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

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.

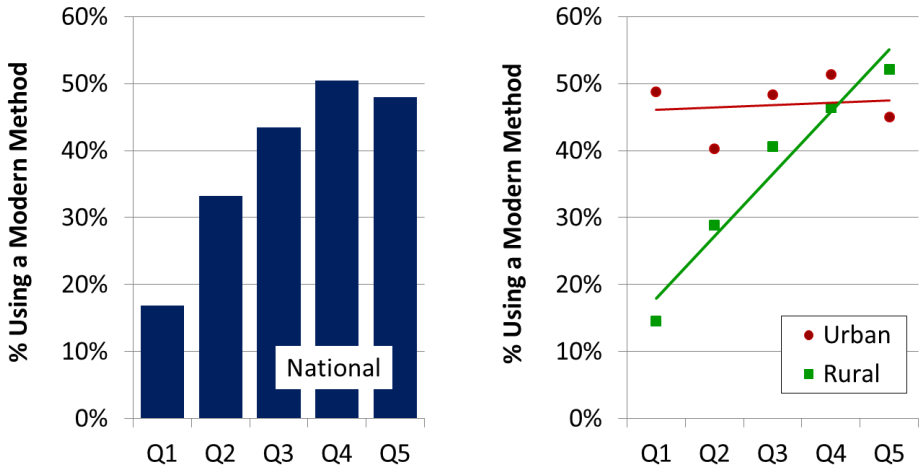
This fact sheet summarizes a few findings from secondary analyses of the Kenya 2008 Demographic and Health Survey (DHS). Separate wealth classifications for urban and rural women were constructed to examine inequalities in key population and reproductive health indicators, including family planning and 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 wealth-related differentials observed at the national level are repeated for rural women, while urban women show only the slightest wealth-related trend. The nearly flat line for urban women is in striking contrast to the 2004 DHS, which had found wealth-related differentials for both rural and urban women. This suggests that the gains in contraception over the previous survey are largely attributable to improvements among the urban poor (analyses not shown).

Figure 1: Poverty-related inequalities in modern contraceptive use

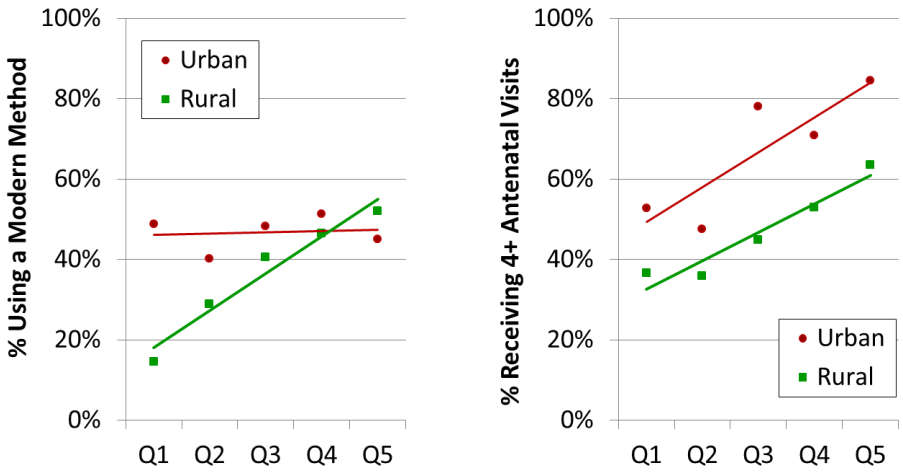


Family Planning vs. Antenatal Care

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. Use of antenatal care is only slightly higher than contraceptive use in Kenya; in addition clear urban-rural differentials in antenatal care can be seen.

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 Kenya 2008 DHS.

- In urban areas only the poorer two quintiles fall substantially below the Millennium Development Goals (MDG) targets for antenatal care, while shortfalls are seen among all rural segments.
- A generalized strategy in rural areas may be advised to bring rural women up to MDG standards, combined with service integration to simultaneously promote contraceptive use, especially among the poorer two rural quintiles.
- A focused pro-poor strategy in urban areas may help expand coverage of antenatal care.
- Better child outcomes may provide additional incentives for increased contraceptive use among urban women and the wealthier rural segments.

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