Reaching the Underserved

Of the several articles on inequalities in health in this issue, I would like to single out 2. The first is by Pavitra Mohan from India, the world’s leader in terms of the absolute number of deaths of children younger than 5 years: 2.4 million in 2000, or about 100 per 1000 births. The second is by Bo Burstrom and colleagues from Sweden, where about 350 children died in 2000, or 4 per 1000. Given this 25-fold difference in mortality rates, are there common lessons to be drawn from these articles?

Mohan shows the extent to which safe water and immunizations are reaching children in rural India. Vaccine coverage depends on spontaneous demand by families and on access to health services. This leads to marked inequalities: 19% of poor children were fully vaccinated, compared with 68% among the better off.

The water supply project, on the other hand, deployed hand pumps in the poorest areas. Whereas the better off had piped water indoors, the poor gained access to hand pumps, resulting in similar levels of access to safe water. This situation is still not ideal, because lower-class women must carry water home, while the rich enjoy a plentiful supply of piped water—and water quantity is at least as important as water quality for preventing disease. Nevertheless, the project had remarkable success in reducing inequalities. Mohan’s study highlights the importance of taking equity into account when planning interventions and designing monitoring systems that allow outcome indicators to be stratified by social class—which few do.

Burstrom et al. report on child deaths in Sweden between 1878 and 1925. Diarrhea mortality declined from 59 to 2 per 1000, and social inequalities were sharply reduced. The authors show how ensuring universal access to safe water contributed to reduced mortality and improved equity.

Both articles highlight the health importance of safe water. But there are also broader lessons to be learned. The first relates to the appalling magnitude of global inequalities. Mortality rates in Sweden in the late 1900s were similar to current levels in India. Safe water, long taken for granted in developed countries, has yet to reach almost 40% of people in the least developed countries and contributes to high mortality rates.

The second lesson addresses the current heated debate over targeted versus universal interventions. The Indian project, which provided a low-cost water source, was targeted to poor families, while the Swedish approach enabled the universal extension of piped water to the entire population. Both reduced inequities, but the Swedish strategy was more egalitarian because the same source of water was available to all.

Finally, the Swedish article concludes with a piece of wisdom: “in spite of the powerful interventions and action that took place, the decline of diarrhea mortality in Stockholm took quite some time. This demonstrates the need for patience when evaluating also large scale intervention projects in poor countries today” (p 215). Bilateral and multilateral development agencies are becoming ever less patient when evaluating also large projects funded by grants and loans. This attitude favors vertical, disease-specific interventions that may result in rapid gains but often do so at the expense of sustainability. Sustainable investments in human resources and in infrastructure require a time frame of decades, rather than years, and this lesson should be learned by funding agencies and governments alike.

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