



Children's rights in urban settings

Children whose needs are greatest are also those who face the greatest violations of their rights. The most deprived and vulnerable are most often excluded from progress and most difficult to reach. They require particular attention not only in order to secure their entitlements, but also as a matter of ensuring the realization of everyone's rights.

Children living in urban poverty have the full range of civil, political, social, cultural and economic rights recognized by international human rights instruments. The most rapidly and widely ratified of these is the Convention on the Rights of the Child. The rights of every child include survival; development to the fullest; protection from abuse, exploitation and discrimination; and full participation in family, cultural and social life. The Convention protects these rights by detailing commitments with respect to health care, education, and legal, civil and social protection.

All children's rights are not realized equally. Over one third of children in urban areas worldwide go

unregistered at birth – and about half the children in the urban areas of sub-Saharan Africa and South Asia are unregistered. This is a violation of Article 7 of the Convention on the Rights of the Child. The invisibility that derives from the lack of a birth certificate or an official identity vastly increases children's vulnerability to exploitation of all kinds, from recruitment by armed groups to being forced into child marriage or hazardous work. Without a birth certificate, a child in conflict with the law may also be treated and punished as an adult by the judicial system.¹ Even those who avoid these perils may be unable to access vital services and opportunities – including education.

Obviously, registration alone is no guarantee of access to services or protection from abuse. But the obligations set out by the Convention on the Rights of the Child can be easily disregarded when whole settlements can be deemed non-existent and people can, in effect, be stripped of their citizenship for want of documentation.

An environment for fulfilling child rights

Inadequate living conditions are among the most pervasive violations of children's rights. The lack of decent and secure housing and such infrastructure as water and sanitation systems makes it so much more difficult for children to survive and thrive. Yet, the attention devoted to improving living conditions has not matched the scope and severity of the problem.

Evidence suggests that more children want for shelter and sanitation than are deprived of food, education and health care, and that the poor sanitation, lack of ventilation, overcrowding and inadequate natural light common in the homes of the urban poor are responsible for chronic ailments among their children.² Many children and families living in the urban slums of low-income countries are far from realizing the rights to "adequate shelter for all" and "sustainable human settlements development in an urbanizing world" enshrined in the Istanbul Declaration on Human Settlements, or Habitat Agenda, of 1996.³

Since children have the rights to survival, adequate health care and a standard of living that supports their full development, they need to benefit from environmental conditions that make the fulfilment of these rights possible. There is no effective right to play without a safe place to play, no enjoyment of health within a contaminated environment. Support for this perspective is provided by such treaties and declarations as the International Covenant on Economic, Social and Cultural Rights; the Convention on the Elimination of All Forms of Discrimination against Women; the Habitat Agenda; and Agenda 21, the action plan adopted at the 1992 United Nations Conference on Environment and Development. The Centre on Housing Rights and Evictions, among others, documents the extensive body of rights related to housing and the disproportionate vulnerability of children to violations of these rights. In recent years, practical programming aimed at fulfilling rights has been focused on the pursuit of the Millennium Development Goals (MDGs), all of which have relevant implications for children in urban poverty. One of the targets of MDG 7 – to ensure environmental sustainability – focuses specifically on improving the lives of at least 100 million of the



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A mother holding a one-year-old infant obtains micronutrient powder from social workers in Dhaka, Bangladesh. Micronutrient deficiencies can lead to anaemia, birth defects and other disorders.

world's slum dwellers by 2020. This is only a small percentage of those who live in slums worldwide; the target does not address the continuing growth in the number of new slums and slum dwellers.

This chapter looks at the situation of children in urban settings and considers in particular their rights to health; water, sanitation and hygiene; education and protection.

Health

Article 6 of the Convention on the Rights of the Child commits States parties to "ensure to the maximum extent possible the survival and development of the child." Article 24 refers to every child's right to the "enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health." The Convention urges States parties to "ensure that no child is deprived of his or her right of access to such health care services."

Child survival

Nearly 8 million children died in 2010 before reaching the age of 5, largely due to pneumonia, diarrhoea and birth complications. Some studies show that children living in informal urban settlements are particularly vulnerable.⁴ High urban child mortality rates tend to be seen in places where significant concentrations of extreme poverty combine with inadequate services, as in slums.



OUT OF SIGHT, OUT OF REACH

by Her Majesty Queen Rania Al Abdullah of Jordan,
UNICEF Eminent Advocate

Half the world's population now lives in cities. Throughout history, urban life, so concentrated with humanity, has been a catalyst for trade, ideas and opportunities, making cities engines of economic growth. Today, living in a city is widely regarded as the best way to find prosperity and escape poverty. Yet hidden inside cities, wrapped in a cloak of statistics, are millions of children struggling to survive. They are neither in rural areas nor in truly urban quarters. They live in squalor, on land where a city has outpaced itself, expanding in population but not in vital infrastructure or services. These are children in slums and deprived neighbourhoods, children shouldering the many burdens of living in that grey area between countryside and city, invisible to the authorities, lost in a hazy world of statistical averages that conceal inequality.

The contrast could not be more ironic. Cities, where children flourish with good schools and accessible health care, are where they also suffer greatly, denied their basic human rights to an education and a life of opportunity. Side by side, wealth juxtaposed against poverty, nowhere else is the iniquity of inequity as obvious as in a city.

Over the course of a decade, the state of the world's urban children has worsened. The number of people living in slums has increased by over 60 million. These are mothers and fathers, grandmothers and grandfathers, sons and daughters, scratching out a life in shantytowns the world over. With the direct disadvantages of urban poverty – disease, crime, violence – come indirect ones, social and

cultural barriers, like gender and ethnicity, that deny children from the slums the chance to enrol in and complete primary school. Education is pushed out of reach because there are not enough public schools or the costs are too high. Religious groups, non-governmental organizations and entrepreneurs try to fill the gap but struggle without government support or regulation. As the best chance to escape their parents' destinies eludes these children, the cycle of destitution spins on.

In the Arab world the facts are clear: More than one third of the urban population lives in informal settlements and slums. These environments are hazardous to children; a lack of adequate sanitation and drinkable water poses a major threat to their well-being. In some less developed Arab countries, overcrowding in makeshift houses further aggravates the precarious health conditions of these vulnerable families.

For Palestinian children, city life can be a grim life. Too often, it represents guns and checkpoints, fear and insecurity. Yet their greatest hope is their national pride: a deep-seated belief in education, which they know is essential for building a life and rebuilding their country. Yet, since 1999, across Occupied Palestinian Territory, the number of primary-school-aged children who are out of school has leapt from 4,000 to 110,000, a staggering 2,650 per cent increase. In Gaza, among the world's most densely populated areas, access to and quality of education have deteriorated rapidly. For the sake of these children's futures and of the all-important

search for regional peace, we must set aside our anger and angst and give them the childhoods they deserve, childhoods we expect for our own children, filled with happy memories and equal opportunities.

In a few Arab countries, the fates of disadvantaged urban children are being rewritten. In Morocco, the government programme 'Cities without Slums' hopes to raise the standards of nearly 300,000 homes. By engaging banks and housing developers, a 'triple win' scenario is possible for poor people, the government and the private sector. Jordan, too, is making strides. Amman is one of the region's leading child-friendly cities, with over 28,000 students participating in children's municipal councils to prioritize their needs, rights and interests. The results have been impressive: parks, libraries, community spaces, educational support for children who dropped out of school, campaigns against violence and abuse, and information and communication technology centres for the deaf.

Yet for Arab children – for *all* children – to thrive, nations have to work together. We have to share resources, adopt and adapt successful initiatives from around the globe and encourage our private sectors to engage with disadvantaged families so we can catch those falling through the cracks. In cities across the world, children out of reach are too often out of sight. If we are to raise their hopes and their prospects, we have to dig deep into the data, unroot entrenched prejudices and give every child an equal chance at life. Only in this way can we truly advance the state of *all* the world's children.

The Convention on the Rights of the Child

The Convention on the Rights of the Child, adopted in 1989, was the first international treaty to state the full range of civil, political, economic, social and cultural rights belonging to children. The realities confronting children can be assessed against the commitments to which it holds States parties.

Legally binding on States parties, the Convention details universally recognized norms and standards concerning the protection and promotion of the rights of children – everywhere and at all times. The Convention emphasizes the complementarity and interdependence of children’s human rights. Across its 54 articles and 2 Optional Protocols, it establishes a new vision of the child – one that combines a right to protection through the State, parents and relevant institutions with the recognition that the child is a holder of participatory rights and freedoms. All but three of the world’s nations – Somalia, South Sudan and the United States of America – have ratified the document. This broad adoption demonstrates a common political will to protect and ensure children’s rights, as well as recognition that, in the Convention’s words, “in all countries in the world, there are children living in exceptionally difficult conditions, and that such children need special consideration.”

The values of the Convention stem from the 1924 Geneva Declaration of the Rights of the Child, the 1948 Universal Declaration of Human Rights and the 1959 Declaration of the Rights of the Child. The Convention applies to every child, defined as every person younger than 18 or the age of majority, if this is lower (Article 1). The Convention also requires that in all actions concerning children, “the best interests of the child shall be a primary consideration,” and that States parties “ensure the child such protection and care as is necessary for his or her well-being” (Article 3).

Every child has the right to be registered immediately after birth and to have a name, the right to acquire a nationality and to preserve her or his identity and, as far as possible, the right to know and be cared for by her or his parents (Articles 7 and 8).

Non-discrimination

States parties also take on the responsibility to protect children against discrimination. The Convention commits them to respecting and ensuring rights “to each child within their jurisdiction without discrimination of any kind, irrespective of the child’s or his or her parent’s or legal guardian’s race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status” (Article 2). Children belonging to ethnic, religious or linguistic minorities and those of indigenous origin have the right to practise their own culture, religion and language in the community (Article 30).

Furthermore, “a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child’s active participation in the community” (Article 23). This extends to the right to special care, provided free of charge whenever possible, and effective access to education, training, health care, rehabilitation services, recreation opportunities and preparation for employment.

Participation

One of the core principles of the Convention is respect for and consideration of the views of children. The document recognizes children’s right to freely express their views in all matters affecting them and insists that these views be given due weight in accordance with the age and maturity of the children voicing them (Article 12). It further proclaims children’s right to freedom of all forms of expression (Article 13). Children are entitled to freedom of thought, conscience and religion (Article 14), to privacy and protection from unlawful attack or interference (Article 16) and to freedom of association and peaceful assembly (Article 15).

Social protection

The Convention acknowledges the primary role of parents or legal guardians in the upbringing and development of the child (Article 18) but stresses the obligation of the State to support families through “appropriate assistance,” “the development of institutions, facilities and services for the care of children” and “all appropriate measures to ensure that children of working parents have the right to benefit from child-care services and facilities for which they are eligible.”

Of particular relevance in the urban context is the recognition of “the right of every child to a standard of living adequate for the child’s physical, mental, spiritual, moral and social development” (Article 27). The responsibility to secure these conditions lies mainly with parents and guardians, but States parties are obliged to assist and “in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing.” Children have the right to benefit from social security on the basis of their circumstances (Article 26).

Health and environment

States parties are obliged to “ensure to the maximum extent possible the survival and development of the child” (Article 6). Each child is entitled to the “enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health” (Article 24). This includes child care; antenatal, postnatal and preventive

care; family planning; and education on child health, nutrition, hygiene, environmental sanitation, accident prevention and the advantages of breastfeeding. In addition to ensuring provision of primary health care, States parties undertake to combat disease and malnutrition “through the provision of adequate nutritious foods and clean drinking water, taking into consideration the dangers and risks of environmental pollution.”

Education, play and leisure

The Convention establishes the right to education on the basis of equal opportunity. It binds States parties to make “available and accessible to every child” compulsory and free primary education and options for secondary schooling, including vocational education (Article 28). It also obliges States parties to “encourage the provision of appropriate and equal opportunities for cultural, artistic, recreational and leisure activity” (Article 31).

Protection

States parties recognize their obligation to provide for multiple aspects of child protection. They resolve to take all appropriate legislative, administrative, social and educational measures to protect children from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, even while the children are under the care of parents, legal guardians or others (Article 19). This protection, along with humanitarian assistance, extends to children who are refugees or seeking refugee status (Article 22).

Under the Convention, States are obliged to protect children from economic exploitation and any work that may interfere with their education or be harmful to their health or physical, mental, spiritual, moral or social development. Such protections include the establishment and enforcement of minimum age regulations and rules governing the hours and conditions of employment (Article 32). National authorities should also take measures to protect children from the illicit use of narcotic drugs and psychotropic substances (Article 33) and from all forms of exploitation that are harmful to any aspect of their welfare (Article 36), such as abduction, sale of or traffic in children (Article 35) and all forms of sexual exploitation and abuse (Article 34).

The Convention’s four core principles – non-discrimination; the best interests of the child; the right to life, survival and development; and respect for the views of the child – apply to all actions concerning children. Every decision affecting children in the urban sphere should take into account the obligation to promote the harmonious development of every child.

Recent research from Nigeria suggests that living in a socio-economically disadvantaged urban area increases the rate of under-five mortality even after the data have been adjusted for factors such as mother’s education or income.⁵ In Bangladesh, 2009 household survey data indicate that the under-five mortality rate in slums is 79 per cent higher than the overall urban rate and 44 per cent higher than the rural rate.⁶ Around two thirds of the population of Nairobi, Kenya, lives in crowded informal settlements, with an alarming under-five mortality rate of 151 per thousand live births. Pneumonia and diarrhoeal disease are among the leading causes of death.⁷ Poor water supply and sanitation, the use of hazardous cooking fuels in badly ventilated spaces, overcrowding and the need to pay for health services – which effectively puts them out of reach for the poor – are among the major underlying causes of these under-five deaths.⁸ Disparities in child survival are also found in high-income countries. In large cities of the United States, income and ethnicity have been found to significantly affect infant survival.⁹

Immunization

Around 2.5 million under-five deaths are averted annually by immunization against diphtheria, pertussis and tetanus (DPT) and measles. Global vaccination coverage is improving: 130 countries have been able to administer all three primary doses of the DPT vaccine to 90 per cent of children younger than 1. More needs to be done however. In 2010, over 19 million children did not get all three primary doses of DPT vaccination.¹⁰

Lower levels of immunization contribute to more frequent outbreaks of vaccine-preventable diseases in communities that are already vulnerable owing to high population density and a continuous influx of new infectious agents.

Poor service delivery, parents who have low levels of education, and lack of information about immunization are major reasons for low coverage among children in slums as diverse as those of western Uttar Pradesh, India, and Nairobi, Kenya.



A health worker examines an infant in an incubator at Qingchuan County Maternity and Child Care Centre, Sichuan Province, China.

Maternal and newborn health

More than 350,000 women died in pregnancy or childbirth in 2008,¹¹ and every year many more sustain injuries, such as obstetric fistulae, that can turn into lifelong, ostracizing disabilities. Most of the women who die or are severely injured in pregnancy or childbirth reside in sub-Saharan Africa and Asia, and most of the deaths are caused by haemorrhage, high blood pressure, unsafe abortion or sepsis. Many of these injuries and deaths can be averted if expectant mothers receive care from skilled professionals with adequate equipment and supplies, and if they have access to emergency obstetric care.¹²

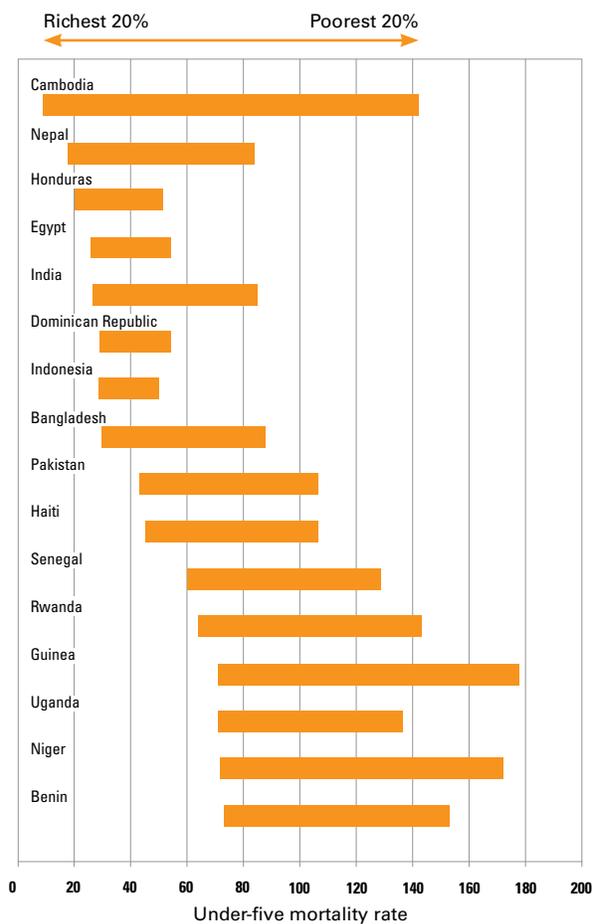
Urban settings provide proximity to maternity and obstetric emergency services but, yet again, access and use are lower in poorer quarters – not least because health facilities and skilled birth attendants are in shorter supply.¹³ Health services for the urban poor tend to be of much lower quality, often forcing people to resort to unqualified health practitioners or pay a premium for health care, as confirmed by studies in Bangladesh, India, Kenya and elsewhere.¹⁴

Breastfeeding

Breastfeeding is recommended during the first six months of life as a way to meet infants' nutritional requirements and reduce neonatal mortality by perhaps 20 per cent. There is some evidence that urban mothers are less likely than rural ones to breastfeed – and more likely to wean their children early if they do begin. An analysis of Demographic and Health Survey (DHS) data from 35 countries found that the percentage of children who were breastfed was lower in urban areas.¹⁵ Low rates of breastfeeding may be attributed in part to a lack of knowledge about the importance of the practice and to the reality that poor women in urban settings who work outside the home are often unable to breastfeed.

Figure 2.1. Wealth increases the odds of survival for children under the age of 5 in urban areas

Under-five mortality rate (per 1,000 live births) in urban areas in selected countries (right end of bar indicates average under-five mortality for the poorest quintile of the population; left end indicates that for the wealthiest quintile)



Source: WHO estimates and DHS, 2005–2007. Countries were selected based on availability of data.

Nutrition

The locus of poverty and undernutrition among children appears to be gradually shifting from rural to urban areas, as the number of the poor and undernourished increases more quickly in urban than in rural areas.¹⁶ Hunger is a clear manifestation of failure in social protection. It is difficult to behold, especially when it afflicts children. However, even the apparently well fed – those who receive sufficient calories to fuel their daily activities – can suffer the ‘hidden hunger’ of micronutrient malnutrition: deficiencies of such essentials as vitamin A, iron or zinc from fruits, vegetables, fish or meat. Without these micronutrients, children are in increased danger of death, blindness, stunting and lower IQ.¹⁷

The rural-urban gap in nutrition has narrowed in recent decades – essentially because the situation has worsened in urban areas.¹⁸ In sub-Saharan Africa, a 2006 study showed that disparities in child nutrition between rich and poor urban communities were greater than those between urban and rural areas.¹⁹

Undernutrition contributes to more than a third of under-five deaths globally. It has many short- and long-term consequences, including delayed mental development, heightened risk of infectious diseases and susceptibility to chronic disease in adult life.²⁰ In low-income countries, child undernutrition is likely to be a consequence of poverty, characterized as it is by low family status and income, poor environment and housing, and inadequate access to food, safe water, guidance and health care. In a number of countries, stunting is equally prevalent, or more so, among the poorest children in urban areas as among comparably disadvantaged children in the countryside.²¹

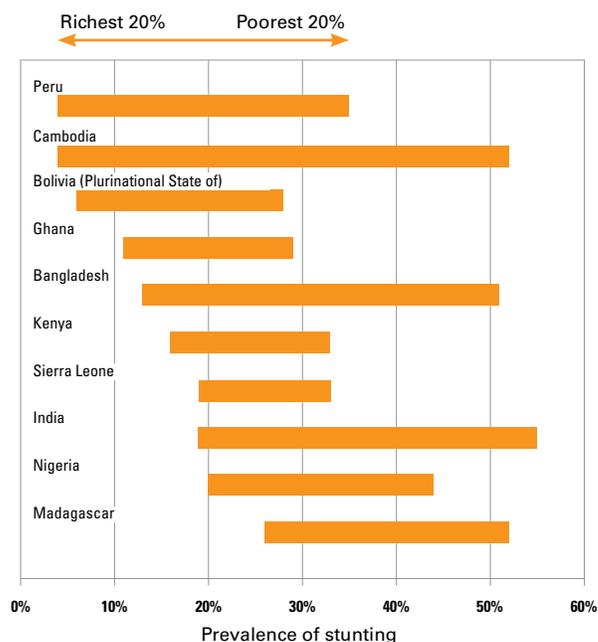
A study of the National Family Health Survey (NFHS-3) in eight cities in India from 2005 to 2006 found that levels of undernutrition in urban areas continue to be very high. At least a quarter of urban children under 5 were stunted, indicating that they had been undernourished for some time. Income was a significant factor. Among the poorest fourth of urban residents, 54 per cent of children were stunted and 47 per cent were underweight, compared with 33 per cent and 26 per cent, respectively, among the rest of the urban population.²² The largest differences were observed in the proportion of underweight children in slum and non-slum areas of Indore and Nagpur.²³

A 2006 study of disparities in childhood nutritional status in Angola, the Central African Republic and Senegal found that when using a simple urban-rural comparison, the prevalence of stunting was significantly higher in rural areas. But when urban and rural populations were stratified using a measure of wealth, the differences in prevalence of stunting and underweight between urban and rural areas disappeared.²⁴ A 2004 study of 10 sub-Saharan African countries showed that the energy-deficient proportion of the urban population was above 40 per cent in almost all countries and above 70 per cent in three: Ethiopia, Malawi and Zambia.²⁵

At the opposite end of the nutrition spectrum, obesity afflicts children in urban parts of high-income countries and a growing number of low- and middle-income countries.²⁶ A diet of saturated fats, refined sugars and salt combined with a sedentary lifestyle puts children at increased risk of obesity and chronic ailments such as heart disease, diabetes and cancer.²⁷

Figure 2.2. Children of the urban poor are more likely to be undernourished

The proportion of children under 5 who are stunted (right end of bar indicates prevalence of stunting for the poorest quintile of the urban population; left end indicates that for the wealthiest quintile)



Note: Estimates are calculated according to WHO Child Growth Standards. Countries were selected based on availability of data.

Source: DHS, 2006–2010.

MATERNAL AND CHILD HEALTH SERVICES FOR THE URBAN POOR

A case study from Nairobi, Kenya

Rapid urbanization has been taking place in Kenya – as in much of sub-Saharan Africa – largely in a context of weak economic development and poor governance. As a result, local and national authorities have not been able to provide decent living conditions and basic social services sufficient to meet the needs of a growing urban population. Between 1980 and 2009, the number of people living in Nairobi, the capital, increased from 862,000 to about 3.4 million. Estimates (2007) indicate that around 60 per cent live in slums covering only 5 per cent of the city's residential land. Moreover, emerging evidence reveals that the urban population explosion in the region has been accompanied by increasing rates of poverty and poor health outcomes. The incidence of child undernutrition, morbidity and mortality has been shown to be higher in slums and peri-urban areas than in more privileged urban settings or, sometimes, even rural areas.

Access to health services

In Nairobi slums, public provision of health services is limited. A study conducted in 2009 shows that out of a total of 503 health facilities used by residents of three slum communities (Korogocho, Viwandani and Kibera), only 6 (1 per cent) were public, 79 (16 per cent) were private not-for-profit, and 418 (83 per cent) were private for-profit. The last category largely consists of unlicensed and often ramshackle clinics and maternity homes, with no working guidelines or standard protocols for services. Yet these substandard facilities

are exactly where most local women go for maternal and child health care – seeking better-quality options only once complications occur. In contrast to public services, which seldom extend to informal settlements, these private facilities are perceived as friendly, accessible and trustworthy, perhaps because they invest more time in building relationships with patients. Only a small proportion of the urban poor has access to more reliable maternal health care services, including those offered at clinics and hospitals run by missionaries and non-governmental organizations.

Urban child undernutrition

In developing countries, child undernutrition remains a major public health concern. Both a manifestation and a cause of poverty, it is thought to contribute to over a third of under-five deaths globally. Insufficient nutrition is one of a wide range of interlinked factors forming the so-called poverty syndrome – low income, large family size, poor education and limited access to food, water, sanitation and maternal and child health services.

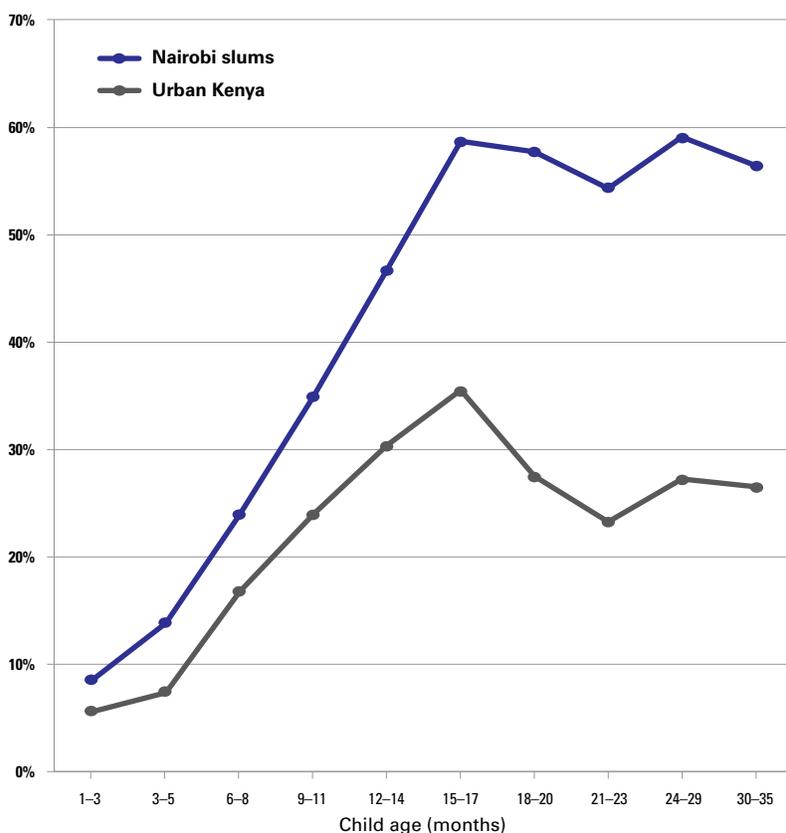
Stunting, underweight and wasting – measured by height-for-age, weight-for-age and weight-for-height, respectively – are the three most frequently used anthropometric indicators of nutritional status. Stunting is considered the most reliable measure of undernutrition, as it indicates recurrent episodes or prolonged periods of inadequate food intake, calorie and/or protein deficiency or persistent or recurrent ill health. Children are stunted if

their height-for-age index falls more than two standard deviations below the median of the reference population; they are severely stunted if the index is more than three standard deviations below the median. Stunting prevalence is a useful tool for comparisons within and between countries and socio-economic groups.

Figure 2.3 portrays the magnitude of inequities in child undernutrition by comparing average stunting levels for urban Kenya against data collected between 2006 and 2010 in the Korogocho and Viwandani slum settlements. The study covers all women who gave birth in the area. The children's measurements were taken periodically up to 35 months of age.

As the graph demonstrates, the prevalence of stunting among children living in slum areas increases sharply from less than 10 per cent during the first few months of life to nearly 60 per cent in the group aged 15–17 months, and then remains at that level. In urban Kenya overall, the prevalence of undernutrition reaches a maximum of 35 per cent among children aged 15–17 months, then declines to around 25 per cent. The gap between the poor (here, slum residents) and the non-poor in Kenya widens from this point. For example, among children above 15 months, the prevalence of stunting stands at around 57 per cent in the slums and nearly 28 per cent in urban Kenya as a whole. Separate analysis (not illustrated in Figure 2.3) reveals that the prevalence of stunting among the urban rich is close to 21 per cent, suggesting

Figure 2.3. Stunting prevalence among children under 3 years old: Comparing the Nairobi slums with overall urban Kenya



Source: Urbanization, Poverty and Health Dynamics – Maternal and Child Health data (2006–2009); African Population and Health Research Center; and Kenya DHS (2008–2009).

that children in urban poverty are nearly 2.7 times as likely to be stunted.

Effective interventions to reduce child undernutrition may include micronutrient supplementation (iodine, iron and vitamin A); food supplementation (for micronutrient deficiencies); infection prevention and treatment; growth monitoring and

promotion; education about infant feeding practices (breastfeeding and complementary feeding); and school feeding programmes.

If the needs of the urban poor are not addressed, progress towards achieving the Millennium Development Goals (MDGs) may be at stake, especially

Goals 1 (eradicating extreme poverty and hunger), 4 (reducing child mortality) and 5 (improving maternal health). In addition to a strong focus on health and nutritional interventions (e.g., antenatal, maternal and neonatal care, immunization, appropriate feeding practices), the importance of reproductive health is being recognized in this context, as family planning can be a cost-effective and high-yield approach to improving the health of mothers and children. The Urban Reproductive Health Initiative, sponsored by the Bill & Melinda Gates Foundation and currently implemented in selected urban areas of India, Kenya, Nigeria and Senegal, is an example. The programme seeks to significantly increase modern contraceptive prevalence rates – especially among the urban and peri-urban poor – through integrating and improving the quality of family planning services, particularly in high-volume settings; increasing provision, including through public-private partnerships; and dismantling demand-side barriers to access.

by Jean Christophe Fotso

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The African Population and Health Research Center (APHRC) is an international non-profit organization whose mission is to promote the well-being of Africans through policy-relevant research on key population and health issues. Originally established as a programme of the Population Council in 1995, APHRC has been autonomous since 2001 and now has offices in Kenya, Nigeria and Senegal. The Center focuses on research, strengthening research capacity and policy engagement in sub-Saharan Africa.

Respiratory illness

Children in low-income urban communities also suffer the effects of air pollution, including respiratory infections, asthma and lead poisoning. Every year, polluted indoor air is responsible for almost 2 million deaths, almost half due to pneumonia, among children under 5 years of age.²⁸ Outdoor air pollution claims about another 1.3 million child and adult lives per year. In Nairobi, Kenya, a 2005 study found that chronic exposure to pollutants in urban areas contributed to over 60 per cent of all cases of respiratory disease among children in these settings.²⁹ Studies in the United States show that chronic exposure to high levels of air toxins occurs disproportionately in poor urban communities settled by people of minority races.³⁰

Road traffic injuries

Vehicular traffic also poses a physical threat to children – one heightened by a lack of safe play spaces and pedestrian infrastructure such as sidewalks and crossings. The World Health Organization estimates that road traffic injuries account for 1.3 million deaths annually³¹ – the leading single cause of death worldwide among people aged 15–29, and the second for those aged 5–14.³²

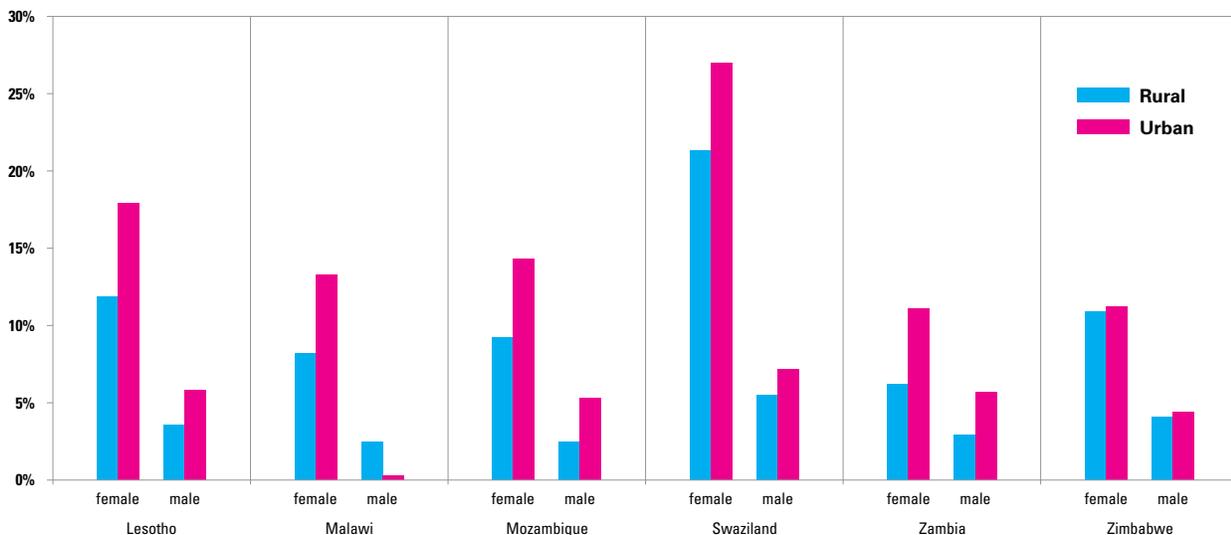
HIV and AIDS

Recent data suggest that new infections with the human immunodeficiency virus (HIV) among children are decreasing amid improvements in access to services preventing transmission of the virus from mother to child during pregnancy, labour, delivery or breast-feeding. About one fourth as many new cases of HIV infection among children are believed to have occurred in 2010 as in 2005.³³ Despite this progress, about 1,000 babies a day were infected through mother-to-child transmission in 2010.³⁴

In addition, nearly 2,600 people aged 15–24 were infected every day in 2010. These infections were mainly the result of unprotected sex or unsafe injection practices. In 2010, some 2.2 million adolescents aged 10–19 were living with HIV worldwide, the majority of them unaware of their HIV status. During a critical period of transition out of childhood, many of these adolescents were left without access to appropriate information, treatment, care or support, including age-appropriate sexual and reproductive health care and prevention services.

Figure 2.4. HIV is more common in urban areas and more prevalent among females

HIV prevalence among young women and men aged 15–24 in urban and rural areas in selected sub-Saharan African countries



Source: Lesotho, DHS 2009; Malawi, DHS 2004; Mozambique, AIS 2009; Swaziland, DHS 2006–2007; Zambia, DHS 2007; Zimbabwe, DHS 2005–2006. Countries were selected based on availability of data.



REACHING EVERY CHILD

Wiping out polio in Mumbai

by Amitabh Bachchan, UNICEF Goodwill Ambassador

For 10 years, I have been telling India the life-saving message that every child should take two drops of oral polio vaccine every time it is offered.

And it is working.

Today, India stands on the brink of eradicating polio – arguably the greatest public health achievement in its history. When the polio eradication campaign started, India was reporting around 500 polio cases per day. Since then, more than 4 million children have been saved from paralysis or death. All our hard work is paying off. But the simple truth is that as long as polio exists anywhere in the world, the threat will persist.

I am immensely proud that independent studies have shown that the ‘Every child, every time’ slogan is one of India’s most recognizable messages. I am even more proud that Indian parents have answered that call. During two annual National Immunization Days, normally held each January and February, approximately 170 million children under 5 are vaccinated by immunization teams going door-to-door to every house in the country. Then, every month from March to December, almost all children under the age of 5 in India’s two traditionally polio-endemic states and highest-risk areas are vaccinated during polio immunization campaigns – campaigns that reach 40–80 million children a year. Pause for a second to examine those numbers. Then consider what characterizes the highest-risk areas for poliovirus transmission: high-density living, poor sanitation,

poor access to clean water, poor access to toilets, poor breastfeeding rates and poor nutrition.

Polio now is a virus of the poorest, making its final stand in the most forgotten places, among the most forgotten people. Reaching these people – the slum dwellers, the nomads, the migrants, the brick kiln workers, the families of construction workers living beside the plush high-rises they build (for a dollar a day) under a sheet of plastic – is one of the greatest challenges in public health. The polio eradication programme is actively following a detailed ‘underserved strategy’ to target India’s hardest-to-reach people, including those living in urban slums, in order to raise immunity among those populations at highest risk. It is not an easy task – literally millions of migrant families move back and forth across the country each week, and in the traditionally polio-endemic states of Uttar Pradesh and Bihar, around 750,000 children are born each month. In order to eradicate polio in India, it is essential to reach and immunize every last child. And in the swelling slums of India’s heaving cities, every last child is hard to find.

Consider Dharavi, one of the largest slums in my home town of Mumbai – home to a million people in just 3 square kilometres. Here, poliovirus immunization teams must follow carefully developed micro-plan maps, walking single file along the tiny lanes, scrambling up rickety ladders to reach the children living in corrugated iron homes stacked one

on top of the other, three or four stories high. The immunization teams then mark those corrugated iron walls with chalk, so that the monitors who will follow in the coming days can see which houses have been reached – and which children have been immunized. Additional teams return to cover any children who were missed.

Mumbai, India’s financial capital and home to its film industry, is among the world’s biggest and richest cities. It is also believed to contain the highest proportion and largest absolute number of slum dwellers. By some estimates, between 100 and 300 new families arrive each day in search of work. All too often, migrant families of low socio-economic status find themselves in a slum. All too often, these arrivals are never tracked, never chartered, never given a name. All too often, the hardest-to-reach children in our country are living right under our noses.

India’s polio eradication programme demonstrates that it is possible to ensure equity in the availability of health services in even the poorest, most densely populated environments. It proves that you can find every last child in the city. And it means that in Mumbai, while the children of the slums continue to face many threats, polio need not be one of them.

Amitabh Bachchan is one of the most prominent figures in the history of Indian cinema. He has won 4 National Film Awards – 3 in the Best Actor category – and 14 Filmfare Awards. He has also worked as a playback singer, film producer and television presenter and was an elected member of the Indian Parliament (1984–1987). He has been India’s polio eradication ambassador since 2002.

HIV prevalence remains generally higher in urban areas.³⁵ Adolescent girls and young women appear to be at particular risk because of poverty, which drives many to commercial sex, and exposes them to a higher incidence of sexual exploitation and forced sex.³⁶

A 2010 review of estimates from more than 60 countries found that while the HIV infection rate had stabilized or decreased in most countries, including those worst affected, it had risen by more than 25 per cent in seven – Armenia, Bangladesh, Georgia, Kazakhstan, Kyrgyzstan, the Philippines and Tajikistan. In these countries, the epidemic is concentrated among people who inject drugs, people who engage in commercial sex and men who have sex with men.³⁷ Young people form a significant portion of the affected populations. In Kazakhstan and the Philippines, they make up 29 and 26 per cent, respectively, of all people aged 15 years and older living with HIV.³⁸ For most of them, infection with HIV is a result of a chain of disadvantages extending back into childhood: violence, exploitation, abuse and neglect – in other words, failures in protection and care.

A 2009 study of adolescents living on the streets of four cities in Ukraine found that more than 15 per cent injected drugs, nearly half of these sharing equipment; almost 75 per cent were sexually active, most having started before the age of 15; close to 17 per cent of adolescent boys and 57 per cent of adolescent girls had received payment for sex; and more than 10 per cent of boys and over half of girls had been forced to have sex.³⁹ Despite these clear vulnerabilities, the same

adolescents who are at greatest risk of HIV infection are often the most likely to be excluded from services. Often, social stigma or barriers created by policies and legislation prevent those adolescents most at risk from obtaining preventive services.

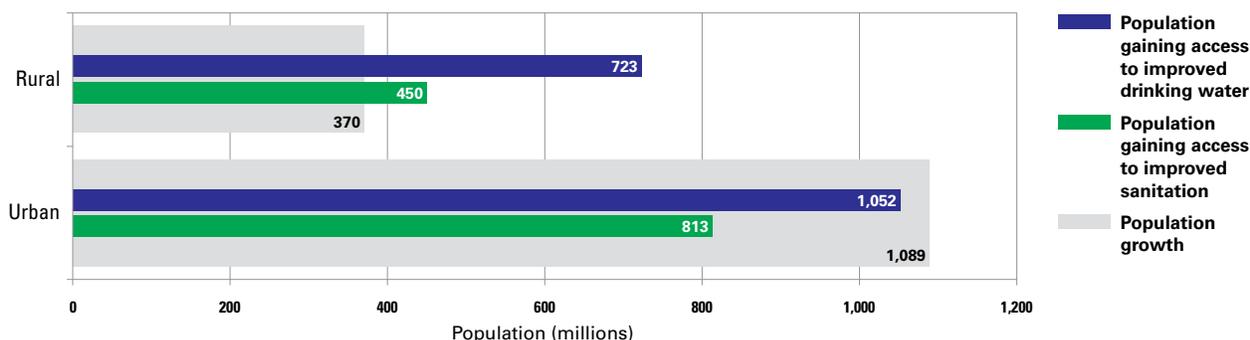
Mental health

Urban life can also have a negative effect on the mental health of children and adolescents, particularly if they live in poor areas and are exposed to the dangers of violence and substance abuse.⁴⁰ Children living in urban poverty experience levels of depression and distress that are higher than the urban average. A review of social determinants of health in the United States concluded that children in neighbourhoods with lower socio-economic status had more behavioural and emotional problems.⁴¹ According to a number of studies, mental health problems experienced during childhood and adolescence may significantly affect growth and development, school performance, and peer and family relationships, and may increase the risk of suicide.⁴² One factor often cited by children and observers as a cause of mental distress is the stigma that comes with being seen as a child of the underprivileged.

Children and adolescents in urban areas are likely to have greater access to alcohol and illegal drugs than their counterparts in rural areas. They may resort to these substances as a means of coping with stress or as an outlet for idleness and frustration in the absence of employment or opportunities for recreation such as sports and youth clubs.

Figure 2.5. In urban areas, access to improved water and sanitation is not keeping pace with population growth

World population gaining access to improved drinking water and sanitation relative to population increase, 1990–2008



Source: WHO/UNICEF Joint Monitoring Programme, 2010.



Washing hands with soap and water at an elementary school in Aceh Besar District, Aceh Province, Indonesia.

Water, sanitation and hygiene

Article 24 of the Convention on the Rights of the Child commits States parties to strive to ensure the highest attainable standard of health for every child. This extends to providing clean drinking water and eliminating the dangers of environmental pollution.

Unsafe water, poor sanitation and unhygienic conditions claim many lives each year. An estimated 1.2 million children die before the age of 5 from diarrhoea. Poor urban areas where insufficient water supply and sanitation coverage combine with overcrowded conditions tend to maximize the possibility of faecal contamination.⁴³

Globally, urban dwellers enjoy better access to improved drinking water sources (96 per cent) than do people living in rural areas (78 per cent). Even so, improved drinking water coverage is barely keeping pace with urban population growth.⁴⁴ And access to an improved water source does not always guarantee adequate provision. In the poorest urban districts, many

people are forced to walk to collect water from other neighbourhoods or to buy it from private vendors.⁴⁵ It is common for the urban poor to pay up to 50 times more for a litre of water than their richer neighbours, who have access to water mains.⁴⁶ Without sufficient access to safe drinking water and an adequate water supply for basic hygiene, children's health suffers. Improving access remains vital to reducing child mortality and morbidity.

The urban population as a whole has better access to sanitation than the rural population, but here, too, coverage is failing to keep up with urban population growth. In consequence, the number of urban dwellers practising open defecation increased from 140 million to 169 million between 1990 and 2008.⁴⁷ The impact of this practice in densely populated urban settlements is particularly alarming for public health. Congested and unsanitary conditions make urban slums particularly high-risk areas for communicable diseases, including cholera.

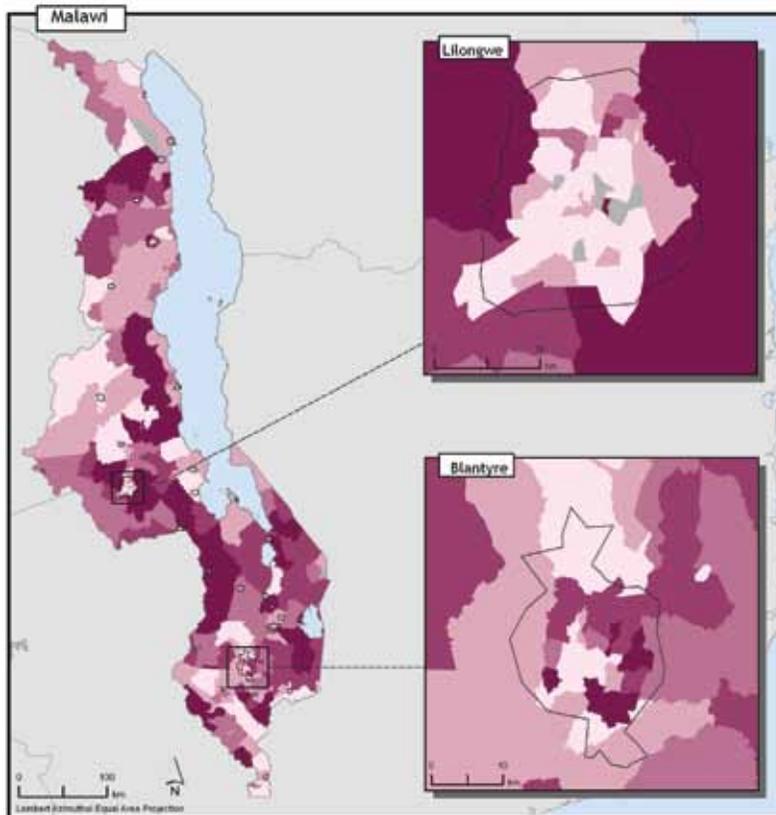
MAPPING URBAN DISPARITIES TO SECURE CHILD RIGHTS

Gathering accessible, accurate and disaggregated data is an essential step in the process of recognizing and improving the situation of children in urban areas. Innovative visual representations of information can help identify gaps, prompting action from local decision-makers.

The concept of mapping poverty originated in London over a century ago as a way to highlight differences in living standards according to social class. Today's computer technology makes it possible to compile simple interactive maps and correlations to show complex information traditionally displayed in columns and tables.

Where detailed data for a province, district or municipality may not be available, the 'small area estimation' approach creates subnational estimates based on national census and household survey information. Integrating the estimates with Geographic Information Systems (GIS) produces maps that can showcase differences between urban and rural areas and within urban zones.

Figure 2.6. Mapping poverty in Lilongwe and Blantyre, Malawi



The shading on the map indicates levels of poverty, with darker shades denoting greater poverty. (Poverty is measured here by the average shortfall between actual household welfare level and the poverty line.) The black line indicates the greater urban area.

Source: Center for International Earth Science Information Network, Columbia University, *Where the Poor Are: An atlas of poverty*, Columbia University Press, Palisades, N.Y., 2006, p. 37, figure 5.5, based on 1997–1998 data. See <www.ciesin.columbia.edu>. Reproduced with permission.

The Columbia University Center for International Earth Science Information Network used this method to highlight disparities in urban income in Malawi (see Figure 2.6). The map displays gradients of poverty, making possible a simple and intuitive urban-rural analysis as well as a comparison of the country's two major cities: Lilongwe, the capital, and Blantyre, a city of comparable size. In this example, where darker shades denote greater poverty, Lilongwe appears to have lower levels of poverty than Blantyre. Yet patterns of deprivation differ. While Blantyre exhibits greater levels of poverty than adjacent areas, Lilongwe is a relatively well-off urban centre surrounded by poorer regions, but also showing pockets of poverty (isolated darker areas) within its limits. This case study demonstrates the variability of urban patterns.

Another example comes from the English Public Health Observatories. Practitioners, policymakers and the general public can use this interactive online tool to illustrate and analyse 32 health profile indicators at the district and local authority level. Examples of

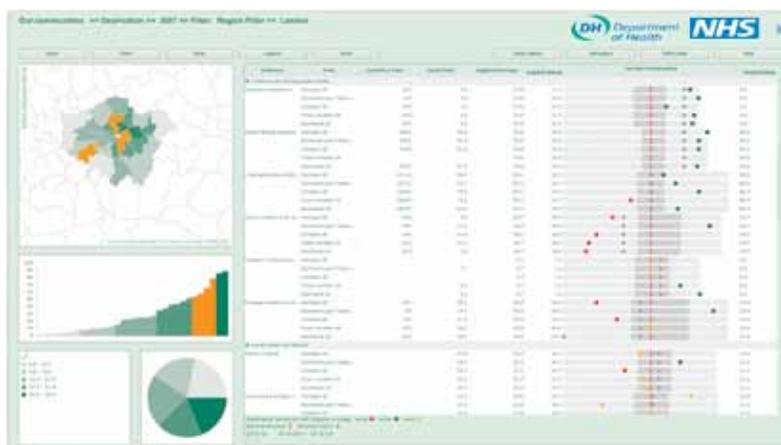
indicators that specifically focus on children and young people include childhood obesity and physical activity, teenage pregnancy, breastfeeding, tooth decay, child poverty, homelessness, educational achievement, crime and drug use (see Figure 2.7).

Larger cities often encompass multiple local government districts, which permits a side-by-side comparison of separate administrative districts within the metropolitan area. Greater London is divided into 32 boroughs. Urban disparities are stark and clear: 57 per cent of children in the inner London borough of Tower Hamlets live in poverty – a greater proportion than in any other borough in England. The City of Westminster has the nation’s highest level of childhood obesity, while Southwark has one of the highest rates of teenage pregnancy nationwide. In contrast, the outer London borough of Richmond upon Thames shows good levels of child health and well-being, and London children overall seem to have above-average dental health.

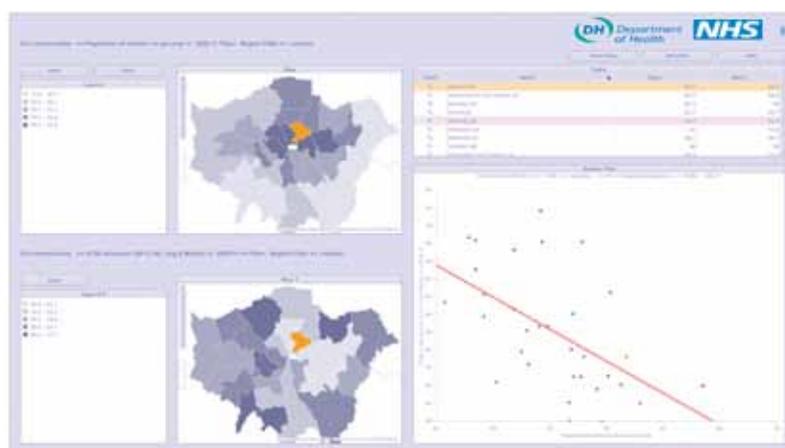
The tool also allows users to correlate variables, such as urban deprivation, with various child health outcomes. Local governments and health services can use this information to work towards reducing health inequalities by focusing on causes as well as results. Mapping urban indicators of child health and well-being reveals that a keen focus on disparities should not be limited to developing countries, as children’s rights and development prospects are uneven in some of the world’s most prosperous cities.

Figure 2.7. Tracking health outcomes in London, United Kingdom

The map on the left is shaded according to levels of deprivation. Boroughs selected for comparison appear in orange. Traffic-light colours in the table on the right indicate comparative performance in each area.



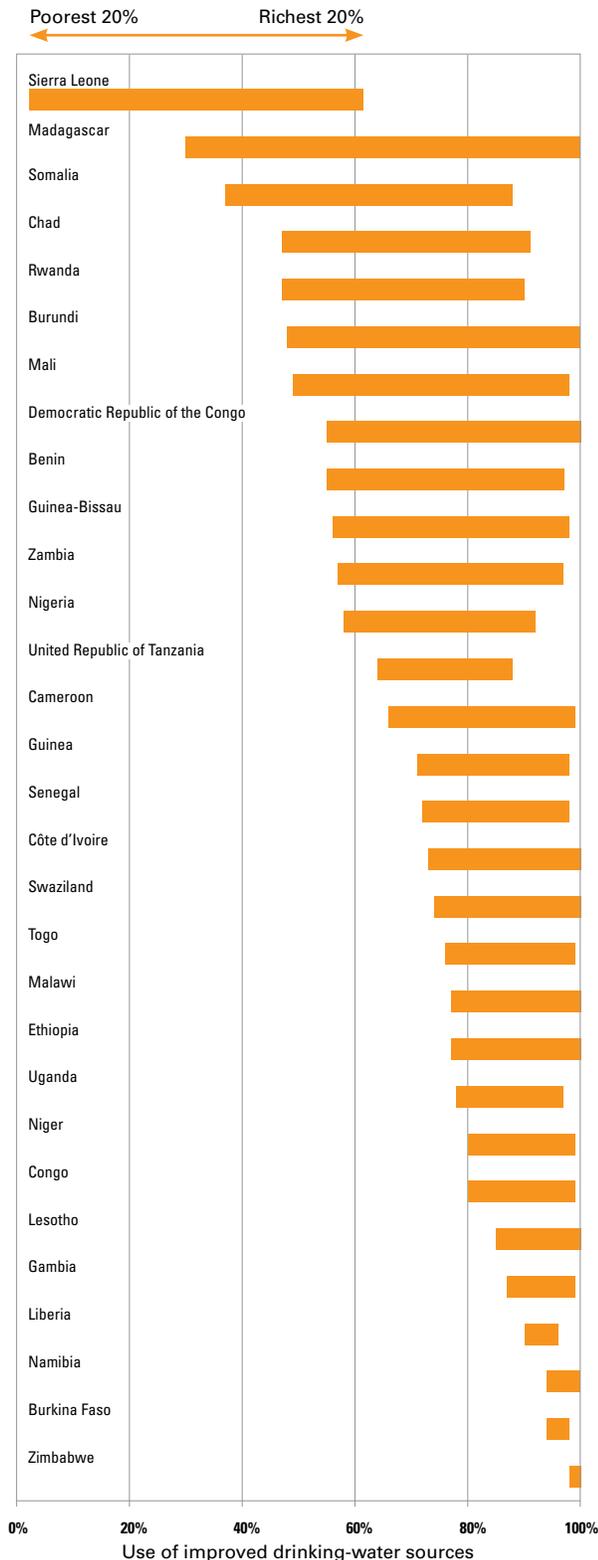
The tool can be used to show correlation between indicators. Below, the scatter plot displays the relationship between the proportion of children living in poverty and educational achievement across London. On the top map, darker shades denote a greater proportion of children living in poverty; on the bottom, darker areas show better educational scores.



Source: English Public Health Observatories working in partnership. Sample snapshots from <www.healthprofiles.info>. Crown Copyright 2011. Reproduced with permission.

Figure 2.8. Urban income disparities also mean unequal access to water

Use of improved drinking-water sources in urban areas in select countries in Africa (left end of the bar indicates access to improved water among the poorest quintile of urban households; right end indicates that for the wealthiest quintile)



Source: MICS and DHS in African countries, 2004–2006. Countries were selected based on availability of data.

Even where improved urban sanitation facilities exist, they are often shared by large numbers of people. Space, tenure and cost considerations limit the construction of individual latrines in slums. Public facilities are frequently overcrowded, poorly maintained and contaminated. Special provision for children is rare, so those waiting to use communal toilets are often pushed aside at peak times. Girls in particular may be exposed to the danger of sexual harassment or abuse, as well as a lack of adequate privacy, especially once they have begun menstruating.

Education

In Article 28 of the Convention on the Rights of the Child, States parties recognize children’s right to education and commit to “achieving this right progressively and on the basis of equal opportunity.”

Children in urban settings are generally considered to have an educational advantage. They are better off across a range of statistical indicators, more likely to benefit from early childhood programmes, and more likely to enrol in and complete primary and secondary school.⁴⁸ As in other areas of social provision, however, the overall statistics can be misleading. In reality, urban inequities profoundly undermine children’s right to education.⁴⁹ In urban areas blighted by poverty, early childhood programming is often notable for its absence. This is lamentable because the first few years have a profound and enduring effect on the rest of a person’s life and, by extension, the lives of so many others.

Early childhood development

Children start to learn long before they enter a classroom. Learning occurs from birth, as children interact with family and caregivers, and the foundation for all later learning is established in the early years. Poverty, ill health, poor nutrition and a lack of stimulation during this crucial period can undermine educational foundations, restricting what children are able to accomplish. By one estimate, more than 200 million children under 5 years of age in developing countries fail to reach their potential in cognitive development.⁵⁰



Some of the 4,000 children who attend Halit Coka Compulsory and High School, built for 1,000 students in Bathore, once a squatter settlement and now the largest suburb of Tirana, Albania.

Establishing good early childhood programmes in poor urban communities is essential to supporting children's survival, growth and learning. Early childhood programmes contribute to children's cognitive, social and emotional development and promote their health, nutrition and hygiene. In addition, they can free mothers and other female caregivers from their traditional roles, enabling them to participate in the public sphere. Yet even where such programmes exist, not all children benefit. While 25 per cent of children in Egypt's urban areas attended kindergarten in 2005–2006, compared with 12 per cent in rural areas, only 4 per cent of those from the poorest 20 per cent of urban households were able to access this service.⁵¹ Children from impoverished urban backgrounds have been found to be similarly disadvantaged in a number of other countries.

Primary education

Similar gaps – reflecting inequalities in parental income, gender and ethnicity, among other factors – persist in grade school, despite the progress many countries have made in pursuing universal primary education. As of

2008, 67 million primary-school-aged children were still out of school, 53 per cent of them girls.⁵²

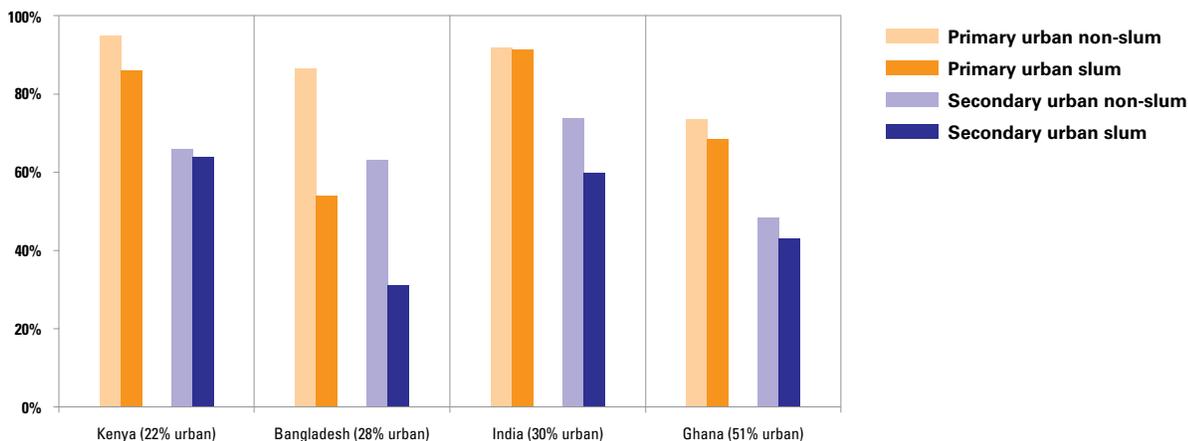
Primary education is generally more readily available in urban than in rural areas but remains beyond the reach of many children growing up in poverty – especially in slums, where there is often little or no public schooling. Families often face a choice between paying



A girl receives speech therapy in Chisinau, Republic of Moldova, as her mother looks on.

Figure 2.9. School attendance is lower in slums

Primary and secondary net attendance rates for urban areas in Kenya, Bangladesh, India and Ghana



Source: Kenya, DHS 2003; Bangladesh, DHS 2007; India, DHS 2005–2006; and Ghana, DHS 2003. Countries were selected for illustrative purposes.

for their children to attend overcrowded private schools of poor quality or withdrawing their children from school altogether.

Even in countries where primary schooling is free, the ancillary costs can leave people who live in poverty at a disadvantage. Students may have to purchase uniforms and classroom supplies or pay fees to take exams, and these taken together are often expensive enough to prevent children from attending school. While parents in Dhaka, Bangladesh, spend an average of 10 per cent of household income per child on schooling costs, this rises to 20 per cent in the poorest families. A recent survey of Sao Paulo, Brazil; Casablanca, Morocco; and Lagos, Nigeria, showed that families in the lowest income quintile spent more than a quarter of household income on schooling.⁵³

Marginalized groups, including children living or working on the street, migrant children and the children of refugees and internally displaced persons, face particular challenges. Until recently in China's cities, for example, migrants who were not officially registered had difficulty sending their children to school.⁵⁴ And all too often, children who are seen as different – because of poverty, language or gender, for example – face discrimination.

Refugees and internally displaced people often live in informal settlements in urban areas, and schools that

are already under strain may have great difficulty in coping with an influx of displaced children. Evidence suggests that displacement severely disrupts children's education – and again, the worst affected are often those who were already marginalized because of poverty, gender, ethnic identity or other factors.⁵⁵

Children from poor urban neighbourhoods are among the least likely to attend school. A survey in Delhi, India, found a primary school attendance rate of 54.5 per cent among children living in slums in 2004–2005, compared with 90 per cent for the city as a whole.⁵⁶ In Bangladesh, according to 2009 data, the differences were even more pronounced at the secondary level: 18 per cent of children in slums attended secondary school, compared with 53 per cent in urban areas as a whole and 48 per cent in rural areas.⁵⁷ Even where progress is made, it cannot be taken for granted. While enrolment improved in the rural and non-slum urban areas of the United Republic of Tanzania, Zambia and Zimbabwe in the late 1990s, it worsened in urban slums.⁵⁸

The quality of available schooling options in poor urban areas is another issue to consider. While data tend to focus on access, enrolment and retention, these are linked to the perceived quality and benefits of available education. Overcrowding and a lack of appropriate facilities such as toilets are among the factors that undermine the quality of education.⁵⁹

Creating employment opportunities for youth is vital as well. Too many young people in urban areas see their improved literacy and educational achievement unrewarded with suitable jobs. Many young people around the world are effectively idle – neither in school nor at work.

Protection

Article 19 of the Convention on the Rights of the Child commits States parties to “take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.” Article 32 recognizes children’s right to be protected from economic exploitation and hazardous work. Article 34 targets sexual exploitation and Article 35, trafficking.

Child trafficking

At any given time, nearly 2.5 million people are in forced labour as a result of trafficking – 22 to 50 per cent of them children.⁶⁰ Child trafficking is frequently hidden, denied or ignored, making comprehensive data difficult to obtain. Some forms take place mainly in urban areas: trafficking for sex work, for example, and trafficking that targets children who live or work on city streets.

Many children are trafficked from rural to urban areas. A 2001 study of sexually exploited girls aged 9–17 in major cities of the United Republic of Tanzania found that many had been trafficked from the country’s interior. Some had been recruited as domestic workers and abused within their employers’ homes; others were trafficked directly into prostitution or recruited into it by peers.⁶¹ One study indicates that most trafficked girls are put to work as sex workers, for example, in the major Indian cities of Mumbai, Delhi and Kolkata. In Bangladeshi cities, large numbers of girls and boys are exploited in street sex markets and brothels.⁶²

In Eastern Europe, children aged 13–18 are particularly at risk of being trafficked.⁶³ Evidence suggests that

poverty, alcoholism, family dysfunction, drug abuse, sexual abuse and domestic violence increase the children’s vulnerability, and that those out of school, on the streets or in institutions are also at greater risk.⁶⁴

Children lacking birth certificates or official registration documents, including refugee and internally displaced children, can be at particular risk of trafficking and are among those most difficult for authorities to trace, much less protect. Many countries have adopted national plans of action to combat child trafficking, but the lack of reliable statistical information remains a significant obstacle – most data focus only on the cross-border trafficking of girls and women for sexual exploitation.



A five-year-old girl sells goods to commuters on a train in Buenos Aires, Argentina. She has been working in the city’s mass transit system selling hairpins and other products since she was 3 years old.

© UNICEF/NYHQ2011-0219/Sebastian Rich



© UNICEF/NYHQ2007-1166/Shehzad Nourani

A boy works in a mechanic's workshop in Herat, Afghanistan.

Child labour

Even in the absence of trafficking, many children are forced to work in order to survive. Around the world, an estimated 215 million boys and girls aged 5–17 were engaged in child labour in 2008, 115 million of them in hazardous work.⁶⁵

Children may work as ragpickers or shoeshiners, serve at tea stalls, sell cigarettes on the street, or work in homes or factories. Many of those engaged in child labour experience its worst forms – including forced and bonded work, illicit activities, armed combat and domestic labour. Because they are largely invisible, these forms of child labour are the most difficult to tackle.

Child domestic labour is predominantly an urban phenomenon; children who work in rural areas tend to be involved in agricultural work as unpaid family members. Domestic workers, most of them girls, are isolated and subject to the whims and arbitrary discipline of their employers, from whom they may suffer abuse. Sexual abuse is frequent but seldom prosecuted.

Child domestic workers can also suffer from psychological problems. Research in Kenya, for example, found that they were more likely than other children to experience insomnia, bed-wetting and depression, among other conditions.⁶⁶

Children living and working on the streets

Estimates suggest that tens of millions of children live or work on the streets of the world's towns and cities – and the number is rising with global population growth, migration and increasing urbanization.

Children resort to living and working on the street for many reasons. Violence or abuse at home or in the neighbourhood drives many away, as studies have shown in cities as diverse as Dhaka, Bangladesh, and Moscow, Russian Federation.⁶⁷ Poverty also plays a part. While abuse, conflict or neglect can happen in any family home, children whose poverty and marginalization leave them with few choices often see the street as the best available option for escape.⁶⁸

Living on the street exposes children to violence, yet crimes against them are rarely investigated, and few people are prepared to act in their defence. On the contrary, in the many countries and cities where vagrancy and running away from home are outlawed, children living or working on the street are often the primary victims of such criminalization. Researchers, national bodies and international human rights groups have reported that police and security forces have abused children on the streets of cities all over the world.

Children's gender, age, ethnicity and disability status influence the extent and type of violence they experience and the coping mechanisms they develop. A 2000 study of children on the streets of Brazil's cities showed

that boys were more likely than girls to go hungry and to experience physical violence at the hands of the police. Girls were less likely to beg for money and more likely to sleep in institutions rather than on the street.⁶⁹ Another study conducted that year indicated that girls more frequently internalize violence and are at greater risk of continuous abuse.⁷⁰

The problems outlined in this chapter constitute an unconscionable assault on the rights of children. The following chapters examine more closely some of the challenges and opportunities that children face in cities, and discuss initiatives that seek to improve life for children in an increasingly urban world.

The Millennium Development Goals

The eight Millennium Development Goals (MDGs) cover a spectrum of issues, from poverty and hunger to education, child survival and maternal health, gender equality, combating HIV/AIDS and building a global partnership for development. Progress towards achieving the goals is measured against 21 specific targets.

MDG 7 contains the commitment to ensure environmental stability. One of its urban facets, Target 11, aims to have achieved a significant improvement in the lives of at least 100 million slum dwellers by 2020. This is also known as the 'Cities without Slums' initiative. In addition to environmental concerns and a specific focus on urban slums, MDG 7 also contains a commitment to halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation.

Although one of the targets of MDG 7 is dedicated specifically to slum dwellers, the goals should be seen as a continuum of development priorities. The lives of people in the world's slums cannot improve substantially

without concerted action to eradicate poverty and hunger (MDG 1); achieve universal primary education (MDG 2); promote gender equality and empower women (MDG 3); reduce child mortality (MDG 4); improve maternal health (MDG 5); combat HIV/AIDS (MDG 6); or create a global partnership for development (MDG 8).

Evidence suggests that national approaches to slums are improving as countries move away from negative policies such as neglect, forced eviction or involuntary resettlement towards more positive tactics such as community engagement, slum upgrading and rights-based policies. Nevertheless, the number of slum dwellers worldwide has increased by 60 million since Target 11 was established in 2000.

Slums are the physical manifestation of the urbanization of poverty. Growing numbers of urban dwellers are poor, and inequality in the urban sphere shows no signs of abating. Future international targets will have to take into account the expanding scale of the problem.