

Diminishing benefits of urban living for growth and development of school-aged children and adolescents in the 21st century

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- 2 children and adolescents in the 21st century
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Optimal growth and development in late childhood and adolescence is critical for lifelong 4 health and wellbeing. Many health programmes narrowly focus on specific features of 5 diet and the environment in cities or rural areas¹⁻⁶, with little consideration of the 6 7 similarities or differences in growth and development outcomes in these settings. We 8 used 2,325 population-based studies, with measurement of height and weight in 71 million participants, to report trends from 1990 to 2020 in height and body-mass index 9 (BMI) of children and adolescents aged 5-19 years by rural and urban place of residence 10 in 200 countries and territories. In 1990, children and adolescents in cities were taller 11 than their rural counterparts in all but a few, mostly high-income, countries. By 2020, the 12 urban height advantage became smaller in most countries, and in many high-income 13 western countries reversed into a small urban disadvantage. The exception, where the 14 urban height advantage increased, was for boys in most countries in sub-Saharan Africa, 15 and in some countries in Oceania, South Asia, and the region of central Asia, Middle East 16 and north Africa. In many of these countries, successive cohorts of rural boys either did 17 not gain height or possibly even became shorter. The difference between age-18 standardised mean BMI of children in urban and rural areas was <1.1 kg/m² in the vast 19 majority of countries throughout this period. Within this relatively small range, BMI 20 increased slightly more in cities than in rural areas, except in south Asia, sub-Saharan 21 Africa, and some countries in central and eastern Europe, where rural BMI increased 22 more. In many countries in sub-Saharan Africa, rural BMI surpassed the median of the 23 WHO reference population, and in some cases approached the threshold for being 24 overweight. Our results show that in much of the world, the growth and developmental 25 advantages of living in cities have diminished in the 21st century, whereas in much of 26 sub-Saharan Africa they have amplified. These global trends, and the macroeconomic, 27 social and health system policies that underlie them, have made rural Africa the 28

epicentre of suboptimal growth and development during school ages, with long-term
 adverse consequences for health and wellbeing.

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32 Throughout school ages (i.e., ages 5-19 years), children and adolescents' growth and 33 development are influenced by their nutrition and environment at home, in the community and at school⁷. Healthy growth and development at these ages helps consolidate gains and mitigate 34 inadequacies from early childhood, and vice versa,⁸⁻¹¹ with lifelong implications for health and 35 wellbeing. Until recently, growth and development of older children and adolescents received 36 substantially less attention than in early childhood and adulthood^{12,13}. Increasing policy attention 37 to health and nutrition during school years has been accompanied by a presumption that 38 differences in nutrition and environment lead to distinct, and generally less healthy, patterns of 39 growth and development in these ages in cities compared to their rural counterparts^{1,4,14-21}, even 40 though some empirical studies, in particular in the USA, have found that food quality and 41 nutrition are better in cities²²⁻²⁵. 42

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Data on growth and developmental outcomes in school ages are needed, alongside data on 44 45 efficacy of specific interventions and policies, to select and prioritise policies and programmes both for the increasing urban population and for children who continue to grow up in rural areas. 46 Consistent and comparable global data also help benchmark across countries and draw lessons 47 on good practice. Yet, globally there are far fewer data on growth trajectories in rural and urban 48 areas in these formative ages than for under-five children²⁶ or for adults²⁷. The available studies 49 have been in one country, at one point in time and/or in one sex and narrow age groups^{24,28-33}; 50 the few studies that covered more than one country³⁴⁻³⁶ mostly focused on older girls, and used 51 at most a few dozen data sources and hence could not systematically measure long-term 52 53 trends. Consequently, many policies and programmes that aim to enhance healthy growth and development in school ages focus narrowly, and somewhat generically, on specific features of 54

nutrition or the environment in either cities or rural areas¹⁻⁶, with little attention to similarities and differences between relevant outcomes in these settings, nor to the heterogeneity of the urbanrural difference across countries.

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59 Here, we report on mean height and body-mass index (BMI) of school-aged children and adolescents in rural and urban areas of 200 countries and territories from 1990 to 2020. Height 60 and BMI are anthropometric measures of growth and development that are influenced by the 61 guality of nutrition and healthiness of the living environment, and are highly predictive of health 62 and wellbeing throughout life in observational and Mendelian randomization studies³⁷⁻⁴¹. These 63 studies have shown than having low height and excessively low BMI increases the risk of 64 morbidity and mortality, and low height impairs cognitive development, and reduces educational 65 performance and work productivity in later life^{37,38,40}. Having high BMI in these ages increases 66 the lifelong risk of overweight and obesity and several non-communicable diseases, and might 67 contribute to poor educational outcomes^{39,41}. 68

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70 We used 2,325 population-based studies that had measured height and weight in 71 million 71 participants in 194 countries (Extended Data Fig.1, Supplementary Table 2). We used these data in a Bayesian hierarchical meta-regression model to estimate mean height and BMI of 72 children and adolescents aged 5-19 years by rural and urban place of residence, year and age 73 for 200 countries and territories. Details of data sources and statistical methods are provided in 74 75 Methods. Our results represent height and BMI for children and adolescents of the same age over time, i.e., successive cohorts, in each country's rural and urban areas, and the difference 76 between the two. For presentation, we summarise the 15 age-specific estimates, for single 77 years of age from 5 through 19, through age standardisation which puts each country-year's 78 79 child and adolescent population on the same age distribution, and allows comparisons to be

made over time and across countries. We also show results, graphically and numerically, for
 index ages of 5, 10, 15 and 19 years in Extended Data and Supplementary Materials.

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83 In 1990, school-aged boys and girls who lived in cities had a height advantage (i.e., were taller) 84 compared to their rural counterparts, except in high-income countries where the urban height advantage was either negligible (<1 cm for age-standardised mean height; posterior probability 85 (PP) for urban children being taller ranging from 0.51 to >0.99) or there was even a small rural 86 advantage (e.g., Belgium, Netherlands, and the UK) (PP for rural children being taller ranging 87 from 0.53 to >0.99 where there was a rural height advantage) (Fig. 1A and Extended Data Fig. 88 2). The largest height differences between cities and rural areas in 1990 occurred in some 89 countries in Latin America (e.g., Mexico, Guatemala, Panama and Peru), east and southeast 90 91 Asia (China, Indonesia and Vietnam), central and eastern Europe (Bulgaria, Hungary and 92 Romania), and sub-Saharan Africa (DR Congo and Rwanda). The urban height advantage in boys and girls in the named countries ranged 2.5-5.0 cm and the PP of urban children being 93 taller than rural children was >0.99 (see Supplementary Table 3 for country-specific numerical 94 95 values of height in rural and urban areas, their difference, and the corresponding credible 96 intervals).

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The urban-rural height gap in the late 20th century differed among low- and middle-income 98 countries based on how much children and adolescents in cities and rural areas had 99 100 approached versus fallen behind their peers in high-income countries, where there was little 101 difference in rural and urban height. In countries such as Bulgaria, Hungary and Romania, urban children and adolescents' height approached that of high-income countries, whereas rural 102 103 children and adolescents still lagged behind, leading to a relatively large gap. In much of sub-104 Saharan Africa and south Asia, the height of both urban and rural children and adolescents lagged behind their peers in high-income countries, such that the urban-rural gap was relatively 105

small. In a third group of low- or middle-income countries that included Indonesia, Vietnam,
 Panama, Peru, DR Congo and Rwanda, urban children were still shorter than in high-income
 countries, while rural children lagged so far behind that the urban-rural gap became large.

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110 By 2020, the urban height advantage in school ages became smaller in much of the world, and, in many high-income western countries and some central European countries it disappeared or 111 reversed into a small (typically <1 cm) urban disadvantage (Fig. 1A, Extended Data Fig. 2 and 112 Extended Data Fig. 9). Countries with substantial convergence over these three decades were 113 114 in central and eastern Europe (e.g., Croatia), Latin America and the Caribbean (e.g., Argentina, Brazil, Chile and Paraguay), east and southeast Asia (e.g., Taiwan), and for girls in central Asia 115 (e.g., Kazakhstan and Uzbekistan). The urban height advantage in the named countries 116 declined by ~1-2 cm from 1990 to 2020; the PP of urban-rural height difference having declined 117 ≥0.90 for named countries). In many other middle-income countries (e.g., China, Romania and 118 Vietnam), the urban-rural height gaps declined, but children and adolescents living in cities 119 remained taller than their rural counterparts (by 1.7-2.5 cm in the named countries for boys and 120 girls; PP of urban children being taller than rural children >0.99). The exception to this 121 122 convergence was for boys in most countries in sub-Saharan Africa and some countries in Oceania, South Asia, and the region of central Asia, Middle East and north Africa, where the 123 urban height advantage slightly increased over these three decades. The largest increase in the 124 125 urban height advantage occurred in countries in East Africa such as Ethiopia (0.9 cm larger height gap in 2020 than 1990; 95% credible interval (Crl) -0.9 to 2.9 and PP of increase = 0.93), 126 Rwanda (1.0, -0.7 to 3.0 and PP = 0.88), and Uganda (1.1, -0.6 to 3.1 and PP = 0.89). For girls 127 in many countries in sub-Saharan Africa and south Asia, the urban-rural gap remained largely 128 unchanged. 129

In middle-income and emerging economies (i.e., newly high-income and industrialised 131 132 countries) where rural children and adolescents' height converged to those in cities, successive cohorts of rural children and adolescents outpaced their urban counterparts in becoming taller 133 and attained what urban children in the same countries had done decades earlier: growing to 134 135 heights closer to those seen in high-income countries (Fig. 2). Successive cohorts of rural children and adolescents in sub-Saharan Africa did not experience the accelerated height gain 136 seen in rural areas of middle-income countries; and, in the case of boys, there was no gain, or 137 possibly even a decrease, in height, which in turn led to a persistence or even widening of the 138 urban-rural gap. As a result of these global trends, by 2020, the largest urban-rural height gaps 139 were seen in Andean and central Latin America (e.g., Bolivia, Panama and Peru), by up to 4.7 140 (4.0-5.5) cm for boys and 3.81 (3.3-4.3) cm for girls, and, especially for boys, in sub-Saharan 141 142 Africa (e.g., DR Congo, Ethiopia, Mozambique and Rwanda) by up to 4.2 (2.7-5.7) cm.

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The urban-rural BMI difference was relatively small throughout these three decades: <1.4 kg/m² 144 in all countries and years, and <1.1 kg/m² in all but nine countries, for age-standardised mean 145 BMI (Fig. 1B, Extended Data Fig. 3 and Extended Data Fig. 10). In 1990, the urban-rural BMI 146 147 gap was largest in sub-Saharan Africa (e.g., Ethiopia, Kenya and Malawi, South Africa and Zimbabwe) and south Asia (e.g., Bangladesh and India), followed by parts of Latin America 148 (e.g., Mexico and Peru); the urban-rural BMI gap in the two sexes in the named countries 149 ranged from 0.4-1.2 kg/m² and the PP of urban children having higher BMI than rural children 150 151 ≥0.89. At that time, girls and/or boys in rural areas of some of these countries had mean BMI levels that were close to, and in some ages even below, the thresholds of being underweight 152 (i.e., >1SD below the median of the WHO reference population 42,43). 153

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From 1990 to 2020, the BMI of successive cohorts of both urban and rural children and adolescents increased in all but a few high-income countries (e.g., Denmark, Italy and Spain)

157 (Fig. 3). There was heterogeneity in low- and middle-income countries in how much BMI 158 increased in cities versus rural areas. In the great majority of countries in sub-Saharan Africa and south Asia, BMI of successive cohorts of children and adolescents increased more in rural 159 160 areas than in cities leading to a closing of the urban-rural difference; the reductions in the urbanrural BMI gap ranged from 0.1 to 0.65 kg/m² for both girls and boys, and the PP of urban-rural 161 BMI difference declining from 1990 to 2020 ranged from 0.52 to 0.95. In both sub-Saharan 162 Africa and south Asia, these changes shifted the mean BMI of rural boys and girls out of the 163 range for being underweight; in many countries in sub-Saharan Africa this shift continued 164 beyond the median of the WHO reference population, and in some cases approached the 165 threshold for being overweight (i.e., >1SD above the median of the WHO reference population). 166 The opposite, i.e., a larger rise in urban BMI happened in most other low-and middle-income 167 countries, leading to a slightly larger urban BMI excess in 2020 than in 1990. High-income 168 169 countries and those in central and eastern Europe experienced a mix of increasing and decreasing urban BMI excess but remained within a relatively small range (-0.3 to 0.6 kg/m² for 170 almost all countries) over the entire period of analysis; at the regional level the urban-rural BMI 171 difference changed by <0.25 kg/m² in these regions. 172

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The urban height advantage was larger in boys than girls in most countries (Extended Data Fig. 7). Urban excess BMI was higher in boys in only about one half of countries; in the other half, mostly in high-income western countries and those in sub-Saharan Africa, urban excess BMI was higher in girls. The urban height advantage was slightly larger at five years of age than at 19 years of age in most low- and middle-income countries, especially for girls, but there was little difference across ages in high-income regions and in central and eastern Europe (Extended Data Fig. 4).

Since the introduction of modern sanitation in 19th century, cities provided substantial nutritional 182 183 and health advantages in high-income and subsequently low- and middle-income countries^{25,44,45}. Our results show that, in the 21st century, during school ages these advantages 184 185 have disappeared in high-income countries and diminished in middle-income countries and 186 emerging economies in Asia, Latin America and the Caribbean, and parts of Middle East and north Africa. Specifically, in countries of these regions, successive cohorts of school-aged 187 children and adolescents living in cities were outpaced by those in rural areas in terms of height 188 gain but gained slightly more weight, typically in the unhealthy range. This contrasted with the 189 world's poorest region, sub-Saharan Africa, where the urban height advantage persisted or 190 even expanded while rural mean BMI went beyond remedying underweight and surpassed the 191 median of the WHO reference population in 2020, hence consolidating the urban advantage. 192 193 South Asia had a mixed pattern of urban versus rural trends from 1990 to 2020, with children 194 and adolescents in rural areas gaining both more height and more weight for their height than those in cities in. Importantly, our results also show that differences in height and BMI between 195 urban and rural populations within most countries are smaller than the differences across 196 197 countries, even those in the same region.

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Long-term follow up studies have shown that children and adolescents do not achieve their 199 height potential without sufficient and diverse nutritious foods, or if they are exposed to repeated 200 or persistent infections which result in loss of nutrients^{37,46-48}. Studies with data on household 201 socioeconomic and environmental variables have indicated that these physiological 202 determinants of height are themselves affected by income, quality of the living environment, and 203 access to healthcare in rural as well as urban areas^{49,50}. This evidence indicates that, underlying 204 our finding on small urban-rural height differential in high-income countries may be a greater 205 206 abundance of nutritious foods, including some fortified foods, better healthcare, and greater ability to finance programmes that promote healthy growth in countries with greater per-capita 207

208 income and better infrastructure. Variations across these countries in the urban-rural height gap 209 within this small range may be due to socioeconomic inequalities, poverty differentials and differences in availability and cost of different foods between cities and rural areas, and whether 210 211 there are specific programmes that improve nutrition of disadvantaged rural and urban groups⁵¹ ⁵³. The more striking changes in height in urban versus rural areas took place in middle-income 212 countries and emerging economies. Case studies in some countries where the of heights of 213 214 rural and urban children and adolescents converged show that the convergence was partly due to using the growth in national income towards programmes and services that helped close 215 gaps in nutrition, sanitation and healthcare between different areas and social groups⁵⁴⁻⁵⁹. In 216 countries in central and eastern Europe, transition to a market economy and increases in trade 217 may have reduced disparity in access to, and seasonality of, healthy foods between urban and 218 219 rural areas⁶⁰, and partly underlie the convergence of height seen in our results. In contrast, 220 country case studies show that where economic growth was accompanied by large inequalities in income, nutrition and/or services, the urban advantage persisted⁶¹⁻⁶⁷. 221

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We also found that the urban-rural BMI gap, although dynamic, changed much less than the 223 224 BMI of either subgroup of the population, and less than commonly assumed when discussing the role of cities in the obesity epidemic^{1,4,14,17,19,20}. Urban-rural BMI differences were especially 225 small in high-income countries, consistent with the evidence from a few countries that diets and 226 behaviours are affected more by household socioeconomic status than whether children and 227 adolescents live in cities or rural areas^{23,53,68-70}. Urban BMI excess increased slightly more in 228 middle-income countries in east and southeast Asia, Latin America and the Caribbean, and 229 Middle East and north Africa, a trend that was the opposite of the convergence in BMI of adults 230 in these same regions²⁷. Additional analysis of NCD-RisC data for young adults (20-29 and 30-231 232 39 years) showed that the shift from a small divergent trend to convergence of BMI between urban and rural areas happens in young adulthood (Extended Data Fig. 8), a period during 233

which there is substantial, but variable, weight gain among population subgroups⁷¹⁻⁷³. These shifts in trends from adolescence to young adulthood might be a result of changes in diet and energy expenditure that accompany changes in household structure, social and economic roles and the living environment⁷⁴⁻⁸⁰.

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The notable exception in the global trends was sub-Saharan Africa, where a stagnation or 239 reversal of height gain in rural areas led to persistence or widening of urban-rural height 240 differences, while the opposite happened for BMI. Case studies of specific countries have 241 indicated that unfavourable trends in nutrition in rural Africa, where the majority of the world's 242 poorest people live⁸¹, started from macroeconomic shocks in the late 20th century, and the 243 subsequent agriculture, trade and development policies that limited improvements in income 244 and services in rural Africa, which increased urban-rural income inequality, and emphasised 245 agricultural exports over local food security and diversity⁸²⁻⁸⁷. These macroeconomic factors in 246 turn led to less diverse diets, with higher caloric intake rather than shifting to protein- and 247 nutrient-rich foods (e.g., animal products, seafood, fruits and vegetables)⁸⁶⁻⁹⁴, while the slow 248 expansion of infrastructure and services in rural areas restricted improvements in other 249 determinants of healthy growth such as clean water and sanitation and health care^{94,95}. 250 Secondary factors underlying the observed trends in height and BMI in rural sub-Saharan Africa 251 may be changes in the age of puberty onset, which is influenced by weight gain during 252 childhood, and might affect height gain during the adolescent growth spurt and in late 253 adolescence^{96,97}, differential trends in survival beyond five years of age in rural and urban areas, 254 and possibly rural to urban migration. 255

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257 Some researchers and international development organisations have argued that the 258 simultaneous rise, as a result of the COVID-19 pandemic and of the invasion of Ukraine, in 259 poverty and the cost of agricultural supplies like fertilisers and food, especially of nutrient-rich

foods, can hinder and set back the gains in growth and development throughout the world⁹⁸⁻¹⁰². 260 These setbacks may be particularly large in poor countries and population subgroups, both 261 those in rural areas who rely on food production and those in cities who purchase foods. These 262 groups, especially those in rural Africa, already face food insecurity^{91,103} and emerged in our 263 264 results as the most pronounced loci of suboptimal growth and development during school ages, with potential long-term adverse consequences for health and wellbeing. As attention in global 265 health turns to older children and adolescents¹⁰⁴, there is a need for policies and programmes 266 that take into account patterns of growth and development in population subgroups. Our results 267 on growth and development outcomes in rural and urban areas of different countries, together 268 with the extant evidence on the role of poverty and poor infrastructure and services⁵⁰, indicate 269 that there is a need for social, economic and development policies that reduce poverty and 270 infrastructure inadequacies and inequalities across and within rural and urban areas^{105,106}. 271 272 Second, as these macro policies are implemented and with deteriorating global poverty and food crises, based on the evidence from specific countries on the benefits of targeted nutrition 273 programmes and health and social services^{58,107-115}, there is an urgent need for programmes 274 that equalise nutrition, and health and social services for children and adolescents at home, 275 276 school and in the community.

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587 Methods

We estimated trends in mean height and BMI for children aged 5-19 years from 1990 to 2020 by rural and urban place of residence for 200 countries and territories listed in Supplementary Table 1. We pooled, in a Bayesian meta-regression, repeated cross-sectional population-based data on height and BMI. Our results represent estimates of height and BMI for children and adolescents of the same age over time, i.e., for successive cohorts, in each country's rural and urban settings.

594

595 Data sources

We used a database on cardiometabolic risk factors collated by the Non-Communicable 596 Disease Risk Factor Collaboration (NCD-RisC). Data were obtained from publicly available 597 multi-country and national measurement surveys (e.g., Demographic and Health Surveys 598 (DHS), WHO-STEPwise approach to Surveillance (STEPS) surveys, and those identified via the 599 Inter-University Consortium for Political and Social Research, UK Data Service, and European 600 Health Interview & Health Examination Surveys Database). With the help of World Health 601 Organization (WHO) and its regional and country offices as well as World Heart Federation, we 602 603 identified and accessed population-based survey data from national health and statistical agencies. We searched and reviewed published studies as detailed previously¹¹⁶ and invited 604 eligible studies to join NCD-RisC, as did we with data holders from earlier pooled analyses of 605 cardiometabolic risk factors¹¹⁷⁻¹²⁰. The NCD-RisC database is continuously updated through all 606 the above routes and periodic requests to NCD-RisC members to suggest additional sources in 607 their countries. 608

609

We carefully checked that each data source met our inclusion criteria, as listed below. Potential duplicate data sources were first identified by comparing studies from the same country and year, followed by checking with NCD-RisC members that had provided data about whether the

sources from the same country and year were the same or distinct. If two sources were confirmed as duplicates, one was discarded. All NCD-RisC members were also periodically asked to review the list of sources from their country, to verify that the included data meet the inclusion criteria and are not duplicates.

617

For each data source, we recorded the study population, sampling approach, years of 618 measurement, and measurement methods. Only data that were representative of the population 619 were included. All data sources were assessed in terms of whether they covered the whole 620 country, multiple subnational regions (i.e., one or more subnational regions/provinces/states, 621 more than three cities or more than five rural communities), or one or a small number of 622 communities (limited geographical scope not meeting above national or subnational criteria), 623 and whether participants in rural, urban or both areas were included. As stated in the sections 624 on statistical model, these study-level attributes were used in the Bayesian hierarchical model to 625 estimate mean height and BMI by country, year, sex, age and place of residence using all 626 available data while taking into account differences in the populations from which different 627 studies had sampled. All submitted data were checked by at least two independent persons. 628 629 Questions and clarifications were discussed with NCD-RisC members and resolved before data were incorporated in the database. 630

631

Anonymised individual data from the studies in the NCD-RisC database were reanalysed according to a common protocol. We calculated mean height and mean BMI, and the associated standard errors, by sex, single year of age from five to 19 years, and rural or urban place of residence. Additionally, for analysis of height, participants aged 20-30 years were included, assigned to their corresponding birth cohort, because mean height in these ages would be at least that when they were aged 19 years, given that the decline of height with age begins in the third and fourth decades of life¹²¹. All analyses incorporated sample weights and

639 complex survey design, when applicable, in calculating summary statistics. For studies that had 640 used simple random sampling, we calculated mean as average of all individuals within the group and their associated standard errors (standard deviation divided by the square root of 641 sample size); for studies that had used multistage (stratified) sampling, we accounted for survey 642 643 design features including clusters, strata and sample weights, to weight each observation by the inverse sampling probability and estimate standard error via Taylor series linearisation, as 644 implemented in the R 'survey' package¹²². Computer code was provided to NCD-RisC members 645 who requested assistance. For surveys without information on place of residence, we calculated 646 age- and sex-stratified summary statistics for the entire sample, which represented the 647 population-weighted sum of rural and urban means; data on the share of population in urban 648 versus rural areas were from the United Nations Population Division¹²³. 649

650

Additionally, summary statistics for nationally representative data from sources that were identified but not accessed via the above routes were extracted from published reports. Data were also extracted for two STEPS surveys that were not publicly available. We also included data from a previous global-data pooling study¹²⁰, when not accessed through the above routes.

655

656 **Data inclusion and exclusion**

⁶⁵⁷ Data sources were included in the NCD-RisC height and weight database if:

• measured data on height and weight were available;

• study participants were five years of age and older;

• data were collected using a probabilistic sampling method with a defined sampling frame;

• data were from population samples at the national, subnational, or community level as 662 defined above; and

• data were from the countries and territories listed in Supplementary Table 1.

We excluded all data sources that were solely based on self-reported weight and height without a measurement component because these data are subject to biases that vary by geography, time, age, sex and socioeconomic characteristics¹²⁴⁻¹²⁶. Due to these variations, approaches to correcting self-reported data may leave residual bias. We also excluded data sources on population subgroups whose anthropometric status may differ systematically from the general population, including:

studies that had included or excluded people based on their health status or cardiovascular
 risk;

• studies whose participants were only ethnic minorities;

• specific educational, occupational, or socioeconomic subgroups, with the exception noted below;

• those recruited through health facilities, with the exception noted below; and

• females aged 15-19 years in surveys which sampled only ever-married women or measured height and weight only among mothers.

679

We used school-based data in countries and age-sex groups with school enrolment of 70% or higher. We used data whose sampling frame was health insurance schemes in countries where at least 80% of the population were insured. Finally, we used data collected through general practice and primary care systems in high-income and central European countries with universal insurance, because contact with the primary care systems tends to be as good as or better than response rates for population-based surveys.

686

We excluded <0.01% of all participants whose age was <18 years and whose data not reported by single year of age because height and weight may have non-linear age associations in these

689 ages, especially during growth spurts. We excluded BMI data for females who were pregnant at 690 the time of measurement (<0.01% of all participants). We excluded <0.2% of all participants who had recorded height outside the range <60 cm or >180 cm for ages <10 years; <80 cm or 691 >200 cm for ages 10-14 years; <100 cm or >250 cm for ages ≥15 years, recorded weight 692 693 outside the range <5 kg or >90 kg for age <10 years; <8 kg or >150 kg for ages 10-14 years; <12 kg or >300 kg for ages \geq 15 years, or recorded BMI outside the range <6 kg/m² or >40 kg/m² 694 for ages < 10 years; <8 kg/m2 or >60 kg/m² for ages 10-14 years; <10 kg/m2 or >80 kg/m² for 695 ages ≥15 years. 696

697

698 Conversion of BMI prevalence metrics to mean BMI

In 0.5% of our data points mostly extracted from published reports or from a previous pooling analysis¹²⁰, mean BMI was not reported, but data were available for the prevalence of one or more BMI categories, for example, BMI \geq 30 kg/m². In order to use these data, we used previously validated conversion regressions⁴³ to estimate the missing primary outcome from the available BMI prevalence metric(s). Additional details on regression model specifications along with the regression coefficients are reported on <u>https://github.com/NCD-RisC/ncdrisc-methods/</u>.

705

706 Statistical model overview

We used a Bayesian hierarchical meta-regression model to estimate mean height and BMI by country, year, sex, age and place of residence using the aforementioned data. For presentation, we summarised the 15 age-specific estimates, for single years of age from 5 through 19, through age standardisation which puts each country-year's child and adolescent population on the same age distribution, and hence allows comparisons to be made over time and across countries. We generated age-standardised estimates by taking weighted means of age-specific estimates, using age weights from the WHO standard population¹²⁷. We also show results, graphically and numerically, for index ages of 5, 10, 15 and 19 years in Extended Data and
Supplementary Materials.

716

The statistical model is described in detail in statistical papers^{128,129}, related substantive 717 papers^{13,26,27,43,117-120,130} and in the section below on model specification. In summary, the model 718 had a hierarchical structure in which estimates for each country and year were informed by its 719 own data, if available, and by data from other years in the same country and from other 720 countries, especially those in the same region and super-region, with data for similar time 721 periods. The extent to which estimates for each country-year were influenced by data from other 722 years and other countries depended on whether the country had data, the sample size of the 723 data, whether they were national, and the within-country and within-region variability of the 724 available data. For the purpose of hierarchical analysis, countries were organised into 21 725 726 regions, mostly based on geography and national income (Supplementary Table 1). Regions were in turn organised into nine super-regions. 727

728

We used observation year, i.e., the year in which data were collected, as the time-scale for the analysis of BMI and birth year as the time scale for the analysis of height, consistent with previous

analyses^{13,43,131}. Time trends were modelled through a combination of a linear term, to capture gradual long-term change, and a second-order random walk, which allows for non-linear trends¹³², both modelled hierarchically The age associations of height and BMI were modelled, using cubic splines, to allow non-linear changes over age, including periods of rapid as well as slow rise.. Periods of rapid rise represent adolescent growth spurts, which occur earlier in girls than boys^{42,133,134}, was reflected in placement of spline knots for boys and girls, respectively, as detailed in the section on model specification. Spline coefficients were allowed to vary across

countries, based on their own data as well as in a hierarchical structure, as previously
 described¹³⁰.

741

742 The model also accounted for the possibility that height or BMI in subnational and community 743 samples might differ systematically from nationally representative samples and have larger variation than in national studies. These features were accounted for through the inclusion of 744 fixed-effect and random-effect terms for subnational and community data as detailed in the 745 model specification section below. The fixed effects accounted for systematic differences 746 between subnational or community studies and national studies. The inclusion of random effects 747 allowed national data to have greater influence on the estimates than subnational or community 748 data with similar sample sizes, because the subnational and community data have additional 749 variance from the random effect terms. Both were estimated empirically as a part of model 750 751 fitting.

752

Following the approach of previous papers^{26,27,128}, the model included parameters representing 753 the urban-rural height or BMI difference, which is empirically estimated and allowed to vary by 754 country, year, and age. We further expanded the model to allow urban-rural difference in height 755 or BMI to vary by age, as height or weight with age may vary between rural versus urban 756 children. If data for a country-year-age group contained mixed urban and rural children, but 757 were not stratified by place of residence (21% of all data sources), the estimated BMI difference 758 759 was informed by stratified data from other age groups, years and countries, especially those in the same region with data from similar time periods and/or ages. 760

761

762 Statistical model specification

As stated earlier, for each data source, we calculated mean height and BMI, together with corresponding standard errors, stratified by sex, age and rural or urban place of residence. For

sources that did not stratify the sample on the place of residence, we obtained age-and-sexstratified data. Each study contributed up to 30 mean BMI data points or 32 mean height data points for each sex with the exact number depending how many age groups were represented in the study, and whether or not the study provided data stratified on urban and rural place of residence. The likelihood for an observation at urbanicity level *s* (urban-only, rural-only or mixed; referred to as stratum hereinafter) and age group h, with age *z*, from study *i*, carried out in country *j* at time *t* is:

$$y_{s,h,i} \sim N(a_{j[i]} + b_{j[i]}t_i + u_{j[i],t_i} + \gamma_i(z_h) + X_i\beta + e_i + I_{s,i}[p_{j[i]} + q_{j[i]}t_i + r_{j[i]}z_h + d_i], SD^2_{s,h,i} - \tau_i^2)$$

772

where the country-specific intercept and linear time slope from the j^{th} country ($j = 1 \dots J$, where J 773 = 200 which is the total number of countries in our analysis) are denoted a_i and b_i , respectively. 774 We describe the hierarchical model used for the a's and b's in *Linear components of country* 775 776 *time trends* section. Letting T = 31 be the total number of years from 1990 to 2020, the *T*-vector u_i captures smooth non-linear change over time in country j, as described in Non-linear change 777 section. The age effects of the h^{th} age group (with age z) in study i are denoted by γ_i ; we 778 describe the age model in Age model section. The matrix X contains terms describing whether 779 780 studies were representative at the national, sub-national or community level. In addition, a random effect, e_i, is estimated for each study, described in Study-level term and study-specific 781 random effects section. 782

783

784 Linear components of country time trends

The model had a hierarchical structure: studies were nested in countries, which were nested in regions (indexed by k), which were nested in super-regions (indexed by l), which were, of course, all nested in the globe (see Supplementary Table 1 for list of countries in each region, and regions in each super-region). This structure allowed the model to share information across units to a greater degree when data were non-existent or weakly informative (e.g., have a small
 sample size or were not nationally representative), and to a lesser extent in data-rich countries
 and regions¹³⁵.

792

The *a* and *b* terms are country-specific linear intercepts and time slopes with terms at each level of the hierarchy, denoted by the superscripts c, r, s, and g, respectively:

$$a_j = a_j^c + a_{k[j]}^r + a_{l[k]}^s + a^g$$
$$b_j = b_j^c + b_{k[j]}^r + b_{l[k]}^s + b^g$$
$$a_j^x \sim N(0, \kappa_a^x)$$

 $b_i^x \sim N(0, \kappa_b^x)$ (where $x = \{c, r, s\}$)

795

796

797 The κ terms are each assigned a flat prior on the standard deviation scale¹³⁶. We also assigned 798 flat priors to a^g and b^g .

799

800 Non-linear change

Mean BMI or height may change non-linearly over time^{13,43,116,120,131}. We captured smooth nonlinear change in time in urban and rural strata of country *j* using the vector u_j . Just as a_j and b_j are each defined as the sum of country, region, super-region, and global components, we defined:

$$u_j = u_j^c + u_{k[j]}^r + u_{l[k]}^s + u^g$$

805

In order to allow the model to differentiate between the degrees of non-linearity that exist at the country, region, super-region, and global levels, we assigned each of the *u*'s four components a Gaussian autoregressive prior as in Breslow and Clayton¹³⁷ and Rue and Held¹³². In particular, the *T*-vectors u_i^c (j = 1 ... J), u_k^r (k = 1 ... K), u_l^s (l = 1 ... L), and u^g each have a normal prior with mean zero and precision $\lambda_c P$, $\lambda_r P$, $\lambda_s P$, and $\lambda_q P$ respectively, where the scaled precision

811 matrix *P* in the Gaussian autoregressive prior penalizes first and second differences:

$$P = \begin{bmatrix} 1 & 0 & 0 & \cdots & 0 \\ -2 & 1 & 0 & \cdots & 0 \\ 1 & -2 & 1 & \cdots & 0 \\ 0 & 1 & -2 & \cdots & 0 \\ 0 & 0 & 1 & \cdots & 0 \\ \vdots & \vdots & \vdots & \ddots & \vdots \\ 0 & 0 & 0 & \cdots & 1 \end{bmatrix} \begin{bmatrix} 1 & -2 & 1 & 0 & 0 & \cdots & 0 \\ 0 & 1 & -2 & 1 & 0 & \cdots & 0 \\ \vdots & \vdots & \vdots & \vdots & \ddots & \vdots \\ 0 & 0 & 0 & 0 & 0 & \cdots & 1 \end{bmatrix}$$
$$= \begin{bmatrix} 1 & -2 & 1 & 0 & 0 & \cdots & 0 \\ -2 & 5 & -4 & 1 & 0 & \cdots & 0 \\ 1 & -4 & 6 & -4 & 1 & \cdots & 0 \\ 0 & 1 & -4 & 6 & -4 & \cdots & 0 \\ 0 & 1 & -4 & 6 & -4 & \cdots & 0 \\ \vdots & \vdots & \vdots & \vdots & \vdots & \ddots & \vdots \\ 0 & 0 & 0 & 0 & 0 & \cdots & 1 \end{bmatrix}.$$

812

P is multiplied by the estimated precision parameters λ_c , λ_r , λ_s , and λ_g , thus up-weighting or 813 down-weighting the strength of its penalties and ultimately determining the degree of smoothing 814 at each level. For each of the four precision parameters, we used a truncated flat prior on the 815 standard deviation scale $(1/\sqrt{\lambda})$ as recommended by Gelman¹³⁶. We truncated these priors such 816 that $\log \lambda \leq 20$ for each of the four λ 's. This upper bound is enforced as a computational 817 convenience: models with $\log \lambda > 20$ are treated as equivalent to a model with $\log \lambda = 20$ as they 818 819 essentially have no extra-linear variability in time. In practice, this upper bound had little effect on the parameter estimates. Furthermore, we order the λ 's a priori: $\lambda_c < \lambda_r < \lambda_s < \lambda_g$. This prior 820 constraint conveys the natural expectation that, for example, the global BMI trend has less 821 822 extra-linear variability than the trend of any given region.

The matrix *P* has rank T - 2, corresponding to a flat, improper prior on the mean and the slope of the u_j^c 's, the u_k^r 's, the u_l^s 's and of u^g , and is not invertible¹³⁸ Thus, we have a proper prior in a reduced-dimension space as discussed in Rue and Held¹³², with the prior expressed as:

$$P(u_j^c|\lambda_c) \propto \lambda_c^{\frac{T-2}{2}} \exp\left\{-\frac{\lambda_c}{2}u_j^{c'}Pu_j^c\right\}$$

827

Note that if u_j^c had a non-zero mean, this would introduce non-identifiability with respect to a_j^c . By the same token, b_j^c would not be identified if u_j had a non-zero time slope, and similarly for the other means and slopes. Thus, in order to achieve identifiability of the *a*'s, *b*'s, and *u*'s, we constrained the mean and slope of u^g and of each u^s , u^r , and u^c to be zero. Enforcing orthogonality between the linear and non-linear portions of the time trends means that each can be interpreted independently.

834

In cases where we have observations for at least two different time points, this improper prior will not lead to an improper posterior since the data will provide information about the mean and slope. However, to enforce the desired orthogonality between the linear and non-linear portions of the model, we constrained the mean and slope of the u_j^c 's, u_k^r 's, u_l^s 's, and of u^g to be zero, using the approach described by Rue and Held¹³².

840

For the six countries with no height data, and seven countries with no BMI data, we took the Moore-Penrose pseudoinverse of P^{139} , setting to infinity those eigenvalues that correspond to the non-identifiability. This effectively constrains the non-identified portions of the model to zero, as the corresponding variances are set to zero¹³⁷; in this case the Rue and Held correction¹³² is not needed. An intermediate case occurs when data are observed for only one time point in a country. In this case, the full conditional precision has rank T - 1 because the mean but not the linear trend of u_j^c is identified by the data. We thus constrained the linear trend of u_j^c to zero by taking the generalised inverse of the full conditional precision. We then constrained the mean of u_j^c to zero using the one-dimensional version of the correction described in Rue and Held¹³².

850

851 Age Model

To capture sex-specific patterns of growth, especially adolescent growth spurts, we modelled age using cubic splines. The number and position of splines' knots were selected based on a combination of physiological and statistical considerations, as described in a national level analysis¹³. For age group *h* with age *z*, in study *i*, the age effect for height and BMI is given, respectively, by:

857
$$\gamma_{i}(z_{h}) = \gamma_{1i}z_{h} + \gamma_{2i}z_{h}^{2} + \gamma_{3i}z_{h}^{3} + \gamma_{4i}(z_{h} - k_{1})_{+}^{3} + \gamma_{5i}(z_{h} - k_{2})_{+}^{3} + \gamma_{6i}(z_{h} - k_{3})_{+}^{3} + \gamma_{7i}(z_{h} - k_{4})_{+}^{3}$$
858
$$\gamma_{i}(z_{h}) = \gamma_{1i}z_{h} + \gamma_{2i}z_{h}^{2} + \gamma_{3i}z_{h}^{3} + \gamma_{4i}(z_{h} - k_{1})_{+}^{3} + \gamma_{5i}(z_{h} - k_{2})_{+}^{3}$$
(BMI)

859

For height, four spline knots were placed at ages $\{k_1, k_2, k_3, k_4\} = \{8, 10, 12, 14\}$ for girls and at ages $\{k_1, k_2, k_3, k_4\} = \{10, 12, 14, 16\}$ for boys. For BMI, we used two spline knots (at ages 10 and 15 years) because, at the population level, changes in BMI with age are smoother than those in height^{13,42,133}. Each of the spline coefficients was allowed to vary across countries, with a hierarchical structure as described in a previous paper¹³⁰, using the equation below, where ψ is the global intercent and *c*, *r*, *s* are the country, region and super-region random intercepts, respectively, The age effect coefficients ($\gamma_{k,i}$) for each age group *h*, with age *z*, are given by:

867

$$\gamma_{k,i} = \psi_k + c_{k,j}[i] + r_{k,l}[i] + s_{k,m}[i]$$

$$c_{k,j} \sim N(0, \sigma_{k,c}^2)$$

$$r_{k,l} \sim N(0, \sigma_{k,r}^2)$$

 $s_{k,l} \sim N(0, \sigma_{k,s}^2)$

A flat improper prior was placed of each of the σ_k 's.

(height)

869

870 Study-level term and study-specific random effects

Mean height or BMI from individual studies may deviate from the true country-year mean due to factors associated with sampling, response or measurement. We used a study-level term to help account for potential systematic differences associated with data sources that are representative of sub-national and community populations. Our model thus included timevarying offsets (referred to as fixed effects above) for sub-national and community data in the term $X_i\beta$:

$$\begin{aligned} \boldsymbol{X}_{i}\boldsymbol{\beta} &= \beta_{1}I\left\{X_{j[i],t[i]}^{cvrg} = \text{subnational}\right\} + \beta_{2}I\left\{X_{j[i],t[i]}^{cvrg} = \text{subnational}\right\}t_{i} + \\ \beta_{3}I\left\{X_{j[i],t[i]}^{cvrg} = \text{community}\right\} + \beta_{4}I\left\{X_{j[i],t[i]}^{cvrg} = \text{community}\right\}t_{i} \end{aligned}$$

877

where $X_{j[i],t[i]}^{curg}$ is the indicator for whether the coverage of study *i*, in country *j* and year *t*, is subnational or community.

880

Even after accounting for sampling variability, national studies may still not reflect the country's 881 882 true mean BMI level with perfect accuracy, and sub-national and community studies have even larger variability. In study i, the study-specific random effect e_i allows all age groups from the 883 same study to have an unusually high or an unusually low mean after conditioning on the other 884 terms in the model. Each e_i is assigned a normal prior with variance depending on whether 885 study *i* is representative at the national, sub-national or community level. Random effects from 886 national studies were constrained to have smaller variance (v_n) than random effects of sub-887 national studies (v_s), which were in turn constrained to have smaller variance than community 888 studies (v_c). To make country-level predictions, we set $e_i = 0$, thus not including random effects 889 due to imperfections in study design and to within-country variability of BMI means. 890

892 Urban and rural strata

To model mean height and BMI by urban and rural places of residence, the model included offsets for the two strata. The offsets were captured by country-specific intercept, linear time and age effects, using a centred indicator term ($I_{s,i}$):

896
$$I_{s,i}[p_{j[i]} + q_{j[i]}t_i + r_{j[i]}z_h + d_i] \quad \text{(where, } I_{s,i} = -1 + 2X_{s,i}^{urb} \text{)}$$

897 with

$$X_{s,i}^{urb} = \begin{cases} 1, & \text{if stratum } s \text{ contains only urban individuals} \\ 0, & \text{if stratum } s \text{ contains only rural individuals} \\ X_{j[i],t[i]}^{urb} & \text{if stratum } s \text{ contains a mixture of urban and rural individuals} \end{cases}$$

In other words, for data not stratified by place of residence, the model treats the unstratified mean height or BMI as equivalent to the weighted sum of the (unobserved) urban sample mean BMI and rural sample mean BMI, with the weights based on the proportion of the study country's population living in urban areas in the year of the survey $(X_{j[i],t[i]}^{urb})$.

902

The intercept (p) and slope (q) terms capture the country-to-country variation in the magnitude of the height or BMI difference between urban and rural populations and how the difference changes over time. The slope (r) captures the country-to-country variation in the BMI or height difference between urban and rural populations across age groups. These were specified with the same geographical hierarchy as the country-specific intercepts (a) and slopes (b):

908
$$p_j = p_j^c + p_{k[j]}^r + p_{l[k]}^s + p^g,$$

909
$$q_j = q_j^c + q_{k[j]}^r + q_{l[k]}^s + q^g,$$

910
$$r = r_j^c + r_{k[j]}^r + r_{l[k]}^s + r^g,$$

911
$$p_j^x \sim N(0, \kappa_p^x)$$

912
$$q_j^x \sim N(0, \kappa_q^x),$$

913
$$r_j^x \sim N(0, \kappa_r^x)$$
 (where, $x = \{c, r, s\}$)

The study random effect term d_i incorporates deviations from the country-level urban-rural difference in each study and is analogous to e_i .

916

917 Residual age-by-study variability

The age patterns across communities within a given country may differ from their country's overall age pattern. This within-study variability cannot be captured by the *e*'s, which are equal across age-specific observations in each study, so we include an additional variance component for each study, τ_i^2 . We again assume that there is less residual variability in national studies than in sub-national and community-level studies, with $\tau_n^2 < \tau_s^2 < \tau_c^2$.

923

924 Model implementation

All analyses were done separately by sex because age, geographical and temporal patterns of 925 height and BMI differ between girls and boys^{13,43}. We fitted the statistical model using Markov 926 chain Monte Carlo (MCMC). We started 35 parallel MCMC from randomly-generated over-927 dispersed starting values. For computational efficiency, each chain was run for a total of 75,000 928 iterations. All chains converged to the same target distribution within this number, but with the 929 930 over-dispersed initial values, the length of burn-in required to converge to the target distribution varied. After the runs were completed, we used trace plots to monitor convergence and select 931 chains that had completed burn-in within 35,000 iterations. This resulted in 16 chains for boys 932 and 17 for girls for BMI; 14 chains for boys and 16 for girls for height. Within each chain, post-933 burn-in iterations were thinned by keeping every 10th iteration, which were then combined for all 934 chains and further thinned to a final set of 5,000 draws of the model parameter estimates. We 935 used the posterior distribution of the model parameters to obtain the posterior distributions of 936 our outcomes: mean urban and rural height and BMI, and the urban-rural difference in mean 937 938 height and BMI. Posterior estimates were made for by one-year age groups from five to 19

939 years, as well as for age-standardised outcomes, by year. The reported credible intervals 940 represent the 2.5th and the 97.5th percentiles of the posterior distributions. We also report the 941 posterior standard deviation of estimates, and posterior probability that the estimated change in 942 height or BMI in rural or urban areas, and in the estimated urban-rural height or BMI difference 943 over time, represents a true increase or decrease.

944

Convergence was confirmed for the country-sex specific posterior outcomes – namely mean urban height and BMI, mean rural height and BMI and the urban-rural difference in mean height and BMI – for reporting ages (5, 10, 15, 19 years and age-standardised) and years (1990 and 2020) using the R-hat diagnostic^{140,141}. For height, the 2.5th to 97.5th percentiles of the R-hats for the reporting ages and years were 0.999-1.010 for girls and 0.999-1.004 for boys. For BMI, the 2.5th to 97.5th percentiles of the R-hats were 0.999-1.004 for girls and 0.999-1.005 for boys.

951

We applied the pool-adjacent-violators algorithm, a monotonic regression that uses an iterative algorithm based on least squares to fit a free-form line to a sequence of observations such that the fitted line is non-decreasing^{142,143}, on the posterior height estimates to ensure that each birth cohort's height increased monotonically with age. In practice, this had little effect on the results, with height at age 19 years adjusted by an average 0.26 cm or less for both boys and girls.

957

958 Strengths and limitations

An important strength of our study is its novel scope of presenting consistent and comparable estimates of urban and rural height and BMI among school-aged children and adolescents, which is essential to formulate and evaluate policies that aim to improve health in these formative ages. We used an unprecedented amount of population-based data from 194 countries and territories covering ~99% of the world's population. We maintained a high level of data quality and representativeness through repeated checks of study characteristics against
965 our inclusion and exclusion criteria, and did not use any self-reported data to avoid bias in height and weight. Data were analysed according to a consistent protocol, and the 966 characteristics and quality of data from each country were rigorously verified through repeated 967 checks by NCD-RisC members. We used a statistical model that used all available data and 968 969 took into account the epidemiological features of height and BMI by using non-linear time trends and age associations. The model used the available information on the urban-rural difference in 970 height and BMI and estimated the age- and time-varying urban-rural difference for all countries 971 972 hierarchically.

973

Despite our extensive efforts to identify and access data, some countries and regions had fewer 974 data, especially those in the Caribbean and Polynesia, Micronesia, and sub-Saharan Africa. Of 975 976 the studies used, fewer than half had data for children aged 5-9 years compared with nearly 977 90% with data for children and adolescents aged 10-19 years, which increases the uncertainty of findings. The scarcity of data is reflected in the larger uncertainty of our estimates for these 978 countries and regions, and younger age groups. This reflects the need to systematically include 979 school-aged children in both health and nutrition surveys, and especially in countries where 980 981 school enrolment is high, to use schools as a platform for monitoring growth and developmental outcomes for entire national populations and key subgroups such as those in rural and urban 982 areas. Though urban and rural classifications are commonly based on national statistical offices 983 definitions, classification of cities and rural areas may, appropriately, vary by country due to their 984 985 demographic characteristics (e.g., population size or density), economic activity, administrative structures, infrastructure and environment. Similarly, urbanisation takes place through a variety 986 of mechanisms such as changes in fertility in rural and urban areas, migration, and 987 reclassification of previously rural areas to urban as they grow and industrialise. Each of these 988 989 mechanisms may have different implications for nutrition and physical activity, and hence height and/or BMI, and should be a subject of studies that follow individual participants and changes in 990

their place of residence. Finally, there is variation in growth and development of children within rural or urban areas, based on household socioeconomic status and community characteristics that affect access to and the quality of nutrition, the living environment and healthcare^{29,50,144}. Among these, in some cities, a large number of families live in slums^{25,145}. School-aged children and adolescents in slums have nutrition, environment and healthcare access that is typically worse than other residents of the city, although often better than those in rural areas^{25,145-148}.

997

998 **Data availability**

Estimates of mean BMI and height by country, year, sex, single year of age as well as agestandardised, and place of residence (urban and rural) will be available from www.ncdrisc.org in machine-readable numerical format and as visualisations upon publication of the paper. Input data from publicly available sources can also be downloaded from www.ncdrisc.org upon publication of the paper. For other data sources, contact information for data providers can be obtained from www.ncdrisc.org.

1005

1006 **Code availability**

1007 The computer code for the Bayesian hierarchical model as well as code to generate tables and 1008 figures used in this work will be available at www.ncdrisc.org upon publication of the paper.

1009

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1096 Supplementary information

This file contains Supplementary Tables 1-4, Supplementary Figures 1-6 and SupplementaryReferences.

1099

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1106

1107 Author contributions

AM, BZ, ARM, HB and RS led the data collection and management. AM, BZ, ARM, HB, CJP, JEB and ME developed the statistical method. AM, BZ, ARM and HB coded the statistical method. Am conducted analyses and prepared results. Pooled Analysis and Writing Group contributed to study design, collated data and checked data sources in consultation with the Country and Regional Data Group. Country and Regional Data Group collected and reanalysed data and checked pooled data. ME, AM, BZ, ARM and HB wrote the first draft of the report. Other authors commented on the draft report.

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Fig. 1. Change in the urban-rural height and body-mass index (BMI) difference from 1990
to 2020.

2460

(A) Change in urban-rural difference in age-standardised mean height in relation to change in
age-standardised mean rural height. (B) Change in urban-rural difference in age-standardised
mean BMI in relation to change in age-standardised mean rural BMI. (C) Change in urban-rural
difference in age-standardised mean height and urban-rural difference in age-standardised
mean BMI.

2466

Each solid arrow in lighter shade shows one country, beginning in 1990 and ending in 2020. The dashed arrows in darker shade show the regional averages, calculated as the unweighted arithmetic mean of the values for all countries in each region along the horizontal and vertical axes. For urban-rural difference, a positive number shows higher urban mean height and BMI and a negative number shows higher rural mean height and BMI.

2472

See Extended Data Fig. 2 and Extended Data Fig. 3 for urban-rural differences in agestandardised mean height and BMI, and their change over time shown as maps, together with uncertainties in the estimates. See Extended Data Fig. 4 for results at ages 5, 10, 15 and 19 years.

2477

We did not estimate the difference between rural and urban height for areas classified as entirely urban (Bermuda, Kuwait, Nauru and Singapore) or entirely rural (Tokelau).

2480 Fig. 2. Urban and rural height in 2020 and change from 1990 to 2020.

2481

The maps show age-standardised mean height in 2020 and change from 1990 to 2020, by 2482 urban and rural place of residence for girls and boys. The density plot below each map shows 2483 2484 the distribution of estimates across countries. The top right graph in each panel shows the agestandardised mean height in 2020 for all countries, together with their 95% credible intervals. 2485 2486 Countries are ordered by region and super-region. The bottom right graph in each panel shows the change from 1990 to 2020 in mean height in relation to the uncertainty of the change 2487 measured by posterior standard deviation. Each point shows one country. Shaded areas show 2488 the posterior probability (PP) of an estimated change being a true increase or decrease. The PP 2489 of a decrease is one minus that of an increase. If an increase in mean height is 2490 2491 statistically indistinguishable from a decrease, the PP of an increase and a decrease is 0.50. 2492 PPs closer to 0.50 indicate more uncertainty, those towards 1 indicate more certainty of change. 2493

See Extended Data Fig. 5 for a map of PPs of the estimated change. See Supplementary 2494 Figure 3 for results at ages 5, 10, 15 and 19 years. See Supplementary Table 3 for numerical 2495 results, including credible intervals, as age-standardised and at ages 5, 10, 15 and 19 years.

2497

2496

We did not estimate mean rural height in areas classified as entirely urban (Bermuda, Kuwait, 2498 Nauru and Singapore), mean urban height in areas classified as entirely rural (Tokelau), or their 2499 2500 change over time in these areas, as indicated by grey colour.

Fig. 3. Urban and rural body-mass index (BMI) in 2020 and change from 1990 to 2020.

2502

The maps show age-standardised mean BMI in 2020 and change from 1990 to 2020, by urban and rural place of residence for girls and boys. See Fig. 2 caption for descriptions of other sections of the figure and for definitions.

2506

See Extended Data Fig. 6 for a map of posterior probabilities of the estimated change. See Supplementary Figure 4 for results at ages 5, 10, 15 and 19 years. See Supplementary Table 4 for numerical results, including credible intervals, as age-standardised and at ages 5, 10, 15 and 19 years.

2511

We did not estimate mean rural BMI in areas classified as entirely urban (Singapore, Bermuda and Nauru), mean urban BMI in areas classified as entirely rural (Tokelau), or their change over time, as indicated by grey colour.

2515 Extended Data Fig. 1. Number of data sources used in the analysis, by country.

Extended Data Fig. 2. Urban-rural height difference in 2020 and change from 1990 to
2517 2020.

2518

2519 The top map in each panel shows the urban-rural difference in age-standardised mean height in 2520 2020 for girls and boys. A positive number shows higher urban mean height and a negative number shows higher rural mean height. The bottom map in each panel shows the change from 2521 2522 1990 to 2020. The density plot below each map shows the distribution of estimates across countries. The top right graph in each panel shows the urban-rural difference in age-2523 standardised mean height in relation to the uncertainty of the change measured by posterior 2524 standard deviation. The bottom right graph in each panel shows the change from 1990 to 2020 2525 in urban-rural difference in mean height in relation to the uncertainty of the change measured by 2526 2527 posterior standard deviation. Each point shows one country. Shaded areas show the posterior 2528 probability (PP) of a true difference (top right panel) and of a true increase or decrease in difference (bottom right panel). 2529

2530

2531 See Extended Data Fig. 9 for PPs of the urban-rural difference in age-standardised mean height 2532 and its change. See Supplementary Figure 5 for results at ages 5, 10, 15 and 19 years.

2533

We did not estimate the difference between rural and urban height for areas classified as entirely urban (Bermuda, Kuwait, Nauru and Singapore) or entirely rural (Tokelau), as indicated by grey colour. Extended Data Fig. 3. Urban-rural body-mass index (BMI) difference in 2020 and change
 from 1990 to 2020.

2539

The maps show the urban-rural difference in age-standardised mean BMI in 2020, and its change from 1990 to 2020 for girls and boys. A positive number shows higher urban mean BMI and a negative number show higher rural mean BMI. See Extended Data Fig. 2 caption for descriptions of other sections of the figure.

2544

2545 See Extended Data Fig. 10 for posterior probabilities of the urban-rural difference in age-2546 standardised mean BMI and its change. See Supplementary Figure 6 for results at ages 5, 10, 2547 15 and 19 years.

2548

We did not estimate the difference between rural and urban BMI for areas classified as entirely urban (Bermuda, Kuwait, Nauru and Singapore) or entirely rural (Tokelau), as indicated by grey colour. Extended Data Fig. 4. Change in the urban-rural height and body-mass index (BMI)
 difference from 1990 to 2020, by age.

2554

(A) Change in urban-rural difference in mean height in relation to change in mean rural height at
ages 5, 10, 15 and 19 years. (B) Change in urban-rural difference in mean BMI in relation to
change in mean BMI in at ages 5, 10, 15 and 19 years. (C) Change in urban-rural difference in
mean height and urban-rural difference in mean BMI at ages 5, 10, 15 and 19 years.

2559

Each solid arrow in lighter shading shows one country, beginning in 1990 and ending in 2020. 2560 The dashed arrows in darker shade show the regional averages, calculated as the unweighted 2561 arithmetic mean of the values for all countries in each region along the horizontal and vertical 2562 2563 axes. For urban-rural difference, a positive number shows higher urban mean height and BMI 2564 and a negative number shows higher rural mean height and BMI. The dark vertical dashed lines indicate the median of the WHO reference population. For BMI, the lighter vertical dashed lines 2565 are placed one standard deviation below and above the median of the WHO reference 2566 population. 2567

2568

2569 We did not estimate the difference between rural and urban height for areas classified as 2570 entirely urban (Bermuda, Kuwait, Nauru and Singapore) or entirely rural (Tokelau).

Extended Data Fig. 5. Posterior probability of increase in mean height in urban and rural
 areas from 1990 to 2020.

2574

The maps show the posterior probability (PP) that the age-standardised mean height increased from 1990 to 2020. The PP of a decrease is one minus that of an increase. If an increase in mean height is statistically indistinguishable from a decrease, the PP is 0.50. PPs closer to 0.50 indicate more uncertainty, those towards 1 indicate more certainty of an increase, and those towards 0 indicate more certainty of a decrease.

2580

2581

We did not estimate PP for change in mean height in rural areas in countries classified as entirely urban (Bermuda, Kuwait, Nauru and Singapore) or change in mean height in urban areas in countries classified as entirely rural (Tokelau). Extended Data Fig. 6. Posterior probability of increase in mean body-mass index (BMI) in
 urban and rural areas from 1990 to 2020.

2587

- The maps show the posterior probability (PP) that the age-standardised mean BMI increased from 1990 to 2020. The PP of a decrease is one minus that of an increase.
- 2590

We did not estimate PP for change in mean rural BMI in areas classified as entirely urban (Bermuda, Kuwait, Nauru and Singapore) or change in mean urban BMI in areas classified as entirely rural (Tokelau).

- Extended Data Fig. 7. Comparison of urban-rural difference in height and body-mass
 index (BMI) by sex in 2020.
- 2596
- 2597 We did not estimate the difference between rural and urban BMI or height for areas classified as
- entirely urban (Bermuda, Kuwait, Nauru and Singapore) or entirely rural (Tokelau).

2599 Extended Data Fig. 8. Trends in body-mass index (BMI) by place of residence for 2600 children, adolescents and young adults.

2601

The figure shows trends in mean BMI at ages five and 19 years, and in age-standardised mean BMI for young adults (20-29 years and 30-39 years). Shaded areas show the 95% credible intervals. Trend for young adults were estimated using a model similar to the one described in Methods, where BMI-age patterns were allowed to vary flexibly via a cubic spline function without knots. 2607 Extended Data Fig. 9. Posterior probability of urban-rural height difference and its 2608 increase from 1990 to 2020.

2609

The maps show the posterior probability (PP) that age-standardised mean height in 2020 in urban areas was higher than in rural areas (left-hand panels), and the PP that the urban-rural difference in age-standardised mean height increased from 1990 to 2020 (right-hand panels). For 2020, if estimated age-standardised mean urban height is statistically indistinguishable from rural height, the PP is 0.50. PPs closer to 0.50 indicate more uncertainty, those towards 1 indicate more certainty of urban children being taller, and those towards 0 indicate more certainty of rural being taller.

2617

We did not estimate the PP for differences between rural and urban height for areas classified as entirely urban (Bermuda, Kuwait, Nauru and Singapore) or entirely rural (Tokelau), as indicated by grey colour. Extended Data Fig. 10. Posterior probability of urban-rural body-mass index (BMI) difference and its increase from 1990 to 2020.

2623

The maps show the posterior probability (PP) that age-standardised mean BMI in 2020 in urban areas was higher than in rural areas (left-hand panels), and the PP that the urban-rural difference in mean BMI increased from 1990 to 2020 (right-hand panels).