THE STATE OF THE WORLD'S CHILDREN 1981-82

James P. Grant
Executive Director of the
United Nations Children's Fund
(UNICEF)

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Children in dark times

A year of silent emergency

FAR FROM BEING priceless, a child's life was worth less than $100 in 1981.

Wisely spent on each of the poorest 500 million mothers and young children in the world, such a sum could have bought improved diets and easier pregnancies, elementary education and basic health care, safer sanitation and more water. In other words, it could have brought the basics of life. And at the same time as meeting the most pressing human need in the world today, it could have helped to slow down population growth and accelerate economic growth in the world of tomorrow. In short, meeting the needs of all the world's children was both the greatest of humanitarian challenges and the best of investment opportunities.

In practice, it proved too high a price for the world community to pay. And so, every two seconds of 1981, a child paid that price with its life.

About those 17 million children who died during the year, there is little more to be said. Whoever they once were, whatever religion they were growing up in, whatever language they were beginning to speak, and whatever potential their lives held, they were simply failed by the world into which they were born.

Not ten per cent of them were immunized against the six most common and dangerous diseases of childhood. The cost of so immunizing all of the Third World's infants works out at approximately $5 per child. The cost of not doing so works out at approximately five million deaths a year.

For the children of 1982, the facts of life on earth will not be significantly different. Of the 125 million who will be born, 17 million will again be dead before their fifth birthday. And between 1981 and 1982, although there is no trend so pronounced as to break through the inevitable imprecision of available figures, there is every reason to suggest that times are getting darker for the world's poorest children.

To the extent that this annual decimation of the world's newborn is a reprisal for the failings of economic development, the immediate future holds little hope of a reprieve.

For most oil-importing developing nations, where the vast majority of the poor now live, economic growth has stalled and fallen to its lowest level in a decade. Combined current account deficits have doubled to approximately $80 billion in the two years to 1980; accumulated external debts have passed the $400 billion mark; the rate of growth in output has fallen below four per cent a year; the terms of trade have worsened by 7.5 per cent between 1979 and 1980 alone; and both import and export capacities have been reduced.

Hardest hit are the already poorest nations of Africa and South Asia where some countries are actually facing a reversal of development. It is here that average incomes in the 1980s are unlikely to increase by more than $1 or $2 a year. It is here that most of the world's 'absolute poverty' is to be found. And it is here that over three-quarters of 1981's infant deaths have occurred.

South of the Sahara, 1981 was also the tenth successive year of declining food production per head and a total of 34 nations containing 260 million people are now reporting acute food shortages. Most at risk, as is always the case when malnutrition tightens its grip, are the growing minds and bodies of Africa's children.

Compounding that risk in 1981 has been the unstaunched flow of Africa's refugees and displaced peoples. In a continent of 800 distinct ethnic groups and more than 1,000 different languages, through which insensitive borders run along lines drawn by colonial rulers, there are now over six million refugees – one person in every 75 of Africa's population. And almost half of them are children.

This has been, therefore, another year of 'silent emergency': of 40,000 children quietly dying each day; of 100 million children quietly going to sleep hungry at night; of ten million children quietly becoming disabled in mind or body; of 200 million 6-11 year olds quietly watching other children go to school; of one-fifth of the world's people quietly struggling for life itself. But it has also been a year in which economic trends indicate that progress against such poverty is not only slowing down in many nations, but being thrown into reverse. Only two years ago, the World Bank reported that the total number of people living in absolute poverty was 780 million. Optimistically, said the Bank at that time, that number would fall to 720 million by the end of the 1980s. Pessimistically, it would rise to 800 million during the decade.

Yet a more recent United Nations study has now concluded that 'the world economy is experiencing greater instability and a more severe disruption of steady growth than at any time since the end of the Second World War . . . unless specific steps are taken, the consequence of this adverse external environment will be to increase the numbers of the absolute poor to one billion before the end of the Third Development Decade'.

It was a conclusion accepted by the heads of all United Nations agencies, including the World Bank itself. And, in all probability, it means that, in many countries, more children will die next year than this.

Social goals and the slowing down of progress

Last year, in this report, UNICEF asserted that by the year 2000 the number of infant deaths in low-income countries could be reduced to 50 per 1,000 or less, that average life expectancy could be raied to 60 years or more, and that every child should have at least the four years of primary education necessary to acquire literacy. The report noted that although idealistic in the context of past experience, these goals are realistic in the sense that the principal obstacle standing in the way of their realization is the absence of the will and commitment to achieve them.

In December 1980, those targets (advocated by many organizations in recent years) were incorporated into the International Development Strategy (IDS) for the 1980s and adopted by the General Assembly of the United Nations. 'An important new feature of the strategy', said Mr. Niaz-Naik who chaired the committee which prepared the IDS, 'is that it conceives of development as an integral process, and the objectives of social and human development have been accorded a new emphasis.'

But with the decade just beginning, it is already clear that its principal economic target – a seven per cent a year average rise in the GDP of the developing nations – is unlikely to be met. Unless special measures are taken, therefore, the vision of its social goals is already clouding over.

To reach such goals, progress towards them would in fact have to be two or three times as fast over the next 20 years as it has been over the last 20. But in many nations today, the rate of development as measured by all three of the chosen indicators is already slowing down.

The Third World's infant mortality rate – that sensitive indicator of the well-being of mothers and children – fell by a steady four or five points a year in the 1960s. For the past five years, it has barely flickered. Average life expectancy, which increased by seven or eight months a year in the 1960s and early 1970s, is now increasing by only two or three months a year. School enrolment rates, which again rose by a regular four or five per cent a year up to the mid-1970s, now seems to have reached a plateau.

With the developing world's infant mortality still ten times higher than in the industrialized world, with its life expectancy still 15 years less, and with a third of its 6-11 year olds still out of school, this deceleration of progress cannot be explained by the approach of any natural limits. Rather it is a sign that development itself is in some nations becalmed and in others actually drifting backwards.

In short, the optimism of the 1960s which gave ground to the realism of the 1970s has now receded even further to make room for the doubt and pessimism which seems to be settling into the 1980s. It is a process of disillusionment both aggravated and symbolised by the decline in the share of the rich world's wealth which has been invested in aid. In 1965, when the United Nations first called upon the donor countries to increase the level of their aid to 0.7 per cent of their GNPs, the actual level stood at 0.49 per cent. Today, despite the efforts of a handful of nations who have met that target, the average level rests at 0.37 per cent.

Not in a generation have expectations of world development, and hopes for an end to life – denying mass poverty, been at such a low ebb.

In such a context, to advocate the rapid acceleration of development progress for the world's poorest billion people in order to significantly improve the lives of their children by the end of this century is to invite the charge of naivety.

It is a 'naivety' which UNICEF intends to pursue with the utmost vigour. Working with communities and families to provide for the health and education of their children is not only a matter of justice. It is also a productive investment in the world's economic and social future.

The 'Realism' of meeting children's needs

The realism or naivety of any goal is almost always as much a question of priorities as of possibilities. And it is not the possibility of achieving primary health care and primary education for the great majority of children which is in question. It is its priority.

Such goals could be achieved, for example, for less than the industrialized world spends on alcoholic drinks each year. Similarly, the broader goals of meeting the basic human needs of the overwhelming majority of men, women and children on earth could be realized by devoting as much each year to the task of achieving them as is now devoted every six weeks to the task of maintaining and increasing the world's military capacity.

However uncomfortable such comparisons may be, they are necessary to put into perspective the accusation that the goal of making significant improvements in the lives of the world's children by the end of this century is 'naive', and to put in its place a decision about priorities.

In dark times, children need priority. And while there will always be emotion behind that statement, it is also an appeal to reason.

More specifically, it is an appeal to two reasons – one of which is timeless and one of which is particular to this, the last quarter of the twentieth century.

Ninety per cent of the growth of the human brain and 50 per cent of the growth of the human body occurs in the first five years of the human life. The corresponding susceptibility of those years should alone argue that priority be given – in family affairs and in world affairs – to the needs of the young.

In the acquisition of their needs, and in the defence of their rights, children themselves are relatively powerless. They have neither physical strength, nor economic sanction. They have no unions, and no votes.

Usually it is the parents who are empowered to protect and provide. But if parents are deprived of that power, then the responsibility falls to the community of which the child is part.

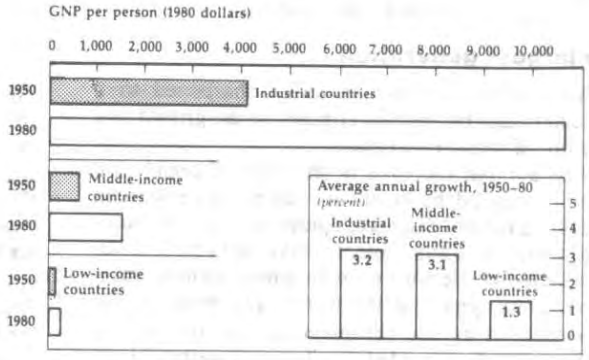
In the very earliest human societies, as Richard Leakey has shown, average life expectancy was probably little more than 20 years and many children were deprived of both their parents before they were of an

Three decades of progress: income, health, education, 1950-80

Income

GNP per person (1980 dollars)	*1950*	*1960*	*1980*
Industrial countries	4,130	5,580	10,660
Middle-income countries	640	820	1,580
Low-income countries	170	180	250

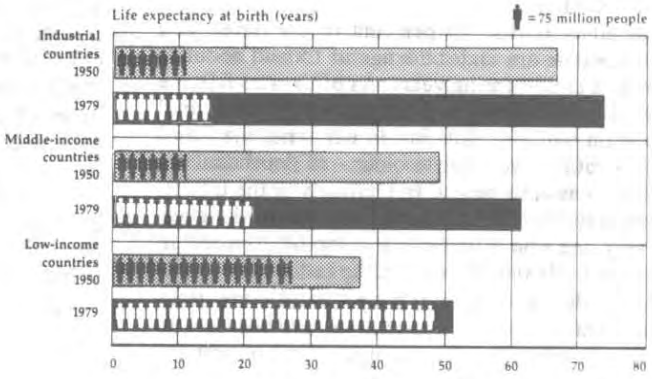
Average annual growth (percent)	*1950–60*	*1960–80*
Industrial countries	3.1	3.3
Middle-income countries	2.5	3.3
Low-income countries	0.6	1.7



Health

Life expectancy at birth (years)

	1950	*1960*	*1979*	*Increase 1950–79*
Industrial countries	67	70	74	7
Middle-income countries	48	53	61	13
Low-income countries	37	42	51	14
Nonmarket countries	60	68	72	12

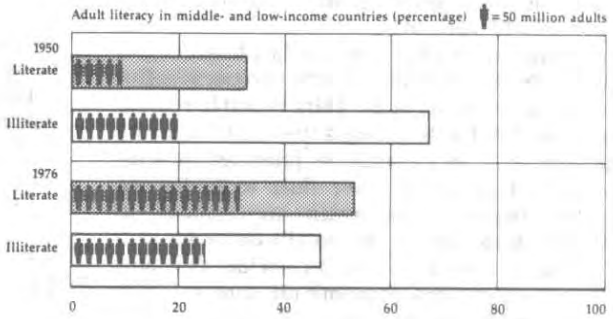


Education

Adult literacy rate (percentage)

	1950	*1960*	*1976*
Industrial countries	95	97	99
Middle-income countries	48	53	72
Low-income countries	22	28	39
Nonmarket countries	97	97	99

Note: All tables exclude China.



Source: World Development Report published for the World Bank by Oxford University Press, New York. Reproduced by kind permission.

age to provide for themselves. The survival of the child, and the continuing survival of the community, therefore depended upon the assumption of that responsibility *by* that community.

However large and complex the community may have grown, that special relationship of responsibility to its children is still an indispensable ethic of civilization. Indeed it is an increasingly relevant ethic as science and technology increasingly invest the earth with the attributes of a global village. And in this century there has been a growing recognition that if a local community is unable to meet the needs of its children then the responsibility extends to the national and international community.

In 'loud' emergencies, such as starvation in Kampuchea, the world community does respond, often magnificently. Indeed the mass starvations in the Ireland of 1846-7 or in the Bengal of 1943 – both of which occurred despite sizeable local food stocks – are much less likely to happen today. But in 'silent' emergencies – the more dispersed and less dramatic toll of hunger and illness and child deaths which add up to a Kampuchea every few weeks – the international response is also more muted. Like an echo of the paradox, the traditional cry of 'women and children first' applies only to such 'loud' emergencies as fire and shipwreck. In the silent emergencies of everyday need, the reality is usually 'women and children last'.

In the 1980s, there are many millions of parents – and especially mothers – whose power to protect and

provide for children has been eroded or washed away by unemployment or landlessness, by poverty or by lack of knowledge, by sickness or disability, by oppression or by demoralization. And in exercising its responsibility to those children, the task facing both national and international communities is to find ways of restoring that power to their parents.

The largest generation

This timeless concern is today sharpened to a particular edge by specific changes in the growth and structure of world population.

After a rapid increase in the rate of population growth – caused by relatively sudden successes in controlling certain diseases, epidemics and faminines which meant that more infants survived to have children of their own – fertility rates have now begun to fall in almost every region of the world. The beginning of this decline is as unprecedented as was the surging increase which preceded it. Taken together, both forces now have a special bearing on the state of the world's children.

One effect is that 40 per cent of the developing world's people are under the age of 15 and about to enter their child-bearing years. As birth rates fall, the numbers of children as a proportion of the total population will also fall. But in our time, the Third World's ratio of younger to older – of dependants to providers – is at its height. In Germany or the USSR, for example, there are now two people of working age for every one who is too young or too old to work. In Bangladesh Mexico or Nigeria, the ratio is one to one.

The result is a temporary but powerful extra strain on the Third World's capacity to provide for its children. In education, for example, those of primary school age now amount to 25 per cent of the population. In the industrialized world, the corresponding figure is only 15 per cent.

The decline in fertility which is just beginning to become visible will in time lower that proportion. But meanwhile the capacity of the Third World to provide essential services for the young is stretched to the limit – and beyond – by quantitative pressures on low-income countries which leave little room for the qualitative improvements which are required to improve the well-being of the world's children.

When these internal pressures coincide, as is now happening, with external economic pressures resulting from world-wide recession, then the welfare of the largest generation of children in history is further squeezed.

As nutrition, health, education and the normalcies of childhood are usually preconditions of successful parenthood, it is vital to both this generation and the next that the children of today be protected against the present economic weather.

The welfare of children – and future parents – is not the only issue at stake. For the question of whether or not improvements in the lives of the young are brought about in the 1980s is also crucial to the slowing down of population growth itself.

Acceptance of family planning and a decline in birth rates is closely connected with such changes as the improvement of health care, the decline of infant mortality, and the spread of education (especially for girls). A setback in progress towards these social goals is, therefore, likely to also be a setback in the trend towards lower population growth – so increasing the numbers of children in future generations at the same time as decreasing their parents capacity to provide for them.

Conversely, the stepping-up of national and international efforts to meet such needs would have the opposite effects of both improving life for the children of today, investing in their capacity as the parents of tomorrow, and creating the conditions necessary for a further slow-down in population growth itself. Extrapolating the experience of those developing countries which have lowered death rates, for example, suggests that the very same improvements in human welfare which would be required to meet the International Development Strategy's year 2000 target of reducing infant mortality to 50 per 1000 births or less would also result in 12 to 20 million fewer births each year. History demonstrates that when overall death rates make that first precipitous fall from around 40 per 1000 as a result of eliminating mass famines and epidemics, then the decline in birth rate lags far behind. And in that space between the fall in death rates and the fall in birth rates, the 'population explosion' takes place. But history is equally conclusive that those countries whose death rates stood at around 15 per 1000 in 1960 – which is around the average for low-income countries *today* – have since seen their birth rates fall by several points for every one point fall in the death rate. Colombia's 6 point fall in death rates (from 14 to 8 per 1000) during the first two development decades was answered by a 15 point fall in the birth-rate (from 46 to 31 per 1000). Over the same period, a three-point fall in Jamaica's death rate meant a ten-point fall in birth rates and in South Korea a five point fall in the death rate found echo in a 20 point fall in birth rates.

The commonly held view that reducing infant mortality only stores up more births and more trouble for the future is, therefore, a mistaken one. Meeting basic human needs is not only necessary to prevent human suffering in the present, but also to reduce the growth of population itself, thereby avoiding more human suffering in the future. Whether today's world population of 4.5 billion eventually stabilises at 10-11 billion or 13-14 billion sometime around the end of the next century depends heavily on what happens to birth rates in the last two decades of this century.

Present and future needs, therefore, cry out with one voice. And each decade into that future will see a magnification of either the successes or the failures of the world community's response to the needs of the present times.

This choice between compound failure and compound success is made the more crucial by the numbers involved. We can allow the largest generation of children to grow up malnourished, unhealthy and uneducated in order to become the parents of another generation of malnourished, unhealthy and uneducated children. Or we can accord to our children the priority they deserve by increasing efforts and resources to a maximum, rather than a minimum at this time when such a large proportion of the world is young. Paradoxically, the present sees the future at its most vulnerable.

In sum, bringing about a significant improvement in the lives of children by the end of this century will certainly need a significant increase in the resources available for the task and in the effectiveness with which they are deployed. But it is a question of priorities not possibilities. It is a matter of choice in which both reason and emotion argue for children. And it is a crucial moment at which to decide. For between the vicious and the virtuous spiral, a choice must now be made.

Wanted: more benefits per dollar for children

THE PLEA for priority for children – and for resources – has been made. But if another 'realism' dictates that the resources available nationally and internationally for meeting the needs of children are to remain close to present levels then the only possible response is to seek to increase the ratio between resources and results. Somehow, ways must be found to get more development per dollar.

Learning from experience, better use of available knowledge, wisdom, research, and most important of all, the *will* – these are the qualities which can convert additions to economic resources into multipliers of human benefits. And, in an increasing number of cases, social improvement programmes are coming to be seen not as an inevitable drain on national budgets, nor even as just cost-effective welfare expenditures, but as productive investments in themselves.

In the United States for example, it has been shown that for every $1 which government invests in rehabilitation for the disabled, $9 comes back in taxes paid by disabled people who get jobs as a result.

In Egypt, the ten-year campaign to control the water-borne disease known as schistosomiasis is likely to save a multiple of the investment in curative costs and lost productivity.

In Venezuela, the government has estimated that its scheme to bring water and sanitation to large areas of the country will pay for itself five times over within a decade.

In New York, a recent study has concluded that an investment of $2.7 million a year to improve pre-natal care for low-income women could save between $10 million and $12 million a year in high-cost intensive care for premature babies – not including the savings in lifelong support for children born with mental or physical disabilities.

Internationally, the successful campaign to eradicate smallpox, to which the U.S.A. contributed $50 million, is already saving the United States more than double that amount each year in immunization, quarantine and surveillance costs.

In 1981, the ratification of the WHO/UNICEF 'International Code of Marketing of Breastmilk Substitutes' by the World Health Assembly represents one of the greatest opportunities of recent times to effect a change which would combine improvements in human life with reductions in economic costs. The improvement for infants can be illustrated in a single fact – because of the nutritional and immunological properties of mother's milk, those who are breastfed for less than six months, or not at all, are five to ten times more likely to die in the second six months of life than those who are breastfed for more than six months. But for a Third World currently spending $1 billion a year on infant formula products, and for low-income families spending $3.50 out of a weekly wage of $15 to buy it for their children, the switch from the promotion of bottlefeeding to the promotion of breastfeeding could also mean a very significant economic saving.

The scope for such combinations of social progress and economic gain is clearly far from exhausted. It cannot make economic sense for one third of all children's hospital beds in the developing world to be occupied by children suffering from cheaply preventable diarrhoeal diseases. It is neither socially nor economically acceptable to have 500,000 children a year being affected by poliomyelitis when 20,000 shots of vaccine cost less than $1,000. Nor is it either humane or sensible to have allowed over 500 children to lose their eyesight every day during 1981 when Vitamin A tablets costing only a few cents could have prevented it.

Meeting the most basic needs of the majority of the world's children is a less direct and self-contained task than these examples imply. But in the wider arenas of nutrition, health care and education, ways have to be found of using human wit and wisdom as much as money itself in bringing about improvements in the lives of the world's children.

Such breakthroughs rarely happen by accident. They happen by an interaction between the experience of the past, the opportunities of the present, and increased priority to the needs of children and low-income families. It is that interaction which UNICEF seeks to catalyse. And it is to that experience, and to those opportunities that this report now turns.

Recruiting an army of paraprofessionals

In the task of providing basic services to meet the greatest needs of the greatest numbers, past experience suggests that an army of paraprofessional development workers – backed by more specialized government services and stimulating the people's own involvement in the creation of those services – is probably the only way forward for the 1980s.

From one point of view, the use of paraprofessionals is an economic necessity. To train, equip and install a fully qualified medical doctor in every Third World community (even if such doctors were prepared to serve there, which the majority are not) is an impossibility for the foreseeable future.

From another point of view, the use of paraprofessionals is also more appropriate. The essential requirements of 'health for all' as set out by the World Health Organization, for example, are: 'adequate food and housing, with protection of houses against insects and rodents; water adequate to permit cleanliness and safe drinking; suitable waste disposal; services for the provision of ante-natal, natal and post-natal care (including family planning); infant and childhood care, including nutritional support; immunization against the major infectious diseases of childhood; prevention and control of locally endemic diseases; elementary care of all age groups for injury and diseases; and easy access to sound and useful information on prevailing health problems, and the methods of preventing and controlling them.'

The appropriate response to such health needs is not to devote available resources exclusively to the training of more doctors to cure disease. It is a combination of social and economic development plus the training

of literally millions of primary health care workers or community development workers who can advise on nutrition, water, hygiene and waste disposal; provide maternal and child health care, promote breastfeeding and advise on family planning; organize immunization campaigns; work with the people towards preventative public health; deal with common local illnesses and injuries; and refer more serious cases to more qualified people.

From yet another point of view, the use of paraprofessionals is also a virtue. Even in the industrialised world there is today a growing disillusionment with the over professionalization of social services. Sweden, for example, is now requiring two out of every five new doctors to commit themselves to primary health care and general practice. And in Finland the proportion of the national health budget allocated to hospitals has fallen from 55 per cent to 43 per cent while the proportion spent on primary health care centres – governed by locally elected health boards – has increased from 11 per cent to 24 per cent. In the Netherlands, which has achieved one of the lowest infant mortality rates in the world, the great majority of babies are delivered at home and attended by mid-wives at a fraction of the cost of births in most industrialized countries.

In the Third World, paraprofessionals chosen for training by and from the communities which they will serve are likely to be more knowledgeable about local skills and resources, more sensitive to local culture and tradition, and more at home with, and acceptable to, those whom they will serve.

In this way, paraprofessional development workers can blur the alienating distinction between experts and people and help to involve rather than exclude the poor from the process of change.

Participation: the foundations of development

If the potential importance of paraprofessional development workers is one of the 'legs' of a strategy of 'more development per dollar', then the concept of people's participation is the other. Indeed without the organized participation of the poor, no community development project has more than the dimmest hope of lasting success. If, amid the scattered hopes of a failed development project, there were a little 'black box' to record what had gone wrong, it would almost always turn out to be the case that, somewhere on the way, the people for whose benefit the project was intended had found better things to do with their time.

That is why 'people's participation' is currently the most popular phrase in the dictionary of development. And although it sometimes seems that the concept is only kept aloft by the hot air of rhetoric, it too has partly arisen because of financial necessity.

Probably only through community participation can progress in public hygiene, water supply, and safe sanitation be made and maintained on the scale required to bring about significant improvements in the quality of life.

In Malawi, for example, piped water today flows in a water-scarce region for 150,000 villagers who themselves dug the trenches, laid the pipes, and built the concrete aprons and constructed the soak-away pits. Through their involvement in the construction of the system, costs were kept down to $3 per person served – a small fraction of the normal construction costs – and the maintenance of the system is both more competent and more likely.

In practice, participation in the process of change is probably the exception rather than the rule. But where it is to be found, its virtues are always to be seen.

As the 1981 World Development Report from the World Bank points out, for example: 'The quality of life for the bulk of the Chinese people is strikingly better than in most low-income countries.' Looking at what lies behind this achievement, the Bank concludes that 'every level of society from the production team to the commune to the national level plays a role in providing social services. Production Brigades may finance the training of one or more "barefoot" doctors, who provide primary health care and often participate in the Brigade's work as well. State subventions pay for some of the programme, but participating groups also provide support, and participate in decisions concerning them.'

Of equal importance is individual participation. A mother who knows the benefits of breastfeeding or of boiling contaminated water before drinking, for example, greatly reduces the need for subsequent and costly curative measures.

But the necessity of people's participation can sometimes obscure the fact that being involved in the decisions and processes which affect one's own life is an end as well as a means and that people's participation therefore has a double valency with the development process. As Denis Goulet has observed: 'Development is not a cluster of benefits "given" to people in need but rather a process by which a populace acquires greater mastery over its own destiny.'

This virtue, as distinct from the necessity, of participation is, again, increasingly being rediscovered in the industrialized world itself. Whether it be through self-help preventative health, or the growing of natural foods, or sweat-equity housing, or home-energy saving, an even larger number of people are becoming re-involved in the process of meeting more of their own and their family's needs.

And as this process of re-involvement gets under way, that same combination of financial and human gains which is so crucial to progress of the developing nations, is beginning to show itself in the industrialized world.

On the food front, for example, American citizens saved $14 billion in 1977 by growing vegetables rather than buying them. For the average gardener, that meant a saving of $375 a year in addition to the benefits of more exercise and better food. In health, the University of California's Self-Care Programme for diabetics has halved the incidence of diabetic emergencies over two years whilst saving $1.7 million in hospital and patient fees.

Paraprofessionals and people's participation therefore represent virtue as well as necessity. But as an approach to development, there are those who accuse it of making the former out of the latter.

It might, for example, be said that primary health care workers are merely the lowest and cheapest rung in a 'delivery system' directed from the top downwards and designed to provide a second-class service to the poor in order to contain the problem of poverty and so avoid change in the society of which that poverty is a part.

In some instances, this is undoubtedly true. It is still the case that, across the Third World as a whole, 80 per cent of health budgets are being spent on doctors and hospitals for the urban few whilst primary health care workers are packed off to look after the rural many. In such cases, the concept of people's participation, similarly, is usually just a fancy name for making the poor responsible for their poverty.

In other cases, the pattern of paraprofessionals and

people's participation in the provision of basic services is seen not as an end but as a beginning, not as a minimum service but as the maximum which can be achieved at any particular time and at any particular place, not as a separate health service for the poor but a means by which the existing health services – including doctors and hospitals – can be geared to the needs of the poor. And however loosely the term 'barefoot doctor' is nowadays used, China's primary health care workers gain significantly in both credibility and effectiveness through being able to refer the poorest child in a rural commune up through a system which can lead to the most sophisticated clinic in Beijing if that is the appropriate level of treatment for his or her complaint.

The training, referral, and support services implied in this re-gearing of health services to serve the majority, should alone dispel any notion that primary health care is a low quality solution. To bring basic health services to every community in the poor world – even by the most appropriate and efficient methods possible – will mean a very significant increase in the resources available for the improvement of human health. Such an increase in 'human capital' would almost certainly pay large dividends in economic growth and development (a health scheme for workers in Indonesia, for example, was seen to raise productivity within eight weeks) but from the point of view of human health alone the efficiency of the primary health care concept resides not in any absolute lowering of the cost but in ways of using additions in resources to produce multiplication in benefits. And without doubt, basing community development strategies on participation and paraprofessionalism will lead to more development per dollar.

Synergisms: making one plus one equal three

One of the most obvious lessons of the development effort is that prevention is almost always more cost-effective than cure. And concern for the prevention of illness means that primary health care is inseparable from such issues as agriculture, housing, sanitation, water supply, education, female emancipation, or the questions of work and wages which are the basis of an adequate diet and a healthy people. The best trained and best supported primary health care workers therefore cannot help but become community development workers. And it is this wider scope of the community development worker which offers another major opportunity for increasing the effectiveness with which available resources are applied.

Poverty, like a self-sharpening knife, finds the means of making each of its disadvantages reinforce the other. A disease like measles, for example, can carry a 50-50 risk of death if contracted by a child who is also malnourished. But the converse is also true. And almost all improvements in the well-being of a community will tend to compound each other's benefits.

Immunization programmes, for example, both strengthen and are strengthened by the other elements of basic health care. 'Simple and low-cost services act synergistically to break the vicious cycle of malnutrition and infection,' says Dr. Ralph Henderson, Director of WHO's Expanded Programme of Immunization, 'and the success of any one service in reducing morbidity and mortality is expected to help to convince the community of the worth of all the other services.'

Of particular importance in the International Drinking Water Supply and Sanitation Decade (1981-90) is the synergistic relationship between clean water and health education. Water may be clean when it is brought to the surface by the new handpump, for example, but if it gushes into a bucket lined with germs, or if the cloth placed on top of the bucket to prevent water from spilling out on the way home is brown with filtered dirt, or if the water is stored for hours in an open jar near the door, then its benefits are likely to be reduced by the time it is used. Counting the number of wells drilled or standpipes installed, is, in such circumstances, only superficially satisfying. And time might be better spent contemplating the shift of, say, ten per cent of the investment in water supply to a corresponding programme of health education designed to extract maximum benefit from that investment.

A cat's cradle of such synergisms links almost every aspect of development: female literacy catalyses family planning programmes; less frequent pregnancies improves maternal and child health; improved health makes the most of pre-school or primary education; education can increase incomes and agricultural productivity; better incomes or better food reduces infant mortality; fewer child deaths tend to lead to fewer births; smaller families improve maternal health; healthy mothers have healthier babies; healthier babies demand more attention; stimulation helps mental growth; more alert children do better at school . . . and so it continues in an endless pattern of either mutually reinforcing or mutually retarding relationships which can minimize or multiply the benefits of any given input.

For such synergisms to work positively, and so increase the ratio between results and resources, the integration of services is obviously necessary. And that brings us right back to the broad range of the primary health or community development worker's concerns.

Far from the village, separate government departments for agriculture, health, education and employment may make their separate services available. But the community development worker living with the problem of underdevelopment at village or community level has no temptation to see nutrition, health, education and poverty as separate issues – and every opportunity to feel the pulse of those inter-relationships which can convert 'inputs' into the beginnings of development. A recent study of six major international development projects has noted: 'Integration is usually achieved more easily at the lower echelons of the hierarchy than at the top'.

Linking what science knows to what people need

In devising ways to extract more 'development per dollar', science has made many breakthroughs in both increasing effectiveness and reducing costs of the technologies involved in fighting poverty. And its failure to fulfill its promise is not so much a failure of science itself, but of social organisation, a failure poignantly identified in R.F. Fendall's epitaph on Twentieth century medicine: 'Brilliant in its scientific breakthroughs, ingenious in its technological invention, and woefully inept in its application to those most in need.'

Nowhere is that gap between what science knows and what people need more tragically evident than in the estimated five million young lives claimed each year by diarrhoeal disease.

Repeated bouts of diarrhoea drain life-sustaining fluids and salts out of the body. Prevention depends

upon a combination of nutrition, food hygiene, water supply and sanitation. But as all of these are several years if not decades away from the poor majority, an effective curative treatment is necessary if millions of lives are to be saved in the meantime.

In the 1960s, the 'cure' was rehydration fluid administered through an intravenous drip by trained medical staff in hospitals or clinics. In other words, it was a cure 'woefully inadequate in its application to those most in need.'

Since the early 1970s, there has been another way. In laboratories in India, Bangladesh and the United States, a rehydration treatment has been devised which costs only a few cents, is based on easily available salts and sugar, is made up in the home by mixing with boiled water, and is administered by mouth rather than by intravenous drip.

Tested under 'worst possible conditions' in emergency camps, the new treatment cut child deaths from diarrhoeal disease by 90 per cent. 'Very few should die if treatment can start early and, preferably, at home,' says Dr. Dhiman Barua, WHO Medical Officer for the Diarrhoeal Diseases Programme.

In the million villages of the Third World, doctors are not going to be at hand to begin treatment 'early and at home'. Primary health care workers could be.

The aim of WHO and UNICEF is to make oral rehydration treatment available before 1983 to at least a quarter of all children under five who are affected by diarrhoeal disease. Scientists can devise the correct formula of salts; doctors, hospitals and clinics can run training courses and hold stocks; but only tens of thousands of primary health care workers can make the technique available to individual parents as and when they and their children need it.

In the organization of immunization coverage which requires three injections for each infant and two for each mother, in the weight checking of pregnant women and newborn babies which is the most sensitive indicator of either their well-being or their need for help, in the early detection of disability which is crucial to either prevention or reduction of its impact on the normal life of the child, it is the on-the-spot presence of people trained in basic health knowledge and backed by specialized services which can extract the maximum human benefits from scientific investment by making its breakthroughs less 'woefully inept' in their application to those most in need.

Beyond the theory

Such a summary of what primary health care can do inevitably elides its complexities into too smooth an outline. 'To build a workable and affordable health care system which will serve the great majority of needy families' says a recent analysis of the Lampang Project in Thailand 'is a considerably more complicated, time-consuming and expensive undertaking than is generally realized by those who have not actually tried.'

'Nevertheless,' the report concludes, 'it has to be done because this is undoubtedly the most effective and feasible way – probably the *only* way – to meet the crucial and long-neglected basic health needs of the people.'

That is why primary health care is no longer an untempered theory but an idea going into action, in all its various permutations, across the developing world.

In Africa, Botswana is training one 'family welfare educator' for each village; Ethiopia is retraining 28,000 traditional birth attendants and community health workers; Malawi is trying out a 12-week primary health care course across one of its regions; Somalia has trained 1,800 community health workers and plans to have two for every village by 1985; the Sudan has trained over 1,000 community health workers for settled communities and 176 for nomadic groups; Zimbabwe is building on its 1,000 former military paramedics in order to create nation-wide primary health care; Niger has trained 560 community health workers with specific emphasis on reducing gastro-enteric diseases in Iwo State; in Senegal, Benin, the Congo, Niger and Upper Volta, the idea of 'health for all through primary health care' – as propounded by WHO and UNICEF at the Alma Ata Conference in 1978 – is now being tested against the realities of the continent's problems.

In Asia, India has already trained 100,000 community health workers and retrained 150,000 traditional birth attendants in its attempt to provide one primary health care worker for each of its 580,000 villages; Bangladesh is training one community health worker for every 1,000 people in six test areas; Indonesia is experimenting with the training of '*prokesas*' (voluntary health workers) chosen by each block of 30 families; Thailand has already trained 11,000 village health workers and 112,000 'village health communicators' who now serve 25 per cent of its population; Nepal plans to extend primary health care to all 27,000 communities; Vietnam's community development workers, selected and paid for by their own communities, are now backed by 8,500 health centres across the country; and in China, the original 'barefoot doctors', backed by an increasingly sophisticated medical service, are providing the appropriate level of care – from bandages to brain surgery – for almost a billion people at a cost of less than $7 per person per year.

In the Americas, the primary health care approach of Cuba and Costa Rica have achieved infant mortality rates among the lowest in the Third World; Nicaragua is now training 2,000 community health workers and health volunteers and making oral rehydration treatment locally available to more than 100,000 children; in Jamaica, Colombia, Ecuador, and Panama, primary health care experiments have been launched.

And in the Democratic Republic of the Yemen, Saleh Hamshali, a newly trained health guide, has today been called away from the orchard where he earns his living. He has been sent for by a mother who has become desperate about her one-year-old daughter. The child has had diarrhoea for two days and is obviously failing. As Saleh hurries from the fields he passes by many of the men and women who elected him, a few months ago, to be trained as their health guide. Some of them are burning garbage as he approaches the edge of the village.

Within a minute or two, he arrives at the child's home and stoops through the stone doorway. The girl is lying on a mattress on the floor. Immediately he asks for boiled water to be brought and unslings the satchel from his shoulder. Tearing open a foil sachet of what he knows as 'UNICEF Salts' he mixes the powder with four Coke bottles full of water. The mother looks on anxiously as Saleh carefully transfers the liquid from one clean bowl to another to make sure that the salts are fully dissolved. Spluttering, the child drinks the fluid from a clean tin mug. She will certainly live. Two years ago, Saleh's own one-year-old daughter exhibited the same symptoms. Her grave is a small mound of sandstone rocks on a hill just outside the village. At that time, Saleh did not have his three weeks training nor ten cents worth of salts.

Investing in children – social justice and economic sense

AT THE community level, paraprofessionals and people involvement are the most important ways in which the 1980s can extract more development per dollar and improve the lives of the world's children even within the financial constraints of the years to come. But implemented in isolation from changes in national and international priorities, they are unlikely to fulfill more than a fraction of their potential or to be the beginning of the end for absolute poverty. For a broader and ever more powerful synergism also exists between improvements in health, nutrition, education, and improvements in social and economic development– in productivity by and for the poor majority.

But as the budget of the Third World's governments – and the aid flows they are likely to receive from the industrialized world – are also severely affected by world recession, ways must also be found at the national and international level of making every dollar go further.

Basic needs and a new economics

Again, the lessons of the development effort in recent years point to one outstanding way in which this might be done. In summary, that lesson is that the creation of productive employment opportunities by and for the poor, and of social services designed to meet their needs, will not only alleviate poverty now but will actually help to accelerate economic growth itself.

The implicit proposal – a direct rather than indirect attack on absolute poverty through the provision of services and employment opportunities designed to meet the needs of the poor majority – ran counter to contemporary economic wisdom. Such approaches it was said were inefficient and would lead to decreases in investment and to a slowing down of the very growth which made the expansion of such services possible.

But as the 1960s became the '70s, it was clear that the persistence of poverty represented not only a continuing human tragedy but also an undermining of the process of growth itself.

Labour is as important as capital in the process of increased production. And a malnourished, unhealthy and illiterate population was therefore a serious constraint on productivity. From this point of view, social services which build up 'human capital' are not consumption but investment. Humanitarian concern thereby acquired economic respectability. Says former World Bank President Robert McNamara: 'Human development – education and training, better helath and nutrition, and fertility reduction – are shown to be important not only in alleviating poverty directly but also in increasing the incomes of the poor and GNP growth as well.'

In agriculture – on which approximately three-quarters of the Third World's people depend for their livelihood – the advantages of redistributing land in order to invest in the smaller farmers and the poorer households has now proved itself in many developing nations where the smaller farmers have effective access to credit, markets, technology, education and health facilities. In general, the larger the farm, the less intensively it is cultivated, the less labour it uses, and the less per acre it produces. After land reform in Taiwan, for example, average yields per acre rose by 80 per cent. And in South Korea, one of the reasons behind its increased agricultural productivity is that between 1945 and 1965 the percentage of rural households who worked on land which they themselves owned rose from 14 per cent to 70 per cent. Such landholdings, as in Taiwan and Japan, averaged only one hectare in size. And in all of these cases, the numbers of agricultural workers per 100 acres rose sharply as did the number of days worked by each person – thereby increasing their incomes and their ability to feed, educate and otherwise care for their children. We have only recently begun to recognise that the difference in agricultural productivity between different countries and regions is not primarily a question of their cultural background, although that has some impact, but of the organisation of their agriculture and of whether or not farmers have incentives and access to support systems. 'The outstanding success of the 1970s has probably been the improved productivity of small farmers,' says the 1981 World Development Report. 'Their extra output has been the key to impressive growth in such countries as India, Indonesia, and Malaysia'.

Greater attention to the allocation of assets, services and opportunities for poorer households and small producers can increase the efficiency with which resources are used. It can help to meet needs now. It can help to increase productivity. It can help to ensure that the benefits of that increased productivity accrue to the majority. And, for the reasons discussed elsewhere in this report, it can help to slow down the rate of population growth and thereby assist development in the future as well as in the present.

In theory, then, the approach of trying to meet basic needs – for food, health-care, education and jobs – represents increased value for development expenditure.

In practice, comparisons across different developing countries also show that economic growth in those countries with high life expectancy and literacy rates grew faster in the 1960s and '70s than those where health and education services lagged behind. Many of those countries and regions which achieved sustained per capita growth in GNP of 6% or more during the 1960s and 1970s – such as Japan, Singapore, Taiwan, Hong Kong, Romania or South Korea – made a greater than usual effort, and with greater than usual effectiveness, to advance the well-being of low-income families and their children. Sri Lanka, long chastised by conventional economists for its profligate 'consumption' through social services in the 1950s, was seen to be succeeding in bringing about lower infant mortality, longer average life expectancy, higher literacy, and lower birth rates than either India or Bangladesh whilst at the same time seeing its economy grow more quickly than its neighbours.

In 30 developing countries surveyed by the World Bank, primary education was found to be the most

productive investment opportunity available – able, in time, to yield a hard economic return of approximately 24 per cent. In the same study, the productivity of farmers with four years of primary education was found to be 13 per cent higher than that of farmers who had never attended school (where the necessary farm inputs were available in both cases).

China, South Korea, Taiwan, all gave their evidence that investing in people through services designed to reduce poverty could reinforce rather than detract from the process of growth itself over a time-span of a decade or more. And in all of these cases, the International Development Strategy's social goals of reducing, in all countries, infant mortality to 50 per 1,000 or less, increasing average life expectancy to 60 or more, and reaching a literacy rate of at least 75 per cent, have been achieved at a level of GNP per head which is well within the range of all developing countries by the year 2000. And in all, the PQLI (Physical Quality of Life Index*) rating is well above the average for middle-income countries which have per capita incomes several times higher than a China, a Kerala, or a Sri Lanka.

The potential of such 'human development' strategies for increasing the efficiency of the development process – and hence for achieving a significant improvement in the lives of children even within the economic restraints of the late twentieth century – has therefore been demonstrated in both theory and practice.

Political will and changing priorities

Almost all of these ways of achieving more benefits for children and mothers per dollar – whether they be broad strategies of switching emphasis to human development or more detailed plans to build 50 health centres rather than one hospital – require changes in priorities. And such changes are not easy in view of established interests in existing patterns.

For they are strategies which contribute to and depend upon the greater priority to low-income families implied by a 'basic needs first' approach to development.

All of the policies designed to meet such needs – switching the emphasis from universities to primary schools, from hospitals to primary health care, from cities to rural areas, from large estates to small farms are policies which bring more benefits to the children of the poor and can, at the same time, accelerate a nation's economic growth. It is not, in most cases, a question of dismantling hospitals, it is a case of reharnessing hospitals and doctors to the needs of the majority – often through the provision of training, referral and back up services to primary health care workers.

But while there can be little doubt that switching priority to the majority of children and mothers renders more efficient the process of using available resources to improve the quality of life, such decisions are ultimately political.

The political will required to invest in the poor majority is perhaps the scarcest resource of all in the struggle for world development.

There can be no artificial substitutes for that will to create or to permit the efficiency of greater equity. But it is a process which the industrial world can facilitate by changes in the terms of trade and levels of aid which could help to increase the resources available to the nations of the developing world for financing projects whose main beneficiaries are the poor and the powerless. International broadening of economic opportunity can therefore reinforce the same process within nations.

But the political will required to do so seems just as scarce. The attempts to create that will – through special sessions of the United Nations General Assembly, through the meetings of the United Nations Conference on Trade and Development, through the North-South talks in Paris, through the Brandt Commission and over the summits of Ottawa, Melbourne and Cancun – have been hinged partly on moral arguments and partly on the idea that the transfer of resources to the developing south is also a method of regenerating the economies of the industrialized north. Such a strategy echoes, at the international level, the 'new economics' of the basic needs approach to development in its suggestion that investing in the productivity of the poor perhaps could be as good for the world economy as investing in the productivity of poor communities could be good for national economies.

In practice, however, trade policies which restrict the developing world earnings – and aid policies which direct more than 50 per cent of official development assistance to the wealthier developing countries – put a brake on progress towards improving the lives of the world's children.

Technology and social organization

The 'equity factor' is therefore important at both national and international levels in determining how much development can be derived from each available dollar. But at the local or community level, that same equity factor has to be one of the key considerations in projecting the efficiency with which any development project involves and benefits the poor. Otherwise a well-drilling programme which begins as an attempt to improve the health of the poor can end as little more than a subsidy to the landowner; the launch of a new highly-yielding crop variety which begins as an effort to increase nutrition can end by increasing the size of farms and the numbers of the landless; the introduction of a tractor which begins as an attempt to enable larger acreages to be ploughed can end as onerous extra hours in the fields for the women who do the weeding and the gleaning.

At every level of the development process, such choices have to be faced. To move forward in the belief that money and technology can work independently of social relationships is to repeat a formula which has been tried and failed. Technical solutions can be, and often are, brilliant solutions to a part of the problem. And more scientific research is needed on the health and agricultural problems which affect the lives of 1 billion people yet which claim less than 1 per cent of the world's research budgets in those two fields. But when science and technology are treated as the

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**The PQLI fuses the rates of literacy, infant mortality and life expectancy at age one into a single composite index with a high of 100 and a low of zero. For each of these three individual indicators, a rating of 100 represents the highest point which any country in the world can expect to achieve by the year 2000. A rating of zero, at the other extreme, represents the lowest rate prevailing anywhere in the world of 1950. One hundred on the life expectancy scale, for example, represents the 77-year average which a country like Sweden can expect to reach by the end of the century, whereas zero represents the 38-year life expectancy which prevailed in very poor countries 30 years ago.*

The PQLI gives equal weight to all three indicators and averages them to provide a measure of the physical well-being of a given population.

solution to the whole, they are, to borrow an image from Zen, like the sound of one hand clapping.

To move forward, and to make what has been achieved in the realm of technique more truly useful to the lives of the majority, it will be necessary to turn again to face the irreducible problems of political and social relationships – whether we are talking of people's participation or economic inequalities – with which humanity has always had to struggle but from which dramatic advances in techniques seem to have given us a temporary respite.

Unlike technical difficulties, such problems are not susceptible to the imposition of centralized solutions worked out by the few and applied to the many. They depend upon a decentralized diversity of approaches and experiments and are based as much on accumulated wisdom as on breakthroughs in know-how.

In other words, these are the really difficult problems of development. And they underlie many of the failures and the disappointments of the development effort in recent years.

As long as development is viewed as a question of scientific intervention by experts as opposed to a question of social organization by people, such disappointments are as inevitable as the discouragement which follows them.

And because disillusionment is as great a threat to progress as is economic recession, this report, which has focused on the ratio of resources to results, should conclude by re-calibrating the criteria by which 'results' are judged in order to take account not just of targets aimed for and resources available, but the fact that development is about social organization, and depends upon a process whose complexities we are only just beginning to understand.

Learning from development's disappointments

For too long now, the Third World has been portrayed to the industrialized world as a uniform entity within which one simple formula for development can be everywhere applied. To say that India, for example, has 500,000 villages conjures up in the mind not 500,000 villages but one village replicated 500,000 times. Yet no community in the developing world is less complicated than any community in the industrialized world. All communities have cultural and social norms, vested interests and class divisions, loyalties and jealousies, leadership patterns and change procedures, and established habits of body and mind. All communities are affected by psychological and cultural accommodations to what has been possible or necessary in the past. And no community is a blank slate on which outside experts can write prescriptions for improvement.

Perhaps because of the exigencies of raising funds, or because no one likes to see achievements fall short of hopes, there has been in the past a great reluctance to acknowledge disappointments in the field of development. And the public image of its workings become seriously distorted as a result.

There is still, for example, an abiding notion in the minds of many that an expert need only go into a village or a slum and impart his wisdom for it to be unanimously adopted to the instant benefit of all concerned.

In view of comparable efforts in the industrialized world, this is a strange misconception. For many years, experts possessed of knowledge have been using much more sophisticated communications technologies to reach a much more educated audience with the messages that cigarette smoking is injurious to the health, that seat belts save lives, that women should have equal rights, that the prevention of environmental pollution is cheaper than its cure, that lower automobile speeds save fuel and lives, that obesity is a health hazard, that the over-prescription of the abuse of drugs is not to be recommended, or that drinking and driving is anti-social. Yet the conveying of these messages has not automatically or instantly resulted in mass changes of behaviour, and, indeed, many of these 'logical and obvious benefits' have had to be assisted by legislation in order to increase their level of public acceptance.

It would be too generous to credit the Third World with a much greater capacity for instant change, and it is therefore reasonable to lower the pretence that every single cent allocated by governmental or private agencies to the task of world development is instantly translated into substantial and lasting benefits for the poor. Such a deception may warm the conscience of the donor, but it bears little relationships to the complexities of poverty and development.

In this context, the heresy of development projects which are less than 100 per cent successful is easier both to acknowledge and to learn from.

In adult literacy campaigns, for example, it has often been found that half of those who enrol do not complete the course and half of those who do fail to become literate.

In nutritional education, the World Health Organization has commented that 'many of these efforts have been unsuccessful in improving dietary practice'.

In women's training courses designed to impart income-earning skill, it is not uncommon to find that less than ten per cent of the participants are actually earning any money as a result.

In water programmes, UNICEF's own research publication reports that 'in one example, after the first year of its implementation, up to 80 per cent of the handpumps are reported out of order.'

In employment creation schemes, a recent study by the International Council for Educational Development reports that 'the record of success has generally been disappointing'.

The six-nation study referred to here was in fact financed by major foundations such as Ford and Rockefeller and by aid agencies of the governments of the Netherlands and the United States, as well as by several international voluntary organizations, for the purpose of analysing what had been learnt from the failures – and the successes – of projects designed to improve conditions in rural areas of the Third World. In his introductory overview to this study, project editor Philip H. Coombs sums up the dangers of regarding development as something to be delivered to the grateful poor:

> 'The mistaken assumption that underlies many top-down programmes, is that villagers, because they are illiterates, are unintelligent and must be treated like children. Hence the 'message' devised by experts at higher echelons often tends to talk down to the rural people, telling them what is 'good' for them (without really explaining *why*) and urging them to abandon various traditional practices in favour of innovative ones which the experts consider to be better.
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> 'But in reality most rural people, far from being stupid, have acquired considerable wisdom through the years of struggling for survival. They may cling to certain ill-founded myths and taboos that do them more harm than good, but they also have a very practical sense and a great fund of local knowledge that exceeds that of the outsider. Their

cautiousness about accepting advice from 'outsiders' is usually well-founded; they have been burned too often before. They may listen politely to them, but are unlikely to heed their advice – for example, to alter their diet or to adopt modern family planning methods or some agricultural innovation – until and unless they are convinced in their own mind, and by their own logic, that it is in their own best interests to do so. They are far more likely to accept the advice of a respected neighbour whom they consider the local expert on a particular matter than to follow the advice of outside specialists.

'Thus much of the impetus for change must come from *within* the community. The problem is how to spark this impetus and then how to get the community effectively organized for self-help, self-direction and broad-scale change.'

Such a conclusion may seem untidy, unsatisfying and elusive. But all of UNICEF's experience says it is close to the heart of the problem. And however less 'attractive' that problem may seem than the kind of problem which can be solved in a laboratory or on a computer or by a technical breakthrough, the development effort in the 1980s must again address itself to the issues of social and political relationships if it is to bring about significant improvements in the lives of the world's children. The questionmark for human progress during the remainder of the century hangs not over our ability to manipulate external circumstance, but over our ability – internationally, nationally and locally – to create just and sustainable social relationships. And the greatest lesson of the last three decades, and the one which holds out most hope of a better future for the world's children, is that world development is not just a process of technological intervention, but also of social organization, an art as well as a science.

UNICEF: Applying the lessons

In its attempt to assist in this process, UNICEF itself has changed its methods of operation since its inception 35 years ago. Then, almost three-quarters of its staff were housed at headquarters in New York. Now, more than three-quarters of its staff are living and working in the developing world. And, whenever possible, UNICEF now works through national offices and officers to find 'decentralised' solutions to the task of bringing more benefits to children for every available dollar.

The lessons which have been learnt over those decades and which have been discussed in this report – lessons about paraprofessional development workers, about peoples participation, about the synergistic benefits of integrated approaches, about prevention rather than cure, about the importance of social relationships as well as technological interventions – have led to the 'strategy of basic services' which now guides UNICEF's work for children in over 100 nations of the world. This 'basic services' approach is not a central formula for the imposition *of* development but decentralised strategy of participation *in* development. And as such it is based on training and assisting development workers to provide essential services to mothers and children in cooperation with poor communities throughout the world.

The result is that – in the last twelve months alone – UNICEF has helped to train over 115,000 health workers and to equip almost 43,000 health centres; to train over half a million village level nutrition workers and expand nutrition programmes in over 130,000 villages; to cooperate in almost 100,000 water supply systems and in the installation of over a quarter of a million sanitary latrines; to train over 90,000 teachers and to equip 88,000 primary schools.

Work of this kind by UNICEF and by governmental agencies needs to be backed by broader scale economic and social policies which concentrate national and international resources on the needs of the one-fifth of the world's people who today are the 'absolute poor'. And the more resources which can be made available for this investment through increased aid and more liberal trade policies in industrialized countries, and through increased priority to the poorest in the developing countries, the sooner will absolute poverty be abolished.

But this, the largest ever generation of children cannot wait. Their childhood, which is so threatened by the darkness of today's economic climate, will not stand still to await the restoration of economic growth. For them action is needed now to shift priorities in favour of mothers and young children, to refine and implement strategies for increasing the ratio between resources and results, and to make that most crucial investment in today's children and tomorrow's world. 'Each generation should pay to its successors the debt it owes to its fore-runners, 'wrote James Connolly,' and by spending itself for the benefit of its children, the human race ensures the progressive development of all'.