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THE YOUNG CHILD: APPROACHES TO ACTION IN DEVELOPING COUNTRIES

A draft report and recommendations

by the Executive Director

Contents

74-07623

(16 p.)

FOREWORD

A great deal about the young child in developing countries can be stated in the following table:*

	Children under five	Annual deaths under 5	GNP per inhabitant 1970
Developing countries	412,000,000	16,500,000	$ 250
Industrialized countries	96,000,000	470,000	2,750

The figures are estimates but the general picture given is accurate enough. The developing countries, with 4 times more children under 5 years of age than the industrialized countries, have 35 times the number of child deaths - this means overall a young child death rate eight times higher. But even these figures understate the situation. Not revealed, because they cannot be assessed, are the costs in chronic ill-health, and stunted mental and physical development among those who survive.

It is an unacceptable situation, a challenge to all mankind. Poverty is, of course, a main contributing cause of the disadvantages to which so many children are subject; whether in the industrialized or developing countries that the average inhabitant of the developing countries has less than one tenth the income his counterpart in the industrialized countries is a special challenge, but that is not the subject of the present report. However, it is not necessary to wait until poverty is removed. Rather, a young child policy can contribute to removing it.

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* Based on a table in D.Morley, Paediatric Priorities in the Developing World (London, Butterworths, 1973), p.2. Statistics extracted from World Population Prospects as Assessed in 1968, (United Nations publication, Sales No.72.XIII.4) and Trends in Developing Countries (Washington, D.C., World Bank, 1973).

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Scientific and technical advances have greatly increased the means for reducing the contrast in the fate of children born in developing and industrialized countries. Safe and sufficient water can be provided through tube-wells bored more easily, and if necessary to a greater depth, than open wells. Most countries, even most communities, can grow the foods their children need. Immunizations against children's diseases have become cheaper, especially in recent years measles and polio vaccines, and cheap specific drugs make simple treatments available for many illnesses. Mothers can be taught literacy for the equivalent of about $10 per year for one or two years, and many home and village improvements are accessible. The reader of chapter III will be struck by the large amount of technical information now available, and waiting to be applied on a large scale.

The will to put these means to work on a large scale may be weak for a number of reasons. Often there is not sufficient awareness of the situation of young children; this can be remedied by political leadership and the mass media. Many feel that in any cased effective action is not possible; this report argues against that view. Some think it is better to concentrate on economic growth, and leave social problems to be solved by the benefits as they "trickle down"; there is extensive experience that this is not a satisfactory solution, and that, on the contrary, social measures can themselves greatly help national development. Some think that extending investment in human resources down to the young child is too long-term; in fact, it is no longer-term than a hydroelectricity plant or steel complex, and has much more widespread returns. Some think that the reduction of child mortality exacerbates the problem of population growth; on the contrary, the strongest motive for responsible parenthood lies in the aspirations of parents for the health and advancement of the individual child.

More can be done with present resources, by using them more effectively. In addition, developing countries need to commit a larger share of government resources to expand services to benefit the young child, and external aid agencies should help them in this field. Above all, more should be done to encourage local initiatives, and to help release local community energy and resources through such means as the reduction of illiteracy and seeking community co-operation and participation in the design, installation and recurring costs of services.

INTRODUCTION

1. This draft report has been prepared as a basis for a review by the Board, on what more can be done for the young child (up to six years of age) in developing countries. It suggests the main elements to be considered by the countries in establishing policies, and in deciding to expand services or programmes. It also makes recommendations about emphases in UNICEF assistance policies to benefit the young child. Indications are given of the vulnerability of the young child and his [1/] large unmet special needs, particularly those for which more effective action can be taken within the means of developing countries. Emphasis is on progressive advances that can be made by countries for the young child in the more deprived population groups, at different stages of national development; on community involvement in improving the well-being of the family; and on measures to increase the mother's capacity to look after her children, and to lighten her burden and provide her with greater opportunities for education.

2. After receiving the comments of the members of the Board, and after further consultations with specialized agencies and others concerned, a revised report will be prepared for circulation. In developing countries the main audience for the report, will presumably be planners and administrators in governmental units concerned with over-all planning, and in sectoral ministries; outside the Government it may be found useful by teaching and research institutions, professional groups, information media and non-governmental organizations (both of an operating and advocacy type) concerned with various aspects of social development.

3. This is not a technical report nor does it attempt a complete statement of the problem; rather it is focused on suggesting advances which are practical for developing countries to envisage, with some

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1/ In accordance with English usage the male pronoun "he" is used in this report to refer to both the female and male child.

help from UNICEF and other outside assistance. References are given for the reader who wants sources for further technical and operational information. It is not the object of the report to help the professional reader in his own profession, but to give him an overview of related fields.

4. The Executive Director hopes that in industrialized countries the main lines of this report will be of interest to bilateral aid agencies, to those formulating positions of their Governments in intergovernmental bodies dealing with social issues, and to non-governmental organizations having international programmes.

5. The report will provide guidelines to UNICEF field staff as they discuss with Governments the linking of UNICEF aid with national development, and as they review specific programme proposals. In line with UNICEF's programme co-operation with other agencies in the United Nations family such discussions should, of course, also bring into the picture the expertise and technical support of these agencies.

6. This study is the second of its kind reviewed by the Board. An earlier study entitled "Reaching the young child" (E/ICEF/520) was the basis of a main agenda item at the Board's 1965 session. A summary of the study, the Board's discussion of it and the Board's conclusions are set forth in the report of the Board on that session (E/ICEF/528/Rev.1).[2/] The basic conclusion of the present report is the same as that of the earlier one, namely, that very much more can be done to benefit the young child given a greater awareness of both the problem and the possibilities for action, and given steady efforts by the developing countries and by the sources of external aid.

7. The young child has been of special concern to UNICEF for many years. Although most individual programmes that UNICEF has assisted have proven useful in improving his situation, the Board's view at its 1973 session was:

2/ The Board's conclusions are reproduced in E/ICEF/L.1308, a compilation of basic policy decisions excerpted from reports of the Executive Board, to be circulated to Board members prior to the 1974 session.

> "In general, there has not been enough progress in developing a systematic approach to the infant, weanling and pre-school-age child that would encompass the whole range of his needs with special emphasis on those areas where action seemed possible - and that would involve parents and community" (E/ICEF/629, para.84).

8. The Executive Director wishes to express his appreciation for the work done in the preparation of this study by a number of his associates in UNICEF, including Mr. Tarlok Singh, Deputy Executive Director (Planning), members of his staff and Dr. Charles P. Gershenson, Visiting Professor of Child Development, Florence Heller School of Advanced Studies in Social Welfare, Brandeis University, the special UNICEF consultant who was responsible for the organization of a number of country studies (see annex II), and the bringing together and analysis of materials from them. The Executive Director wishes to record his special thanks to Mr. E.J.R. Heyward, Deputy Executive Director (Operations), who wrote much of the present draft.

9. In addition to the country studies, extensive use was also made of programme experience which UNICEF has had since the first study in 1965, as well as that reflected in numerous studies, publications and conference reports, which are referred to in the text and in the selected bibliography (annex I). The technical agencies of the United Nations family, and particularly their advisers to UNICEF, have contributed substantially to various sections of the report; the wealth of information from the agencies is reflected in the bibliography. There has not been adequate time, however, for the agencies to comment on the draft text itself, and they therefore cannot be presumed to have approved it. We look forward to the further contribution of their views and suggestions, which will be taken into full account in the preparation of the final report. For similar reasons of time and distance, we have still to benefit from the comments of our field staff on this text.

10. Finally, special thanks are due to the International Children's Centre, which agreed to contribute a study on the training of personnel for services for the young child (E/ICEF/L.1303/Add.1). This, in effect, forms part of the present report.

I. NATURE OF THE PROBLEM

Contents

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Summary

11. This chapter points out that young children need special attention for three main reasons:

(a) Their bodily growth and probably also their mental and behavioral development requires food somewhat different from the family's meals - more per kg. of body weight, more easily digestible, and richer in protein, vitamins and minerals than minimum adult requirements;

(b) They are particularly vulnerable to infectious disease, as they lose the passive immunity given by their mother, and face the hazardous years during which those who survive develop some resistance of their own. The hazards are especially high for children in marginal environments, especially if they are malnourished because of early weaning;

(c) The basic development of intellectual, emotional and social aspects of personality during this period affects their adult life and their contribution to society.

12. The young child depends on his family. Government and community services can support him indirectly through the mother and the family to a greater extent than by direct service to the child himself.

13. Government health and social services are at present reaching a small minority of children in developing countries. Budgetary limitations are a powerful constraint. Many countries with a GNP per inhabitant of approximately $100 or less in 1971 were spending annually no more than $1 per inhabitant on health services. However, some countries, as a matter of policy, manage to do more, and this is a very important contribution. In addition to bringing direct benefits, services for the young child should be seen as a long-term investment in human resources. From the latter point of view some

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have felt that the investments are too long-term in comparison with other human resource investments; however, they are no more long-term than many other investments in development.

14. The later chapters argue that it is possible to extend the resources available in developing countries by securing participation from the population served; by adopting better forms of organization for the delivery of services; and by a better-informed commitment of the nation to its new generations.

Importance of the first five years

Risk of mortality

15. The foreword has shown that as a global average the death rate of children below five years of age is eight times higher in developing than in industrialized countries. Deaths in that age group in developing countries usually account for from 30 to 50 per cent of all deaths compared with 3 to 5 per cent in industrialized countries. The total of deaths is usually broken down into two components - deaths of infants under one year of age, and deaths of young children aged one to four - between which there are some differences. Infant mortality [3/] has been declining throughout the world for some decades. In many industrialized countries it has decreased to between 15 and 25 deaths per thousand births, while in many of the developing countries the rate is recorded as between 50 and 100 per thousand or higher. Mortality statistics for the developing countries usually understate deaths, particularly in the rural areas.[4/] Often the registration for vital statistics covers only part of the country including the urban areas. Special enquiries, such as the one referred to in footnote 4/ give more reliable information.

3/ Deaths under 1 year of age per 1,000 live births.

4/ R.R. Puffer and C.V. Serano, Patterns of Mortality in Childhood (Washington, D.C., PAHO Scientific Publication No. 262, 1973), chap.2.

16. The death rate is lower for children aged one to four years than in infants under one, but the contrast between industrialized and developing countries is even greater. In the industrialized countries this death rate is often one per 1,000 live births, or less. In the developing countries it can be 10 to 20 times this rate. In industrialized countries deaths of children in the age group one to four years, which account for mortality during four years of the young child's life, are one quarter or one fifth of mortality during the first year of life. In developing countries typical levels are two fifths, half or two thirds. Thus there is substantial scope for reduction of the death rate in developing countries from birth to age five. The higher infant and child mortality is largely reflected in the lower average expectation of life at birth, which as a global average, is 50 years in developing countries and 70 years in industrialized countries. Where vital statistics are weak, this is a more reliable indicator than recorded death rates.5/

Laying foundations for later growth and development

17. Survival of the young child is of the highest priority, but survival is not enough. Disease and malnutrition can leave indelible scars. Deprivation, particularly of maternal care, can have lasting effects on the child's personality. Failure to meet the basic physiological and psychological needs of the child sufficiently, or at the appropriate time, will hamper his future growth and development.

18. Although it is not fully known which early deprivations are reversible through rehabilitation, studies indicate that the more severe are the deprivations and the earlier they occur, the less likely it is that the effects will be reversed. In any case it is not desirable to allow conditions to develop for which special, and relatively costly, rehabilitation services are required, and which

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5/ Human Development and Public Health, WHO Technical Report Series No. 485 (Geneva, 1972), sect.2; also Demographic Yearbook 1971, (United Nations publication, Sales No. E/F.72.XIII.1), tables 29 and 31; The World Population Situation as Assessed in 1970, (United Nations publication, Sales No. E.71.XIII.4).

will not be available for most of the children who need them. The foundation for growth and development through the years of elementary school-age, adolescence, youth and adult life is laid in infancy and early childhood. In some respects the foundation begins in the womb; for example, low birth weight is likely to be followed by many health problems and a higher risk of mortality. Each stage of life, is, in part, a preparation for the next.6/

Vulnerability to nutritional deficiency diseases

19. The child grows most rapidly during his first three years and needs food to provide for this as well as for maintenance of his daily activities. He needs sufficient food, prepared in a form he can digest, since he can hardly handle family food as usually served; and for growth he needs a diet richer in proteins, minerals and vitamins than adults can live on. This requires special provision for the young child in the family food, and in a national food policy.

Vulnerability to other diseases

20. In the first few months of life, adequate maternal antibodies are usually present to protect the body against certain (but not all) infections. By the age of six months these antibodies are greatly reduced and may have disappeared by the end of the first year. The young child must develop his own immunological systems of resistances. If the environment is grossly unhygienic, the child is exposed to a host of infectious agents that he is physically unable to withstand.7/ Up to the age of five or six years, the typical child will often be ill with diarrhoea, respiratory infections and malaria; he may suffer trauma (burns and scalding), and a skin or eye disease; and also catch whooping cough, measles or chicken pox.

6/ Erik H. Erikson, Childhood and Society (New York, Norton, 1963), chap.7; Training of Personnel for Services for Young Children, International Children's Centre (E/ICEF/L.1303/Add.1), chap.1, sect.7.

7/ Human Development and Public Health, op. cit., sects.10.2 and 10.3.

Dependence on the mother

21. Up to six years of age, the child is primarily dependent upon the mother and mothering persons. The extent and quality of the interaction between child and mother, and the early nurturing environment, profoundly affect his psychological development, including intellectual functioning. The interval between pregnancies and the number of pregnancies have important consequences for the survival, health and well-being of the mother and the family.

Interrelationship of the above five factors

22. Many of the above factors are interrelated and reinforce each other. For example, the degree to which dependence on the mother is fulfilled through breast-feeding commonly affects an infant's state of nutrition, and directly provides some immune bodies; this in turn affects his vulnerability to infectious diseases. Many illnesses are associated with malnutrition, which increases the severity of the illness. In many cases, death results from what in an industrialized country would be a relatively benign illness (e.g. measles). Infection and illness in turn exacerbate nutritional deficiency. The combined effect of intestinal infections, malnutrition and respiratory diseases, or of any two of these factors, is responsible for a high proportion of the deaths of young children. Chapter III argues that this interdependence should be reflected in the convergence of services, e.g., immunization, nutrition and other maternal and child health services.

Basic physical needs and the gap in services

23. No attempt is made in this report to define the basic needs of the young child in absolute terms. For action purposes, these have to be defined in relation to their cultural and economic context. In this report the emphasis is primarily on those needs which appear to have a physical and psychological universality and also:

- are acute in the poorest developing countries and among the deprived groups in other developing countries;
- can be recognized as needs by the people; and
- for which government services and community action are feasible, (including some services almost entirely dependent on government).

24. The basic physical needs are water, food, shelter, clothing, and health. Water and food are discussed below. Needs for shelter and clothing are not discussed, though chapter III includes a section on home improvement. Instead of elaborating on the "need for health", this section discusses immunization, other maternal and child health services, and provision for a sanitary environment. Indications are given of the magnitude of unmet needs, and the financial limitations on government services. This section is followed by a discussion of the psychological needs of the child (which are of course interrelated with physical needs) and demands on the mother (paras. 54-66).

The magnitude of current needs

25. Much less than we wish for is known about the extent of unmet needs, even in the elementary terms referred to above. This is partly because the needs are so vast that it may seem that there is little use in measuring them. Countries tend to measure needs only when responsible people see possibilities of doing something about them. However, more than enough is known now to justify a large extension of action. What global information is available is summarized at the end of the discussion of each basic need. Such global information is of little use in diagnosing the situation of a particular country, because of the variations among countries and among different zones of the same country. But it gives an idea of the size of the problems facing the world community.

Safe and sufficient water

26. Polluted water carrying bacteria or parasites is a contributing cause of the sickness and death of the young child. In many

situations and quantity of water used is just as important, because it affects family and household hygiene. Quantity depends on accessibility. Carrying water is a time consuming daily task for most rural women in developing countries, and this reduces the quantity used. Making conveniently accessible an abundant supply of safe water for drinking, bathing and washing, in addition to its other values, reduces exposure to innumerable pathogens in the immediate environment and thereby enables infants and very young children to make a smoother transition from the passive immunity provided by the mother to immunity acquired by gradual exposure.8/

27. Availability of safe water. Over 85 per cent of the rural population and some 30 per cent of the urban population of developing countries do not have access to an adequate supply of safe water.9/

Food

28. Maternal nutrition and birth weight. Foetal development, birth outcome, and the young child's growth are closely related to nutrition. The calorie consumption of the expectant mother affects the birth weight of the infant. It is preferable not to be underweight at the beginning of pregnancy, and when supplementation is needed it is desirable to begin it in the early stages. However, in many situations it is not feasible to provide supplementary food except during the second or third trimester. The concept of low birth weight (defined by WHO as 2.5 kg. or 5 1/2 lbs. or less) is used for

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8/ Human Development and Public Health, op. cit., sect. 10.4. The importance of water supply in Central and West Africa was emphasized in a special resolution adopted at the Conference of Ministers in Lomé. /Children, Youth, Women and Development Plans in West and Central Africa: Report of the Conference of Ministers held in Lomé, Togo, in May 1972 (UNICEF, Abidjan, 1972)/, pp. 132-133. The Malawi case study, for example, states that "The value of good water supply is priceless, since the good water supply usually means an increase in health, which in turn means better workers for the fields, improved gardens, healthier and more alert students in schools, and generally a higher standard of living".

9/ "Basic Sanitary Services: the WHO programme for the advancement and transfer of knowledge and methods in community water supply and wastes disposal", WHO Chronicle, vol.27, No.10 (Oct.1973); World Health Statistics Report, vol.26, No.11 (1973) reports on the water supply situation in 91 countries, and the sewage disposal situation in 61 countries.

working purposes instead of prematurity (because often the gestation period is not known). Low birth weight brings with it a higher risk of illness and death. Adequate protein, minerals and vitamins, are also essential for a good pregnancy outcome.[10/] Anaemias due to deficiencies of iron and folate are especially prevalent in pregnant women in developing countries and affect their resistance to disease and their capacity to work.

29. Breast-feeding. The infant who is successfully breast-fed by a properly nourished mother does not require additional food before four to six months; but unfortunately mothers are shortening the period of breast-feeding.[11/] Mother's milk is the best food for infants. It also conveys some antibodies, and the psychological advantages to mother and baby are an important part of the mother/child interrelations referred to below. Reasons for shortening the period of breast-feeding includes images of "modernization", which are often supported by commercial advertising and promotion, and the pressures of urban life and wage employment. The abandonment of breast-feeding often causes problems for the family budget. The family cannot afford

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10/ J.P. Habicht, C. Yarbrough, A. Lechtig and R.E. Klein, "Relationships of birthweight, maternal nutrition and infant mortality", Nutrition Reports International, vol.7, No. 5 (May, 1973) and "Relation of maternal supplementary feeding during pregnancy to birth weight and other sociobiological factors", Myron Winick (ed), Nutrition and Foetal Development (New York, Wiley Interscience, 1974). The authors say that data from Guatemala suggest that calories ingested early in pregnancy have the same effect as calories ingested in the last trimester. The earlier in pregnancy supplementation is begun, the more likely adequate amounts will be ingested.

The Lomé conference country reports drew attention to the immediate effects that malnutrition in pregnant women has on childbirth - miscarriages, hyperanaemic women in labour, underweight babies and undersized babies. They also pointed out that malnutrition in mothers is not a phenomenon unique to the rural environment, but is sometimes even more acute in peri-urban areas. Lomé conference report, op. cit., p.19.

11/ "Breast-feeding and weaning practices in developing countries and factors influencing them", PAG Secretariat, PAG Bulletin, vol. III, No. 4 (1973); "A survey of nutritional - immunological interactions" WHO Bulletin, vol. 46 (1972), pp. 537-546 discusses inter alia the role of breast-feeding in protection against diarrhoeas.

enough of the substitute foods, especially of the commercial formulas. They are diluted too much, and the baby is underfed. The baby's bottle, used without the means to sterilize it, becomes an instrument of illness and death.

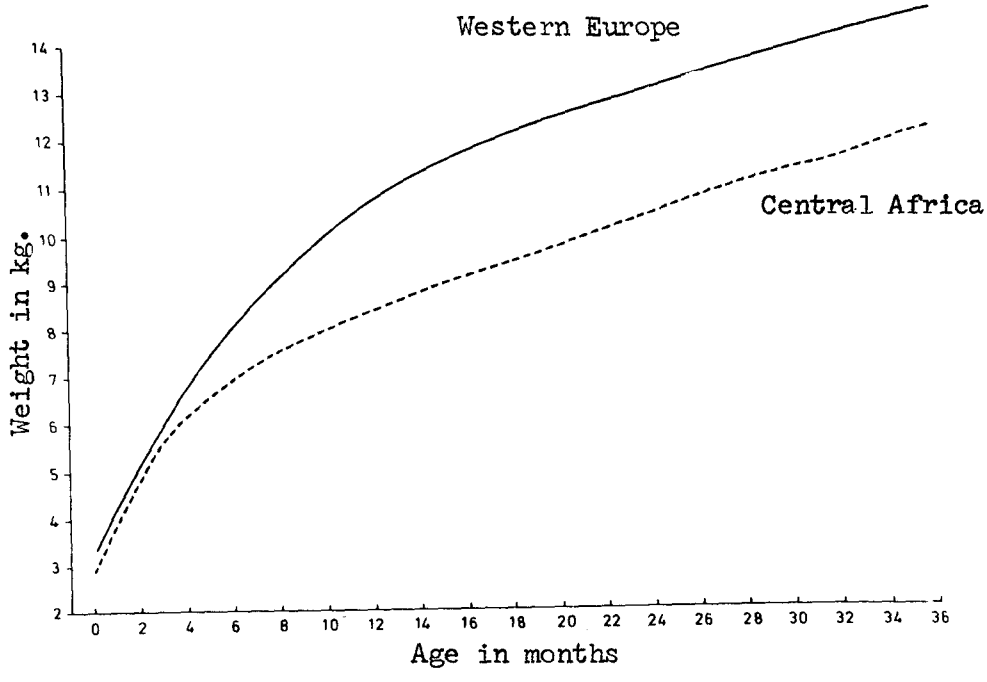
30. Transitional feeding. After breast-feeding only, ideally for four to six months, the baby begins a transitional period of mixed feeding in which breast milk is supplemented by other foods. Ideally, and especially in conditions of low income and a rather highly infected environment, this period should continue until the child is 18 to 24 months old, when he would be completely weaned. The weaning process, the desirability of prolonging breast-feeding, and the need for special preparation of food for the young child (para.19 above) are often not sufficiently understood by the mother.[12/] In fact, the infant often receives the wrong kind of specially prepared food, e.g., paps that provide little more than calories, and even those in inadequate amounts because of their volume and dilution. In some places the traditional foods were better than those now given. The diet has deteriorated because of higher prices for such ingredients as curds and legumes, or because of the competition of "convenience foods", which are often less nutritious.[13/]

12/ At the Lomé conference most of the country studies expressed concern about the mother's lack of knowledge of proper weaning procedure resulting in an abrupt or premature ending of breast-feeding without the gradual introduction of transition foods (Lomé conference report, op. cit., p.18). The Malawi case study cites the common practice of giving the child during weaning a maize flour porridge and a little relish, which he eats from a family bowl. A survey taken in 1969 in Malawi showed that malnutrition becomes acute between the ages of 12 and 17 months.

13/ For example, the Yemen case study reports a decline in use of shabiza, a mixture of cereal, legumes, fat and sugar, for these reasons.

Figure 1

Comparison of median (50th percentile) weight of boys from Shi et Havu, Zaire, and St. Gilles, Belgium from birth to 36 months of age a/
(1970)



Source: Colloque Sur L'Allaitement Maternel, (Paris, International Children's Centre, 1973), p.41.

a/ Average birth weight approximately 2.9 kg.

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31. The typical growth situation in developing countries is illustrated in figure 1. Up to the age of four to six months, while he is on the breast, the infant grows as well, or almost as well, as does the infant in industrialized countries. As soon as he begins to need other food and is susceptible to various infections from the environment, he falls behind. Although the chart shows only retardation in weight, other handicaps frequently accompany this. The result is, as is stated in the Zambian case study, that "the incidence /of protein-calorie malnutrition/ is at its highest peak between one and four years of age ... The main biochemical nutritional deficiencies are protein, riboflavin, retinol (vitamin A) and iron". In some situations serious difficulties begin as early as six months of age, or even earlier if weaning is started earlier.

32. Extent of malnutrition. Although precise data generally are not available, a considerable amount is known about the extent of malnutrition. Seventy-seven sample surveys conducted in 46 developing countries during the last ten years, and analysed by WHO, have shown the range of prevalence of protein-calorie malnutrition of children at the time of the survey.[14/] This is shown in the table below:

14/ Protein-calorie malnutrition is due primarily to shortage of both calories and protein in the diet. There is stunting of growth and development, and as the condition becomes more severe disruptions of metabolism become apparent and there is increased susceptibility to infections. Two extremes of the condition are recognized clinically nutritional marasmus and kwashiorkor. Emaciation is a main feature of marasmus, whereas in kwashiorkor there is oedema. Children who are 25 to 40 per cent below standard weight for their age are considered to have "moderate PCM", while those more than 40 per cent below standard weight are severe cases. If oedema is present in a malnourished child, the case is severe regardless of weight. (General reference: Joint FAO/WHO Expert Committee on Nutrition, Eighth Report, WHO Technical Report Series No. 447 (Geneva, 1971).)

Ranges of prevalence of protein-calorie malnutrition (PCM) in community studies made between 1963 and 1972 in three regions of the world

Region	No. of communities surveyed	No. of surveys	No. of children examined	Percentage prevalence of PCM: Severe forms	Moderate forms	Severe and moderate forms
Latin America	20	29	116,179	0-12.0	3.5-32.0	4.6-37.0
Africa	16	32	34,184	0- 9.8	5.6-66.0	7.3-73.0
Asia	10	16	43,326	0-20.0	13.0-73.8	14.8-80.3
	46	77	193,689	0-20.0	3.5-73.8	4.6-80.3

Source: J.M. Bengoa "The Problem of Malnutrition", WHO Chronicle, Vol. 28 (January 1974).

33. In order to obtain a global figure, it could be said that on the average, 3 per cent of young children in developing countries are suffering from severe protein-calorie malnutrition (kwashiorkor or marasmus). As a global total, this estimate means that there are between 9 and 10 million young children with these diseases at any one time, and the rate of mortality is high.[15/] An additional 20 per cent of young children suffer from moderate malnutrition and they will not reach their genetic potentials in growth and development.

34. Nutritional deficiency diseases. In large areas of many developing countries, nutritional deficiency diseases are prevalent, arising from lack of minerals (iron, iodine, etc.) and lack of vitamins,

15/ J.M. Bengoa op.cit., and D.B. and E.F.P. Jelliffe (eds.), Nutrition Programmes for Pre-School Children. Report of a Conference held in Zagreb, Yugoslavia, Zagreb: Institute of Public Health of Croatia, 1973, p. 5.

especially vitamin A. A high proportion of pregnant women suffer from iron-deficiency anemia in Asia, this is estimated at 40 per cent and in the Eastern Mediterranean, 20-25 per cent. The proportion of young children affected is much higher.[16/] In most developing countries deficiency of iodine, leading to the risk of cretinism, and the debilitating condition of goitre, is widespread in mountain areas where neither water from melted snow nor locally produced foods contain it. A WHO global survey showed that vitamin A deficiency, with the risk of blindness of young children in severe cases, is widely distributed, especially in South-East Asia, and also in parts of the Eastern Mediterranean, Africa (areas bordering on deserts) and Latin America. In sample surveys 8-10 per cent of young children are found with ocular signs of vitamin A deficiency.[17/] The number of children going blind each year from this cause is well over 100,000 in South-East Asia.

Immunizations and protection against endemic diseases

35. The need for immunization is discussed here before other maternal and child health services because even in countries lacking funds to provide a wide coverage of health centres, it is possible to provide some immunizations through travelling vaccinators or mobile teams. The infant needs to be immunized against the same childhood diseases as do infants in the industrialized countries - diphtheria, pertussis and tetanus (DPT), smallpox, measles, polio, tuberculosis and, in certain instances, typhoid. His need for protection seems to be greater than in industrialized countries, in part because of more massive infection in the environment, and in part because his resistance is usually lower due to poor nutrition. Pregnant mothers need to be immunized against tetanus to provide protection to the child at birth.

16/ J.M. Bengoa op.cit.

17/ "The Prevention of Blindness", WHO Chronicle, vol.27, No. 1 (Jan. 1973). The India case study states that in some regions, 10-15 per cent of the children suffer from "night blindness". There are estimated 1 million cases of severe vitamin A deficiency in India.

36. Measles deserve special mention as one of the most important causes of death of young children in developing countries, along with diarrhoeas with which they are often associated, thus triggering a process of deterioration in which malnutrition also plays an important part. During the first ten years of life, nearly every child catches measles, and the proportion who die is very high - it commonly ranges from 10-25 per cent. The study of mortality in the Americas already referred to showed that 20 per cent of deaths in the second year of life were due to measles.[18/] Measles are a severe problem in many parts of Africa, Latin America and Asia. An Arabian proverb says "Edd awladak ba'ad al-hasba ma-trouh" (count your children after the measles are gone).[19/] The complex of measles, diarrhoeas and malnutrition is more deadly than any of the components alone.

37. In addition to immunization, protection or treatment against a number of endemic or epidemic diseases can be given by relatively simple means. The most widespread is malaria, which in addition to affecting large numbers of children gravely, is also a major cause of low birth weight in some areas.[20/] It has been estimated that there are from 400 to 500 million cases of trachoma in the world, particularly the arid regions. In many cases the infection begins in the young child, when whole populations have been affected with trachoma and seasonal conjunctivitis, it is not uncommon to find 1 per cent totally blind and 4 per cent "economically blind" (i.e. unable to perform any useful work in which sight is essential).

38. Coverage. (a) Most countries immunize widely against smallpox, because this can be done by vaccinators or mobile teams, with boosters required only after five years. Increasingly, BCG vaccination against tuberculosis is being given to children at the same time. (b) Immunizations required only by the young child (e.g. DPT) may also be given by mobile vaccinators in ad hoc campaigns, in which case the coverage can be extensive. If they are given only to those children who attend

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18/ N.S. Scrimshaw, C.E. Taylor, J.E. Gordon, Interactions of Nutrition and Infection (Geneva, WHO, 1968); Patterns of Mortality in Childhood, op.cit., pp.146-152 and 349.

19/ Morley, op.cit., chap. 12.

20/ Morley, op.cit., p.79; "Prevention of blindness", WHO Chronicle, vol. 27, No. 1 (Jan. 1973).

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health centres the coverage is much lower (about 10 per cent). Measles and polio vaccines have been considered too costly for wide use, but in fact are now within the budget possibilities of many developing countries, with some external aid for supplies of vaccine. There are also other factors limiting coverage. One is the difficulty and cost of organizing a delivery network that guarantees the administration of a potent vaccine, particularly where this requires a chain of refrigeration to conserve a live vaccine (e.g. measles). Another is the need for mothers to bring children back to the health centre or assembly point for the visit of a vaccinator for a series of shots. DPT requires three shots. In Zambia, a country relatively well covered with health centres (1:8,000 population approximately) the country case study reports that of children taking the first DPT shot, only 40 per cent complete the series. (c) Treatment for malaria and other endemic diseases tends to be limited by the small proportion of the population having access to health centres.

Maternal and child health services

39. There is little need to discuss the fact that people need access to health services for proper maternity care and for care for their young children. Maternal and child health services are required as an instrument for better nutrition and for immunization, and to provide essential additional services. As explained above, immunizations against a number of children's diseases are commonly delivered, not in specific campaigns by mobile vaccinators, but at maternal and child health centres or through them. The mother will get her information about child rearing from the centre, which also may distribute food supplements to pregnant and nursing women and young children. The centre helps the mother with the surveillance of the growth of her child, and with treating the inevitable children's illness. It both supports the mothers[21/] and provides essential medicines.

21/ On the reduction of child mortality to be obtained by helping mothers raise the level of their child care, see W. McDermott, "Modern medicine and the demographic disease pattern of overly traditional societies: A technologic misfit" in H.V.Z. Hyde (ed.) Manpower for the World's Health, a report of the 1966 Institute on International Medical Education. Evanston, Illinois: Association of American Medical Colleges, 1966.

40. Family planning services are also given through maternal and child health services where it is government policy to provide them. The spacing of births and regulation of the number of births is needed for the health of the mother and of the children.[22]

41. If an index of need for health services were required, it could be found in the recourse by mothers to traditional midwives and healers where other services are too far away (and sometimes because the mother feels more confident with the indigenous practitioner). Another indication of need is the widespread sale of modern drugs in countries where they are available in shops.

42. Coverage. Overall it is estimated that less than 10 per cent of the rural population of developing countries is within walking distance of a health centre, sub-centre or dispensary. The situation varies greatly from country to country and within zones of the same country. Among five developing countries, for example, the proportion of pregnant women attending a pre-natal clinic ranges from 6-43 per cent, and the number of infants attending a clinic within the first year of life ranges from 6-80 per cent.[23]

Environmental sanitation

43. Environmental sanitation bears a direct relationship to infant and child health; particularly through diarrhoeas and worms. The Tanzanian case study, for example, reports for the Kilimanjaro District a high incidence of intestinal infections in children, particularly worms due to soil pollution. Other case studies (Ghana and India) comment on the poor state of sanitation in overcrowded shanty-towns

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22/ A.R. Omran, "Health benefits for mother and child", /From health and family planning/, World Health (Jan. 1974), p. 6 (Geneva, World Health Organization).

23/ N.R.E. Fendall, Auxiliaries in Health Care (Baltimore, Johns Hopkins Press, 1972), table VI-1.

and slums. Obviously the problem becomes worse in areas of greater population density. The absence of latrines bears particularly on the comfort and health of women in areas where by custom they do not use the fields during the day. The provision of water from taps without drainage leads to inconvenience from mud, and also to puddles where the vectors of malaria and other diseases breed.

44. Coverage. In rural areas, over 90 per cent of the population have inadequate facilities for excreta disposal. In urban areas, it is estimated that some 30 per cent of the population are served by public sewerage, and some 40 per cent have their own domestic systems, leaving 30 per cent unserved.[24/]

Psychological needs in relation to the mothering person

45. Mothering persons are essential to the child's emotional, and even physical, maturation.[25/] An infant may languish and die if deprived of mothering, even if physiological needs are met. A toddler will survive, but many exhibit bizarre behaviour and are unable to relate to people. Primarily it is the mother whose interaction with the child is so intimate that for some purposes it is appropriate to think of "mother/child" as a unit rather than of the child alone. The child also affects the mother, and it is this two-way process that is fundamental for the child's ultimate growth and development.

24/ "Basic sanitary services", WHO op.cit. For a discussion of overcrowding and unsanitary conditions in slums and shanty-towns and their effect on child health, see the study presented to the UNICEF Executive Board in 1971, "Children and adolescents in slums and shanty-towns in developing countries", document E/ICEF/L.1277 and Add.1.

25/ J. Bowlby, Maternal Care and Mental Health, WHO Monograph Series No. 2, (Geneva, 1952).

46. Just as the body needs food and water, the child's mind needs experiences that facilitate the first stages of intellectual functioning. At birth the child is helpless and it is primarily through the continuing mothering experience that he begins to perceive the world, develop sensory motor activity, become aware of self, socialize, verbalize and incorporate moral values. These early experiences provide the foundation for a child's subsequent development, and will affect such matters as relations with others, school performance, work skills (for example through his ability to adapt to changing agricultural technology and geographic mobility), and his enjoyment of life.

47. During the first two years the child needs a stable figure who is responsive to his pre-verbal communications. He needs to play with simple objects, to perceive relationships, to develop curiosity, and to feel secure in his relationships with family members.

48. The close infant-mother relationship and physical contact[26/] are thought to contribute to the advanced sensory motor development of the African infant during the first year. The African child sits, crawls, stands, and walks earlier than does the child in Western societies.[27/] As pointed out in paragraph 31, however, at about six months of age, when he begins to need a supplment to breast-feeding, he falls behind in his growth.

49. As the young child grows older, others share the responsibility for rearing. In many instances a sister or brother of about 7-10 years of age cares for the child after the age of 2 years while the mother works.[28/] However, the physical needs of the child still bind him psychologically to the mother, and he continues to be dependent upon her.

26/ In rural villages of East Africa, for example, the infant sleeps with the mother and maintains close body contact during the first two years.

27/ M.O.S. Ainsworth, Infancy in Uganda (Baltimore, Johns Hopkins Press, 1967), pp. 319-320.

28/ In slums and shanty-towns the young child may be left all day long in the street under the "supervision" of the older child. "Children and adolescents in slums and shanty-towns" op.cit., para. 114. The Tanzanian case study refers to the practice of mothers in the Moshu district of feeding the young child before leaving to work with the family and locking him in with a somewhat older sister until they return.

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50. When the child is reared in an extended family network, often three generations living in one household or in proximity, the mothering role is shared with grandparents, relatives and older children. This is specially true in the rural areas. However the extended family has come under stress from urbanization and modernization, the substitution of governmental authority and services for patriarchal authority, and in urban areas from the lack of housing, and various economic factors. The nuclear family of parents and children becomes the norm.

51. Child-rearing in many places gives little attention to symbolic thought, cause-and-effect relationships, and motivation for learning. There is often a low level of stimulation, an absence of activities, and an emphasis on polite and submissive behaviour. This is particularly the case when there is under-nutrition, which in itself tends to make the child passive. These limitations are detriments to subsequent school and adult work performance, and development of the adult's potential.

52. The father. The role of the father is important. However, current evidence suggests that, particularly in rural areas, he generally plays an indirect rather than a direct role in rearing the young child, since he does not spend much time with him; he is more involved in his relationships with the mother and as head of the household. In some regions, inadequate work opportunities in rural areas results in a rural father going to an urban area looking for work, living in a shanty town and unable to return regularly to his family for lack of public transportation and money. A proportion acquire a new urban family. His absence affects the mother, and this is reflected in her activities with her children. There are countries in which up to one third of all families are headed by women.[29/]

29/ Helvi Sipila, "Third World Woman: master of her own destiny", UNICEF News, Issue 76 (July 1973), pp. 4-7.

53. Services and coverage. In this field, there can be few direct services, but literacy of the mother and the education available to her through such channels as extension services, clubs and communications media can give her essential support. "Mothers with little or no education usually are of families with low income, poor housing, deficient water supply and sanitary facilities, and without adequate pre-natal and other medical services".[30/] The Pan-American mortality study from which this quotation is taken, draws the conclusion that education of the mother can be used as an indicator of many socio-economic variables. The present report argues in chapter III that it is also a practical means of raising the status and the knowledge of the mother. According to census data there were around 1970 some 450 million illiterate women in developing countries, amounting to 60 per cent of the female population over age 15.[31/] With outstanding exceptions in a few countries, present campaigns to teach literacy are not of a sufficient scale to change this situation very much. The slow growth in the proportion of girls completing at least four years of primary school can change it. However, this proportion is quite low in rural areas, and adequate change through this means only would take many decades.

Demands on the mother

Romantic myths

54. There are myths still prevailing in the western world and the urbanized elite of developing countries, about the attitudes and preferences of the women in the rural areas of the poorer countries. These myths centre on the women's presumed stoicism and resignation to hardship. Thus many people accept without question the notions that women not only give birth and start working again in the fields the same day, but prefer or easily accept doing so; that they accept willingly the daily chores of walking many miles - infant on the back - to fetch water; the many hours of daily work in pounding millet; or the absence of any time for rest from all their back-breaking chores.

30/ Patterns of Mortality in Childhood, op.cit., page 349.

31/ UNESCO Statistical Yearbook, 1972, table 1.3; Literacy 1967-69, Progress achieved in literacy throughout the world (Paris, UNESCO, 1970)

55. This form of "romanticization" of the lot of peasant or village women leads not only to ignoring their needs but to reinforcing traditional patterns that have become anachronisms in the light of social and economic progress in the very areas in which these women live.

56. The evidence negates the "happy stoic peasant" image of the woman. Where even primitive facilities are provided for deliveries, many miles from households, women try to get there. It is not only for midwifery help, but to have a rest of at least a day or two, which they would not have at home. Make a cart available for fetching water if there is no well nearby and it will readily be used, and mechanical arrangements for grinding grain are heavily patronized.

Women as workers

57. The vast majority of mothers in developing countries are workers, whether they live in rural or in urban areas, work full-time or part-time, work seasonally or through the year, work for wages or in self-employment on crops or handicrafts. In the rural areas, most mothers work; in Africa, women provide more than half of the agricultural labour. Generally they receive no wages for their work, much of which is devoted to subsistance farming. It is ironic that the general practice has been to provide technical advice in farming for men and not women, even where women have been doing most of the subsistence-crop farming themselves. In some societies the husband works the money-crop and may not share the cash from it with the mother. In the urban areas she works primarily in service occupations, and in unskilled industrial jobs for meagre wages.

58. In addition to this work, the mother continues with all her child-bearing, childrearing, and household activities. Modernization, while offering numerous advantages, also places increased stresses on the mother in adapting the family to new living conditions. In the towns and cities the mother in the recently arrived family usually bears the main burden of coping with the adjustments required by urban life and a cash economy.

Beneficial women's programmes also make demands

59. In a number of countries programmes of education and training are being developed to offer rural mothers and out-of-school girls opportunities to acquire new knowledge, skills and attitudes in informal settings - through women's clubs, community centres and local self-help activities. In addition to being concerned with nutrition, health and better family living conditions and with community improvement these programmes sometimes try to increase the earning capacity of the women.[32/] Such "women's" programmes are being developed under a number of different auspices. Some are governmental, others voluntary, and still others mixed. In some countries there may be several such programmes under the auspices of two or three ministries or even different departments of a single ministry.

60. In addition, other ministries or departments with specialized interests, e.g. health, family planning, environmental sanitation, education, nutrition, agricultural and home economics extension may also be trying to reach the mother because they realize she is essential for the programmes they are trying to advance.

61. Their programmes, good as they may be in themselves, may present a fragmented approach in trying to involve the one family member - the critical mothering person for the young child - who works longer and harder than any other, who is generally illiterate and who has the least possibility of taking advantage of the opportunities being offered for information, education, and service.

62. A glimpse of the possibilities of lightening the excessive work of women is given by the recommendations made at the Lomé conference which included the following:

32/ A study of "women's" programmes in developing countries was presented to the UNICEF Executive Board in 1970 in "Assessment of projects for the education and training of women and girls for family and community life". This study and a summary of the Board's discussion of it is contained in document E/ICEF/Misc.169.

- Arranging for a mother or girl to take care of the children of a group of families during the agricultural working day (village day-care group);
- Increasing water points, wells and standpipes or fountains (fetching water);
- Reafforestation of land near villages (wood-gathering);
- The organization of granaries;
- Distribution of light transport facilities for crops, water and wood;
- Distribution of equipment for fishing and fish drying and smoking;
- Providing communities with light machinery for pounding or grinding millet and grain.

63. The Lomé conference report stated that these methods should be applied generally. It pointed out, however, that as yet there were very few Government departments likely to promote them; moreover, some technical solutions have not yet been tested (e.g. convenient individual transport to haul loads).[33/]

64. Services and coverage. Home and village improvements may be promoted and assisted by agricultural extension services, community development, co-operatives, or non-governmental organizations. Usually, however, such services do not cover the country, and have little time for these activities.

Need for social welfare services

65. The care of the young child can be improved in part through family-centred social education as well as services such as day-care facilities for the children of working mothers; playgrounds; facilities for the treatment and rehabilitation of the handicapped; means for the care of orphans and abandoned children, and the children of destitute parents; and the protection of children suffering from severe neglect or abuse. In general, the volume of need for these services is not met because of lack of resources. From the point of

33/ Lomé conference report, op. cit., Part I, 2nd Chap.

view of numbers of young children affected, day-care is the most important, and it is included briefly in the present report. The others are only referred to in chapter III.

66. Needs for day-care. The need for creches and day-care centres is strongly felt by working mothers, those working in the fields as well as those in urban employment. Day care is especially needed where the mother has left the circle of the extended family. Facilities are far too few to meet the needs, usually providing at best for no more than 1 or 2 per cent of the age group. Where mothers cannot leave children in the care of a neighbour, they are left under the care of an older child, sometimes with freedom to go outside, or sometimes locked into the living quarters, where they are prone to fear, loneliness and serious accidents.

Financial limitations

67. Financial constraints have been mentioned a number of times in relation to lack of services. The budgetary limitations on countries with GNP per inhabitant of approximately[34/] $100 or less at 1970 prices are easily understood. Countries with more than this but with a GNP under $200, are near a threshold where it becomes easier to provide basic social services. The following table shows the number of such countries in each continent.

GNP per inhabitant (1970)	Africa	Asia	Latin America	Total population (millions)
	- No. of countries -			
Approx. $100 or less	15	14	1	1,057
$110 - $200	15	9	1	938

68. At the Lomé conference for West and Central African countries it was clear that a number of these countries face an understandable resistance to expanding the proportion of their government budget now goint to health, education and social services. The proportion of

34/ The actual cut-off was taken at $110, because there are a number of countries with just over $100 GNP per inhabitant.

current expenses going to services benefiting children, youth and women was approximately 20 per cent for several countries, and approximately 30 per cent for several others. These levels are often seen as ceilings, and in that case expansion of the governmental budget for services depends on expansion of GNP and tax revenue.

69. Some governmental expenditures for health and education are shown in table 1 to illustrate the situation. It is not the purpose of this table to make comparisons between countries; that is hazardous because of varying distribution of expenses between government, and local authorities and private financing which are not shown, and because of the distortion introduced by the translation of currencies into United States dollars. Nevertheless, it is clear that a low GNP limits the government capacity to raise taxes, and consequently to finance social services. To take the case of health services for the large group of countries with approximately $100 per inhabitant or less, in 1970 health services were typically provided for approximately $1 per inhabitant per year. The table also indicates, however, that a few countries do, as a matter of policy, make a special effort to provide a higher proportion of their budget for health services, and this can make a very important difference.

70. It may seem self-evident that with such a low budget, it is impossible to cover the country even with simple health services. In many cases most of the $1 per inhabitant is spent on hospitals mainly serving the urban population. The distribution of expenditure among different components of health services and different zones of the country is also significant. As this report discusses in chapter III,

more could be done even with the present level of resources[35/] and as a further step, an increase in the level is thoroughly justified. Possibilities of effective low-cost health services will be examined in a report being prepared by WHO and UNICEF for the 1975 session of the UNICEF Executive Board on approaches to providing basic health services, particularly for mothers and children in disadvantaged areas of developing countries.

35/ Teachers and research workers in Makerere University, Uganda, have designed a model showing how it would be possible to cover a country with basic services at a cost of $1 per inhabitant. Maurice King (ed.), Medical Care in Developing Countries, (Nairobi), Oxford University Press, 1966), chaps. 1-3. These cost estimates were made in the early 1960s and probably $1.50-$2.00 would now be required. Models of this type have not been extensively adopted, possibly because of the emphasis on health centres and auxiliary personnel rather than hospitals, and specialist personnel - an emphasis which seems to conflict with the practice of the industrialized countries, the professional training of key people responsible for the services, the supposed expectations of the population, and various short-term political considerations.

Table 1

Per capita governmental expenditures on health and education

Per capita GNP	Year	Per capita GNP (1)	Per capita expenditure (2)		Per cent of total public expenditure (2)	
			Health	Education	Health	Education
($US equivalents)		($US equivalents)			(percentages)	
Less than $100						
Burma (revised estimates)	1971	80	0.66	1.60	5.7	13.8
Malawi	1971	90	1.09	3.09	4.5	12.8
Nigeria a/	1969	-	0.73	1.93	5.2	14.2
$100 - $199						
India (State Government) b/	1971	110	0.74	1.98	7.3	19.3
Uganda (voted estimates)	1971	130	2.07	5.27	7.3	18.6
United Republic of Tanzania	1971	110	1.60	3.46	6.3	13.7
Sri Lanka (provisional results)	1971	100	3.49	6.92	7.1	14.0
$200 - $399						
Colombia	1971	370	3.56	7.22	7.8	15.9
Egypt	1971	220	4.05	10.30	9.2	23.5
Ghana	1971	250	2.06	6.21	6.8	20.6
Guatemala	1971	390	...	...	12.3	18.3 (3)
Honduras (voted estimates)	1971	300	3.42	9.03	7.1	18.7
Morocco (Central Government) c/	1971	260	3.04	11.38	4.9	18.2
Philippines	1971	240	1.21	5.10	6.7	28.1
Thailand	1971	210	1.08	6.58	3.0	18.1
Zambia	1969	290	7.55	17.21	5.9	13.4
$400 or more						
Mexico (voted estimates)	1970	700	2.64	11.87	5.9	26.7
Peru	1971	480	...	...	6.6	20.7 (3)

Sources

(1) GNP per capita at market prices. International Bank for Reconstruction and Development. World Bank Atlas: 1971, 1972 and 1973.

(2) Mid-year estimates for population and exchange rates. International Monetary Fund. International Financial Statistics, February 1974. For public expenditures: Public Finance, United Nations Statistical Yearbook 1972.

(3) Economic and Social Progress in Latin America, Inter-American Development Bank 1972.

a/ Governments of Eastern States are excluded.

b/ Refers to State Government expenditures.

c/ Refers to Central Government expenditures.

... No data available.

II. APPROACHES TO POLICY AND ACTION

Contents

Tables

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Summary

71. The object of this chapter is to clarify some general approaches before discussing the content of services and programmes in chapter III.

72. Table 2 lists hypotheses about the factors usually determining the situation of the young child. A young child policy has to adapt itself to some of these; its objective is to modify others. This chapter suggests that rather than promulgating uniform standards it is better to follow a developmental approach to improving services from their present situation, whatever it is. One objective is to seek the help of the community wherever its interest can be stimulated.

73. The present report starts from the problem of disadvantaged areas with few services, usually taking the example of rural areas. In such cases the best impact on the reduction of child diseases, handicapped growth or death will come indirectly from services to the community, the family and the mother (see table 3). At a higher economic level more direct and specialized services to children will be provided.

74. Services for children can more readily be improved in areas where some economic development is going on; but specific provision is needed to bring about this result; economic progress will not automatically "trickle down" to benefit children. Zones of the countries selected for development offer an opportunity for improving the situation of children at the same time. Making a special effort to improve children's services in development zones may temporarily

strengthen the tendency for areas with poorer services to fall behind the rest of the country. Zonal development plans may be extended progressively to other disadvantaged areas, as quickly as the country's resources make this possible, in a phased development extending through several five-year plans.

75. A major administrative problem is the absence of channels from the central government to the community. As many as 12 ministries might be involved in one aspect or another of a child policy (table 4). Much more can be accomplished if the services provided by these ministries are arranged to be mutually supporting. A possible organization of planning is discussed, covering the planning commission and planning cells in the main ministries concerned.

Greater awareness and assurance that action is possible

76. Given a greater awareness of the special needs of the young child, and greater assurance that there are real possibilities of meeting them in some degree, much more can be done even in societies with limited means. Awareness may begin at any level, from parents who are concerned about the many deaths among their young children to a minister or high government official worried about the problem of food and nutrition. At the top level awareness is needed by planners and those formulating over-all development and sectoral policies and programmes.[36] It is needed by the various professions, including those engaged in teaching and training activities and in research, by community leaders and by workers engaged in social

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36/ The country case studies and other available evidence show that all the countries are trying in a number of ways to reduce young child mortality and morbidity. A number, however, are doing little about the nutritional needs of the young child, particularly during the weaning period. One country - India - in preparing its 1974-1979 national development plan included a number of essential services to benefit the mother and the young child in especially disadvantaged areas of the country (slums, tribal, drought-prone, remote),

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programmes at all levels. It is needed by political parties, non-governmental organizations, and local village and neighbourhood groups. Awareness is also needed by the conveyors of information through mass media, which can often confer status and help enforce social norms. The radio is an especially important channel for communicating awareness in developing countries.

Factors to be dealt with by a young child policy

77. The first step in preparing a policy and programmes for young children is to consider what are the main factors determining the situation of young children, and to what extent they could be modified by programmes falling within the framework of such a policy. Since the nature of these factors and their relative importance differs to some extent from country to country, we have listed in table 2 a series of working assumptions for use in the assessment of any given situation. These factors fall into three groups insofar as concerns action for the young child: (a) some factors like the basic natural environment and ecology cannot be modified; policy has to adapt to them; (b) other factors, such as income distribution, can be modified by national policy, and may be very important in their effect on the young child, but normally a country would not undertake to modify them as part of a young child policy; and (c) among the rest it remains to select the key points for intervention in order to benefit the young child, e.g. the level of participation of the population in programmes, the financial resources provided and the models selected for organizing services can be major elements in a policy for the young child.

78. At this point the emphasis is on the content and limits of a young child policy, on which it is necessary to decide for working purposes in each country. However, a young child policy is an important component of over-all national policy (a) for the welfare

Table 2

HYPOTHESES CONCERNING DETERMINANTS OF YOUNG CHILD SITUATION

Main factors determining situation of young child	Aspects to be considered within framework of a policy and programmes for young child
Environment, ecology, e.g. water and food availability, density of parasites and infections	Policy and programmes have to adapt to basic situation, e.g., hot, arid areas have specific needs different from those of warm, humid areas
Income level of parents; employment opportunities for both parents; women's work	Can be modified by general rather than young child policy
National income distribution - relative equality of population groups	Depends on general rather than young child policy
Density of population and road network	Transport network affects costs and accessibility of services, but would not be modified by a young child policy
Traditions, beliefs, culture, knowledge level of parents and extended family and taboos about child-care, nutrition, etc.	Programmes can raise knowledge level
Family size	Support of responsible parenthood and improving the status of women, particularly through social programmes, can influence family size. Support by family planning services
Level of patticipation of population in programmes	Programmes benefiting children are a good means of raising popular participation
Quality of services of village healers, traditional midwives, etc.	Training and co-operative arrangements by government services can improve quality
Stimulus of traditional life to young child	Policy can be concerned with preserving good values, especially where endangered by social changes, and with combining better child-care practices with existing customs
Financing and planning of government services - central, state and local	One of the main operational areas for children's policy re: amount of financing and the models for organization of services
Services of non-governmental organizations	Can undertake tasks not possible for governmental services and/or do pioneering work in areas not yet covered by the government

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and development of children and adolescents, and (b) for economic and social development as a whole. It would be an important component of an attack on poverty, or a programme to meet minimum needs, for example. Many services to meet the special needs of the young child ideally form part of services for the whole community, e.g. basic health services, support for village and family food production. In fact services for the young child may constitute growing points for the development of wider services.

Indirect and direct services

79. A young child policy will obviously include services delivered directly to the child or the mother, e.g., immunization, a food supplement, a health treatment. However, as explained in chapter I, the welfare and development of the young child also depends to a very large degree on what happens to him in his family and home. It follows that very important factors of a policy for the young child will relate to indirect services that improve his environment, both in his home and outside of it.

80. The possibilities for improving the situation of the young child through indirect and preventive services is illustrated by a statistical study made by the Ivory Coast as part of its preparation for the Lomé Conference. Analyzing the causes of deaths in hospitals of children up to the age of five, it was found that 90 per cent could have been prevented: (a) by preventive health care (e.g. vaccination), (b) by action on the environment (e.g. clean drinking water supply or village production and use of foods required for the family); or (c) giving parents better knowledge about how to rear and care for their children (e.g. through literacy, and health and nutrition education).[37/] Thus indirect and preventive services could reduce the demand for medical

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37/ Lomé conference report, op. cit., Part I, 3rd chapter.

care at present largely unmet in most countries, to more manageable proportions. The direct and indirect services are complementary, and both are needed.

81. While indirect services benefit the community as a whole, and this is an added advantage, analysis of a given situation usually shows that many of them are among the most important measures that can be taken to improve the situation of the young child and, therefore, fully justified on that account alone. Table 3 lists examples of both indirect and direct action.

Step-by-step approach

82. In the past a good deal of attention has been given to trying to agree on reasonable standard levels of service which could be applied on a country-wide basis, or throughout the developing countries of the world. These standards have not been very widely applied. The difficulties of making the necessary budgetary provision for recurring costs and of finding personnel have been major obstacles. International agencies are now advocating that the varying resources and priorities of different areas should be important factors in deciding on the organization of services.

83. The approach suggested in this report is to adopt a policy of raising the level (the coverage and the quality) of existing services, whatever it may be. In practice, levels of service vary considerably among different areas of the same country. At eacn of the different levels there is usually scope for very desirable improvements. Instead of adopting an absolute standard, a policy for the young child could sketch out a process of step-by-step growth and improvement, and as many areas of the country as possible could

Table 3

APPROACHES TO VARIOUS CATEGORIES OF ACTION FOR THE YOUNG CHILD

By community and Government	By Government primarily
Indirect	
Safe drinking water	Food and nutrition policy
Food production and storage (home and village)	Health and nutrition education
Non-formal education, literacy	Environmental sanitation
Home improvement (including latrines)	Education in primary and secondary schools on family life and child-rearing
Labour-saving devices (home and village)	Manpower planning and training of personnel
	Radio and other mass communications
	Income supplementation programmes
Direct	
Maternity care and family planning	Nutritional deficiency prevention (minerals and vitamins)
Health and medical care	Treatment and malnutrition
Weaning foods	Health and nutrition surveillance
Supplementary feeding	Immunizations
Toys and playgrounds	Endemic and epidemic disease prevention
Day care	
Pre-primary education	
Handicapped children	
Clothes and shoes	

/...

be encouraged and given help to advance to the next higher stage. It is possible to do this while at the same time having in view the reduction of the gap between the lower and higher socio-economic groups.

84. The step-by-step approach is better if there is also a longer-term perspective of objectives extending over several plan periods; this can serve as a framework for shorter-term improvements. The main point is to give more attention than in the past to the best ways for services to grow. In the present report this principle is applied only to services benefiting the young child, directly or indirectly, but it is applicable to services for the community generally. As stated in paragraph 78 above, young child services are ideally a component of community services, for which they can become the growing edge.

Responsibilities of the central government and local community

85. Generally it has not proven possible for an adequate expansion of services to be financed from the central government budget alone. It is, therefore, useful to identify the services that the people want in the light of their present knowledge, and to which they are prepared to contribute labour or cash. For example, people are usually interested in, and ready to pay something toward, water supply or maternity care; on the other hand, they may not understand the need for immunization until it is a well-established practice, and they cannot be expected to contribute to the training of personnel or the costs of supervision. Such activities have to be developed primarily by the centre (i.e., the central government or the federal and provincial governments). It is usual for communities

to organize and finance day-care services, sometimes with the national government providing training of staff and setting standards. The experience of a few countries shows that the community can also contribute to such services as water supply, a village pharmacy, village improvement and literacy training. Table 3, in addition to illustrating the division between direct and indirect services, also separates those that could interest the community, in terms of local contributions, from services primarily dependent on a central or provincial government. This distinction is also followed in the order of discussion of programmes in chapter III.

Linkage between the centre and the community

86. Of course almost any programme of interest to the community requires some stimulation and technical support from outside. The community cannot participate in providing a service if it does not know that the service exists. Thus it is necessary for people to be made aware of possibilities for improving the situation of their children, and the aim should be to cultivate a continuously expanding range and area of interest in the community. The introduction of measures dealing with less-felt needs is based on success in meeting "felt needs". In this connexion information media, both modern and traditional, can play an important role.

87. The interest and participation of the community offer starting points. Where one improvement has been made, it is important to go on to another, with continuous support from the centre. Contributions from local communities will not be renewed unless they are seen as a component of sustained co-operation between local communities and public authorities in matters of concern to local communities. After an initial local response in respect of intensely felt needs, to get the local effort to continue and to grow, it is essential that there

should be steady expansion in the services that become available to local communities.

88. It is also most important for the central and state or provincial government to have information coming upward from the local level about what the problems are, what the people want, and how programmes are developing. This subject is touched on below under monitoring (para. 116).

89. Even for a service in which the community is already ready to participate, a link is required with a governmental or non-governmental agency for technical support and for material assistance for items beyond the means of the local community. It is obviously easier for governments and external assistance agencies to support a standardized programme; it is more difficult to respond to local initiatives. It would be impractical and too costly to expect the centre to be able to respond to any local initiative, even a sound one, whatever it is. But at least assistance could be available for a range of types of programmes or services.

90. If the aid from the centre is to be used efficiently, it is important to be able to support local initiatives rather than to equalize support to all communities, whether or not they are contributing themselves. This policy may have political difficulties, but emulation among communities is one of the important factors in the spread of better conditions.

91. As experience with community development has shown, the prevention of the bureaucratization of the link between the centre and the community is a difficult administrative problem. Despite the current atmosphere of discouragement on this administrative issue it is necessary to strengthen the development of links between the

centre and the community along which information can flow in both directions.

92. Often it is also useful for non-governmental organizations to stimulate and support local participation. In different countries this is done by such channels as co-operatives, the social section of the political party or parties, women's clubs, social services, charitable and religious trusts or organizations, and training institutions through their field practice areas.

Ministries concerned

93. Many ministries have links to urban or rural areas that offer possibilities of contributing to the execution of a young child policy. The names and functions of these ministries differ in different countries, but table 4 provides a listing of the main possibilities. In federal States and in large countries, the functions listed will be divided between central and state or provisional levels.

Mutually supporting services

94. It is common sense that the many services and functions listed in table 4 will have more impact if they support each other. Health services will be largely frustrated if safe water is not accessible, or if there is not enough food. The limitations of sectoral approaches on the part of different agencies of government are nowhere more in evidence than at the point where several needs meet and become an organic whole - the mother and the child. It is often seen that the absence of mutual support has negative effects. A number of country case studies speak of there being too many demands on the mother, as each service expects her to improve her child rearing within its own field. There is a limit to the number of services a family can use effectively and beyond this the services become self-defeating.

Table 4

MINISTERIAL RESPONSIBILITIES FOR SERVICES TO MOTHERS AND YOUNG CHILDREN

Urban	Urban/rural	Rural
	Planning and finance	
	Advocacy; planning; allocation of resources	
	Health	
MCH services (centres, maternities, hospitals, etc.); nutritional rehabilitation, nutrition clinics; supplementary feeding	Immunization and disease control campaigns; family planning; health education; statistical services	MCH services through basic health services, co-operation with and training of traditional midwives and healers, environmental sanitation
	Agriculture, commerce	
Milk policy; commercialization of weaning foods other than milk	Food and nutrition policy	Village food production and storage; home economics services; support of farmers' and co-operative organizations
	Education and universities	
Kindergartens; nursery schools; Ecoles maternelles	Literacy and adult education of women; parent-teachers' associations; school curriculum for girls; training of pre-primary education teachers-monitors; training; research; evaluation	
	Social services, social welfare, community development	
Orientation of mothers and parent education; social and neighbourhood centres and womens' clubs; consumer education; playgrounds; day-care centres; residential institutions; other measures to strengthen the family		Mothercraft/homecraft; animation rurale; bienestar rural; foyers féminines; play groups
	Interior	
		Co-ordination and support of technical services within district or prefecture
	Local government, urbanization and housing	
Clean and safe environment; housing; playgrounds, etc.; local services		Support of local participation in services of interest to the community
	Public works	
	Drinking water supply; roads and transportation	
	Industry, labour	
Factory provision of crèches, day care, health education		
	Justice	
	Legislation covering paternal responsibility, protection of children, and women's rights; special family courts	
	Information	
	Use of various media directed toward mothers, the public and the professions	

/...

While ultimately the integrated use of services occurs within the family, the community may greatly facilitate this by providing for integration of the services at the point of delivery.

95. Co-ordination. Without a heavy machinery of co-ordination the following steps may help to promote mutual support among the various services:

(a) Policy. The existence of a policy for the young child will help each ministry to play its appropriate role. The machinery for preparing a comprehensive policy is discussed below under "Planning for the young child and national development" (paras. 100-108).

(b) Combination at delivery point. Whereas it is useful to have many special services at the centre, a number may be combined in their approach at the community level. In their nature, sectoral programmes derive their resources and authority for delivery from the higher levels of the administration. Greater decentralization of execution within each sector will help to maintain the sectoral structures at the national level while giving the district prefectural, or municipal level responsibility for local political decision-making, as well as co-ordination and execution, thus producing comprehensive services at the local level.[38/]

(c) Geographic distribution. Attention to the geographical map of distribution of services that should be mutually supporting will make possible their synergistic effect.

38/ The Tanzanian case study points out that the decentralization of many of the sectoral activities by transferring authority for execution of programmes from the national to the district level has made possible increased participation of the local community, especially in the Ujamaa villages.

This principle should not be pushed to the point of conflict with the encouragement of local initiative. However, a good deal can be accomplished by directing the resources of persuasion, technical assistance and material support to encourage the establishment of services that really need to go together. (Geographical distribution is referred to again below in paragraphs 109-113.)

(d) Multiple use of administrative channels. In the light of the absence of sufficient links between the centre and the community, it is frequently desirable to make use of the links that do exist for several services. A country with a limited budget for social services cannot provide every service with a direct link into the community. New programmes and new functions should not always require new channels, but could be carried by adding to existing programmes. Thus, in Brazil, a rural development bank (ABCAR) got involved in agricultural extension and then in community health services. From the point of view of its function the maternal and child health centre is ideal for the accretion of services benefiting the young child. In Panama, for example, the Ministry of Health became concerned with village-level food production for family use. However, the school network is usually the most widespread, and it is sometimes used to tackle problems of young children through the parent-teachers association, and through teaching school children to help their younger siblings. In general this opportunity seems to be under-used, perhaps because a number of attempts have been disappointing. This may have been due to the fact that the teacher was expected to undertake a good deal more responsibility without any additional training or remuneration./...

(e) Information to potential users. Since the final integration of services takes place in the user-family, programmes of information to potential users about available services can raise their awareness and improve their selection of appropriate services. There will then be popular interest in improving the accessibility of services.

Local participation

96. The basic needs of the mother and the child during his first two or three years, and the developmental needs of the child in the pre-school age-period, call for a variety of formal and informal working arrangements at the community level; these should be built up progressively. They involve close co-operation among local institutions, leaders, and organized services, and promotional and educational work undertaken by a wide range of public authorities.

97. In many places, neither the people nor the organized services are yet ready for the roles expected of them. Education and reorientation as well as more systematic training of workers have to be carried out all along the line until the local community as a whole is reached, and through it, the family, and especially the mother. This is best done through community leaders who have the ability, natural or acquired with experience and education, to understand new messages and pass them on to the people in terms that they understand. The identification and training of leaders at very early stages of the process of community stimulation and the use of information media can be instrumental in winning the people to the idea of change. The messages that these leaders carry are related to actions that require communal acceptance or, at a later stage, active participation. Since the process envisaged is one of progressive growth, only one or two priority messages should be carried at one time.

98. Local participation means, as a first step, active involvement in making and implementing decisions of immediate concern to the community. Even where few local resources are available for support, people should participate in the development of services that will affect the daily lives of their families. This will improve the efficiency of the services and lead people to make greater use of them. Whether we consider maternal and child health, nutrition rehabilitation, literacy training or day care, we observe that social services or social programmes that are sponsored or developed, as it were, externally, usually stop short of an effective delivery to those most in need of them; nor are the potential recipients prepared to receive the services or to use them to maximum advantage.

99. Community development programmes have often been accompanied by the strengthening and elaboration of local government. But it frequently happens that local government is not drawn into the extension of services benefiting children. This appears to be a source of weakness. In some instances local committees and child care councils are established that are solely devoted to children's services; their functions may include both advocacy and action, they provide a linkage between social services and the people, and they help to bring about a convergence of programmes affecting mothers and children.[39/]

Planning for the young child in national development

100. Government action to improve the situation of the young child will be more effective if it is included in the national development

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39/ The Burma case study refers to local committees, which include the representatives of trade unions, co-operatives, party units, and government departments, and are directly involved in the management of day-care centres.

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programme.[40/] National development plans have usually proceeded on the implicit assumption that, in providing for the population as a whole, the needs of children, even of young children, will also be cared for sufficiently. This approach does not take account of the vulnerability and large unmet special needs of young children and pregnant women and nursing mothers, discussed in chapter I.

101. Reciprocally, a young child policy strengthens the national development programme. It delivers benefits to the population in areas of great concern to them, and raises the level of living directly. It contributes to the reduction of poverty, meeting minimum needs, and greater equality of income distribution. In the longer term, it contributes also to a larger GNP by making the rising generation more productive. Hence a central issue in planning concerns the importance given to the well-being of the child and the mother as an integral part of the design of development being followed by a country. The theme itself is too new for clear-cut priorities to have emerged in general practice. The developing countries have been preoccupied, inevitably, with many urgent and pressing problems. Ensuring the survival of the child and of the mother has obvious priority, but the time has come now for concern with the child's further development. This of course has important implications for several sectors, notably for those bearing on health, food and nutrition, social welfare, rural and urban planning and community development, as well as income distribution and employment.

40/ Hans Singer, Children in the Strategy of Development. Prepared for the United Nations Centre for Economic and Social Information and the United Nations Children's Fund. Executive Briefing Paper 6,(New York, United Nations (CESI/E.12), 1972).

Main groups of concern

102. In a country with a birth rate of 40 per 1,000 population[41/] - a common rate for developing countries - the age groups of concern to a young child policy are approximately as follows at any time:

Women	Per cent of women in reproduction age group	Percentage of total population
Women in the reproductive age group (15-44)	100	23
Pregnant women in last trimester	4	1
Nursing mothers (of infants up to age 6 months)	8	2
Young children		
Infants aged up to 6 months		2
Infants or toddlers aged 6-24 months		5
Young children aged 2, 3 and 4		9
Total under 5 years of age		16
Young children aged 5		3
Total under 6 years of age		19

103. When stating these approximations as whole-number percentages, it is not possible to reflect precisely the decreases in succeeding age-cohorts due to mortality, but the above general magnitudes show the importance of a young child policy for:

41/ A lower birth rate over a period of years would reduce the proportions cited. For a rate of 30 per 1,000 the reduction would be by one quarter.

(a) Those pregnant and nursing mothers most in need of special services. The underlined phrase reduces the number, here taken as 3 per cent of the population, and represents a simplification that should not be misunderstood:

(i) Even the poorest country could offer certain services during the first two trimesters of pregnancy, e.g. a check-up, iron supplementation to those within reach of its health network. The problem is rather that women do not come to the health services during the early stages of pregnancy; more will come during the second trimester. In the last trimester, which forms part of the "perinatal" period, there is a greater need for surveillance and services. At a later stage of development, a country would try to reach all pregnant women. Altogether 3 per cent of the total population, and 13 per cent of the women in the reproductive age, would be pregnant at any one time. (This does not count pregnancies ending in foetal loss from natural causes, which is much higher in developing than industrialized countries.)

(ii) At a later stage, nursing mothers would be kept under surveillance for the whole period of breast-feeding, rather than six months. Taking account of the three trimesters of pregnancy, and breast-feeding up to 24 months would cover 10 per cent of the total population and 43 per cent of women in the reproductive age group.

(b) Infants and young children under six years of age, constituting 19 per cent of the population. Conventionally statistics show infants up to the age of one year. Here the break is taken at six months, because feeding of other foods, in addition to breast milk, should begin at four to six months of age, and risks of malnutrition and illness are greatest from then on until the age of two. With the decline in breast-feeding, this stage may begin even before four months in specific countries or zones of countries. Six months is taken as a global average.

104. If the objective of improving the situation of the young child is approached from the point of view of where mortality can be most effectively reduced, the two key periods are birth (reduction of maternal and neonatal mortality), and from the beginning of weaning up to two years of age. These are critical both for survival and the development of the child. Although mortality is high at these periods, the means are available to make substantial reductions within developing countries.[42/]

National planning machinery

105. A significant degree of correspondence is required between the welfare and development needs of young children and the larger scheme of national, social and economic development.[43/] Two aspects deserve to be emphasized. First, the development of human resources should come within the inner core of the country's planning process. Secondly, the planning agency should be given a central role in planning for the use and development of human resources. Given these two conditions, it becomes much easier to undertake further co-ordination and dovetailing in planning for the young child. This has to precede co-ordination in detailed execution at the national, regional and local levels.

42/ An excellent analysis of young child mortality in the Americas, useful from the point of view of action to reduce it, is given in Patterns of Mortality in Childhood, op. cit.

43/ This is discussed in some detail in Children and Adolescents: Priorities for Planning and Action, (United Nations publication, Sales No. E.73.IV.19); this study was presented to the UNICEF Executive Board in 1973 in an earlier version in document E/ICEF/627.

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