

# Inequity and unwanted fertility in developing countries

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The persistence of inequities in health, with poor and other disadvantaged population groups bearing a disproportionately high burden of ill-health, remains a public health, ethical and human rights challenge.<sup>1</sup> The WHO Constitution enshrines equity thus: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." Addressing inequities in health has been a central concern of development aid and government policies. The Millennium Development Goals (MDGs) have further galvanized efforts to eliminate poverty and to reduce inequities. There has been a quantum increase in the published literature on health inequities, and "pro-poor" programmes have been initiated to redress them. Yet consensus is lacking on many aspects of inequity — its conceptual and operational definitions, its classification criteria and ways to alleviate it.

Most professionals accept that inequities are "differences which are unnecessary and avoidable, but in addition are considered unfair and unjust".<sup>2</sup> However, some argue that it is impossible to formulate irrefutable criteria by which health inequities can be recognized.<sup>3</sup> Moreover, they assert, what is viewed as unjust or unfair may depend on subjective values, political ideologies or normative considerations.<sup>3</sup> Others say "pro-poor" policies oversimplify the problem by focusing only on income disparities, thus ignoring more intricate structural factors which underlie the inequity dynamics in a given context.<sup>4</sup> The evidence from six countries (Cambodia, the Dominican Republic, Ethiopia, Ghana, Kenya and Tajikistan) indicates that differences in health outcomes by ethnic group, educational attainment and region were more pronounced than the differences caused by wealth, the factor which work on inequity generally addresses.<sup>4</sup>

Against this backdrop, Gillespie et al.<sup>5</sup> examine through an equity lens the prevailing differences by wealth quintile in total fertility, unwanted fertility, use of modern contraceptives and access to family planning services in developing countries. More specifically, they consider whether unwanted fertility among the poor compared with wealthier population segments is a case of an inequality (that is, a difference that has no moral implications) or an inequity. Using data from Demographic and Health Surveys in 41 developing countries, the authors conclude that for reproduction and family planning interventions, the equity concept needs to be "applied more cautiously than in the case with health". They further state that this equity analysis is useful in countries where poor segments have high actual and unwanted fertility, low contraceptive use and limited access to family planning information or services.

By extending the equity analysis to fertility and modern contraceptive use by wealth quintile, Gillespie et al. have broadened the discourse on inequities. The countries included in the study show a range from low to high fertility and modern contraceptive use. However, the equity analysis proved useful only for countries with high fertility and low contraceptive use. It is unclear whether this implies that the equity framework has limited application or whether family planning programmes in other countries have succeeded in reducing inequities in fertility. A cross-national comparative analysis omits country-specific social, cultural and economic peculiarities which may mediate the impact of inequities. Also, wealth indices across countries in absolute terms do not indicate how poor the poorest quintile is in one country compared to another. A country-specific analysis would permit a better understanding of linkages at the individual level, rather than the

macro-level broad associations found in this study. Moreover, additional information on factors such as social marketing, social health insurance and public financing of services can also be considered, together with other information on variables relating to fertility and family planning.

Perhaps the most significant findings are the persistent differentials in access to and use of modern contraceptives by wealth quintile, especially in sub-Saharan Africa but also in some countries in other regions. Public-sector family planning programmes have existed for nearly 50 years and have received major international and national funding. By providing free or subsidized services and through innovative social marketing and other initiatives, family planning programmes aim to reduce inequity in access to services. Effective family planning programmes reduce the fertility differential between the wealthiest and the poorest quintiles and make a major contribution to poverty reduction.<sup>6</sup> Impressive achievements in reducing fertility and increasing contraception have been noted.<sup>7</sup> However, success has continued to elude much of sub-Saharan Africa, where inequities in health, fertility and contraception are most pronounced. Long-term commitment and investment are needed to provide culturally appropriate interventions to remove these inequities.

Much progress needs to be made to redress inequity in access to family planning services in order to reach the MDG target of "universal access to reproductive health by 2015".<sup>7</sup> Further work at the country level will help clarify the dynamics of prevailing inequities and enable effective interventions by taking into account contextual factors. ■

## References

Available at <http://www.who.int/bulletin>

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