Urban-Rural and Poverty-Related Inequalities in Health Status:
Spotlight on Uttar Pradesh, India

Introduction

National surveys contain a wealth of family planning, reproductive health, and maternal and child health indicators. Comparing these indicators across subnational groups, such as urban versus rural populations or by relative poverty, can pinpoint inequalities and gaps in coverage and assist policymakers and program planners in developing more effective and efficient interventions.

In most developing countries, poverty is highly correlated with place of residence; that is, urban households tend to concentrate among the highest-wealth groups, while rural households tend to concentrate among the poor. Thus, any national comparison of the least poor with the most poor tends to compare the bulk of the urban population with the poorest of the rural poor, making it impossible to determine to what degree the findings reflect inequalities by wealth and/or inequalities by geography. The development of separate urban and rural wealth indices provides a way out of this dilemma.

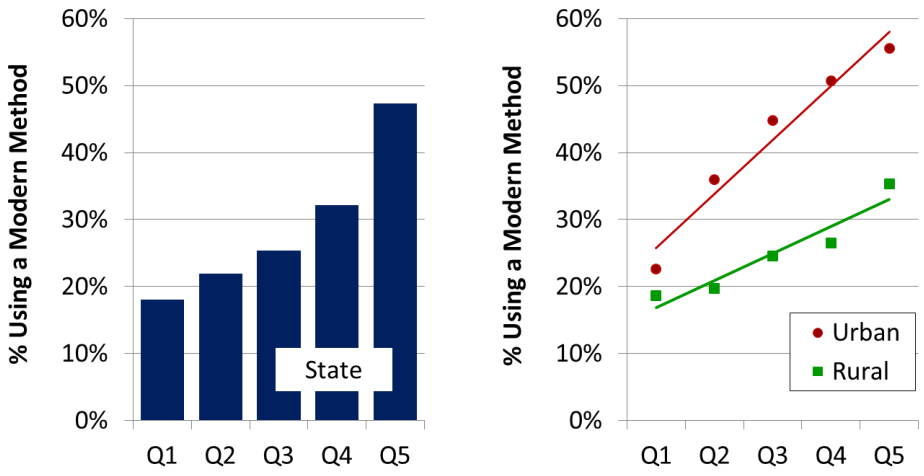
This fact sheet summarizes a few findings from secondary analyses of the India 2005/6 Demographic and Health Survey (DHS) for Uttar Pradesh. Separate wealth classifications for urban and rural women were constructed to examine inequalities in key population and reproductive health indicators, including family planning and antenatal care. The analyses demonstrate that disaggregating wealth by place of residence deepens understanding of state trends and the importance of examining multiple indicators.

Findings

Family Planning – National Quintiles vs. Residence-Disaggregated Quintiles

Figure 1 below compares use of modern contraceptives by state wealth quintiles with contraceptive use by urban- and rural-specific wealth quintiles. In addition to the wealth differentials, it is striking to note that rural women overall show lower or comparable contraceptive use than the poorest two urban quintiles.

Figure 1: Poverty-related inequalities in modern contraceptive use

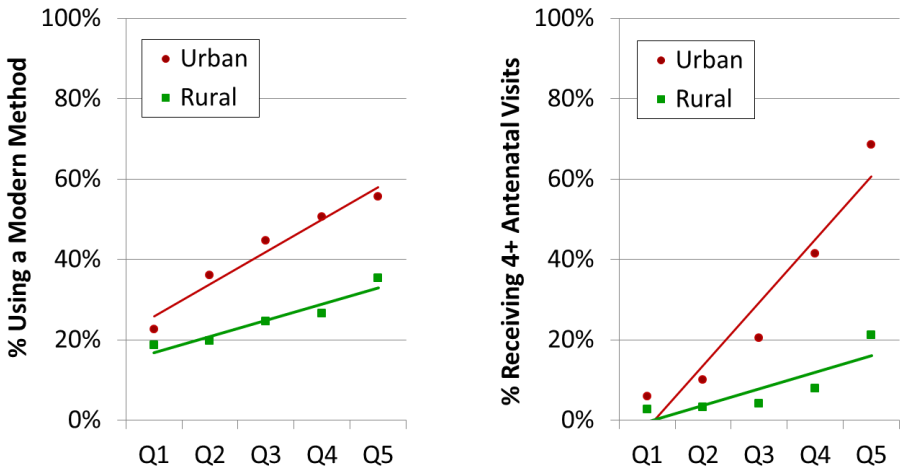


Family Planning vs. Antenatal Care

A potential ambiguity in interpreting differences in family planning is that use is affected not only by access to and ability to pay for modern contraceptives but also by women's interest in and motivation to regulate their fertility. In settings marked by cultural differences and/or variation in educational and economic opportunities for women and girls, it is possible that rural and poorer women want more children than their urban and wealthier counterparts.

Maternity care is a less ambiguous health outcome. Motivation for good outcomes (i.e., healthy mother and healthy child) is unlikely to be subject to cultural factors that may influence family planning. Figure 2 below compares use of modern contraception with adequate antenatal care for the last birth (four or more visits as recommended by WHO and UNICEF). Note that both family planning and antenatal care can be provided in non-clinical settings. Use of antenatal care is appallingly low: while state-wide two-thirds (66%) of births had some antenatal care, no wealth group attained the target of 80% receiving four or more visits.

Figure 2: Contraceptive Use Compared to Antenatal Care



Considerations for program design

The findings presented above are only a few of the further analyses that could be conducted with the India 2005/6 DHS for Uttar Pradesh.

- Given the size of India, state-specific and disaggregated urban-rural wealth analyses are both useful for local planning.
- Use of antenatal care has not kept pace with rapid decreases in fertility and increasing delivery in medical facilities. Only the wealthiest urban women come close to optimal use of antenatal care.
- Program designers and managers may want to consider opportunities for integrating safe motherhood into family planning programs.
- Although rural women show wealth-related differentials in both family planning and antenatal care, their overall low coverage rates suggest that a general rural strategy may be more indicated in the short term than targeted pro-poor interventions.

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