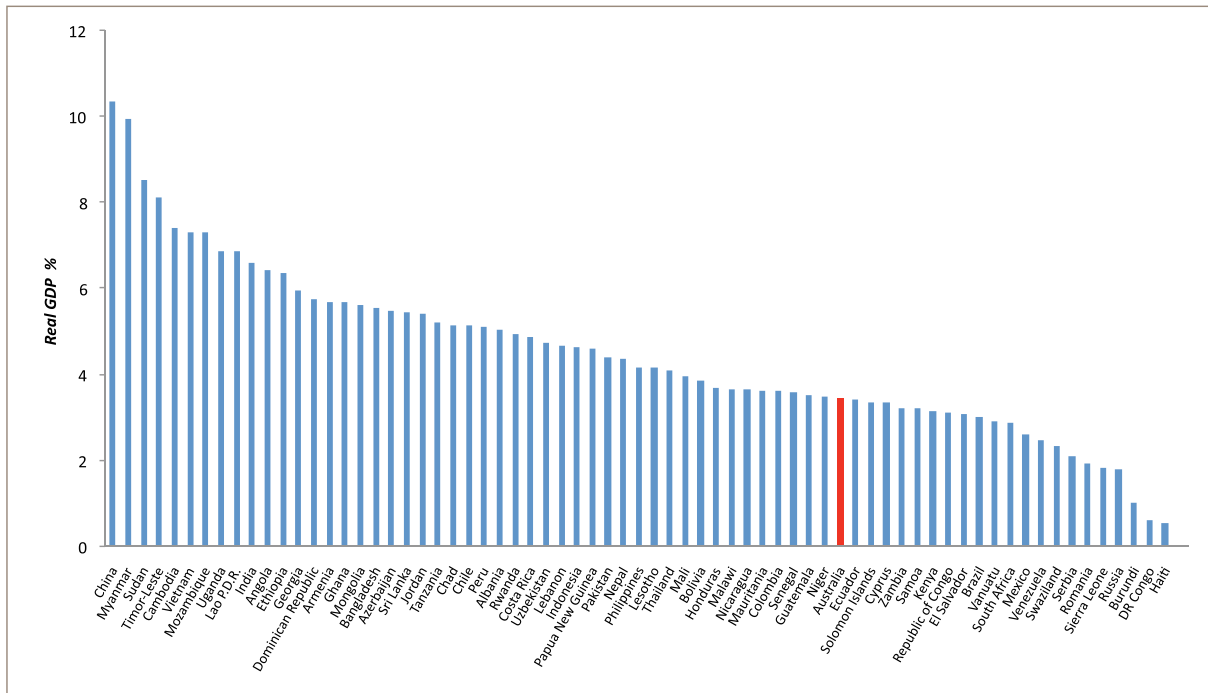




## I. The long boom: did children gain?

The strength of economic growth in many developing countries over the past two decades has undoubtedly been impressive.

**Chart I: Trend growth in real GDP, 1992–2012**



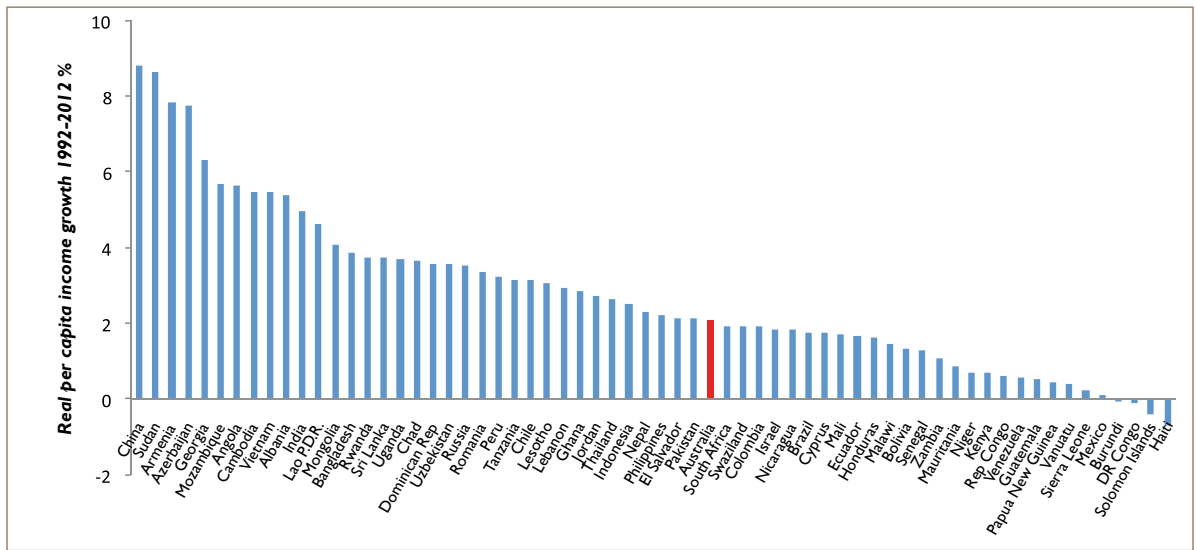
Source: Exponential trend growth calculated from International Monetary Fund, *World Economic Outlook Database* (October 2013) <<http://www.imf.org/external/pubs/ft/weo/2013/02/weodata/weoselgr.aspx>>

Chart I shows trend growth in real GDP (in national currencies) for most of the countries where World Vision runs programmes. Of the 68 developing countries shown, 37 achieved trend growth above four per cent per annum. Further, 47 were above the trend growth achieved by Australia,\* one of the fastest-growing developed countries over the period. This sustained strong economic growth made a major contribution to reducing global poverty. Millennium Development Goal I – halving extreme poverty between 1990 and 2015 – was achieved five years ahead of schedule. The World Bank has estimated that between 1990 and 2010, the proportion of people living in extreme poverty (US\$1.25 a day or less) fell from 47 per cent in 1990 to 22 per cent in 2012, a reduction of some 700 million people.<sup>4</sup> Sustained economic growth over the three decades to 2010 saw the extreme poverty rate in China decline from 84 per cent to 12 per cent, and in India from 60 per cent to 33 per cent. The poverty rate in the 35 lowest income countries also fell, from 63 per cent to 44 per cent over the same period.<sup>5</sup>

\* Australia grew by 3.4 per cent per annum. Singapore and Hong Kong grew faster; the US grew by 2.6 per cent.



**Chart 2: Trend growth in real per capita GDP, 1992–2012**



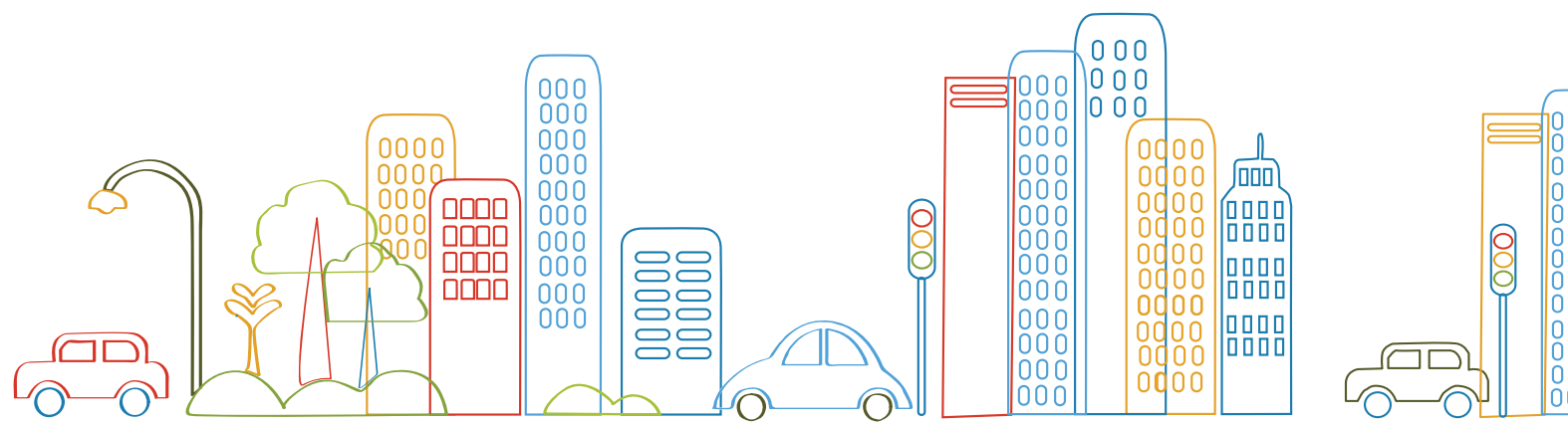
Source: Exponential trend growth calculated from International Monetary Fund, *World Economic Outlook Database* (October 2013) <<http://www.imf.org/external/pubs/ft/weo/2013/02/weodata/weoselgr.aspx>>

Given the strength of growth in national incomes, it is not surprising that for many developing countries, per capita income also increased substantially over the 20 years to 2012. China again led the field, with real per capita income growing by 8.8 per cent per annum. But a diverse range of countries, including India, Cambodia, Vietnam, Angola, Georgia, Armenia and Mozambique, all achieved trend growth of 5 per cent or more per annum over the period (Chart 2).

Historically, sustained economic growth has been clearly positive for major elements of child well-being.

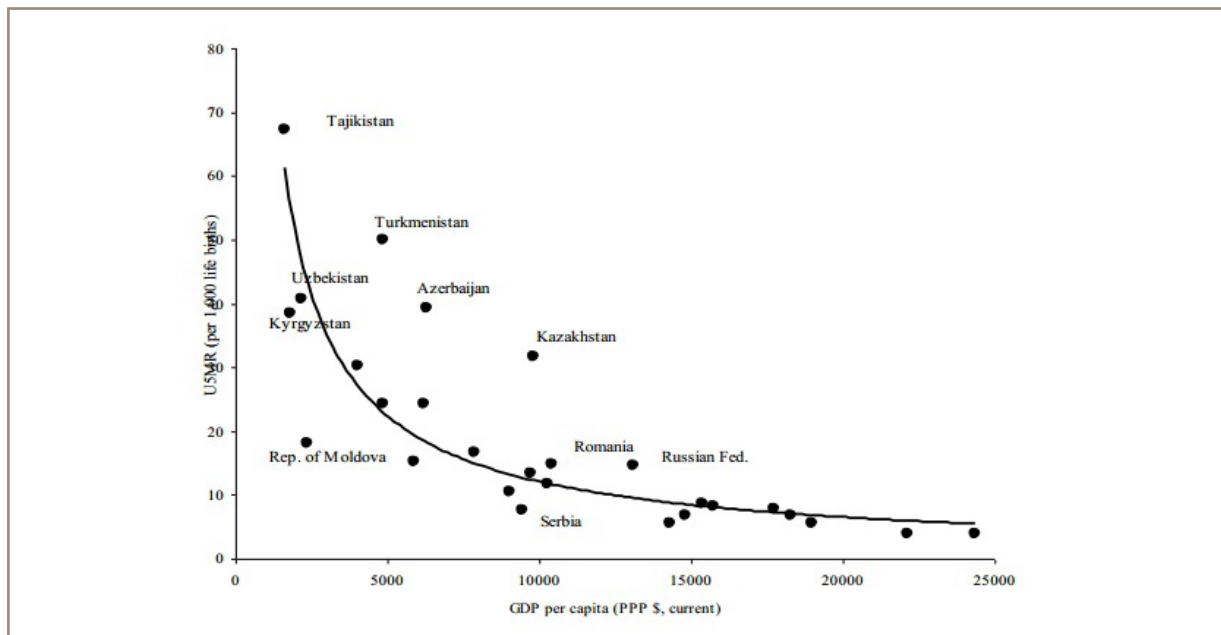
Greater incomes at the household level mean that families can invest more in food consumption, access to clean water and good hygiene, and effective health care. They can also afford more effective child care arrangements. At the community level greater income will eventually lead to better access to and better quality of health care centers and water and sanitation systems.<sup>6</sup>

There is considerable evidence that strong growth in the past has resulted in reduced under-5 mortality and in large numbers of children experiencing improved health and nutrition, more and better education, and other significant benefits as a result.<sup>7</sup> The link is particularly clear in the area of child mortality. Take, for example, the general trend among the countries of central and eastern Europe (CEE) and the Commonwealth of Independent States (CIS). Under-5 mortality declined as income rose, with particularly sharp falls over the annual per capita income range US\$2,500 to US\$6,000 (Chart 3).





**Chart 3: Under-5 mortality rates,\* CEE and CIS by per capita GDP**

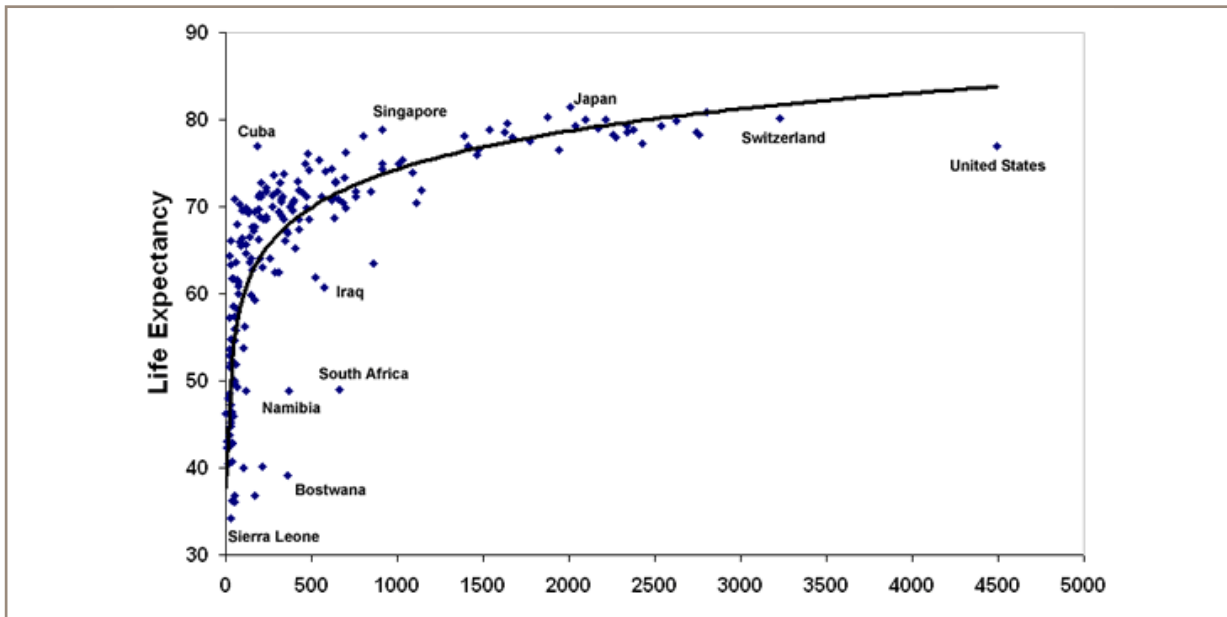


Source: UNICEF, *Child Well-being in Eastern Europe and Central Asia: A multidimensional approach* (2009) p. 4  
<<http://www.unicef-irc.org/publications/581>>  
\* Per 1,000 live births.

Significant improvements in child survival have been achieved in Africa over the past 20 years. Infant mortality across the African continent declined from 99 deaths per 1,000 in 1990 to 71 in 2010, although improvement ranged from no change in Somalia to reductions of 55 per cent in Malawi and 72 per cent in Egypt. There were also substantial but variable reductions in under-5 mortality.<sup>8</sup> In Africa, a general increase in the provision of maternal and child health services has been important in reducing child mortality. On average about 80 per cent of pregnant women in Africa receive at least one antenatal care visit. Attendance of a trained health practitioner at the birth of a child is another important way of reducing infant and maternal mortality. While the average attendance level for Africa as a whole has been roughly constant at around 50 per cent of births for the past 20 years, a number of countries, including Ghana, Kenya, Burundi, Burkina Faso and Morocco, have made specific policy interventions to increase attendance rates.<sup>9</sup>



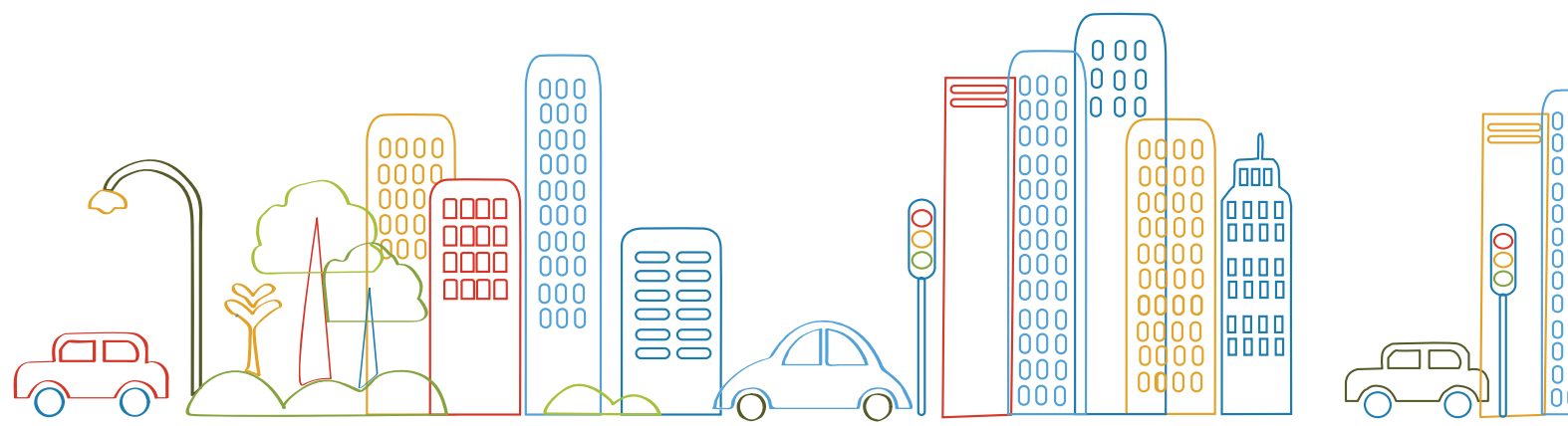
**Chart 4: Life expectancy and total spending on health care for the year 2000\***



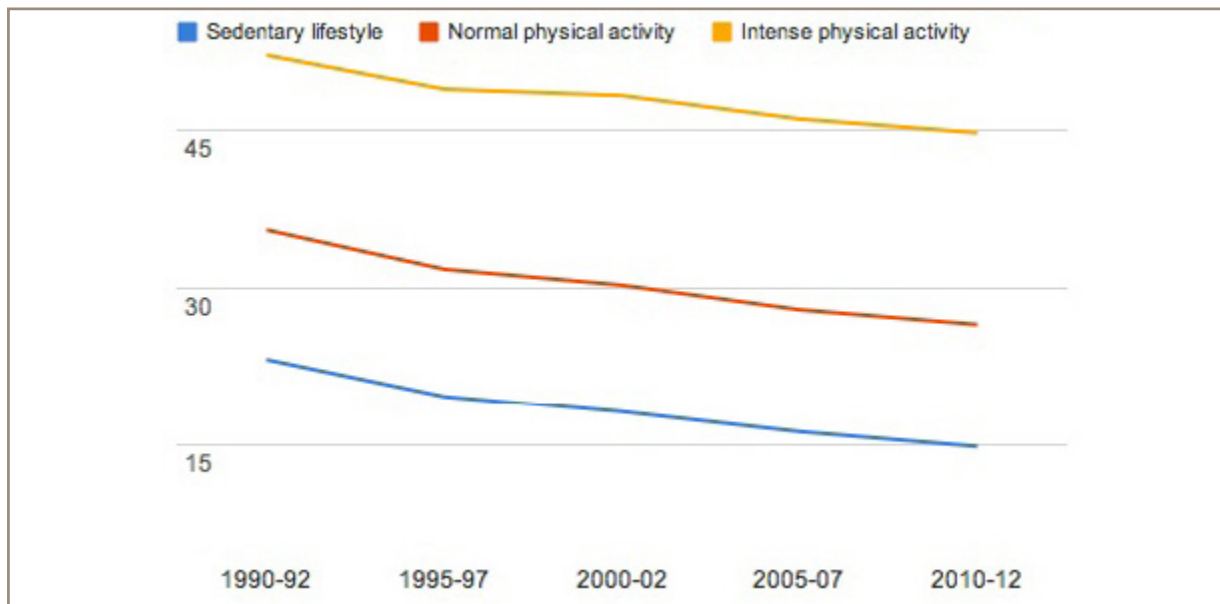
Source: University of California Santa Cruz, *UC Atlas of Inequality* <<http://ucatlus.ucsc.edu/spend.php>>  
\* Includes both government and personal expenditure.

Greater life expectancy and total health care spending show a close relationship. As Chart 4 shows, life expectancy rises with per capita spending on health care. Big improvements can be achieved well before typical developed-country levels of expenditure are reached. Cuba is the obvious example here, with developed-country life expectancy achieved at a fraction of developed-country per capita cost. It is also true that the addition to life expectancy slows markedly as health spending increases. For many of the poorest countries, per capita spending is only a fraction of what is likely to be needed to raise life expectancy to developed-country levels of 70+ years. The converse is that relatively small increases can yield large improvements.

As higher national income is likely to be an important source of higher spending on health care, a period of sustained growth in national income could be expected to result in increased life expectancy in many low-income countries. However, the link between GDP and health care expenditure is not as straightforward as might at first appear. A range of other factors, including demographic trends, disease patterns and characteristics of the health system, contribute to the amount spent on health care. Moreover, total spending on health care is a mix of public and private out-of-pocket spending, and the drivers of private spending differ from those that determine health care spending by governments. However, a UN study<sup>10</sup> found that both government and private out-of-pocket health spending increased with GDP. For low-income countries, the income elasticity was 1 or greater (depending on model specification). So it seems likely that sustained economic growth has contributed to increased public and private health care expenditure, allowing for improvements in life expectancy, particularly in countries where per capita health care spending is low.



**Chart 5: Undernourished children in developing countries**



Source: 'Hunger and malnutrition: the key datasets you need to know' *The Guardian* (23 January 2013)  
<<http://www.theguardian.com/global-development/poverty-matters/2013/jan/23/hunger-malnutrition-key-datasets>>

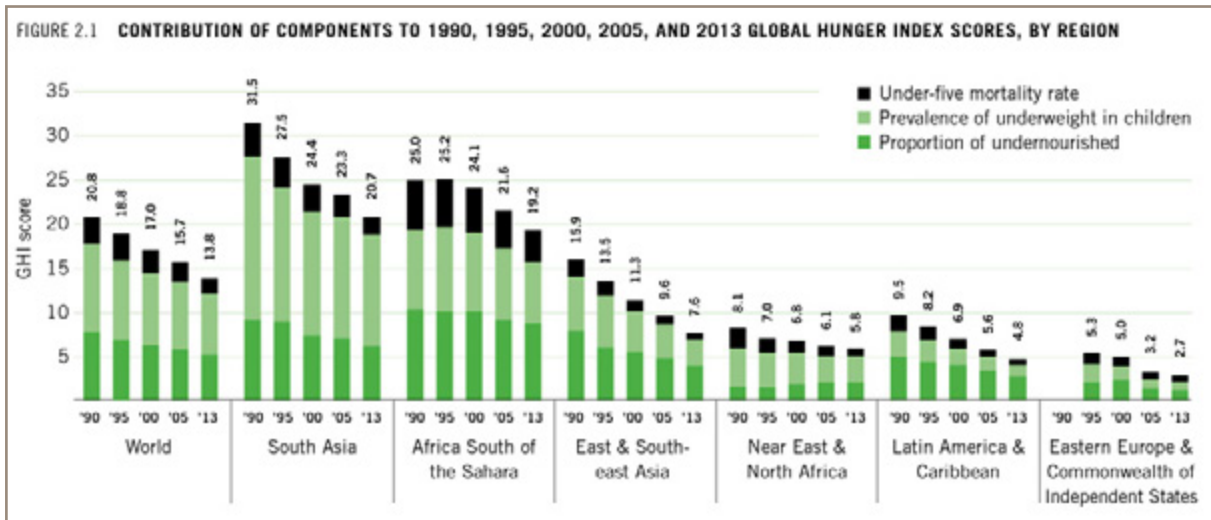
Adequate nutrition is an important element of child well-being. The percentage of children under 5 suffering from stunting, underweight or wasting has been declining in total over the past two decades, although, as Chart 5 shows, the extent of undernourishment is very sensitive to the assumptions made about activity levels and hence the minimum amount of calorie intake needed. Data on child malnutrition is consistent with lower percentages of underweight children both in wealthier developing countries and countries that are growing rapidly, such as China and India. By contrast, in sub-Saharan Africa, the percentage of underweight children remained largely constant for at least a quarter of a century.<sup>11</sup>

The idea that child health has improved over the past two decades is supported by the Global Health Index (GHI). The GHI provides a summary of regional trends in child health. The broad changes in child mortality and in underweight and undernourished children over the past two decades are summarised in Chart 6.





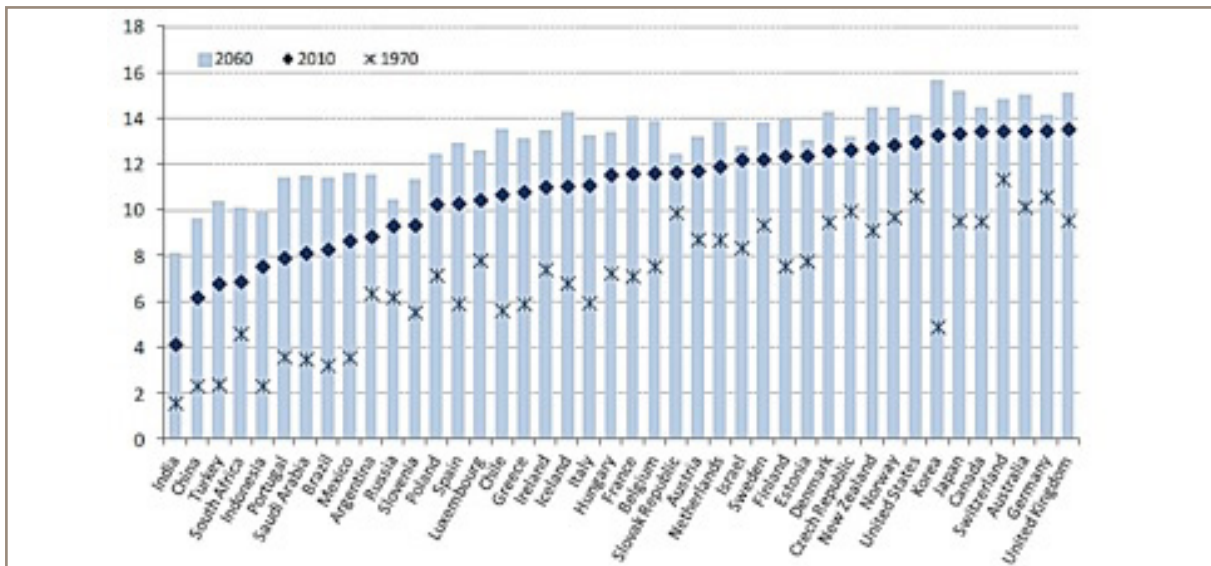
**Chart 6: GHI components by region, 1990–2013**



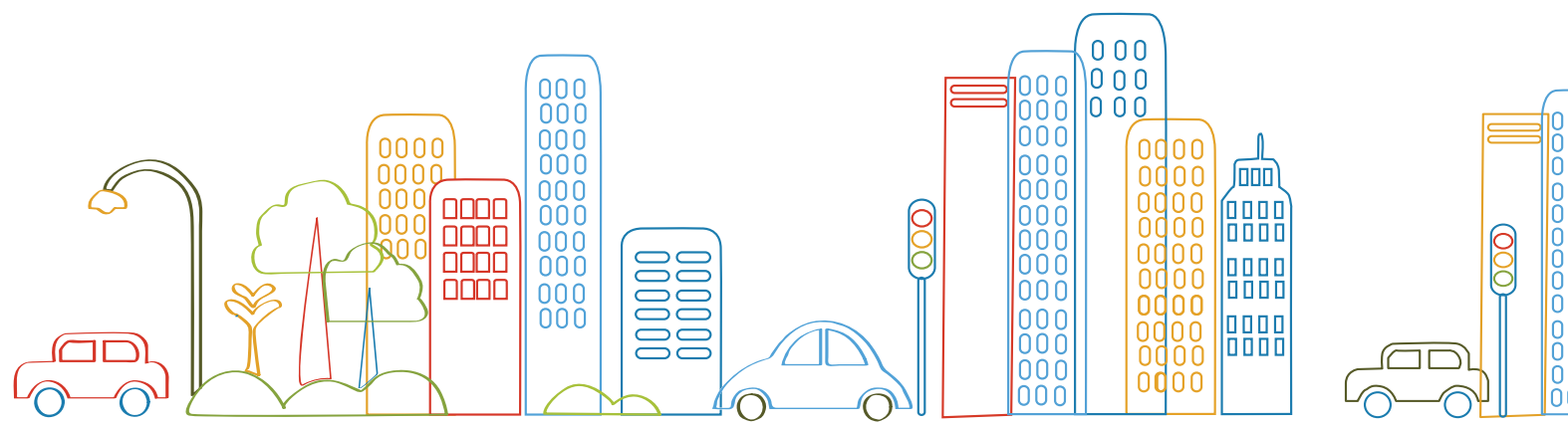
Source: International Food Policy Research Institute, 'Global, Regional, and National Trends' (2013)  
<<http://www.ifpri.org/ghi/2013/global-regional-national-trends>>

Education outcomes also are likely to benefit from sustained income growth. As Chart 7 shows, the average years of schooling in a range of middle-income countries have increased substantially since 1970, with some of the largest increases occurring in economies that have grown rapidly in the past two to three decades, including China, Indonesia, Turkey and India.

**Chart 7: Average years of schooling**



Source: OECD, 'Looking to 2060: A Global Vision of Long-Term Growth', OECD Economics Department Policy Notes, No. 15 (November 2012) p. 4. <<http://www.oecd.org/eco/outlook/2060policynote.pdf>>



There is evidence that higher family incomes lead to more children attending school and/or attending for longer. Using data for Vietnam for the period 1993–1998, Paul Glewwe and Hanan Jacoby found that school enrolment increased faster in the households that experienced greater increases in wealth.<sup>12</sup> This conclusion took into account a range of factors specific to particular localities that might have influenced enrolments, including the number and quality of schools and the opportunity cost of education. The Asian Development Bank has argued that ‘family income has a strong positive association with education attainment’, and a study of Philippine data found that ‘children in poor and rural families have higher dropout rates and lower scores on achievement tests, in part reflecting inadequate access to textbooks and other educational resources’. Asian data also shows a clear inverse relationship between poverty and literacy.<sup>13</sup>

Strong sustained economic growth of itself is not a guarantee that all aspects of child well-being will automatically improve. The African Development Bank has noted, with regard particularly to sub-Saharan Africa,

Increased wealth does not necessarily lead to improved health, particularly for the poorest segments of society. Over the last three decades, Africa has been experiencing its longest period of uninterrupted economic growth and it has shown remarkable resilience in the face of the global financial crisis of 2008/9 and its aftermath. Income per capita has more than doubled in 23 African nations since 1990, and GDP growth rates have averaged 5% per year over the last ten years. ... This rapid economic growth has boosted the amount of resources allocated to health infrastructure and to survival-enhancing social services. In spite of this, issues of governance and income inequality have hampered efforts to improve health outcomes. ... Poverty remains a significant barrier to improving health outcomes, with women, rural dwellers and other marginalized populations bearing a disproportionate burden.<sup>14</sup>

Further, the relationship between higher national income and poverty reduction is complex. Numerous studies of inequality trends have made clear that increased national income does not *guarantee* improvements for the total population, let alone for important subsets such as children. Better outcomes need ongoing government commitment to a range of policies that use increased national income to reduce poverty and benefit children. But increased national income also allows increased private spending on health and education, and sustained improvements in important aspects of child well-being have occurred during the past two decades of strong economic growth. So there is a good *prima facie* case for expecting children overall to have benefitted from the sustained economic growth of the past 20 years. But how much did urban children benefit?



## 2. Rising urbanisation: is it good for urban children?

Understanding how the continuing trend to greater urbanisation is affecting the increasing number of children living in urban centres is important for a number of reasons, not least because of the current scale of urbanisation and also its likely future trend. More than half of the populations of Europe, North America and Oceania were living in urban areas by 1950. Latin America and the Caribbean became a majority urban region in the mid-1960s, and more recently urbanisation has increased rapidly in Africa and Asia. It is estimated that the world's 600 largest cities:<sup>15</sup>

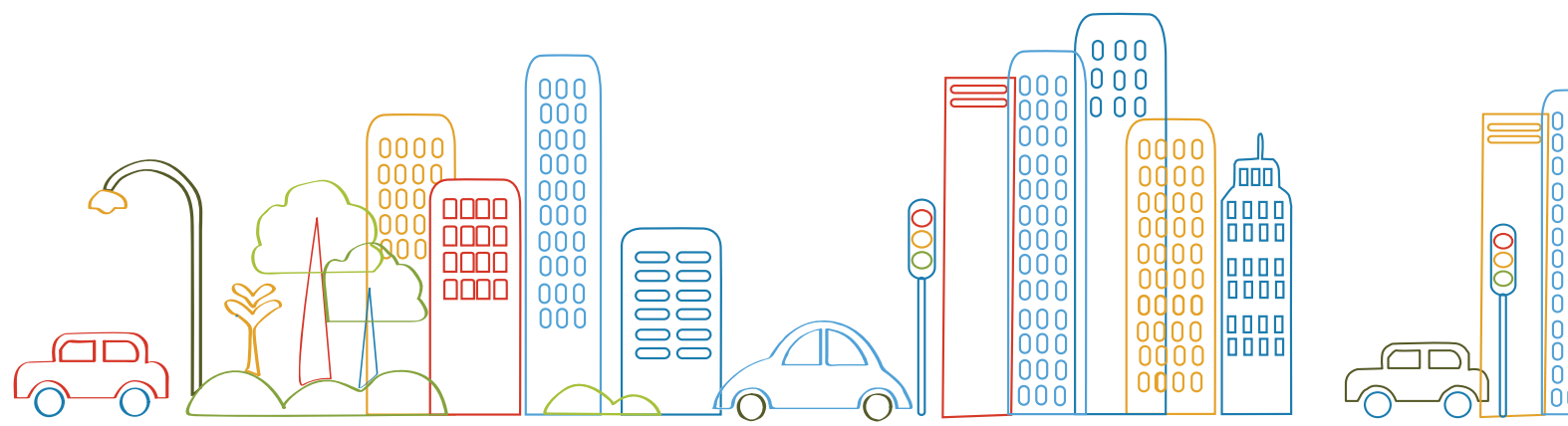
- are home to 1.5 billion people, 22 per cent of global population
- contained 485 million households with an average per capita GDP of US\$20,000
- produced US\$30 trillion of GDP in 2007, more than half of global GDP. The top 100 cities alone generated US\$21 trillion of GDP in 2007, 38 per cent of the global total.

Sustained urbanisation has fuelled the rise of megacities, particularly in Asia. In 2013, 28 urban areas were classified as megacities – cities with populations of more than 10 million people. Asia is home to the seven largest megacities, and only two of the ten largest (Tokyo-Yokohama and New York) are in developed countries. Four of the 28 megacities are in China and three in India.<sup>16</sup> But while the megacities attract most attention, it is smaller cities that are home to most of the world's urban population. Some 9.9 per cent of urban dwellers lived in megacities in 2011, but a similar percentage lived in cities of between 500,000 and one million people, and over 50 per cent lived in urban centres of less than half a million people.<sup>17</sup> The incidence of poverty tends to be higher in smaller cities and towns than in big cities.<sup>18</sup>



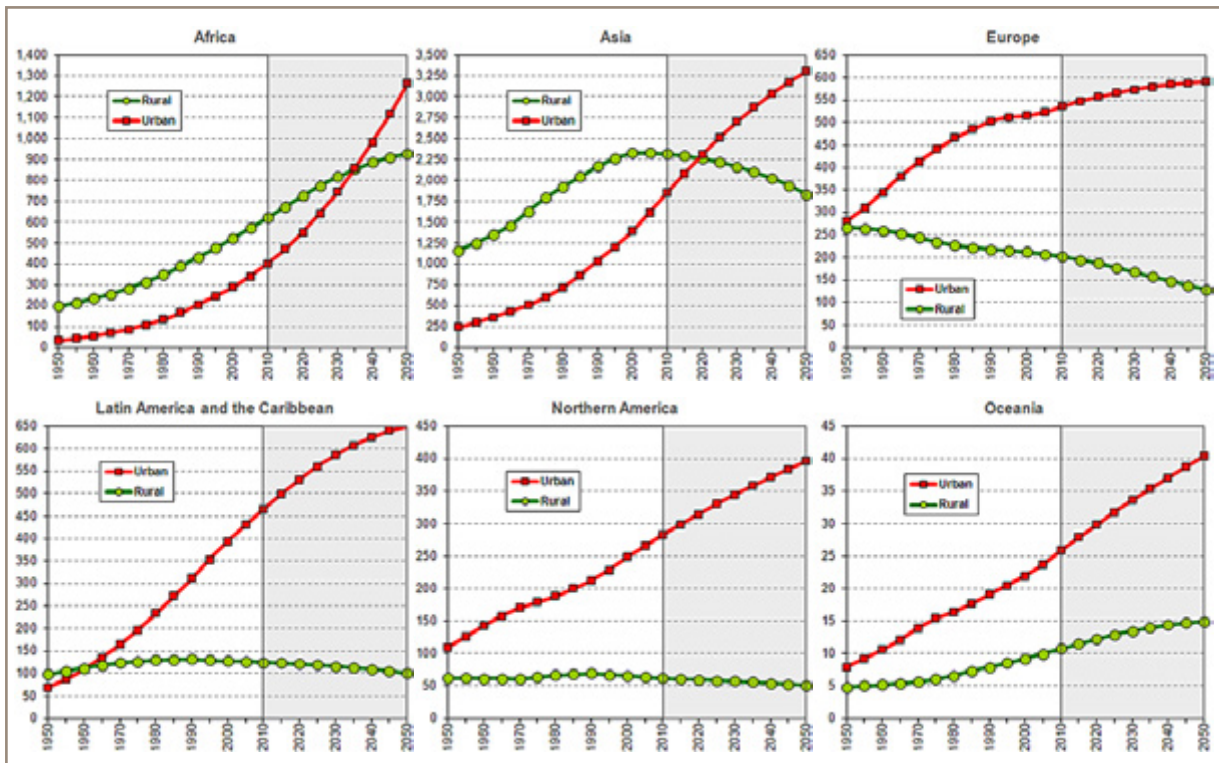
Children working as rag pickers in cities of India.

Despite the rapid urbanisation during the past half century, the trend to greater global urbanisation likely has considerably further to run. Projections by the UN's Department of Economic and Social Affairs indicate increasing urbanisation rates in Europe, North America, and Latin America and the Caribbean due to the combined effects of increasing urban populations and declining rural populations. Asia and Africa are on track to become majority urban regions from about 2020 and 2035 respectively, although, unlike all other regions except Oceania, Africa's rural population is expected grow to at least the middle of this century (Chart 8).





**Chart 8: Urban and rural population (millions) by major region, 1950–2050**



Source: UN Department of Economic and Social Affairs, *World Urbanization Prospects, the 2011 Revision* (2011)  
<[http://esa.un.org/unup/Analytical-Figures/Fig\\_6.htm](http://esa.un.org/unup/Analytical-Figures/Fig_6.htm)>

The impact on children of this powerful trend to greater urbanisation cannot be easily summarised. Urban areas contain a mix of positive and negative forces, and their impact on children is complex. As Günter Fink and Kenneth Hill have noted,

In many respects, urban settlements in developing countries today seem comparable to European cities in the late 19th and early 20th century, with a majority of urban settlements struggling with overcrowding, poor hygiene standards, violence, and frequent infectious disease outbreaks, all of which suggest that child mortality will not necessarily be lower than in rural areas. On the other hand, cities offer transport, infrastructure and access to knowledge and technology, all of which are likely to be highly beneficial to children.<sup>19</sup>

Similarly, Joanne Katz has observed,

How urbanisation might affect the nutritional status of children is not clear. Migration to urban areas could improve access to food and health services, but this might depend on wealth and other inequalities in urban areas. Additionally, the quantity and quality of food is likely to be different in rural and urban areas.<sup>20</sup>

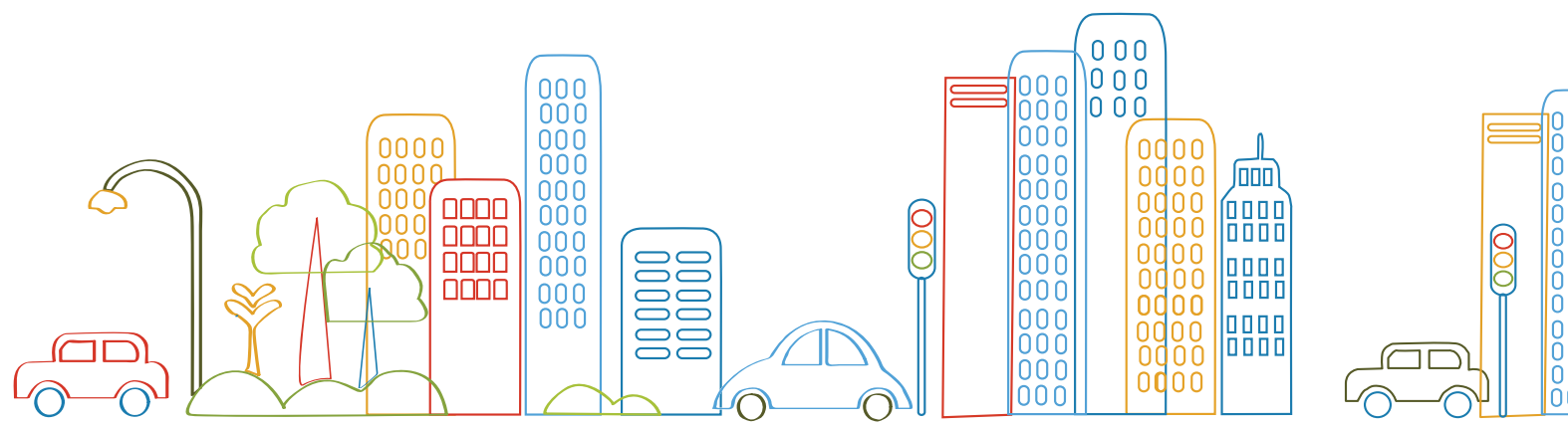


And Sheridan Bartlett has commented,

We are used to thinking of urban children as being better off than rural children in every way – better fed, better educated, with better access to health care and a better chance of succeeding in life. For many children, this is true. But for growing numbers, the so called ‘urban advantage’ is a myth. ... When [the] invisible citizens [on the periphery of cities] are counted, and when the true cost of living and the multi-dimensional nature of poverty are factored into the equation, the numbers of people in urban poverty begin to go way up. UN Habitat estimates, for example, that one in six people in the world live in deprivation in urban slums and squatter settlements. Given the demographics of poor countries and communities, with their relatively high numbers of children, it is not unrealistic to estimate that one out of every four children in the world is living in urban poverty.<sup>21</sup>

A range of data further complicates the picture of urbanisation and child well-being. The rapid and unplanned urbanisation occurring in Africa and South Asia has significant consequences for health arising from a variety of causes, including poor housing, air pollution, poor water and sanitation, and exposure to industrial waste.<sup>22</sup> However, extreme poverty is largely a rural rather than an urban phenomenon, with over 78 per cent of the poor living in rural areas, frequently working as smallholding farmers.<sup>23</sup> There is evidence that urban children, at least in some countries, perform better on basic nutrition and health measures and have better access to health care.<sup>24</sup> Urban children may also attend school more and do less work compared to children in rural areas.<sup>25</sup> And rural students may have lower levels of family socio-economic status, have more likely repeated a grade, and receive less home support for their school work, all of which, in the case of 14 sub-Saharan African school systems, contributed to national urban–rural literacy gaps greater than the gaps between countries.<sup>26</sup>

Under-5 child mortality highlights the complexity of urban environments and the difficulty in making generalisations across different urban contexts. Günter Fink and Kenneth Hill examined data for 37 low- and middle-income countries to cast some light on the impact of urbanisation on child mortality.<sup>27</sup> An important aspect of their study was that they separated the data into rural, small urban (<1 million) and major urban (>1 million), and looked at two time periods, 1991–2000 and 2001–2010. They found that under-5 mortality not only declined for all the classifications in both time periods but that the declines varied considerably not only between rural and urban areas but also across urban contexts. For the 37-country sample in the period 1991–2000, the under-5 mortality rate ranged from 138 in rural areas to 109 in small urban areas and 91 in large urban areas. For the period 2001–2010, mortality rates declined substantially in all classifications, to 92, 73 and 56 respectively. For both periods the gap between each of the classifications was very similar. For the first period it was 29 (small urban vs. rural) and 28 (small vs. large urban); for the second period it was 19 (small urban vs. rural) and 17 (small vs. large urban). Under-5 mortality in large urban areas declined relative to rural areas over the total period, from a ratio of 1.61 to 1.68. Fink and Hill concluded that, with the exception of some HIV-affected countries, ‘children in urban areas continue to fare substantially better in terms of child mortality than children in rural areas’ and despite the many challenges faced by modern metropolitan areas in developing countries, ‘children in large cities fare substantially better than children growing up in smaller urban areas’.



Patterns of child labour and school attendance also confirm that generalisations between rural and urban regions\* and across countries can be risky. In a study of Nepal, Peru and Zimbabwe, Lire Ersado found a complex mix of similarities and differences across regions and countries.<sup>29</sup> In all countries and regions, higher levels of parents' education and higher adult wages were important in reducing child labour and keeping children at school for longer. However, for a range of other factors, the evidence was less clear-cut. Mixed signals came from a number of important variables, including child labour market conditions (higher wages for children increased child labour in urban Peru and Zimbabwe but had no measurable effect in rural areas), poverty (significant in determining school and work participation rates in rural but not urban areas), access to credit (likely to be positive for school attendance in rural, but not urban, Nepal and Zimbabwe, and may actually increase child labour in Peru by assisting people to start their own businesses), and household domestic responsibilities of the mother (the more under-5 children and the more a mother works away from home, the greater the impact on child school and labour decisions in urban compared to rural areas).

So in answer to the question, Is rising urbanisation good for children? there is evidence that, for some basic elements of child well-being, urban environments may be more positive than rural areas. But for important aspects of child well-being, the data is limited and mixed and can vary across regions and countries. In the next section we look more closely at where the gaps in the data are, and we suggest how the picture of urban child well-being can be filled in a little more.

### **Box 1: Urban diets: Not simply more fats and calories<sup>28</sup>**

Taking the discussion down to the level of the impact of rising urbanisation on child well-being quickly runs into data problems and frequently requires careful analysis. To take one example, the impact of urbanisation on the diets and nutritional intakes of children is often characterised simply as an increase in calories, fats and processed foods. But a study of Pakistani Punjabi school children aged between 10 and 12 years, plus two groups of English-born Indian and Pakistani Punjabi children with varying degrees of urbanisation and a control group of British Caucasian children (who had the highest urbanisation ranking) found that the urban Pakistani children had the poorest diets. While all groups had inadequate intakes of iron, zinc, folates and vitamin A, the urbanised Pakistani children had low intakes of pyridoxine, vitamin B12 and vitamin C (something they shared with the least urbanised children). They also had low intakes of thiamine, total carbohydrate and fibre. The English-born children had diets that were often deficient in vitamin E, while the British Caucasian children had the highest level of excess fat intake. Overall, the authors concluded that, at least in terms of micronutrient density, 'diets of various urban groups could have more differences than similarities'.

\* The definition of urban and rural also matters. A study of child labour in Nepal found that the impact of an urban area extended out by as much as five hours of travel time. Marcel Fafchamps and Jackline Wahba, 'Child Labor, Urban Proximity and Household Composition' IZA Discussion Paper No. 1966 (2006) p. 29. <[http://www.iza.org/en/webcontent/publications/papers/viewAbstract?dp\\_id=1966](http://www.iza.org/en/webcontent/publications/papers/viewAbstract?dp_id=1966)>





### 3. Identifying the gaps in the urban data

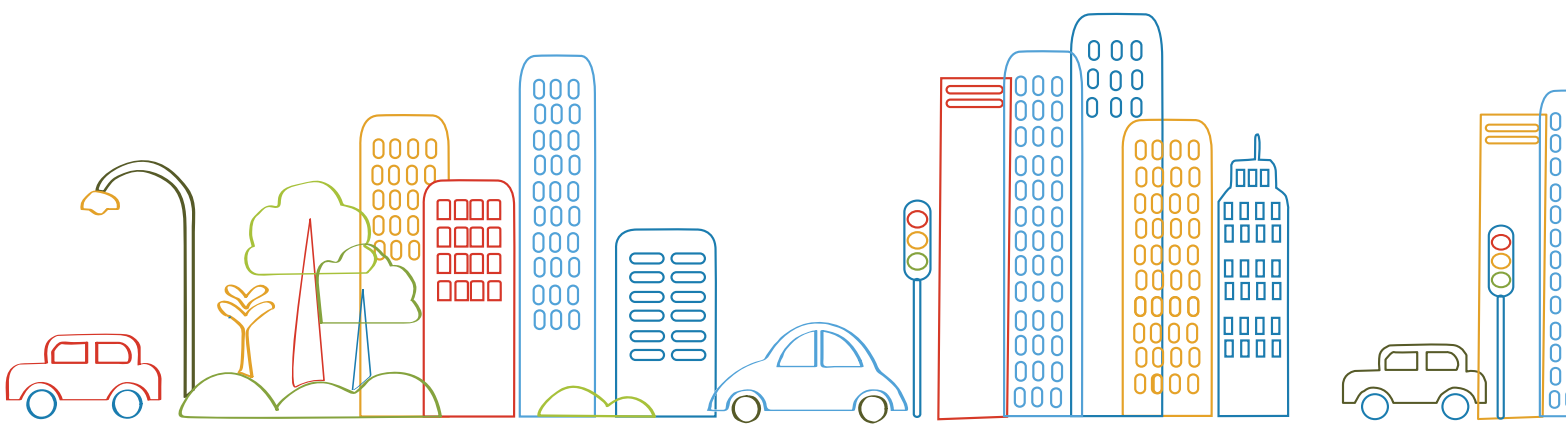
The data on aspects of child well-being in developing countries is vast and collected by numerous agencies. Gaining some idea of the extent of gaps in the data on urban child well-being is a substantial task. Two main issues arise: what indicators should be emphasised to develop a comprehensive picture of urban child well-being, and how adequate is the data on these indicators? To shed some light on these questions, in this section we do two things. First we examine a range of quantitative indicators that World Vision uses to assess the well-being of children in their programmes, and we look at the availability of the data for these indicators at a national and urban level for a sample of nine countries. We then consider a range of qualitative indicators that contribute to a more comprehensive picture of the well-being of urban children.

World Vision's child well-being outcomes (CWBOs) are based on four main elements: health, education, expectations and values, and care and protection. The World Vision *Children's Well-Being Policy* sets out four aspirations that reflect both the range of factors that influence the well-being of children and the varying requirements of infants, children, and youth.

- Children enjoy good health.
- Children are educated for life.
- Children love God and their neighbours.
- Children are cared for, protected and participating.

As with many other organisations, good health and education are cornerstones of World Vision's concept of child well-being. Health and education outcomes are influenced by a range of factors, including the state of food security, the availability of health facilities and trained medical personnel, and the physical presence of schools and adequately trained teachers. There are no mandated indicators for these outcomes, but World Vision's field experience has led to a group of indicators being highly recommended because they are sufficiently broad to encapsulate the essence of the particular aspiration and because they are applicable to a variety of contexts. There is also a range of optional indicators to provide supplementary information about progress towards achieving the CWBOs. While individual programmes do not require collection of data on all four outcomes, a thorough assessment of the overall well-being of children in a community would require information on each. Key quantitative indicators include:

- stunting, underweight and wasting in children under 5
- vaccination of children
- management of diarrhoea and pneumonia in children under 5
- access of children under 5 to a long-lasting insecticide-treated net (LLIN)
- use of HIV testing and counselling of pregnant women
- availability of skilled birth attendants
- ability of parents or caregivers to pay for their children's health costs



- children’s functional literacy rates
- children’s access to food
- children and youth who have birth certificates/registration documents.

Taking these indicators as a reasonable list of important components of overall child well-being, how well are they covered by data from external sources, and is the available data capable of shedding light on the well-being of children in urban areas? The availability of data for the indicators was assessed for the nine countries where World Vision has urban pilot programmes or learning centres. These countries provide a good cross-section of the developing world. They include low- and middle-income countries from Africa, Asia and the Middle East, with varying degrees of urbanisation. Some key characteristics are set out in Tables 1 and 2.

**Table 1: World Vision urban pilot projects and learning sites: country indicators**

Country	Multidimensional Poverty <sup>1</sup>		Population below US\$1.25 a day <sup>2</sup>	GHI <sup>3</sup>
	Population in multidimensional poverty (%)	No. ('000)	% (latest data)	% change 1990–2013/ ranking in 2013
Bangladesh	57.8	83,207	43.3 (2010)	52.9/58
Bolivia	20.5	1,972	15.6 (2008)	37.6/26
Brazil	2.7	5,075	6.1 (2009)	42.5/*
Cambodia	45.9	6,415	18.6 (2009)	47.8/47
India	53.7	612,203	32.7 (2010)	15.9/63
Indonesia	20.8	48,352	16.2 (2011)	48.7/23
Kenya	47.8	18,863	43.4 (2005)	15.9/51
Lebanon	n.a.	n.a.	n.a.	*
South Africa	13.4	6609	13.8 (2009)	25.0/4

Sources: 1. Oxford Poverty and Human Development Initiative ‘MPI Data Tables for 2013’ (2013)  
<<http://www.ophi.org.uk/multidimensional-poverty-index/mpi-data-bank/mpi-data/>>

2. World Bank, ‘Poverty headcount ratio at \$1.25 a day (PPP) (% of population)’  
<<http://data.worldbank.org/indicator/SI.POV.DDAY>>

3. International Food Policy Research Institute, ‘Global, Regional, and National Trends’ (2013)  
<<http://www.ifpri.org/ghi/2013/global-regional-national-trends>>

\*No ranking because GHI less than five.



**Table 2: World Vision Urban Pilot Projects and Learning Sites**

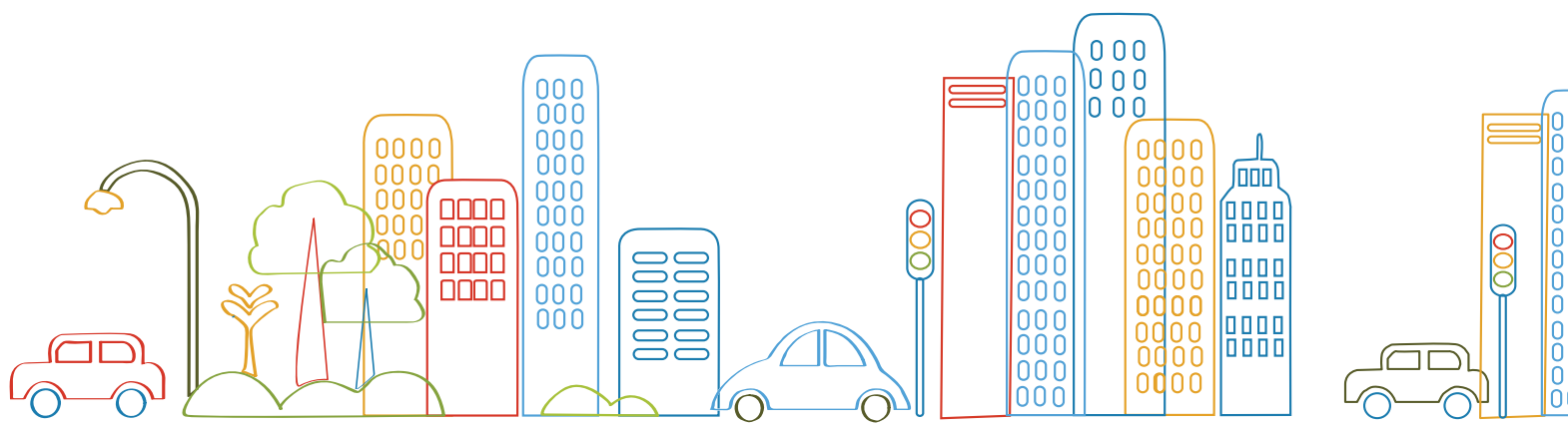
City	Population		Land Area	Density
	million	% slum dwellers in urban population	km <sup>2</sup>	persons per km <sup>2</sup>
Bangladesh – Dhaka (learning site)	14.4	70.8	324	44,500
Bolivia – La Paz (pilot)	1.8	48.8	155	11,400
Brazil – Sao Paulo (learning site)	20.6	28.0	3,173	6,500
Cambodia – Phnom Penh (pilot)	1.7	78.9	166	10,200
India – Kanpur (pilot)	3.0	32.1 (all India)	192	15,900
India – Siliguri (pilot)	0.7		44	15,900
Indonesia – Surabaya (pilot)	4.7	23.0	673	7,000
Kenya – Nairobi (learning site)	4.5	54.8	557	8,000
Lebanon – Beirut (pilot)	2.0	53.1	673	3,000
South Africa – Johannesburg-East Rand (pilot)	7.4	28.7	2,694	2,800

Sources: All except slum dwellers, Demographia, *Demographia World Urban Areas* 9th ed. (March 2013) <<http://demographia.com/db-worldua.pdf>>  
Slum dwellers: UN-HABITAT, ‘UrbanInfo’ <<http://www.devinfo.info/urbaninfo/>>

Table 3 summarises the availability of data for a range of quantitative indicators based on the World Vision CWBOs.



Children play on the streets. Dhaka, Bangladesh.



**Table 3: Child well-being indicators – assessment of data availability**

Main Indicator	Country																	
	Bangladesh		Bolivia		Brazil		Cambodia		India		Indonesia		Kenya		Lebanon		South Africa	
	Nat	Urban	Nat	Urban	Nat	Urban	Nat	Urban	Nat	Urban	Nat	Urban	Nat	Urban	Nat	Urban	Nat	Urban
Stunting	✓	✓	✓	✓	✓	?	✓	✓	✓	✓	✓	✓	✓	✓	?	?	✓	?
Underweight	✓	✓	✓	✓	?	?	✓	✓	?	?	✓	✓	✓	✓	✓	?	?	?
Wasting	✓	✓	✓	✓	?	?	✓	✓	?	?	✓	✓	✓	✓	?	?	?	?
Vaccination	✓	✓	✓	✗	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	?
Diarrhoea management	✓	✓	✓	✓	✗	✗	✓	✗	✓	✓	✓	✓	✓	✓	✓	✗	✓	?
Pneumonia management	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✗	✓	✓	✓	✗	✓	✗
Treated bed nets	✓	✗	✗	✗	✗	✗	✓	✗	✗	✗	✓	✗	✓	✗	..	..	✗	✗
HIV testing during pregnancy	✓	✗	✓	✗	✓	✗	✓	✗	✓	✗	✓	✗	✓	✗	✓	✗	✓	✗
Skilled birth attendant present	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	?	✗	?	?
Ability to pay childrens' health costs	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Child literacy	✓	✗	✓	✗	✓	✗	✓	✗	✓	✗	✓	✗	✓	✗	✓	✗	✓	✗
Birth registration/certificate	✓	✓	✗	✗	✓	✗	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗
Food availability	✓	✗	✓	✗	✓	✗	✓	✗	✓	✗	✓	✗	✓	✗	✗	✗	✓	✗

Notes:

Sources: See Appendix 2.

- ✓ Readily available data from one or more major statistical agencies
- ? Infrequent and/or old data
- ✗ Very infrequent and/or old data, not available or could not be located from public sources
- .. Not applicable

Several points are apparent from Table 3. Key indicators of children’s physical well-being – particularly stunting, underweight, wasting and vaccination – and (later) cognitive well-being are well covered at both the national and urban levels. Data on the management of diarrhoea and pneumonia – two major causes of death among children – is also comprehensive, as is data on presence of skilled birth attendants. However, data on the urban dimension of some important aspects of child well-being – for example, HIV testing of pregnant women, child literacy and food



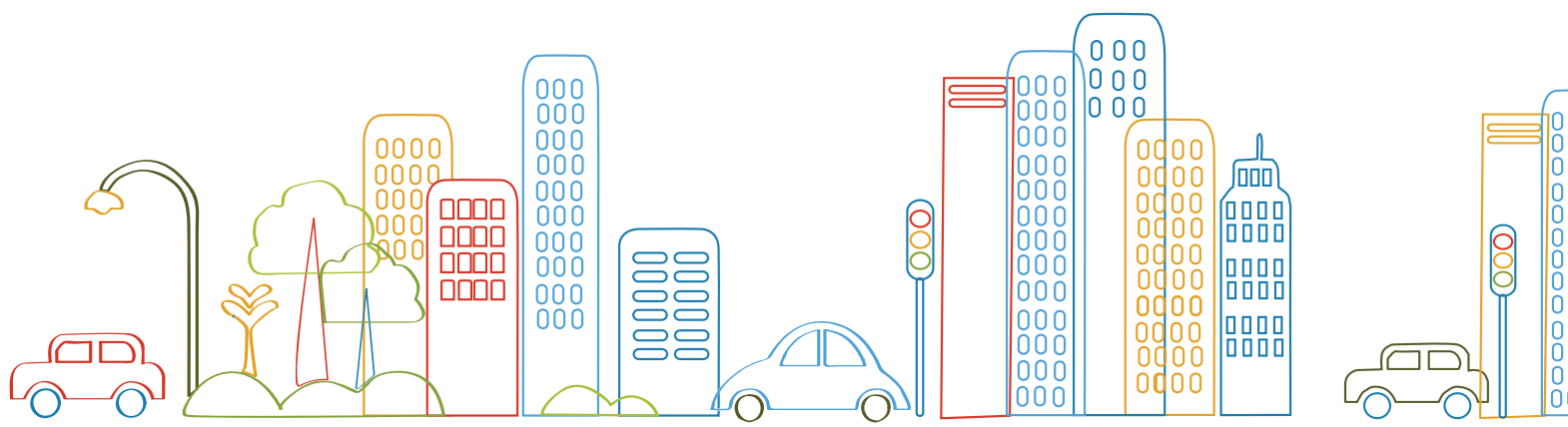


availability – is surprisingly poor given the large and growing urban populations. So too is the data on the ability of families to pay for children’s health costs. This is a significant gap in light of the importance of out-of-pocket health care spending in many developing countries. World Health Organization data shows that out-of-pocket spending was a significant proportion of private expenditure on health (in the range 73–97 per cent for all the countries in the table except Brazil [57.8 per cent] and South Africa [a very low 13.8 per cent]). Further, private spending on health care is often a significant proportion of total health expenditure. For eight of the nine countries in the table it was above 50 per cent. (Bolivia was the exception at 29.2 per cent.)<sup>30</sup> The data in Table 3 also indicates that the amount of information available is not necessarily closely aligned with a country’s wealth. The data available on Brazil and Lebanon, for example, is less comprehensive than the data for much poorer Bangladesh and Kenya. Whether this reflects lower levels of external assistance for data collection in middle-income countries and hence greater reliance on national statistical agencies is not clear. But there is a noticeable difference.

Reasons for data gaps take a variety of forms. Asad Elahi, Secretary of the Statistics Division of the Government of Pakistan, has listed a range of exogenous and endogenous challenges facing data collection in developing countries.<sup>31</sup> As well as general constraints (such as insufficient resources allocated to data collection) and lack of institutional capacity, urban areas have their own challenges, including large informal economies and the heterogeneity of living and social conditions. For time-series data, a commonly encountered problem is that the timing of surveys to collect data varies considerably both within and between countries. For example, in their study of rural and urban child mortality mentioned earlier, Fink and Hill cautioned that the country estimates for each of the decadal time periods examined used the available survey data for each country within each decade rather than being based on data at the beginning of the first decade and the end of the second. Further, the choice of the countries in the sample was dictated by data availability. While there was data for a good proportion of low- and middle-income countries, the results were not representative of the total of low- and middle-income countries.<sup>32</sup>

As well as gaps in the main quantitative indicators of child well-being, particularly at the urban level, there is a second type of gap. While much of the available data on the welfare of children understandably centres on health, nutrition and education, there are more comprehensive concepts of child well-being that consider a range of other non-cognitive influences. These additional indicators typically attempt to capture more qualitative social skills. Inclusion of indicators of psycho-social development reflects current awareness of the importance of non-cognitive skills.

Empirical evidence supports the idea that there are returns to non-cognitive skills (or psychosocial competencies) in the labour market: they offer better job opportunities and incomes. First, aspects such as attitude, communication skills, motivation and ‘personality’ are high on lists of the characteristics sought by employers (Bowles et al. 2001). Second, contemporaneous, self-reported, measures of self-esteem, self-efficacy, future-orientedness and the like are found to explain a substantial portion of the variation across earnings of otherwise similar individuals (Bowles et al. 2001; Cunha et al. 2006). Third, measures of noncognitive skills observed during the childhood period – built using components from a behavioural problem index (antisocial behaviour, anxiety, depression and hyperactivity tests) – are found to predict education and labour market outcomes.<sup>33</sup>



The number of variables used in different measures can be large. For instance, the Australian government’s *Key National Indicators of Child Health, Development and Well-being* framework collects data on 56 indicators grouped under seven headings – health, healthy development, learning and development, risk factors, families and communities, safety and security, and system performance.<sup>34</sup>

World Vision’s approach to child well-being also goes beyond health, nutrition and education to recognise broader psycho-social development. This includes cognitive, social and spiritual dimensions; the nature of the relationships between women, men, girls and boys that influence children’s well-being in their immediate environment; and the wider social environment that influences children’s experience of safety, social justice and participation in civil society. To collect data on these aspects of psycho-social development, World Vision has used the SEARCH Institute’s *Developmental Assets Profile (DAP)* survey. The 40-question DAP can be completed in 10 minutes by those with a 6th-grade reading level. It collects information on young people’s reported experience of eight categories of developmental assets – support, empowerment, boundaries and expectations, constructive use of time, commitment to learning, positive values, social competencies and positive identity. The SEARCH Institute has estimated that some 600,000 young people aged between 8 and 18 have taken the survey since 2005. The use of readily available surveys such as the DAP highlights how NGOs can contribute to the development of a large database of indicators capable of extending the concept of child well-being.



Slum dwellers living in dangerous areas. Dhaka, Bangladesh.



## 4. Urban child well-being: the need for a more complete picture

So far we have argued that the impact on urban children of two decades of rapid urbanisation and strong economic growth in a significant number of low- and middle-income countries has been difficult to gauge. Part of the reason for this is gaps in the data on key indicators of child well-being. Even where there is national data, there can still be a problem of composition: what may be true for a country's children as a whole may not be true for urban children. And even where there is urban data, the extent of inequality in many large cities may mean that the data does not adequately describe the situation of the most impoverished urban children.

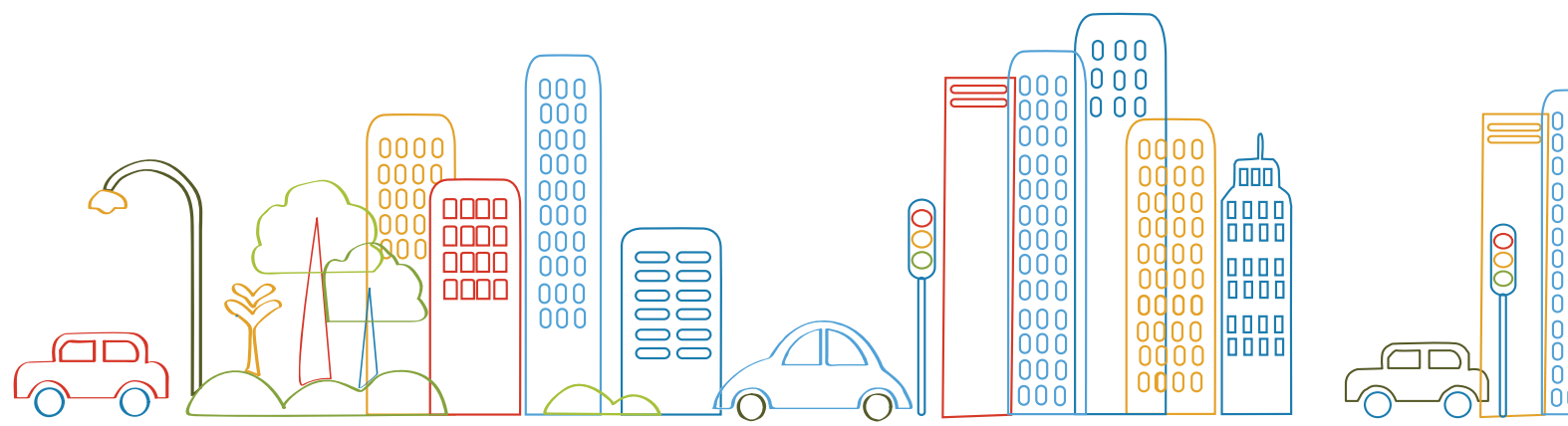
Equally importantly, because much of the available data focuses on a small number of child well-being characteristics, it is likely to give too narrow a view of how urban environments affect children. Broadening the range of indicators to include more psycho-social variables will help. But urban child well-being needs to also explicitly include distinctive features of urban environments that affect the health, welfare and happiness of children. As these may vary from city to city, the detailed knowledge of specific urban contexts acquired by NGOs is valuable. This knowledge is typically acquired through the NGOs' own work on the ground, and through working with local partners who have a deep understanding of their own environment. In particular, careful evaluation by NGOs of their urban programming can increase understanding of complex urban environments, help clarify the mix of changes needed in particular situations to permanently improve child well-being and highlight the differences as well as the similarities between the components of urban and rural child well-being. This section considers some examples of how World Vision and others have uncovered influences on child well-being that either are distinctly urban in character or have taken on added significance in urban environments.

### Insecure land tenure in Cambodia

Urban and rural contexts share many of the determinants – positive and negative – of child well-being, but urban environments can add additional complexity. This was evident in World Vision's land tenure pilot project in Phnom Penh. Although Cambodia's 2001 land law provides a legal basis for land management, the procedures required for land titling and registration have excluded the most vulnerable communities from achieving secure land tenure. Exacerbating the problem, strong demand for land in Phnom Penh and widespread corruption have resulted in large numbers of residents, typically from poor and marginalised communities, being evicted and resettled in designated areas on the fringes of the city. NGOs estimate that up to 100,000 people have faced forced eviction in Cambodia since 2001. Working with other civil society organisations, World Vision facilitated local-level advocacy initiatives and meetings between vulnerable communities and various levels of government to improve security of land tenure and expand community services.

Insecure land tenure and forced eviction negatively affected child well-being in a number of ways. Relocation reduced family incomes by moving people away from livelihoods based around the more densely populated commercial centre of Phnom Penh. Relocated people then faced the choice of either commuting back to the city, often requiring lengthy and expensive travel, accepting often more poorly paid work closer to home, or unemployment. All these options have ongoing adverse effects on family life.

Children in resettled families also suffered from poorer education options. Reduced incomes made payment of state school fees more difficult, and there was widespread concern about the standard of education in the new



areas. Residents in resettlement areas reported larger class sizes in local schools or even an absence of schools, and a 2013 review of World Vision’s land tenure project found that a common concern in communities that had not been evicted was the lack of educational facilities in resettlement areas, and the possibility that children would no longer be able to attend school. Similar concerns have also been expressed about health care in resettlement areas – longer travel times and fewer facilities compared to the range of free or heavily subsidised health services (often provided by NGOs) in the city. For relocated families with members suffering from HIV and AIDS, all these pressures are intensified significantly. An important lesson from this programme has been that access to some of the essential basic facilities that underpin better child well-being outcomes in cities can be quickly disrupted when land tenure lacks a firm basis.

### New urban threats in Nairobi and beyond

In rural contexts, the concept of cared for, protected and participating typically invokes a caring family environment, protection from adverse health events, and participation in education and community life. All these are also valid in an urban environment, but city life introduces additional elements which, if ignored, may seriously distort understanding of the true situation of children in particular places. The physical environment of cities can create new, or exacerbate existing, pressures on the well-being of children. Proximity of people to vehicles (Box 2) or too much water (Box 3) are two examples; contact with waste is a third.

#### Box 2: Children and cars: too often a deadly mix

What can be positive in a simpler rural context can have a quite different impact on the welfare of children in more complex urban environments.<sup>35</sup> Motor vehicles are a good example. Kevin Watkins and Devri Sridhar have noted, ‘Data from low-income countries consistently demonstrates that communities living furthest from roads experience higher levels of poverty, lower levels of school attendance and worse health outcomes.’ But as they make clear, closer proximity to roads brings with it the major hazard of road traffic injury and death. Of the approximately 1.3 million road deaths globally each year, 90 per cent occur in low-income countries. Equally startling, in developing countries road traffic fatalities are the main cause of death of 15- to 19-year-olds and the second largest cause of death for 5- to 14-year-olds, and for each death up to 50 people are injured or disabled. Worse still, the World Bank has forecast that fatalities in low-income countries by 2020 will be 80 per cent above the levels of 2000, and road fatality is expected to be the major cause of health loss as measured in disability-adjusted life years for children 5–14 years of age. While these forecasts have been challenged,<sup>36</sup> there is little doubt that the poorest – those too poor to own cars – are disproportionately affected. ‘In the poorest countries, typically around half of those who die in road traffic crashes are pedestrians, cyclists, or users of two-wheel vehicles.’<sup>37</sup> Road traffic injury also interacts with a range of other elements of child well-being. For example, physical injury and disability, post-traumatic stress and the psycho-social impact on a child from the loss of a parent in a road traffic fatality all adversely affect learning. And the impact on family finances of the death or injury of a parent can be devastating for the health and nutrition of children.<sup>38</sup> While virtually all children are exposed to risks from motor vehicles, the greater concentration of both in urban areas make injury and death from traffic accidents a particular problem for urban children.





World Vision's work in the slums of Nairobi shows how cities can be a source of hazards not encountered by rural children. The aggregate statistics show clearly that urban children have a significantly better chance of survival than children in rural areas. But lower under-5 mortality does not necessarily mean a safe environment. A value-chain analysis of World Vision's waste management project in the Kariobangi and Korogocho slums, located near the vast Dandora rubbish dump 15 kilometres from the centre of Nairobi, highlighted a range of dangers facing the poorest urban children, dangers that rural children never encounter.

Whether trying to earn a meagre income by collecting used plastic bags or stripping a few ounces of copper, aluminium, brass, and zinc from worn-out electronics or just trying to avoid overflowing piles of rubbish, children living in the Kariobangi and Korogocho slums regularly come into contact with heaps of solid and liquid waste. It is common to see children and women sorting waste in the Nairobi and Mathare rivers barefoot, youths rummaging through heaps of decomposing rubbish with their bare hands, and children playing in open sewers containing human, medical and other toxic waste. All these practices expose community members to a range of diseases and poisoning from a variety of toxic materials including dioxins, polychlorinated biphenyls, cadmium, mercury and lead.

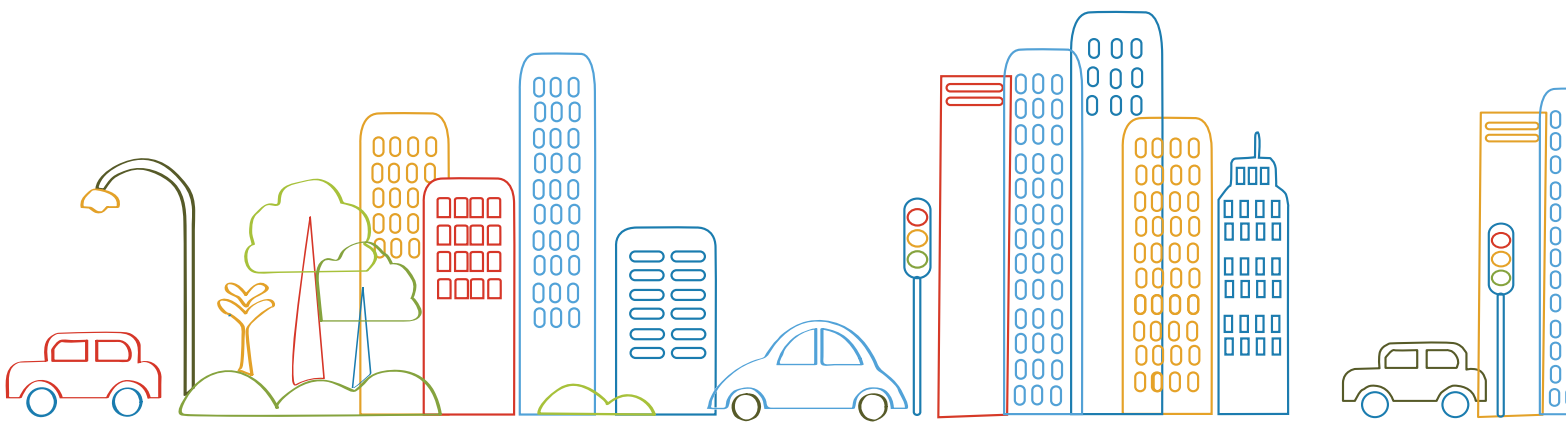
The huge amounts of waste going to Dandora and surrounding areas each year provide genuine income-generating opportunities through recycling and reuse. World Vision Kenya's Kariobangi Waste Management Project is an initiative involving 261 people in 13 self-help groups organised into the Kariobangi Waste

### **Box 3: A changing climate increases urban flooding and drownings**

The interaction of increasing urbanisation and climate change shows how drowning, an age-old source of mortality, can become an increasing threat to child well-being. Drowning is already a major source of child deaths. For example, it is the major cause of deaths among children and adolescents in Thailand, and the second largest cause after road accidents in Vietnam.<sup>39</sup> Although drowning rates are higher among rural children, UNICEF has argued that drowning is still a major risk factor for urban children:

The need for convenient water sources for daily life means that drowning hazards are prevalent throughout urban environments. Where running water is available indoors, bathtubs, buckets and water storage containers place young children at risk, especially when their caretaker is an older sibling and not an adult. Where running water is not available, families are forced to store large volumes of water to meet their daily needs, and these storage containers become drowning hazards for very young children. Outside the home, urban children are at risk from the many drains, ditches, construction sites and other water hazards that are ubiquitous in the environment.<sup>40</sup>

Urbanisation further intensifies the problem of child drowning because flood risks are heightened through increased water runoff and the prevalence of impervious materials in urban environments. Climate change exacerbates these risks through a range of factors including sea level rise and more frequent extreme rainfall episodes. Children living in cities built around rivers, such as in Bangkok, or in dense coastal cities, such as those in South Asia, are particularly affected.



Management Alliance. The Alliance works to improve the returns from waste management while reducing the hazards. But the constant threat to children from exposure to dangerous waste also requires action from local and national governments to reduce the stark inequality of access to sanitation and rubbish removal services that exists in many large urban areas.

### Different cities, different threats to child well-being

The history and geographical location of cities, even in the same country, can have important implications for the well-being of poor and marginalised children. This is evident from two programmes World Vision has run in the northern Indian cities of Kanpur and Siliguri. Kanpur is a medium-sized city of about 6.5 million people in the state of Uttar Pradesh. Its long history of manufacturing, specialising in leather and textile goods, earned it the name of ‘Manchester of India’. As in



Waste pickers. Phnom Penh, Cambodia.

Manchester, Kanpur’s industry has caused environmental damage and social inequity. In recent decades, industrial output has declined and economic activity has diversified into the tertiary sector, particularly banking, information technology and higher education.

Siliguri is a rapidly growing city of around one million, located close to the borders of Nepal (80 km) and Bangladesh (10 km). Its position means it is a rail and road transit point from mainland India to China, Bhutan and neighbouring Southeast Asian countries. Its population growth has been fuelled by the migration of people from elsewhere in India plus countries in the region, particularly Nepal and Bangladesh. Unlike Kanpur, Siliguri has had little manufacturing industry. Rather, it is a bustling commercial city with many informal, as well as relatively established, slum settlements.

Common to both cities is the problem of child protection, but their different backgrounds mean that it takes quite different forms. With an estimated 450 slums in Kanpur, a significant proportion of the city’s population is poor and vulnerable. One outcome of this is the prevalence of child labour. In the short term, this puts children at risk of a variety of hazards: physical harm from exposure to chemicals, disease, waste and machinery; emotional harm from employers or customers – particularly prevalent in domestic work; and sexual abuse, again prevalent in domestic work. In the long term, employment without schooling or alternative vocational training also places



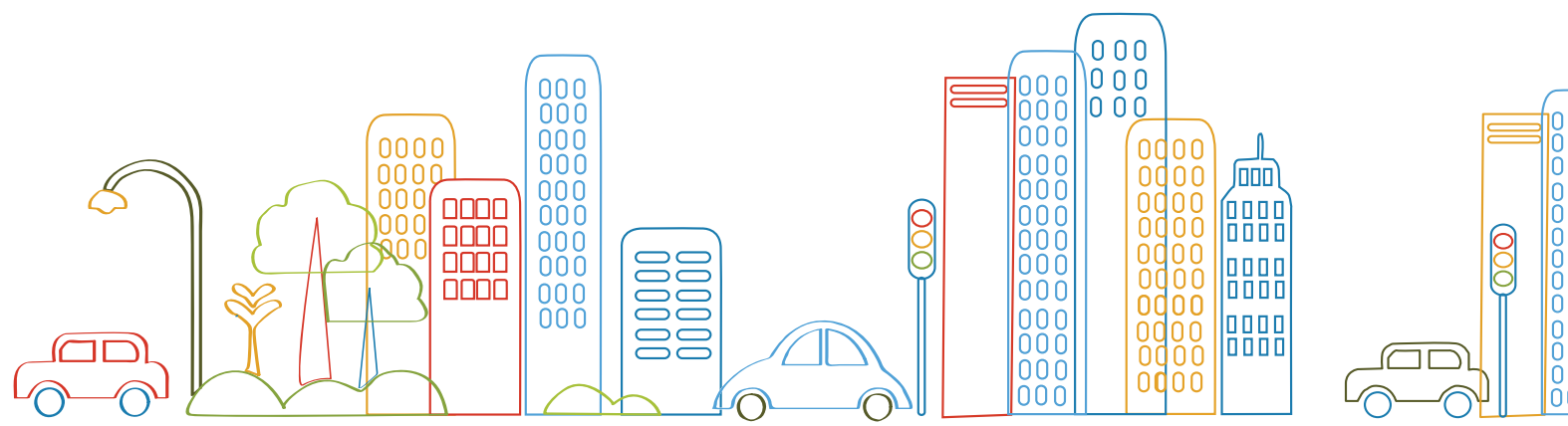
children in highly vulnerable situations, without vital social skills, literacy and numeracy, and the vocational training required for modern forms of work.

While child labour is also present in Siliguri, the city's location has meant that child trafficking has become a greater problem. Siliguri's status as a rapidly growing city, with numerous transit options, emerging slums, inadequate infrastructure and proximity to Nepal, Bangladesh and India's north-east region, means it operates as a hub for many forms of trade – including child trafficking.

The broad issue of child protection is a common thread linking the two cities, and World Vision's responses to child labour in Kanpur and child trafficking in Siliguri share some common features. Both projects use various types of community engagement, including children's clubs, protection units, women's self-help groups, informal education, support for local schools and awareness campaigns. But in Kanpur, World Vision has worked to increase school attendance rather than end all child labour. Most of the children World Vision worked with in Kanpur continued to be employed, which meant that some continued to be exposed to the hazards of working. But increased school attendance opens the possibility of more productive and higher-paid work in adulthood. By contrast, World Vision's role in addressing child trafficking in Siliguri has focused on working with other partners through the Anti-trafficking Network (ATN) and negotiating with the authorities. World Vision's access to key government actors allowed it to be a strategic lever, connecting the ATN to government, industry and the broader public. World Vision's work to improve child safety in these two cities has emphasised the importance of understanding the characteristics of each place in order to both understand the distinctive pressures on child well-being, and develop effective responses to them.



Kasur Kiln, bonded labour. India.





## Conclusion

Two decades of strong economic growth and continuing rapid urbanisation in many parts of the developing world have highlighted a fundamental question: Has the well-being of the most vulnerable children in urban contexts improved? Questions about improvements in the well-being of any group always have a counterfactual aspect. In the case of poor urban children this would be, What would their well-being have been in the absence of increased national incomes and more urbanisation? There is also the question, Compared to whom? One reasonable comparison is with poor rural children. In both cases there are some grounds to believe that urban children may be better off.

The fact is that these questions cannot be answered with any confidence. Nor can more fundamental questions about changes in some key aspects of child well-being over time, or changes in more qualitative aspects of general well-being, or well-being as it relates to living in cities of various sizes. Improving our ability to better answer these questions will be the product of a range of actions. Some will involve better (more frequent, representative and timely) collections of data on essential basic indicators of health, nutrition and education. Some will involve expansion of the concept of child well-being to include more psycho-social dimensions. And some will be to develop indicators more precisely tailored to particular urban contexts so that the impacts of evolving threats and benefits of urban environments are included in both our understanding of how the well-being of urban children is changing over time and of the most effective programming and advocacy to maximise the benefits to children of living in cities, while minimising the costs. Development NGOs, being on the ground and close to communities for extended periods of time, are well placed to contribute to this task.





## Appendix I: Main indicators for World Vision's child well-being outcomes

### *Aspiration 1: Children enjoy good health*

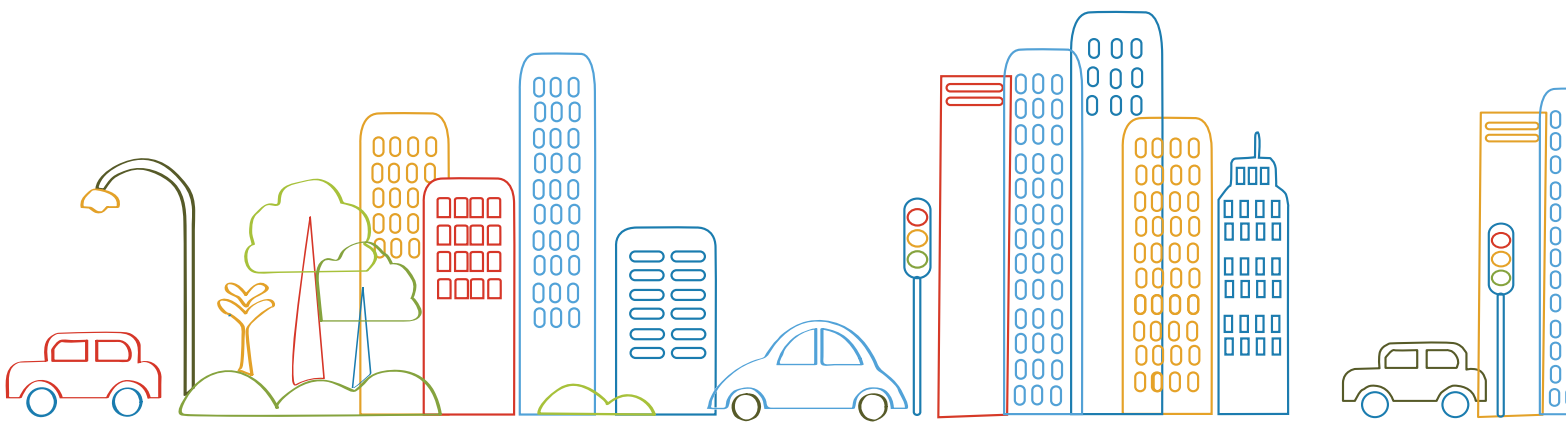
- Prevalence of stunting in children under 5 years of age
- Prevalence of underweight in children under 5 years of age
- Prevalence of wasting in children under 5 years of age
- Coverage of essential vaccines among children
- Proportion of children under 5 with diarrhoea who received correct management of diarrhoea
- Proportion of children under 5 with presumed pneumonia who were taken to an appropriate health provider
- Proportion of households where all children under 5 years slept under a long-lasting insecticide-treated net (LLIN) the previous night
- Proportion of women who were offered and accepted counselling and testing for HIV during most recent pregnancy, and received their test results
- Proportion of infants whose births were attended by a skilled birth attendant
- Proportion of parents or caregivers who are able to pay for their children's health costs without assistance

### *Aspiration 2: Children are educated for life*

- Proportion of children who are functionally literate
- The strengths of the assets and the contexts in which youth live, learn and work as reported by youth 12–18 years of age
- Proportion of youth who have a learning opportunity that leads to a productive life

### *Aspiration 3: Children love God and their neighbours*

- The strength of the *support* asset category as reported by youth 12–18 years of age
- Proportion of youth who have a strong connection with their caregiver
- The strength of the *positive values* asset category as reported by youth 12–18 years of age
- The strength of the *positive identity* asset category as reported by youth 12–18 years of age
- Proportion of youth who rank themselves as thriving on the ladder of life



*Aspiration 4: Children are cared for, protected and participating*

- The strengths of the assets and the contexts in which youth live, learn and work as reported by youth 12–18 years of age
- Proportion of youth who have a strong connection with their caregivers
- Proportion of youth who rank themselves as thriving on the ladder of life
- Proportion of youth with insufficient access to food
- Proportion of parents or caregivers able to provide well for their children
- Proportion of youth (12–18 years of age) who report having birth registration documents
- Proportion of children (aged 0–59 months) with a birth certificate
- The strength of the empowerment asset category as reported by youth 12–18 years of age



## Appendix 2: Sources for data in Table 3

**Stunting:** All except Lebanon: UN Demographic and Health Surveys (DHS), <<http://data.un.org/Data.aspx?d=SOWC&f=inID:106>>; Lebanon: WHO Global Database on Child Growth and Malnutrition; Urban data from WHO Global Database on Child Growth and Malnutrition.

**Underweight:** WHO Global Database on Child Growth and Malnutrition or World Bank. Lebanon: CIA Factbook.

**Wasting:** WHO Global Database on Child Growth and Malnutrition or World Bank.

**Vaccination** for diphtheria, pertussis (whooping cough) and tetanus: World Bank, <<http://data.worldbank.org/indicator/SH.L.MM.IDPT?page=4>>; Bolivia urban (measles only): Urban Health Profile 2003, <[http://www.who.int/kobe\\_centre/measuring/urbanheart/bolivia\\_plurinational\\_state\\_of.pdf](http://www.who.int/kobe_centre/measuring/urbanheart/bolivia_plurinational_state_of.pdf)>; Cambodia urban: DHS 2010, p. 11; India total and urban: DHS 2005-06, p. 229; Indonesia urban: DHS 2012, p. 137; Kenya urban: DHS 2008-09, p. 131; South Africa urban: DHS 2003, p. 130.

**Diarrhoea management:** Bangladesh: DHS 2011, p. 152; Bolivia: DHS 2008, p. 185; Cambodia: total DHS 2010, p. 11; Indonesia: DHS 2012, p. 146; Kenya: DHS 2008-09, p. 136; Lebanon: <[http://www.unicef.org/infobycountry/lebanon\\_statistics.html](http://www.unicef.org/infobycountry/lebanon_statistics.html)>; South Africa total: <[http://www.unicef.org/infobycountry/southafrica\\_statistics.html](http://www.unicef.org/infobycountry/southafrica_statistics.html)>; South Africa urban DHS 2003, p. 136.

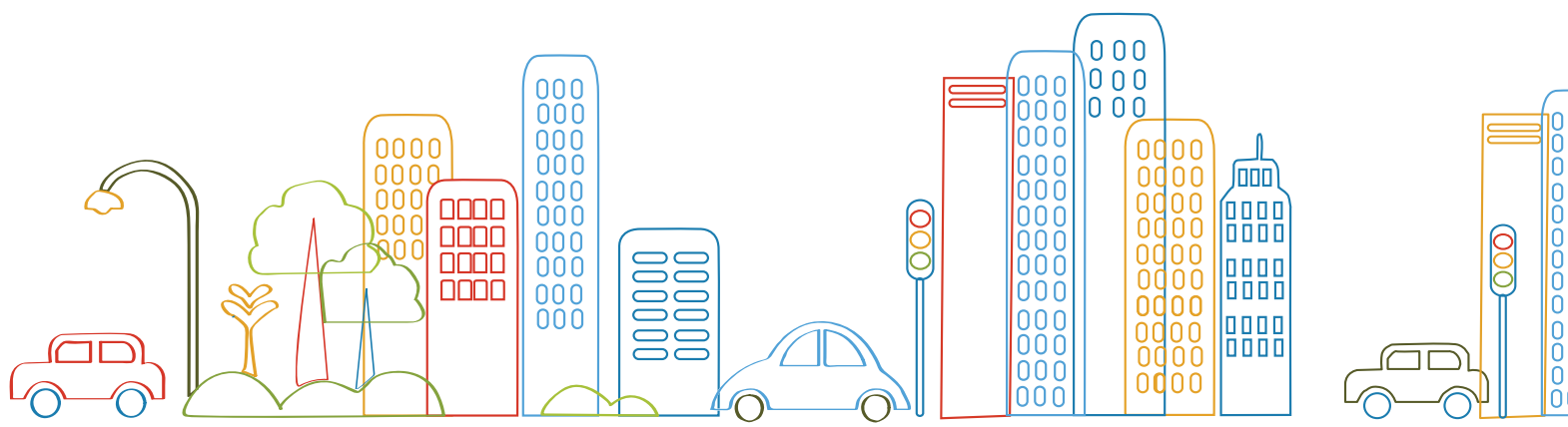
**Pneumonia management – national:** All countries except Bolivia: <[http://www.unicef.org/statistics/index\\_countrystats.html](http://www.unicef.org/statistics/index_countrystats.html)>; Bolivia national: <<http://www.countdown2015mnch.org/documents/2010/2010-Bolivia.pdf>>; urban, all countries except Indonesia, Lebanon and South Africa: <[http://www.childinfo.org/pneumonia\\_countrydataantibiotics.php](http://www.childinfo.org/pneumonia_countrydataantibiotics.php)>.

**Treated bed nets:** Bangladesh: <<http://apps.who.int/gho/data/node.main.A1370?lang=en>>; all other countries: <[http://www.unicef.org/statistics/index\\_countrystats.html](http://www.unicef.org/statistics/index_countrystats.html)>.

**HIV testing during pregnancy:** National data except Lebanon: WHO Global Health Observatory Data Repository: <<http://apps.who.int/gho/data/node.main.627?lang=en>>; Lebanon: <[http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/20131129\\_stocktaking\\_report\\_children\\_aids\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/20131129_stocktaking_report_children_aids_en.pdf)>.

**Skilled birth attendant present:** Bangladesh: DHS 2011, p. 123; Bolivia: <[http://www.childinfo.org/delivery\\_care\\_countrydata.php](http://www.childinfo.org/delivery_care_countrydata.php)>; Brazil: <[http://www.childinfo.org/delivery\\_care\\_countrydata.php](http://www.childinfo.org/delivery_care_countrydata.php)>; Cambodia: DHS 2008, p. 9; India: <[http://www.childinfo.org/delivery\\_care\\_countrydata.php](http://www.childinfo.org/delivery_care_countrydata.php)>; Indonesia: DHS 2012, p. 112; Kenya: DHS 2008-09, p. 114; Lebanon: <[http://www.childinfo.org/delivery\\_care\\_countrydata.php](http://www.childinfo.org/delivery_care_countrydata.php)>; South Africa DHS 2003, p. 121.

**Child literacy:** data for youth aged 15–24: <<http://stats.uis.unesco.org/unesco/TableViewer/tableView.aspx?ReportId=210>>.



**Birth registration/ certificate** children under 5 years DHS: Bangladesh DHS 2011 total and urban, p. 22; Brazil total: UNICEF, <[http://www.unicef.org/infobycountry/brazil\\_statistics.html](http://www.unicef.org/infobycountry/brazil_statistics.html)>; Cambodia total: UNICEF, <[http://www.unicef.org/infobycountry/cambodia\\_statistics.html](http://www.unicef.org/infobycountry/cambodia_statistics.html)>; India: DHS 2005–2006 total and urban, pp. 46–47; Indonesia: DHS 2012 total and urban, p. 20; Kenya: DHS 2008–09 total and urban, pp. 26–27; Lebanon: UNICEF, <[http://www.unicef.org/infobycountry/lebanon\\_statistics.html](http://www.unicef.org/infobycountry/lebanon_statistics.html)>; South Africa total: UNICEF, <[http://www.unicef.org/infobycountry/southafrica\\_statistics.html](http://www.unicef.org/infobycountry/southafrica_statistics.html)>.

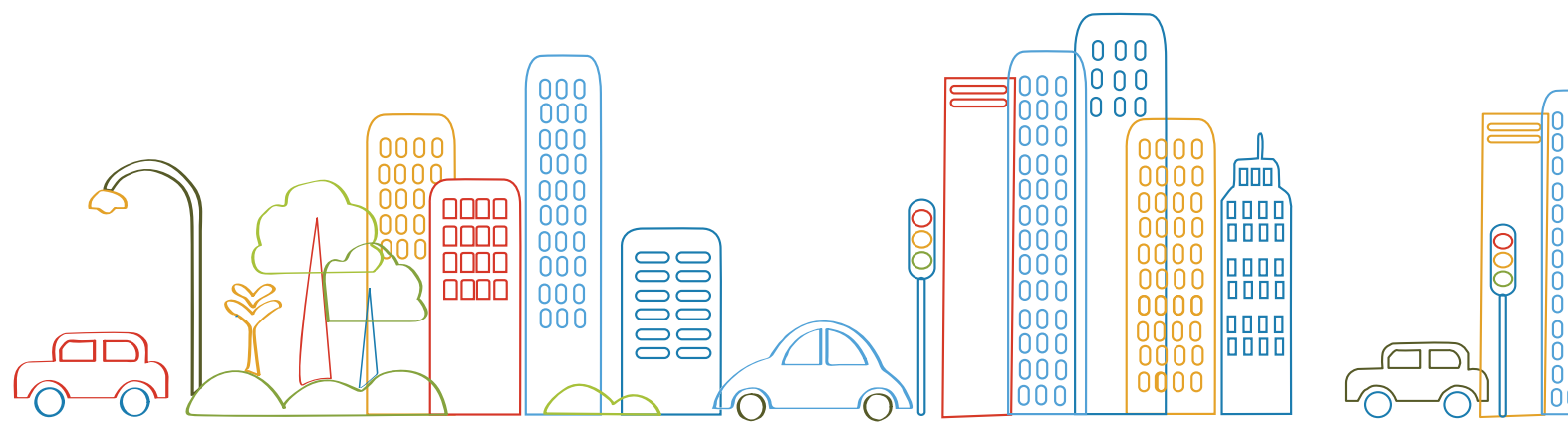
**Food availability:** National data Global Food Security Index, <<http://foodsecurityindex.eiu.com/Country>>.





## Endnotes

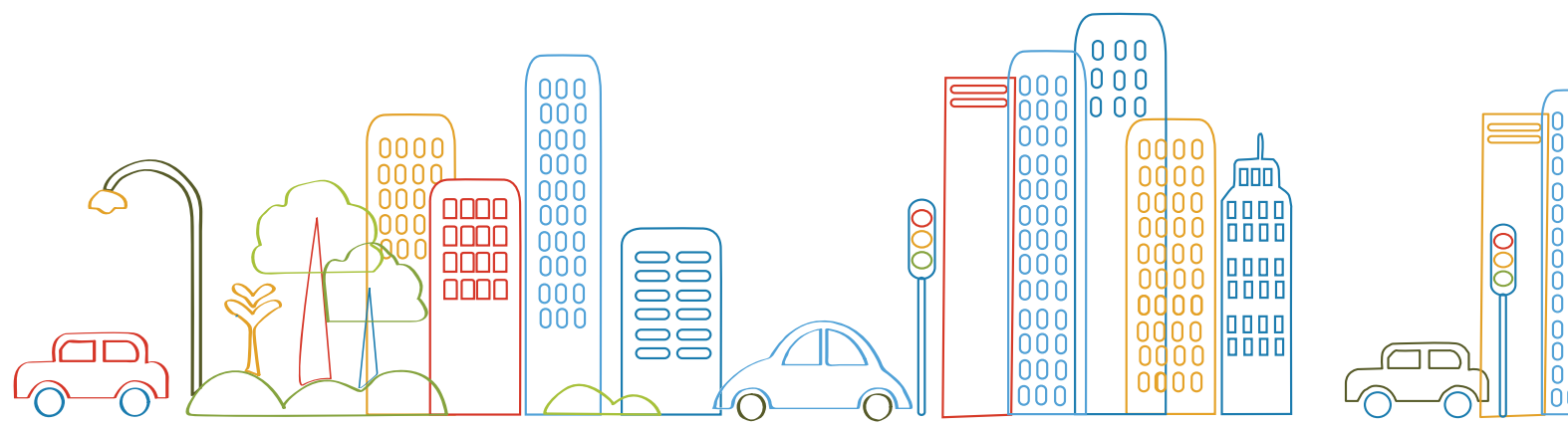
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