

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

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.

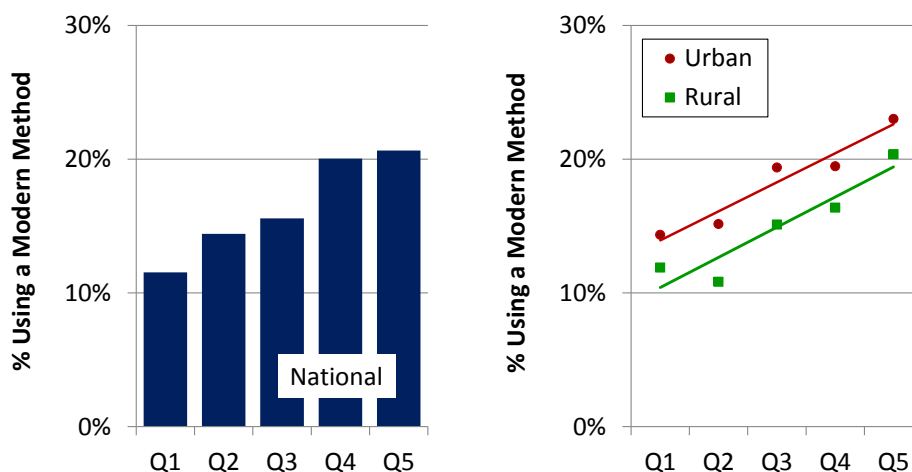
This fact sheet summarizes a few findings from secondary analyses of the Ghana 2008 Demographic and Health Survey (DHS). Separate wealth classifications for urban and rural women were constructed to examine inequalities in key population and reproductive health indicators, including family planning and 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. The clear wealth-related differentials observed at the national level are repeated at the urban-rural levels, and for every group except the poorest quintiles higher contraceptive use is seen among urban women than among rural women.

Figure 1: Poverty-related inequalities in modern contraceptive use

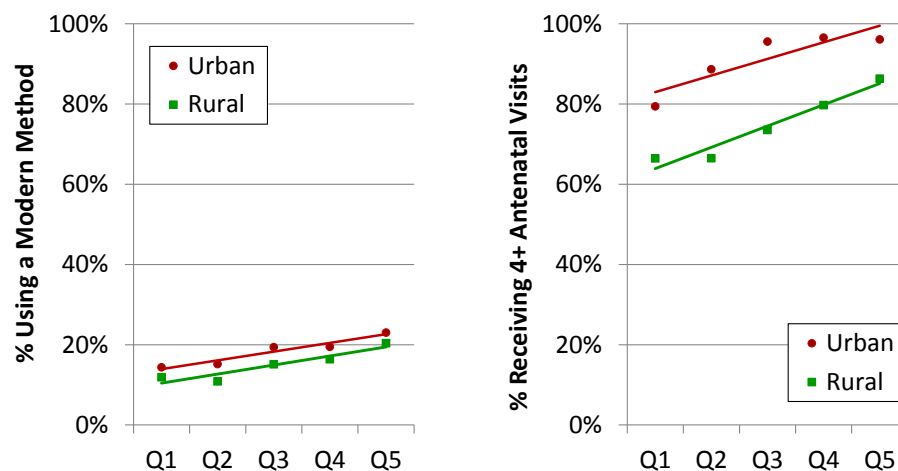


Family Planning vs. Antenatal Care

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 very much higher than contraceptive use, and the urban-rural differentials in contraceptive use are repeated for antenatal care.

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 Ghana 2008 DHS.

- First and foremost, the findings suggest missed opportunities for integration of family planning and antenatal care, in all settings and in all areas. It is striking that urban women in general and the top three rural quintiles have reached or exceeded Millennium Development Goals (MDG) targets for antenatal care while their use of modern contraception scarcely passes 20%.
- Given the overall low use of modern contraception, focused family planning interventions for the poor may not yet be indicated.
- A pro-poor strategy for antenatal care in rural areas may be advised to bring the poorest of the rural poor up to MDG standards.

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