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

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.

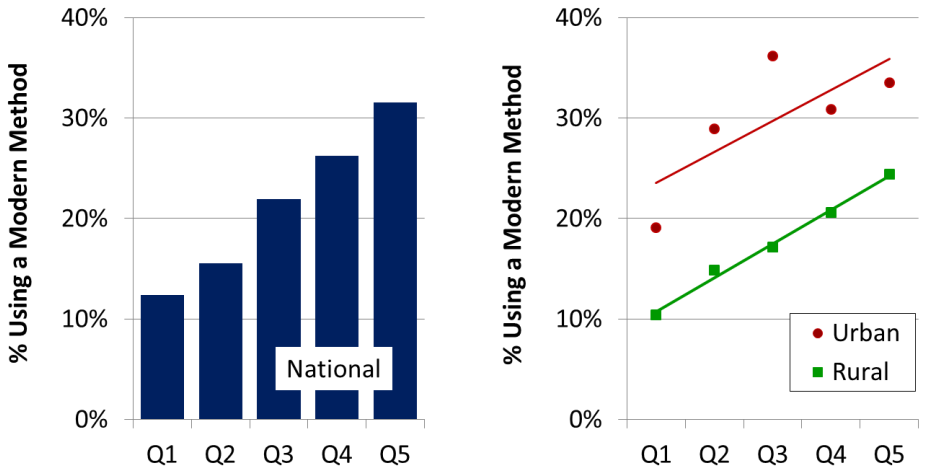
This fact sheet summarizes a few findings from secondary analyses of the Pakistan 2006/7 Demographic and Health Survey (DHS). Separate wealth classifications for urban and rural women were constructed to examine inequalities in key population and reproductive health indicators, including family planning and antenatal care. The analyses demonstrate that disaggregating relative wealth by place of residence reinforces patterns observed in the 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 national trends of increasing contraception are also found within place of residence; moreover rural women are consistently disadvantaged in every wealth group and 80% of rural women show contraceptive use lower than or comparable to the poorest rural quintile.

Figure 1: Poverty-related inequalities in modern contraceptive use

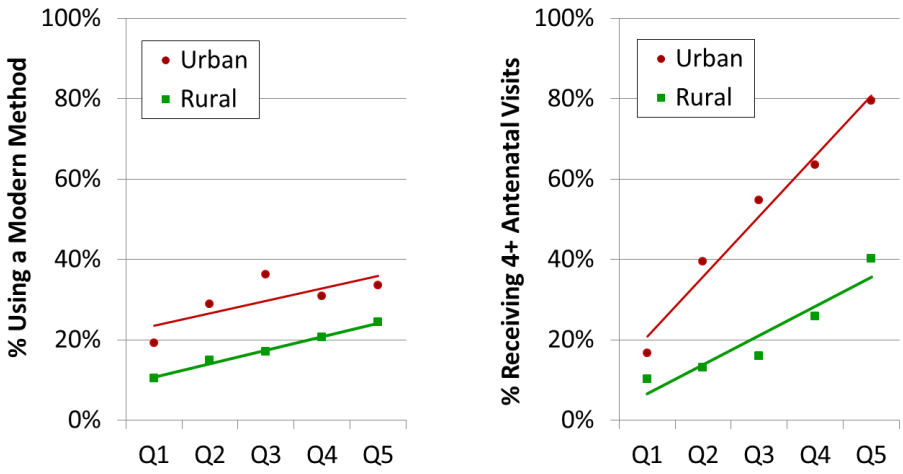


Family Planning vs. Antenatal Care

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 also seen for antenatal care. Moreover, only the highest 20% of urban women report optimal 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 Pakistan 2006/7 DHS.

- Rural women as a whole are severely disadvantaged in both antenatal care and family planning. Despite the wealth-related gradients in services use, program planners may want to consider a generalized rural strategy for the near term rather than a pro-poor focus in rural areas.
- Maternal care interventions in urban areas may want to consider special pro-poor efforts for the bottom two quintiles in addition to more generalized safe motherhood efforts.
- Program designers may want to look for opportunities to integrate family planning and safe motherhood, for example post-partum family planning. It is noteworthy that more than half of women with three or more children want to terminate childbearing. At the same time, most poor women do not deliver in health facilities.

This country brief was made possible by support from the U.S. Agency for International Development (USAID) under the terms of Cooperative Agreement GPO-A-00-08-00003-00 and GPO-A-00-09-00003-00 MEASURE Evaluation PRH Associate Award. The opinions expressed are those of the authors and do not necessary reflect the views of USAID or the United States government