Commentary: Child health surveys: the equity dimension

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Larson and colleagues make an important contribution to the literature on inequities in child health in Asia, by providing evidence of marked gender and socioeconomic bias in diarrhoea management in Bangladesh. Their findings speak
for themselves. Oral rehydration (ORS), a low-cost intervention that could prevent ~13% of all under-five deaths in the world, was significantly more likely to be administered to boys than to girls, and to the least poor than to the poorest. Antibiotics, that are only indicated in a small proportion of diarrhoea episodes but are nevertheless widely used, were also more likely to be used by boys and by the least poor. This commentary will concentrate on the issue of social inequities rather than on the deplorable preference for treating male children.

These findings must be interpreted in light of the marked progress Bangladesh has achieved in terms of child survival in recent years. Under-five mortality dropped from 149 in 1990 to 77 in 2004. The country is currently one of seven—among the 60 countries with the highest burden of under-five deaths—to be on target for reaching the corresponding Millennium Development Goal. Nevertheless, as shown by Larson et al. and Bryce et al. a large proportion of Bangladeshi children who have diarrhoea still fail to receive ORS. Scaling up the use of this simple solution can make a major contribution to the further reduction of mortality levels at low cost.

Three points caught my attention while reading this paper. The first is the documentation of important inequities within three geographically distinct strata. It is quite remarkable that socioeconomic inequities in child health, in the context of low and middle income countries, were almost completely overlooked until the last 10 years or so. The exception is Latin America, the most inequitable region of the world, where social epidemiology is strongly rooted. Studies from Africa and Asia are particularly uncommon, perhaps because of the assumption that poverty is somehow uniform and would affect all children to the same extent. Yet, nothing could be further from the truth. Larson and colleagues expanded on previous work carried out in Bangladesh at the national level by showing that social inequities are present at different levels: within children living in rural areas, smaller cities or large metropolitan strata. Their data also suggest that care-seeking and treatment rates in the top quartile are considerably higher than those in the other three quartiles, a pattern that we have referred to as ‘top inequity’. These findings have policy implications. Within each geographical stratum, it is not possible to identify a specific subgroup to target interventions, but a broad population approach should be used to scale up ORS.

The second point of interest is that inequalities occur not only for treatments that are indeed effective, such as ORS, but also for those wrongly perceived as being effective, such as antibiotics. As noted by the authors, there are precise indicators for antibiotics in diarrhoea episodes, such as dysentery and cholera, that account for fewer than 10% of all cases. Yet, two in every five children with diarrhoea received an antibiotic, signalling a great waste of resources not to speak of the risk of antimicrobial resistance. The higher use of antibiotics by the upper social groups is of concern not only in terms of the current situation, but also because of future trends inasmuch as innovations—whether good or harmful—tend to be initially adopted by the elite. Recent examples are caesarean sections in Brazil and vaccine refusal in the UK. Current antibiotic usage patterns among the Bangladeshi better off children may spill over to poorer groups in the future.

The third, and in my view, the most important point arising from this paper is that the private sector in Bangladesh is highly inequitable. Earlier analyses of similar data from several countries had shown that the private sector tends to be more inequitable than the public sector in providing maternal and child services. Whilst this may appear to be an obvious truth—because the fees charged are less likely to be afforded by the poorest—there is a current tendency to emphasize the role of the private sector in providing services, an approach supported by major funding agencies. This strategy is particularly promoted in Asia, where utilization of government facilities is often low and the informal private sector accounts for a large share of all consultations. However, utilization of public facilities may increase substantially when the quality of services improves, as shown recently in Bangladesh so that predominance of the private sector should not be taken for granted as an irreversible reality. In fact, the present study found that children from urban, non-slum when compared to poorer rural and slum households, were twice as likely to use services from the public sector, possibly because these were more readily accessible to them.

The relatively simple analyses presented in this population-based study should be replicated in other settings so that policy regarding child health can be guided by local evidence. Incorporation of the equity dimension in population surveys can make an important contribution to reducing unacceptable inequalities in child survival.

References


