Urban-Rural and Poverty-Related Inequalities in Health Status: *Spotlight on Ethiopia*

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.

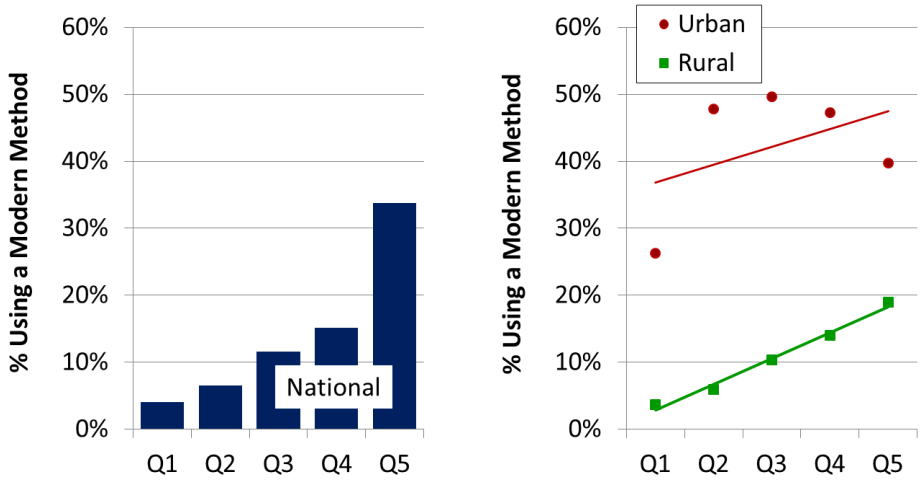
This fact sheet summarizes a few findings from secondary analyses of the Ethiopia 2005 Demographic and Health Survey (DHS). Separate wealth classifications for urban and rural women were constructed to examine inequalities in key population and reproductive health indicators, including family planning and antenatal care. The analyses demonstrate that disaggregating relative wealth by place of residence may reveal patterns obscured by national 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 national wealth quintiles with contraceptive use by urban- and rural-specific wealth quintiles. Behind the national trends are striking urban-rural differences: even the wealthiest rural women lag behind the poorest of the urban poor. Note also that the urban wealthy are only half as likely to use injectables as women in quintiles 2 and 3 and show the highest use of periodic abstinence of any residence/wealth group (analyses not shown).

Figure 1: Poverty-related inequalities in modern contraceptive use

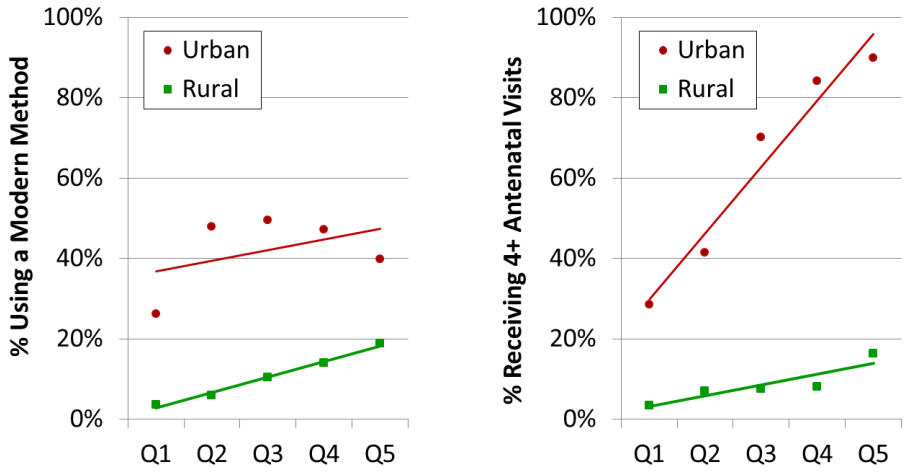


Family Planning vs. Antenatal Care

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. Urban-rural and poverty differentials are clearly present for both contraception and antenatal care, and rural populations are especially disadvantaged in both services. Also striking are the low levels of antenatal care among the bottom two urban quintiles.

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 Ethiopia 2005 DHS.

- There is a clear and urgent need to improve family planning and antenatal care among all segments of the rural population.
- Maternal and child health program might consider targeting focused interventions to the urban poor, and program planners and managers might be advised to look for ways to integrate family planning and antenatal care.
- Patterns of family planning use in urban areas warrant further study once the 2010 DHS is completed in 2011 to see if low use of hormonal methods among the wealthiest groups and higher use of periodic abstinence persist. Commercial sector availability of hormonal methods may be a factor.

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