with such programmes in sub-Saharan Africa, little reliable evidence exists that adjustment promotes sustainable economic growth.^{1,5} Although adjustment packages now include measures to protect poor people, plenty of opportunity remains for aid to reduce existing debt and alleviate poverty. Oxfam advocates that at least a fifth of aid should be allocated to support basic services in health, water and sanitation, and education. Britain's aid programme is better than most in terms of its allocation to health care and social programmes, but much more could be done.

Why is allocating aid for projects such a complicated business? Surely donors just finance activities known to reduce poverty? Unfortunately, the world is not that simple. Poverty is about politics, and inequities in resources and power have no overnight solution. Targeted activities providing short term improvements in poverty or health may look good in consultants' reports to donor agencies, but their implementation often interferes with existing structures and does not address underlying economic, political, and organisational problems. Supporting activities in countries where success is likely to be high almost certainly means that the donor is not helping places where the need is greatest. In areas of deprivation, structures for organising things are weakest and doing anything is hard. Donors cannot guarantee success in areas of need. There has to be risk, and efforts may fail without it being someone's fault. Bureaucratic demands for measurable success may also lead donors to plump for safe, well worn approaches. These demands sometimes compel them to avoid tricky problems such as institutional reform. Improving these is vital but difficult to do and not easily measured.

The need for accountability remains

Yet the complexity is no excuse for a lack of accountability among donors. Ensuring that money is well spent—in other words, doing what it was allocated for and benefiting those for

whom it was intended—is even more important as an increasing proportion of British aid is being channelled through the European Union.² Although this will allow greater harmonisation of the aid effort, the calls for greater transparency provide an opportunity to review the impact on poverty of various forms of aid. This should be a part of the process of improving the effectiveness of aid and should avoid academics hijacking the process with highly complex analysis of data.

What is needed is more accessible information about the successes and failures, focusing on end points relevant to the inputs and activities, in a form of audit rather than an attempt to provide scientific proof. Although donors constantly do this through their own monitoring mechanisms, common methods for evaluation would help; wider access for donors and non-government organisations to the lessons learnt and successes achieved would augment the existing wealth of institutional knowledge that informs efforts to ensure that aid is spent effectively. Such methods could also improve accountability to the public paying for the aid and, ultimately, to the people in developing countries whose lives are being affected by it.

Greater public insight into development, not only through reports describing outcome but also through descriptions of the realities of implementation, can only enhance the public's understanding of aid and help campaigns to increase budgetary allocations.

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Protecting adolescent girls against tetanus

Would save many lives in the developing world

Time and again tetanus has been described as a neglected disease.¹ An estimated 8 million babies and 2 million children and adults may die from tetanus during the 1990s, mostly in developing countries—despite the World Health Organisation's call to eliminate the disease by this year. Vaccination to prevent post-abortion and maternal tetanus has been largely ignored. The primary aim of prevention programmes has been to eliminate neonatal tetanus²; the two commonest prevention programmes—immunisation of preschool children and of pregnant women—have omitted adolescent girls.

Fauveau and colleagues collected data on 1101 cases of maternal tetanus in developing countries published between 1958 and 1990: 27% were attributed to post abortion and 67% to post partum sepsis.³ One third of all cases described were from Nigeria, which has a high rate of induced abortion, many of them performed under septic conditions. In a population based study in south east Nigeria, which found high rates of reported abortion,⁴ we also found that a high proportion of girls were seronegative for antibodies to tetanus—so that they were at a high risk of infection (unpublished observation).

Ekanem *et al* report that many unvaccinated pregnant women are young and single, and lack of money is cited as the main reason why they do not register at health centres when pregnant. This shows the negative effect of incorporating tetanus vaccination with prenatal services for which fees are charged.⁵ Vaccinating adolescent girls would therefore reduce tetanus related maternal deaths in Nigeria and could have a similar impact in other places where abortion rates are high and tetanus vaccination coverage is low.

Current monitoring is ineffective

The World Health Organisation is now promoting vaccination of all women of childbearing age by screening a woman's tetanus toxoid vaccine status at every contact with the health services,⁶ but this approach says little about adolescents. Most developing countries still administer tetanus toxoid only to pregnant women and since WHO's policy is delivered through health facilities, adolescents will be poorly covered because most are not regular attenders. Paradoxically, the success of a policy to vaccinate women of

child bearing age can only be established by immunisation records or serological studies that show high levels of immunity in adolescent girls.⁶ Monitoring systems are currently ineffective, however, and virtually no information exists on coverage of the female adolescent population (A Galazka, personal communication).

Immunisation strategy

A strategy expressly targeting girls would be feasible in some countries. It would require five properly spaced injections and would most likely provide protection from tetanus for life.¹⁷ Even four doses of tetanus may protect for as long as 20 years, and if delivered at the end of primary school would certainly protect during adolescence and possibly beyond. In developing countries the proportion of children, including girls, attending primary schools is growing. Analysis of statistics collected by Unicef shows that in many of the countries with high death rates in children under 5, the proportion of pregnant women who have been vaccinated is low.⁸

A school health service delivering a programme of tetanus vaccination may be a feasible route for improving coverage of adolescent girls who otherwise may not be vaccinated during pregnancy. There are other advantages to immunising school-girls, including the opportunity to raise health consciousness at an early age and to encourage the use of personal vaccination records. School based delivery of health interventions is currently of great interest and, in developing countries, could be combined with distribution of vitamin A and anthelmintics. In this regard, some evidence exists that giving vitamin A at the time of tetanus vaccination significantly improves the response to vaccine.⁹

Recently it has been suggested that a late dose of an acellular pertussis vaccine and a second dose of measles vaccine should be given towards the end of childhood or in adolescence—to reduce the pool of susceptible girls and to protect future infants.¹⁰ In developed countries, such reasoning has led to the targeting of adolescents for rubella vaccination.

Vaccinating adolescent girls against tetanus could bring about substantial long term gains. Implementation will require an assessment of the proportion of girls who can be

reached in schools or who can be called in to local schools on vaccination days. High risk areas, perhaps based on reported abortion rates, could be targeted.¹¹ Young women should be strongly urged to acquire an immunisation card, high potency primary vaccination and tetanus boosters must be free, while a system to monitor antibody responses among girls needs to be in place.

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Falls after strokes

They are common and need a multi-intervention approach

See p 83

Thirty years ago Lord Brain remarked that hemiplegic patients rarely fell because they had to concentrate so hard to walk at all.¹ Yet the paper in this issue by Forster and Young, which looks at falls in patients who had had strokes and were living at home, shows that, far from being rare, falls are more than twice as likely in this group than in the rest of the elderly community (p 83).² So why has our view of this group of patients changed? Probably because, as a result of demographic change and improved rehabilitation and community services, elderly patients living at home now considerably outnumber the younger and fitter patients seen by neurologists in the past.

The important point about the patients in Forster and Young's study is that they were elderly and therefore at an increased risk of falls even without the stroke. About 30% of

people over 65 living in the community fall each year,^{3,4} and although only one in 10 falls results in serious injury, there is considerable morbidity and loss of independence resulting from fear of further falls.

Attention to balance

An elderly person who has frequent spontaneous falls (as opposed to someone who has a single trip or accident) usually has several impaired components of his or her system of balance. Maintaining balance while standing depends on the integration of sensory inputs (somatosensory, visual, and vestibular) with motor processes in the limbs and trunk.⁵ In old age loss of sensory information is poorly tolerated and there is an inability to weigh and select appropriate responses