ALSO CF/HST/080

HISTORY OF UNICEF*

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ORIGIN AND EARLY PRIORITIES

In 1947 when UNICEF commenced operations in Europe millions of children were still in a condition of deprivation and malnutrition as a result of the war. In seeking to restore their agricultural production most of the European countries had to concentrate on such staples as grains and potatoes. Because of the destructive effect of the war on livestock produce none of the countries had an adequate indigenous source of supply of the protective foods - milk, fats, meats - needed for children and nursing and pregnant mothers; nor, because of high costs and lack of foreign exchange, were they able to import these foods in sufficient quantities. In addition, warm clothing, shoes, diapers, and medical supplies were urgently needed.

The substantial aid provided by the United Nations Relief and Rehabilitation Administration (UNRRA) had prevented major famine. But in August 1946 a decision was taken to liquidate UNRRA, and with it the daily supplementary meals it was helping provide to some five million European children. A Standing Committee of UNRRA on the Rehabilitation of Children and Adolescents pointed out that the years 1947 to 1950 would be the critical period for relief to children in Europe and China. The UNRRA Council proposed to the United Nations that a Children's Fund be created, and that part of its work be financed from the residual assets of UNRRA.*/

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*/ It was not known at the time how large these residual assets, if any, would be; ultimately they totalled over $33.3 million.

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Although the General Assembly in creating the United Nations International Children's Emergency Fund*/ (UNICEF) in December 1946 placed no restriction on countries which were eligible to apply for assistance, it accorded a priority for children of countries who were victims of aggression and of countries which were receiving assistance from UNRRA. Because of the acute post-war emergency needs and the uncertain resources of the new agency, there was general recognition that the initial activities of UNICEF should be confined to emergency relief, mainly child feeding in war-devastated countries of Europe.

Nevertheless it was possible from the very outset to envisage a broader scope for UNICEF. The General Assembly resolution provided, within the priorities it had established, that the resources of the Fund were to be used "for the benefit of children and adolescents" and "to assist in their rehabilitation" and "for child health purposes generally" (General Assembly Resolution 57 (1)).

At the peak of UNICEF operations in Europe some six million children received a daily supplementary meal. In addition clothing and shoes, processed from raw materials provided by UNICEF, were provided to some five million children.

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*/ This name was shortened in 1953 to United Nations Children's Fund (see paragraph).

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Once its initial operations were under way UNICEF began gradually to enlarge both the variety and geographic scope of its aid. In 1948 a start was made in helping health and food conservation programmes in Europe, and outside Europe UNICEF began providing aid for health and feeding programmes to China, and then to other Asian countries. Likewise in 1948 UNICEF began providing emergency relief for Palestine refugee mothers and children, and the next year it began extending aid, mainly for BCG anti-tuberculosis vaccinations, to several countries in the Eastern Mediterranean area and North Africa. Aid to Latin America for feeding and health programmes was first approved in 1949.

By the end of 1950 UNICEF had spent over $114 million for project aid in fifty-eight countries and territories. Of this amount, seventy-five per cent had gone to Europe, ten per cent each to Asia and the Eastern Mediterranean area, and three per cent to Latin America.*/

THE SHIFT TO LONG-RANGE AID AND TO DEVELOPING COUNTRIES

It had become increasingly clear in 1949 and 1950 as progress was being made in agricultural recovery in Europe and as the war-devastated dairy herds were being rebuilt, that UNICEF aid for post-war emergency feeding of children could soon be terminated in some European countries and considerably curtailed in others. With recovery in Europe there was an increasing demand that UNICEF give more attention to the needs of children in other parts of the world.

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*/ The experience during the period from inception to the end of 1950 is summarized in the Final Report of the First Executive Board E/ICEF/160, January 1951.

The future of UNICEF was uncertain. Some governments believed that, having completed its primary task of helping meet emergency child needs arising out of the war, UNICEF in its existing form would no longer be necessary. Various proposals, including one for a successor agency, were advanced as to how children's needs might be given attention on a long-term basis within the structure of the United Nations and its specialized agencies, with provision also to be made for relief to be given in catastrophes and other special emergencies. However, because of the great magnitude of chronic children's needs in the developing world the proponents of this point of view believed that it would be unrealistic to place major reliance in future international work for children on the provision of supplies, as UNICEF had done for Europe. With the relatively small resources which would be available, they thought that emphasis should rather be placed on the provision of technical aid, which could be expected to yield more lasting results.

Most governments, however, particularly those from the developing areas, could not accept this point of view. They pointed out that UNICEF had helped focus a considerable degree of attention on international action to meet children's needs and that it would be wrong to curb or terminate it activities at a time when these activities were just beginning to become more universal in scope. They contended that because the needs of children in developing countries were of a long-standing nature did not mean that they should be regarded as any less urgent than those of the children in post-war Europe. Material aid was urgently needed in developing countries, and indeed was essential to make

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technical advice bear fruit. Moreover, the provision of technical aid was the responsibility of other agencies in the United Nations family. UNICEF had developed an efficient organization and its methods had proven effective. UNICEF should be continued with the same basic structure, although its terms of reference might be amended to reflect the newer tasks confronting the agency.

A third group of governments wished to postpone for a number of years any decision on the final status of UNICEF.

These issues, and specific proposals in which they were reflected, were discussed in considerable detail from the middle of 1949 to the end of 1950 in various United Nations circles: the Social Commission, the Economic and Social Council, the specialized agencies, the United Nations Secretariat and the Administrative Committee on Co-ordination. This process, in which virtually all member Governments actively participated, culminated in a decision by the General Assembly in December 1950 to extend the life of UNICEF for three years, at which time the General Assembly would again consider the future of the Fund with the object of continuing it on a permanent basis. In the meantime the priorities set in 1946 for children of countries victim of aggression, ~~was~~ were replaced by new terms of reference in which UNICEF was directed to use its resources:

> "for the purpose of meeting, through the provision of supplies, training and advice, emergency and long-range needs of children and their continuing needs particularly in under-developed countries, with a view to strengthening, wherever this may be appropriate, the permanent child health and child welfare programmes of the countries receiving assistance."
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> (General Assembly Resolution 417(V))

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Thus it was clear that the major attention of UNICEF in the future would be directed toward programmes of long-range benefit to children of developing countries. The provision of the General Assembly resolution that UNICEF resources were to be used for "supplies, training, and advice" did not differ substantially from the original 1946 resolution which had authorized UNICEF to provide "supplies, material, services, and technical assistance." While this rather wide leeway was continued, it was also apparent from the discussion in the Third Committee in 1950 that the emphasis should continue to be on the provision of material aid.*/

The effects of the new terms of reference of UNICEF became apparent in the programme allocations made in the course of the next three years. The European share of UNICEF programme allocations fell to 20 per cent in 1951 and to 7 per cent in 1952. By the end of 1953, when the General Assembly again considered the future of UNICEF, aid in one form or another had been extended to 69 countries and territories for some 180 programmes. Seventy-nine per cent of the programme allocations in 1953 were for Asia and Latin America, fourteen per cent for Africa and the Eastern Mediterranean area, four per cent for Europe and three per cent was for projects benefitting more than one region. Allocations for

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*/ The UNICEF Board early in 1951 when it reviewed the implication of the Assembly resolution stated that UNICEF would "give greatest emphasis to the provision of supplies without overlooking, however, the obligation to provide training and advice. However these various means of giving assistance are not mutually exclusive. For example, it would be possible and desirable for the Fund in many instances to provide supplies and equipment for a training programme." (E/ICEF/178/Rev.1, paragraph 17)

long-term projects (maternal and child health, disease control and milk conservation) which during the period 1947-1950 totalled 22 per cent of programme allocations, had risen in 1953 to 70 per cent of the allocations.

The delineation of UNICEF's new stature was reflected in a discussion which took place in the UNICEF Executive Board in March 1953 in which representatives stressed those features which they considered especially significant in relation to the future of UNICEF. Among the characteristics elaborated upon were the following: UNICEF constituted the only agency in the United Nations family whose concern was primarily children, and the only one that provided supplies and equipment; the programmes it aided had long-range values and achieved a large mass impact at relatively little cost; UNICEF had an effective constitutional structure and an economical administration; UNICEF attracted resources that would not have been available had there been no special agency for children; and UNICEF activities constituted one of the best ways for promoting the larger purposes of the United Nations. Despite what had been achieved the Board pointed out that a great deal still remained to be done to extend the benefits of UNICEF to those developing countries which had not yet received UNICEF aid, as well as expand aid in those countries where only a start had been made.

These views, in one form or another, were advanced in the debates on the future of UNICEF which took place later in the year in the Social Commission, the Economic and Social Council, and the General Assembly.

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In October 1953 the General Assembly unanimously decided to continue UNICEF indefinitely. At the same time it reaffirmed the broader terms of reference which it had established for the Fund in 1950. The words "International Emergency" were dropped from the name which now became the United Nations Children's Fund; however, the initials UNICEF were retained since there was general recognition that they had by now become a well-known symbol. Reflecting a growing awareness of the importance of UNICEF in the United Nations family the General Assembly resolution pointed out that UNICEF's activities created "favourable conditions for the development of the long-range economic and social programmes of the United Nations and the specialized agencies." */

The General Assembly resolution of 1953 constituted a formal marking of a new phase for UNICEF which had its gradual beginnings some four years earlier. During this period the debates on the future of UNICEF had stirred the conscience of many governments. Government contributions to UNICEF, which in the first three-year period (1947-1949) had averaged over $43 million a year had, in 1950, the year in which there was such great uncertainty about the future existence of UNICEF, decreased to less than $8 million. From that point on there was a gradual increase and by 1953 contributions from fifty-five governments (as compared to thirty-one in 1950) amounted to $14.3 million.**/

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*/ General Assembly Resolution 802 (VII).

**/ By 1964 the number of governments contributing to UNICEF had risen to 121, virtually all of them on a regular annual basis. Contributions from governments in 1964 amounted to $25.6 million; income from private contributions and other sources brought the total for the year to over $32.9 million.

Government responsibility

The basic responsibility of Governments for programmes benefitting children was explicitly recognized at the time UNICEF was created when the Third Committee in its report to the General Assembly pointed out the "prime responsibility for the rising generation lies with the national Governments...", that within each country responsibility for child care rests with the appropriate national and local authorities, voluntary agencies and individual citizens, and that the purpose of UNICEF was essentially one of providing sufficient supplementary assistance, where needed (A/230). The resolution creating the Fund, provided that UNICEF supplies or other assistance should be made available "to Governments" and that the Fund should not engage in any activity in any country "except in consultation with, and with the consent of, the Government concerned." (Resolution 57 (1), section 2(c))

The reports of the Executive Board reflect throughout this basic point of view. One of the early reports of the Board stated:

> "It is the fundamental policy of the Fund to supplement the efforts of Governments so that with the combined resources of Governments, the Fund, and voluntary agencies, it will be possible to achieve for children a continued policy of the highest possible priority in all national efforts. In following this policy the ICEF is conforming to the principles laid down by the Economic and Social Council that 'emergency measures shall be so developed and administered as to utilize and strengthen the permanent child health and child welfare programmes of the countries receiving assistance'." (E/590, paragraph 33, October 1947)

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Requests for assistance are accepted only from Governments. Assistance is granted only on the basis of a formal agreement with the Governments which constitutes a contractual relationship between the Governments and UNICEF.

The matching principle

The concept of government responsibility has meant that in all cases the administration of UNICEF-assisted projects is entirely in the hands of the governments, or agencies designated by them. With the role of UNICEF confined to supplementing the use of country resources on behalf of children, this concept has also meant that substantial local expenditures are required for staff, buildings, supplies, equipment, and various services and facilities to implement a project assisted by UNICEF. These expenditures are known in UNICEF terminology as "matching".*/

The matching requirement, which essentially reflects the grant-in-aid approach of UNICEF, serves to support the efforts of officials and groups in each country who are most actively concerned with establishing and strengthening programmes benefitting children, helping them to secure budgetary and administrative provisions on various levels of government which would not otherwise have been available. It generates greater local expenditures in behalf of children and enables UNICEF funds to go farther. At the same time it helps to assure that a project is firmly rooted in the country as a basic responsibility of government. The matching principle

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*/ This term, in a sense, is misleading since it implies that the basic responsibility is international rather than national.

thus becomes a device for attaining higher priorities within the country for actions on behalf of children agreed upon by the governments, UNICEF and collaborating technical agencies in the United Nations family. At the same time it gives assurance that the programmes are conceived in practical terms, and are adapted to the financial and administrative possibilities within the country. The extent and character of the locally provided resources are set out in a plan of operations which describes the governments' commitments for a project (as it does also the commitments of UNICEF and the technical agencies of the United Nations family).

When UNICEF began to aid child feeding programmes in Europe, matching by the countries took the form of local foodstuffs equal in caloric value to the milk and other protective foods provided by UNICEF. The measure of matching, however, shifted from calories to monetary terms when UNICEF began providing other types of aid, and the countries were required to provide matching at least equivalent in monetary value to the aid provided by UNICEF.

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In most cases, because of the very nature of the programme, the amount of matching has considerably exceeded the value of aid provided by UNICEF. In the last half dozen years the average amount of matching has ranged from between two and one-half to three times the value of the aid provided by UNICEF.*/

As a fundamental principle in UNICEF operations, matching has never been questioned in the UNICEF Board. In some instances, however, experience showed that the application of the matching principle created difficulties in cases where governments were making creditable efforts because of the interpretation that matching had to consist of "new" expenditures by the country, and, moreover, that these expenditures had to be made over the same period of time as the aid provided by UNICEF.

It became apparent, for example, that in certain cases the cost of supplies provided by UNICEF exceeded the amount of local money required to put them to full use. Since UNICEF did not wish to require matching of a country in excess of that needed to make a project work, it decided that this type of "functional matching" was acceptable.**/

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*/ These figures understate the matching because of ceilings imposed by the UNICEF Secretariat in these calculations, (for example, for new projects no more than six times the amount of the UNICEF allocations is counted). Also the figures generally do not include the full costs of non-governmental efforts. Moreover, they do not include the main expenses to the country, namely those of continuing the project on a permanent basis after UNICEF help has ceased. In the early days of UNICEF there was considerable pre-occupation with the arithmetic of matching; this has been considerably less true in recent years as emphasis has been increasingly directed to the objectives of the matching principle.

**/ This was especially true in the case of feeding projects where the internal distribution costs of the skim milk were less than the costs of UNICEF aid, but were nevertheless sufficient to secure adequate distribution. The Board also provided that if matching for a proposed project appeared insufficient other considerations might be taken into account, such as the total matching required of a country on an annual basis for all types of UNICEF aid.

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Other instances of flexibility in matching requirements were also approved by the Board. In some cases the primary need was to improve the quality of an existing programme, and UNICEF aid was needed to encourage the better use of existing expenditures rather than require new expenditures.*/ In some cases a government may have already been making substantial efforts to deal with a problem and UNICEF aid would make possible an increase in coverage.**/ In these circumstances the Board agreed that new expenditures might not be required where governments had previously provided substantial funds for a project and UNICEF aid was needed to improve the quality or coverage of the services.

Experience had also shown that in some cases UNICEF aid might be required in larger amounts than Government expenditures in the early phases of a project, although a substantial increase in government expenditures could be expected at a later stage. The Board believed that flexibility in the matching requirements under such circumstances might be especially helpful to hard-pressed newly independent countries in getting useful projects started.

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*/ This situation first received the Board's attention in connexion with social service projects where the chief need was to strengthen the co-ordination of the activities of a number of governmental and voluntary agencies for which substantial local expenditures were already being made.

**/ For example, in certain leprosy projects the personnel and organizations were already well established but drugs which UNICEF could supply were in short supply.

These interpretations of flexibility in matching policy came to be applied to individual projects on an ad hoc basis over a period of several years. In 1960 they were formally reaffirmed as policy by the Executive Board.*/

The Board has continued to be concerned, however, about the limitations on its aid to countries unable to develop projects which fulfilled the usual matching obligations since, in effect, this has meant the denial of aid to children in which needs were usually the greatest. From time to time Board members have stated their belief that UNICEF should find ways of giving greater aid to these countries.**/ In 1961 the Board, hoping to meet this problem in part, agreed to finance special help to countries for consultants and local studies where these were needed to prepare acceptable project proposals. This did not meet the major difficulty, however, and the question was again raised in a specific way in the Executive Board in June 1964 by the UNICEF Director for Africa, who proposed that UNICEF policy be adjusted so that special aid could be given to countries lacking the personnel and normal facilities and organization to initiate services on behalf of children; this aid might involve a waiving of matching requirements for a period of time on a decreasing scale. The Executive Director was requested to study the problem and present recommendations to the Board at its session in June 1965.

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*/ See March 1960 Executive Board report, E/ICEF/398, paras. 52-54.

**/ The problem was first recognized in the early years of UNICEF. The Executive Board report summarizing the first four years of experience pointed out that "varying ability to prepare and execute workable plans" posed problems since "the amount of aid for some areas in greatest absolute need might be limited because of difficulties in organizing effective projects". It pointed out, however, that there was no doubt that countries which were able to produce feasible plans were also greatly in need of external aid and expressed the hope that successful aid to this latter group might well serve as a stimulus to the former group to organize effective projects (E/ICEF/160, para. 179).

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Payments for local supplies and services

At the time UNICEF was created there was an acute shortage of foreign exchange in the European countries receiving UNICEF aid; however the financing of supplies and services available within the country was less difficult because of post-war inflation. The Third Committee when it considered the creation of UNICEF suggested that the size of the new agency's budget and the specific character of its operations should be based upon the import requirements of the assisted countries. The foodstuffs and raw materials for clothing to be provided by UNICEF were in short supply in the European countries and there would have been little logic in UNICEF providing funds for their local purchase. UNICEF adopted as a basic policy that it would provide only necessary imported supplies, and that the countries would be required to provide those which were locally available.

UNICEF was confronted with a different situation as the numbers and types of requests for aid grew, as it turned its attention to countries outside Europe, and as it became clear that aid from UNICEF could not, in any case, be a significant element in a country's foreign exchange balance.

While theoretically the assisted countries could be expected to meet all the local costs required for a project, the realities of budgeting showed that in countries struggling to meet many demands on their limited budgets this often did not happen in practice. There were a number of instances in which ministries, otherwise prepared to go ahead with projects,

found themselves unable to get government funds for some of the essential services and materials which did not need to be imported. This problem became more noticeable as UNICEF-aided projects brought services into the villages, the main cost for which was local staff. The localities could usually fulfil the general requirement of equal matching in their provision of staff, buildings, and local supplies. However, the benefits of investing in expenditures for the training of the local staff and their supervision required some time to be first demonstrated and then incorporated in the budgeting process, often of several levels of government. The imported supplies for training programmes provided by UNICEF represented only a small proportion of the total local costs for such programmes which usually required a continuing series of successive local training courses. In many cases therefore UNICEF aid proved insufficient to encourage the establishment of effective training schemes. It became clear that some flexibility in provision of local funds by UNICEF was required.

As a result of a series of Board decisions, the first of which was made in 1952, it became possible for UNICEF to provide stipends in local currency to help defray the living expenses and travelling costs of trainees for refresher, short-term, basic, and specialized training; salaries or honoraria for instructors; salaries for project directors and supervisory personnel in UNICEF-aided projects for limited periods of time (usually in the initial stage of a project); and salaries or honoraria for staff, where needed, to help prepare projects and carry out surveys.

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These decisions by the UNICEF Executive Board were made cautiously and after considerable debate. They contained specific safeguards designed to preserve the basic responsibility of assisted governments for local costs as well as the general principle of matching.*/

In the Board debate on this problem some Board members were concerned that a too liberal policy on provision of local costs might, in the long-run, discourage the assumption by governments of their traditional responsibilities, creating expectations on their part and pressures on UNICEF which would out-weigh the short-term value of breaking bottlenecks in project development. They feared also that UNICEF aid for local costs might set a precedent leading to pressures on the specialized agencies to provide for local costs. Board members in favour of liberal-ization of the policy on the other hand, did not believe that a UNICEF contribution toward local costs, within the over-all framework of UNICEF's matching policy, constituted a significant shift in UNICEF's approach. They believed that, where required it would considerably increase the value of the investment of imported supplies UNICEF was willing to provide, and

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*/ These safeguards, approved in 1954, provided that in bringing forward project proposals containing provision for local costs the Executive Director would continue to be guided by the general Board policies concerning government matching; that the total value of UNICEF aid, including supplies and payment for local training and services would not exceed 50 per cent of the total costs of the project; the payment for local costs would be a small proportion of the total project cost; that the aid would be for a limited period of time, and necessary as an integral part of the project; and that the projects themselves would be of a relatively substantial character in terms of geographic extent, number of units involved, and long-range nature. (E/ICEF/260/Rev.1, para. 68). These specific provisions were superseded by the more general Board policy on local costs made in 1961 (see paragraph).

that the focus of UNICEF should be primarily on what was needed to make a project viable. In their view the form of UNICEF aid was less important than its effectiveness in terms of the strategic needs of each particular project.

Although the Board gradually accorded flexibility in assumption by UNICEF of local costs for training it was more reluctant to do so for payment by UNICEF of locally available supplies.*/ The Board recognized, however, that in certain situations small expenditures of locally purchasable supplies might be required to expedite a project or meet an emergency; such factors as logistics and timing in delivery of supplies, local suitability of the supplies, servicing problems, overall costs for bulky items (taking freight cost into account), and initiating a line of supplies which would be later continued by the governments, required some discretion on the part of the Executive Director in authorizing small amounts for the local purchase of supplies.**/

In addition, without adopting a general policy of flexibility, the Board approved a number of individual projects which included modest sums for the local costs of such supply and service items as preparation,

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*/ The Executive Director proposed such a flexibility to the Board in 1954 but it met with strong opposition on the part of some delegations, and he withdrew the proposal.

**/ The Executive Director authorized UNICEF area and country representatives to approve local purchase of items up to $2,500 a year per project. The UNICEF Directors for each region could authorize an additional amount up to a total of $5,000 per year per project.

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translation and printing of textbooks and panphlets; paper for health education posters; kitchen equipment for nutrition demonstration projects; local seeds; beds for hospitals and large clinics; maintenance costs of X-ray units; laboratory expenses; and office supplies and equipment.

This gradual evolution in attitude was reviewed by the Board in 1961, at a time when it had before it a survey on unmet children's needs, and was, in general, prepared to broaden the scope of UNICEF's approach toward aid.*/The Board approved a policy which permitted greater flexibility in the authorization of local expenditures not only for training and supervisory staff, but for supplies and services as well, where this was the most effective way for aiding a project and funds were not available from other sources.

In the debates on this policy decision some delegations believed that the general practice should be maintained that aid for local costs should be regarded as being of an exceptional character and given only for limited periods; suggestions were made that allocations for local costs approved at any one Board session should be limited to a predetermined percentage of total project allocations, or that a minimum percentage figure might be fixed below which the liability of governments to meet local costs should not be reduced. The general view of the Board, however, was that because of the variety of situations no arbitrary figure should be set. It was agreed that UNICEF cash grants

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*/ See paragraphs

for local costs would always be limited and would not relieve assisted governments of the major responsibility for local costs. Every effort was to be made in the first instance to secure the necessary local funds either from the governments own resources or from bilateral or multilateral funds or voluntary agencies. The principle of matching would be maintained, and over the whole range of assistance to a country the local costs assumed by UNICEF would represent a relatively small part. No particular type of local expenditure would be excluded from UNICEF aid and all proposals were to be considered in relation to the needs which the project served and to the local resources which were available.

Evolution of the UNICEF Approach Toward Aid

Early general criteria

A major continuing problem confronting UNICEF has been how to allocate its resources so that they would be put to effective use and at the same time, so far as possible, treat countries equitably in terms of the relative needs of their children.*/

In the case of distribution of supplementary foods among European countries some fairly clear guide-lines of relative need were available from FAO data and various surveys and observations by experts undertaken under UNICEF auspices. It was apparent quite early in UNICEF history, however, that no mechanical formula could be devised which would in general determine the relative needs as between countries.**/ As UNICEF aid began moving to other types of programmes, and to countries outside Europe, the

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*/ Changes in interpretation of matching requirements have constituted one way of attempting to meet this problem. See paragraphs _____.

**/ In 1947 when aid to children of war-devastated countries was a priority, the Executive Board listed the following elements to be taken into account in determining relative needs: the proportion of undernourished children; the number of homeless and orphaned children; the capacity of the country to meet its own needs out of currently available resources; the extent and duration of deprivation of the children experienced during the war; the extent of wartime destruction of children's institutions; and the availability of other international relief supplies for the same or similar purposes.

chief criterion for aid came to be the intrinsic value of the project, with the child population of the country taken into account as the main statistical indication of need.*/ In order to achieve some degree of equity as between neighboring countries having similar conditions, certain requests were reduced or deferred until the Fund had in prospect sufficient resources to grant aid to each of the neighboring countries in rough approximation to their child population.

Changes in criteria

As the urgent needs for child feeding and clothing began to be filled UNICEF began aiding other types of projects, and ideas for what, in general, constituted the best type of project began to change. By the end of 1950 without explicity adopting a new set of criteria **/ it was clear that the Board had begun to prefer large projects rather than dispersing aid among

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*/ It was recognized that the child population of a country was not in itself a sufficient indication of relative need. From time to time attempts were made to analyze other factors such as the infant mortality rate; life expectancy at birth; per caput income; per caput expenditure for child health and welfare; ratio of doctors, nurses, and midwives per inhabitant; number of inhabitants per hospital bed; ratio of child to total population, etc. Many of these data, however, were not available (particularly for rural area of countries where the need was greatest) or lacked comparability, and in any event, in most cases did not reveal differences of such a degree as to change allocation judgements based upon the criterion of the value of a particular project, with some account taken of child population.

**/ Discussions and decisions on individual projects and the accumulation of experience on a case basis has been characteristic of a good deal of the development of UNICEF's approahh toward the granting of aid. From time to time the Board has reviewed the experience and formally adopted a policy based upon it.

a number of minor projects; those which had the greatest direct impact on large numbers of children; those which conveyed long-term benefits; and those which were strategic in a particular country in dealing with serious problems affecting children or with basic lacks in child care.

Early in 1951, after UNECEF had received revised terms of reference from the General Assembly*/, the Board reviewed its policy in the light of the new tasks confronting the Fund. It reaffirmed that its aid would be predominantly in the form of supplies and decided that it would continue to concentrate in the fields of health and nutrition. In dealing with requests from countries the following factors would be borne in mind:

(a) The extent to which there exist in the country serious problems of child or maternal health, nutrition, or welfare;

(b) The capacity of a country to meet its needs out of its currently available resources;

(c) The extent to which international assistance is required by the country to carry out its plans for development;

(d) The extent to which a country can effectively make use of the assistance which has been sought and the extent to which such assistance complements plans within that country;

(e) The extent to which international assistance from other sources is available for the same or similar purposes;

(f) The extent to which children have suffered through war or other calamity.

(E/ICEF/178/Rev. 1 para. 23)

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*/ See paragraph ____ above.

As to determining priority among competing projects requests the following criteria were set down:

(a) The urgency of need for that project particularly if the denial of it would cause immediate and heavy loss of children's lives, or serious impairment of child health;

(b) The financial assistance required in the context of UNICEF's resources and its current and future obligations;

(c) The relative importance attached to the project by the requesting government;

(d) Projects which would help to complete or perfect work already undertaken or accomplished, in preference to wholly new projects; this, however, should not preclude aid to wholly new projects meeting urgent needs, particularly when UNICEF assistance would help initiate new government activity in a given field;

(e) Projects which would be of long-term value in preference to those of short-term benefits;

(f) Projects which through continuation by the country, or solution of a problem, would not require recurring assistance from the Fund;

(g) Projects which are well adapted to the financial, technical, and administrative possibilities of the country, due consideration being given to appropriate technical approaches;

(h) The possibility of benefits of a project also being made available to other countries.

(E/ICEF/178/Rev. 1, para. 28)

Another criterion which shortly came to be important was the progress made in projects, since an increasing amount of UNICEF aid was for the continuation of projects already approved.*/

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*/ See section of evaluation, paragraphs _____.

In 1953 when the future of UNICEF was under discussion, a special report of the Executive Board briefly summarized the main general considerations in granting aid as follows, emphasizing the predominant interest of the Fund in the value of individual projects:

> Although assistance is provided on the basis of needs these are not construed as total needs of children in general but rather as requirements for which international assistance in supplies and equipment is appropriate and can be effectively used. This implies (a) a serious problem of child care; (b) plans for effective national efforts to meet the problem; (c) a necessity for some imported supplies as in integral part of the country's programme.
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> In order to assure long-range values the Board favours aid for programmes which give results on the basis of low per caput costs, which are within the capabilities of the country to continue after the initial period of international aid, and which set local organizational patterns capable of being duplicated and extended elsewhere in the country.
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> (E/ICEF/226, paras, 15, 17)

Movement towards a broader approach

These principles continued to be accepted in the ensuing years although from time to time some Board members queried the Executive Director as to the extent he had considered possible alternative projects in bringing forward certain projects for approval. As a result in 1957 the Executive Director set forth what he considered to be the main general criteria in the selection of projects to bring forward to the Board for approval. The Executive Director referred to previously agreed upon criteria such as general judgements of the value of the activities to be undertaken; the

practical possibilities of government financing and organization; the overall costs (both to the government and in terms of international aid)*/; the availability of trained staff and the possibilities for training in the future; the efficacy from a technical point of view, of the methods to be adopted; and the extent of long-range impact, including its educational effect on the population.

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*/ In relation to this several Board members have raised the question as to whether the costs per beneficiary should not enter into greater consideration as a guide line for project selection. Cost analyses were made by the Executive Director in 1958 and 1959. While costs per beneficiary in feeding and disease control programmes were relatively easy to determine, considerable difficulty arose in computing costs in other types of programmes because the number of beneficiaries might continue over an indefinite period of time (attendance at maternal and child health centres) or were reached only indirectly (training programmes). Moreover to be comparable, unit costs needed to be adjusted to the long-term benefits conferred upon the child and this was not possible on a statistical basis. The only general conclusion which the Board was able to arrive at in relation to costs was that specialized programmes with a relatively high per caput cost (such as handicapped children and premature baby programmes) needed to be viewed with some reservation for UNICEF aid. However, these were, in any event, usually not accorded a high priority for UNICEF aid.

Granted all these criteria, however, it was still necessary to make a choice in the use of UNICEF's limited resources. The Executive Director suggested two other criteria, namely the government's own priorities for meeting basic child problems and the necessity for arriving at a proper balance between services which met the special needs of children directly and those which affected his welfare indirectly through his family and community. Wherever possible specific measures for the health, nutrition and welfare of children should fit into broader measures for the improvement of family and community levels of living.

In connexion with this last consideration the Executive Director pointed out that the needs of children were not isolated and attempts at their solution should not take on a compartmentalized character. Efforts to meet children's needs were more effective when several problems were attacked simultaneously. The best programmes with which UNICEF aid could be associated were those which acted on as many of the factors in the child's environment as possible. Such programmes usually involved jointly planning by several government ministries or departments. The various forms of international aid were most valuable when they were so co-ordinated as to exercise a mutually reinforcing stimulus upon government programmes which were comprehensive in scope as well as ensuring continuity of effort and consolidation of results.*/

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*/ See Guiding Principles of UNICEF Aid, E/ICEF/342; Report of UNICEF Executive Board, April 1957 session, E/ICEF/344/Rev. 1, paras, 21-22; Report of UNICEF Executive Board, March 1958 session, E/ICEF/380/Rev. 1, para. 28.

In 1959 the Executive Director carried this point of view one step further. It was not enough to save children from hunger and disease; it was necessary also to help them become better prepared for life, and to become active, productive members of their community. Referring to the inter-relationship of children's needs, he reiterated his belief that the concentration of effort on one of these needs to exclusion of the others was less effective than efforts to tackkk the inter-related needs together. He pointed out that the stimulating effect of UNICEF aid was restricted when local initiative was present for certain types of needs but could not be given UNICEF support because aid was restricted to pre-determined fields.*/ In order to help countries develop their services for children in a balanced way, and encourage activities of a number of government ministries, it would be desirable for UNICEF to increase the categories of programmes to which it could give aid.*/

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*/ In 1953 the Board had decided that it would not consider aid for any project unless the field in which it fell had been previously approved in principle by the Board. In the case of health programmes Board approval in principle required a prior recommendation by the UNICEF/WHO Joint Committee on Health Policy (E/ICEF/227, para. 925).

*/ The Executive Director proposed approval in principle of aid for primary education and social services for children; only the latter was approved at the 1959 Board session; aid for primary education became possible only as a result of the June 1961 Board decisions. See paragraphs ____.

The concept of the inter-relationship of children's needs and the desirability of a balanced approach toward them by governments was generally accepted by the Board. However, some Board members did not believe that it necessarily followed that UNICEF, with its limited resources, should undertake aid in all fields related to children's needs. Other Board members urged a flexible assistance policy which would take into account the responsibility of each assisted government for the ultimate choice of the best means of achieving advances for children in the country for which it was responsible. The point was made that the success of UNICEF influence should not be measured solely in terms of direct child beneficiaries but in its effect on government planning and its intensification, wherever possible, of programmes of economic and social improvement.*/

The "New Look"

The stage was beginning to be set for a major review of UNICEF programme policy. In November 1959 the General Assembly adopted a Declaration on the Rights of the Child which served to bring within a wider framework consideration by UNICEF of its own responsibilities.**/ By 1960, ten years had elapsed since the General Assembly had the established new terms of reference of UNICEF and much of the approahh of the Fund since then had been developed on a pragmatic basis. There was no disagreement in the Board that the results

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*/ Report of UNICEF Executive Board, March 1959 session, E/ICEF/380, paras. 26-30; Report of Executive Board, September 1959 session, E/ICEF/391/Rev. 1, paras. 181-183.

**/ General Assembly Resolution 1386 (XIV); See Report of UNICEF Executive Board, March 1960 session, E/ICEF/398, paragraph 40.

had been good. However, there was one group of Board members which wished UNICEF to assume leadership on new initiatives for the benefit of children, and another group which believed that UNICEF should concentrate on its traditional activities and not disperse it limited funds in new fields. In order to have a basis for reviewing guide-lines for UNICEF's programme policy, the Board authorized the Executive Director to undertake a survey of children's needs, in co-operation with beneficiary countries and co-operating technical agencies in the United Nations family.

The decisions made by the UNICEF Executive Board in June 1961, after reviewing the survey of children's needs, had the effect of considerably broadening the scope and increasing the flexibility of UNICEF's approach to children's problems, whilst at the same time continuing to support the traditional programmes which had proved effective in helping countries. This was made possible because of a change in financial procedures which allowed UNICEF to expand its aid at a more rapid rate than its income for a period of several years.*/

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*/ The was made possible by taking into account prospective resources as well as resources in hand, by allocations to projects only for expenditures required for the next twelve month period, and by reducing the working capital to a level only sufficient to finance current operations. See Report of the UNICEF Executive Board, June 1961 session, E/ICEF/431, paras. 165-170.

The study of children's needs revealed that no one fixed pattern of aid was universally applicable. Many developing countries placed a high priority on some needs of children not hitherto covered by UNICEF aid. The Board recognized that each government must devise its own priorities and strategy in meeting the needs of its children. It decided to consider requests for aid relating to whatever problems of children and youth were agreed to be the most important and the most ripe for action in a given country, whether or not they fell within a field of aid previously eligible for UNICEF aid. This meant that UNICEF's aid would no longer be restricted to a set pattern of activities, most of which were concerned with the physical needs of children, but now could also be available to help with those intellectual vocational social and emotional needs of children which governments considered to warrant high priority and for which opportunities existed for effective action programmes.

In order to determine priorities and to devise programmes each government needed to engage in planning. As part of the planning process, assessments of children's needs and the resources available to meet those needs were required and the UNICEF Board agreed to help finance such assessments when necessary. It was hoped that this process would be an integral part of, or closely related to, overall economic and social development planning, and in any event, even if there was not yet such overall planning in a country it would lead to better co-ordination of efforts made on behalf of the younger generation. It would help governments decide on the kind of aid it would find useful from outside sources, including UNICEF.*/

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*/ See Report of the UNICEF Executive Board, June 1961 session, E/ICEF/451, paras. 15-31, 49-71.

There was general agreement in the Board that despite the "new look" UNICEF support for health and nutrition would continue to receive major emphasis and that aid for new fields would be undertaken gradually and only as resources were available.

The June 1961 decisions*/, referred to as the "new look" in UNICEF parlance, ~~[illegible]~~ marked the beginning of what might be called a third stage in UNICEF's approach toward aid. In the first stage emphasis was on meeting emergency post-war needs; in the second stage attention was shifted to long-term projects in the developing countries; in the third stage an evolution began from what might be called "a project" approach, under which UNICEF offered aid to certain well-defined fields, mostly to achieve a single purpose, to a more comprehensive multi-purpose programme or even a "country" approach for the benefit of children, which could be fitted in more logically and effectively than single projects into overall national development programmes.

Relation to national development planning

In earlier years it had often been left to international agencies to make major decisions as to priorities. However, developing countries in the light of their limitations of budget and personnel, were tending more and more to establish long-term planning machinery in order to make the best use of available resources for economic and social development and to establish priorities among the many needs. In most of the plans, however, no special emphasis had been placed on the particular needs of children and youth.

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*/ Other actions to broaden the scope of UNICEF aid taken at the June 1961 Board session are discussed in paragraphs _____ and _____.

In December 1961 the General Assembly had designated the decade of the 1960's as the "United Nations Development Decade" and had invited the organizations in the United Nations family to consider the intensification of action in the fields of economic and social development. In view of the evolution in UNICEF over the previous several years this invitation could hardly have been better timed.

The spread of national development planning and the greater flow of external aid to countries to promote economic and social progress had served to broaden considerably the context in which UNICEF might deploy its aid with maximum effect for children and youth. The emphasis in the Development Decade on the potential of human resources in national development was closely related to the trend of UNICEF thinking about helping meet more than the physical needs of the child, and the shift from a sole interest in the individual project to a wider concern with the ways in which UNICEF might contribute to over-all improvement of the condition of children in a given country. As the only United Nations body concerned exclusively with the needs of children the Board believed that UNICEF had certain responsibilities in addition to assisting country projects.*/

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*/ The Board in June 1961 had agreed that one of these responsibilities was to help countries assess the needs of their children. See paragraph _____.

It was with this background that the UNICEF Executive Board in June 1962 considered what might beddone within the framework of national development plans to prepare children and young people to contribute effectively to self-sustained economic growth and social progress in their country.

The Board was encouraged by the general circumstances in which it would be able to deploy its resources for the benefit of children add youth during the course of the next decade. The developing countries were increasing their own expenditures for economic and social programmes and there were good prospects for a considerable expansion in the flow of international resources to help them. The Board believed that although raising the productivity add income level of the population constituted the over-all goal of development planning, economic progress alone did not automatically ensure that children and youth would be protected from the major ills which afflicted them, or from the additional problems resulting from rapid social change or that they would be adequatley prepared as adults to carry on and their nationdd development process. This could not be achieved unless there was a deliberate and systematic considemation of children's needs in the regular work of ministries, such as those of health education, agriculturalin relation to nutrition) social welfare, community development, housing, and labour. But since many needs cut across the boundaries of ministries add professions, planning by ministry or function - the basic procedure in development planning - required supplementation in each country by arrangements for a regular review of the effects of the total national effort on the development of the child from infancy to maturity. Moreover since in many countries there were a number of independent services affecting the child, both governmental and private, some process for a horizontal look across sectors was necessary to avoid gaps

and ensure the most effective mobilization of resources. While there was no need for a separate sector for children in national development plans it was important for each country to formulate a national policy for its children. This would permit it to make a fuller use of its own resources as well as a better application of external aid, including UNICEF aid, to the needs and potential of children and youth.

The Executive Board realized that internationally, as well as nationally, a wide circle of collaboration and harmonization was necessary; the work to be done internationally on behalf of children and youth went far beyond the efforts which UNICEF alone could make. If real progress was to be made, the importance of preparing the coming generation to play a constructive role in a developing society needed to be accepted as a major long-term goal of general development, not only by the developing countries, but by the many sources of external aid. This applied not only to the agencies in the United Nations system but also to multinational and bilateral sources of aid, from which a vastly greater volume of aid was being given for economic and social development than was being provided through United Nations channels. The Board agreed that UNICEF should take the initiative in developing closer relations with the regional economic commissions, the regional development institutes, and multilateral, bilateral, and non-governmental sources of international aid with respect to their policies and activities affecting children and youth and that it should make an appropriate contribution to the training of officials responsible for aspects of planning relating to children and youth. The Board adopted

a Declaration of a Long-term Policy for Children in Relation to the Development Decade incorporating its views about adequately preparing children for life and the importance of this in ensuring the human resources necessary for attainment of the goals of the Development Decade.*/

The UNICEF Board at its June 1962 session also approved some general guide-lines for the orientation of assistance policies designed to give greater encouragement to a regular consideration of the needs of children and youth as part of over-all national planning and of regular departmental operations. This included undertaking longer-term commitments say for a period of five years, for some projects which formed part of a country's development plan. Without excluding valuable smaller projects with a growth potential more projects should be encouraged which were so comprehensive in nature, strategic in their impact and so related to the general development problems of the country as to command attention at the policy-making or cabinet level of the country concerned. Projects should also be encouraged which would provide operational and leadership experience to national personnel; such projects would usually be larger than the usual pilot or demonstration projects which provided experience with technical methods. UNICEF should also be alert to the possibilities for aid to nuture the beginnings of a project until it became important enough for bilateral aid on a national scale; and to extend the scope of a bilaterally-aided project by aiding it with aspects relating to children.**/

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*/ See Report of the Executive Board session, June 1962 E/ICEF/454/Rev.1 paras. 41-31.

**/ Ibid. paras. 32-34.

To stimulate interest in the place of children and youth in the planning of national development and to provide a concrete framework for national action the Executive Board in January 1964 approved the holding of three conferences. One of these, held in co-operation with the United Nations Department of Economic and Social Affairs and the specialized agencies in Bellagio, Italy in April 1964, brought together a small group of ministers and economists directly engaged in planning for national development, and authorities concerned more directly in their own disciplines with the specific needs of children. Theoother two are regional conferences, one to be held in Asia in September 1965 and the other in Latin America in December 1965. It is hoped that both of these regional conferences will examine particularly those problems which require solutions through inter-ministerial co-operations as well as specific ways to improve methods for formulating and carrying out plans. In addition it is expected that the conferences will bring out specific and practical ways in which it would be appropriate for UNICEF to co-operate with governments in this general field.

The scope of UNICEF aid

At its session in June 1964 the Board engaged in an extensive discussion of how far UNICEF aid could be extended without losing its focus on children. This discussion had been brought about at the request of some Board members who had become concerned that with the possibility that UNICEF might digress from its central function of direct response to the needs of children.*/ They felt that primary attention should be given to

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*/ Specific questions had been raised about forms of aid included in certain health and nutrition projects. See paragraphs _____.

programmes directly related to the key problems of children and care should not be taken to spread UNICEF aid too thinly in fields of marginal benefit. UNICEF should not dissipate its resources in an attempt to meet all the needs of children but rather should concentrate on helping meet a few major needs as effectively as possible. Some clear limits needed to be set to the scope of UNICEF action, and it was important that programmes aided by UNICEF should be distinguished from programmes directed to economic and social development in general, from which children, of course, would benefit as well as adults. There was an increasing complexity of co-ordination between agencies within the United Nations family as each expanded its activities into areas in which the others operated. Further, so far as UNICEF was concerned, there was a need to preserve its image with donor governments and private contributors as an agency directing its limited resources to the basic needs of children.

A major question about which some Board members were concerned was whether projects of benefit to the whole community could be justified as appropriate for UNICEF support. The Executive Director reaffirmed his view that community problems without special significance for children should not find a place in the UNICEF programme. Children had special needs which required help from UNICEF; at the same time it was also clear that

many of the problems of children could only be solved within the context of the family and the community.*/ However, projects to be aided by UNICEF needed to be evaluated primarily from the point of view of their benefits to children.

A number of representatives stressed the necessity for flexibility and adaptability in programme policy, rather than an approach which would be rigidly defined. They believed that by basing its aid upon the priorities established by the requesting governments as made possible by the June 1961 session, taking into account the possibilities for effective action and aid available from other sources, UNICEF was able to avoid any dispersion of its resources in each aided country. It was essential to take advantage of opportunities which presented themselves at particular times in particular countries when certain types of aid would be welcome and could be usefully absolved. These opportunities should be seized by UNICEF as long as they constituted a concrete step in helping children, whether they were confined in their application directly to children or whether they affected a whole community but improved the condition of children indirectly but with unquestioned effect. The issue should be viewed in terms of the gravity of the problem for the child; if the problem affected him seriously then it should be given priority even if the rest of the community also benefited. At the same time it

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*/ The Declaration on Long-Term Policy for Children in Relation to the Development Decade which was adopted by the Board in June 1962 (see paragraph ____) stated that "...help for children and young people cannot be regarded as an isolated field of work; it must be related to the improvement of conditions in the family, the community and the nation." (E/ICEF/454/Rev. 1 para. 12)

was always necessary to view the project in the wider context of strengthening permanent services of benefit to children and making the child and object of central government policies and concern.

Between the views of the Board members summarized in the preceding paragraph and those in paragraph___were a group of members who took a middle position considering that UNICEF's aid should not be too narrowly concentrated on the immediate alleviation of children's problems nor too broadly focused on the total environment.

There was a general agreement at the conclusion of the UNICEF Board debate that while the task of putting UNICEF's limited resources to most effective use was a difficult one, on the whole the main line of approach was correct and that a great deal had been accomplished owing to the judicious use of the limited funds available. The action taken by the Executive Board at its June 1961 session is broadening the scope of UNICEF aid was generally endorsed, and there was a feeling that sufficient time had not yet elapsed to allow for a critical review of the results.*/

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*/ Report of the Executive Board session, January 1964, E/ICEF/492, paras. 52-73.

MATERNAL AND CHILD HEALTH AND BASIC HEALTH SERVICES*/

The period through 1950

UNICEF aid in the field of maternal and child health began in 1948 with short-term group refresher courses in Europe for doctors, public health workers, nurses, and other professional workers to make up for their professional isolation during the war years, and in Asia with some post-graduate fellowships for study abroad pending the working out of projects.**/

The first UNICEF supplies and equipment for maternal and child health were given to European countries as part of the provision of medical supplies to these countries as soon as it became apparent that the emergency feeding programmes were on their way to becoming well established. Since many of the European countries already had fairly well developed maternal and child health services, the aid was used for specialized purposes - x-ray equipment, orthopaedic supplies, incubators for premature infants, supplies for school health programmes, production equipment for immunization, etc. In some cases, however, vehicles to extend services to rural areas and equipment for rural health centres were also provided.

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*/ See note on UNICEF programme terminology, Annex .

**/ In Europe the courses, which were taken by some 900 professional workers during the period 1948-1950, were given in France, Sweden, Switzerland, and the United Kingdom as part of their contribution to UNICEF. The International Children's Centre, which was established in 1950 with support from UNICEF, arose out of the experience with the training courses in France. The fellowships in Asia, which included other health fields as well as MCH, were originally intended to be closely related to UNICEF-aided projects; however, because of the time it took to work out the projects, only about half of the some 150 fellows trained worked on UNICEF-assisted projects after their return from study abroad. Most of the others, however, worked in government services or universities in activities related to the health and welfare of mothers and children.

A start was also made in Asia and the Americas, mainly in the form of supplies for MCH centres and the training of auxiliary health workers. By the end of 1951 virtually all of the assisted countries in Asia and half of the assisted countries in the Americas were receiving aid with MCH projects. From the inception of UNICEF to the end of 1951, 7 per cent of all UNICEF aid went to MCH work, amounting to the not inconsiderable sum of $3.7 million. Of this amount 44 per cent went to Asia and 7 per cent to the Americas.

The early pattern

Unlike the supplementary feeding programmes and mass disease campaigns which had relatively limited and specific objectives and which were, to a degree, self-liquidating, maternal and child health had permanent and developing aspects. Maternal and child health, moreover, bore a close relationship to the ultimate effectiveness of the mass disease campaigns*/ in which the governments and UNICEF were investing at a considerably larger scale. The numbers to be reached were very large since in developing countries about one-fifth of the population is under five years of age and two-fifths under fifteen years of age; mothers and children together make up over two-thirds of the population. Disease and death have their highest toll among this vulnerable group, largely from preventable causes.

In 1948 when the WHO first came into being, maternal and child health was one of the four subjects selected for priority of attention. The WHO Expert Committee on Maternal and Child Health which held its first session in January 1949 recommended that UNICEF provide supplies and equipment to be used for a

*/ For a discussion of this relationship see paragraphs ____.

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wide range of services which would include "maternal, infant, pre-school, and school health, dental and immunization services, services for handicapped children, child guidance clinics, maternity and children's hospitals, schemes for the care of premature babies, and for the training of personnel";-such provision to be undertaken on the recommendation of WHO maternal and child health specialists after discussion with the countries requesting the aid.*/ The Expert Committee's recommendations were subsequently approved by the UNICEF/WHO Joint Committee on Health Policy and the UNICEF Board.

No technical guide-lines for this aid were recommended by the Expert Committee**/ or by the UNICEF/WHO Joint Committee on Health Policy, and no general policy regarding maternal and child health was adopted by the Board. Provided that the general UNICEF criteria were met***/ each project was judged on its own merits, and policy emerged gradually as a result of decisions on a number of cases - decisions taken in the field by the governments in consultation with UNICEF field staff and WHO experts, by the Executive Director in

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*/ Official Records of the World Health Organization, No. 19, pages 34-35.

**/ The Expert Committee stated that the objective of WHO should be the development of a demand for improved services while at the same time demonstrating the optimum pattern of services in the particular environment. It emphasized the importance of training and recommended that there be established in national health departments an administrative united for MCH under the direction of a well-qualified and experienced full-time MCH administrator.

***/ See paragraphs _____.

/...

his decisions as to which projects to bring forward to the Board for approval, by WHO in its technical approval of individual projects and by the Board when it indicated its preference as it discussed individual projects.

The pattern actually set was considerably narrower than the wide scope authorized by the Board as a result of the WHO Expert Committee's recommendations. Emphasis had to be on what was feasible in the light of the limiting factors of relatively small and most urgent budgets, few skilled staff, and often ineffective use of the money the and staff which were available.

The immediate interest in most places was on an extension as rapidly as possible of simple practical measures aimed at producing concrete results soon where the need was greatest. In practice this meant an emphasis on work in rural areas where eighty per cent of the mothers and children lived and where because there had been less central government interest, less money and fewer doctors and nurses, medical facilities were usually far more rudimentary than in the cities. In many rural areas the only services available were a few MCH centres in the larger towns, usually run by voluntary agencies, and a few maternity homes. The majority of births were attended by untrained traditional birth attendants.

Under these circumstances the first MCH assistance was often for the improvement of the existing isolated centres and the starting of training for the traditional birth attendants and other MCH auxiliary workers. This was followed by the extension of simple MCH services - much of it maternity care -

to new areas as soon as personnel was trained. There had been a successful experience in China with UNICEF aid in 1948 and 1949 in providing cheap and effective "on-the-ground" training for village people who had little schooling in practical MCH auxiliary services - safe normal deliveries, simple sanitation, ordinary vaccinations - and UNICEF wished to encourage this elsewhere on a large scale. It was clear that short-course training for these people could proceed at a much faster pace than training for the more highly skilled workers such as nurses, midwives, and health visitors who would later act as supervisors for auxiliary workers as well as provide direct services. The traditional birth attendants who were self-employed could be trained even in advance of the opening of any centres.*/

Conditions, of course, varied among the countries and in some, because of higher educational levels, more health workers and a better health organization, as well as historical and political factors, it was possible at the very outset to place greater initial emphasis on improving quality of service as well as extending coverage. This included more attention at an early stage to the training of professional as well as auxiliary workers, and to developing supporting services for the individual centres.

In these early years WHO was interested in helping countries to organize in select areas demonstration and training projects for which UNICEF in a number of instances contributed equipment and supplies. With their national counterparts, WHO personnel assigned to these projects aimed at demonstrating modern methods and training local staff in the necessary techniques.

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*/ It was because of this need that the UNICEF Board in 1952 departed from its previous policy and agreed on stipends in local currency, limited, however, to the training of auxiliary health workers. See paragraphs _____.

/...

The most important result of these projects was that they provided large numbers of trained health workers; but some of them became the starting points of more comprehensive local health services, and others led the people to appreciate health services or introduced preventive medicine to the area. Their main weakness appears to have been that they sometimes followed too closely practices appropriate to more developed countries and that their staffs and equipment were sometimes too elaborate to be copied by the national administration.*/

The interest of countries for aid from UNICEF for maternal and child health services grew despite the fact that over half of UNICEF aid was going into mass disease campaigns. In 1951 aid for MCH constituted 12 per cent of all UNICEF aid; in 1952, 22 per cent; and by 1953 it had risen to over 30 per cent. Aid for maternal and child health averaged about $2.25 million annually during this period By the end of 1953 it was being given to 42 countries for which aid had been approved for 5,700 centres.**/

In 1953 the WHO Secretariat presented to the UNICEF Executive Board a progress report on maternal and child health programmes jointly aided by the two agencies, particularly for 15 demonstration and training programmes for which WHO had provided about 80 international staff members*/. Encouraged by UNICEF and WHO

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*/ The First Ten Years of the World Health Organization, WHO, 1958, page 356. See also paragraph _____ below.

*/ About 4,000 of these were in Asia. Of the 42 countries aided by UNICEF, 16 were in Asia; 12 in Latin America; 9 in the Eastern Mediterranean; and 5 in Europe. No aid in this field had yet started in Africa. The scope which UNICEF aid had reached by this time is illustrated by the following summary of aid approved by the Board at its October 1952 session:

> "the amount...(allocated)...includes provision for sets of simple equipment for more than 1,100 rural maternal and child health centres (generally costing a little over $300 per set), and sets of drugs, milk, fish-liver oil capsuls and soap (ranging in cost between $500 and $800 per centre) to go over 1,700 centres. Also included is provision for 6,000 simplified midwifery kits to be used by traditional midwives after training; equipment for 26 midwifery training centres, 15 schools of nursing, and 10 schools for assistant midwives; technical equipment for maternity and children's wards in provincial hospitals and teaching hospitals, and transport to aid in the establishment and supervision of sub-units of maternal and child health centres and in the field practice of students. For four countries limited sums are provided for stipends in local currency for midwife trainees..."
>
> (E/ICEF/212, para. 15)

aid, the report found that many of the countries had established Divisions of Maternal and Child Welfare as part of their general health administration. This augured well for the future even though the Divisions generally had not yet had a chance to become effective. Many of the centres were overwhelmed with treatment leaving no time for preventive work with mothers and children. Where programmes were weak or slow in getting started it was due to insufficient direction and supervision in both the administrative and technical aspects, including inadequate control over the quality of training and the performance of staff. The main obstacle to expansion was lack of operating personnel. Not only were greatly expanded budgets and facilities for training and re-training needed, but also incentives for professional staff to work in rural areas. A fundamental shortcoming was lack of home visiting, particularly in rural areas where fewer mothers could get to the centres. Although village midwives helped with births there was a glaring need for pre-natal service. More attention needed to be given to nutrition work as an essential part of maternal and child health services. School health programmes needed more emphasis. It was clear that little practical progress could be made in health education until it was supported by environmental sanitation activities in the community.

The report pointed out that the demonstration and training projects had not been used extensively as a means of incorporating more maternal and child health training into the education of medical students. More of this was required in the future together with the improvement of paediatric teaching centres, which needed to be more closely related to measures for preventive health work.

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In its conclusion the WHO report pointed out that while many governments were making great efforts to increase their maternal and child health services, there was, however, a limit to the pace at which the programmes could move forward. International aid needed to be carefully timed to avoid pushing plans beyond the possibility of the governments to provide the necessary staff and supporting services for effective implementation.

Criteria for aid to health centres

With accumulating experience certain criteria for aid to health centres came to be developed, and were progressively included in the project recommendations placed before the Board.

Equipment for health centres was classified according to their staffing. Centres with less well qualified staff received simpler types of equipment than those with higher-level personnel. Centres to which doctors were permanently assigned were eligible for additional equipment, including diagnostic instruments, and even instruments for simple surgery if the centre were properly equipped. Midwives and nurses in centres without doctors, but which received regular supervisory visits from doctors, were eligible for certain additional equipment. Public health nurse/midwives who conducted clinics daily at different centres received certain portable equipment to help them in their work. All centres were required to have adequate premises before equipment was issued to them.

Midwifery kits were graded in three standards, and issued to all centres according to the qualifications of the midwives attached to them. Bicycles were provided for home visiting and domiciliary midwifery.

Criteria for issue of drugs and diet supplements were similarly refined. Although the principles were established that UNICEF provisions of drugs and diet supplements were to supplement and not replace provisions by the governments, and that responsibility was progressively to be taken over by the government, in fact in many cases UNICEF supplies have remained the only supplies available to the centres. Where governments provided some supplies, these usually consisted of items like alcohol and aspirin, which were in any case not included on UNICEF lists. In a few countries, comparatively ample provisions were made by the governments, but often in the form of cash grants from which the centres' personnel had to arrange purchase themselves, frequently at market prices or little less, which drastically reduced the quantities available.

In practice, therefore, the issue of UNICEF drugs and diet supplements came to be an increasingly important feature of health centres' work. With these supplies at their disposal, midwives and nurses could give mothers concrete assistance, which provided strong incentive for the mothers to return and become regular clients. Without supplies, the personnel had little more than advice to give, which the mothers could rarely follow.*/ Thus in many cases, it could be said that the drugs and diet supplements provided by UNICEF make the difference of whether or not the health centre has clients.

This experience resulted in the establishment of various criteria: UNICEF would provide only selected drugs and diet supplements valuable particularly for pregnant women, nursing mothers, infants, and young children; these would be of

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*/ One WHO regional advisor put it: "It's no use telling a pregant woman who has to help her husband in the fields, take care of several children, cook the meals, wash the clothes, and clean the house, that she should have bed rest."

basic types (no special or proprietary drugs); where countries themselves produced certain types, or had other sources for obtaining them; they were eliminated from the UNICEF provisions. A reporting system was introduced to ensure as far as possible that each centre got as much as it needed for its clientele, but no more (replenishments issued against receipt of consumption reports).

Safeguards were set up in the field for the issue both of equipment and of drugs and diet supplements. Questionnaires were required to be filled in, and reporting systems devised, by which it could be judged whether a centre was well enough patronized to be making adequate use of its equipment and supplies. As the programmes developed, the same reports could be used to judge whether a centre had been up-graded sufficiently to qualify for more and better equipment and supplies.

In many countries, the reporting systems instituted in the early days for control of UNICEF equipment and supplies have become incorporated into the governments' normal procedure, and have become a chief source of basic information for the ministries concerned. From them it has been possible, for instance, to gauge increases in toddler attendance at health centres, to select midwives requiring refresher-training, to select areas in which to post supervisory nurse/midwives, etc.

In the matter of transport UNICEF provides bicycles (in some cases motorized bicycles and scooters where practical) for domiciliary midwifery and home visiting and field workers in environmental sanitation. Cars are provided for supervisory purposes and to enable physicians, public health nurses and midwives to visit sub-centres to hold clinics. Vehicles are also provided to transport trainees to and from field practice areas.

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Criteria for hospital aid

Supplies and equipment for hospitals had been provided by UNICEF in the early years in a number of instances, but by 1953 it had become clear that guide-lines were needed to assure that this aid was given in the context of preventive health measures. UNICEF was reluctant to become involved in encouraging hospital construction which would constitute a heavy financial burden on the country for purely curative activities and might endanger the scope of public health activities and preventive services.

The JCHP recommended guiding principles*/ which were adopted by the Board. These principles, subsequently given detailed interpretation by UNICEF and the WHO staff restricted aid to maternity and children's hospitals and maternity and children's services in general hospitals. Priority was accorded for aid to training hospitals where the training of staff who work with mothers and children, especially in public health work, was an integral part of the hospitals' activity. Since almost all hospitals do some training it was necessary to be sure that the training programme helped was really a serious one. Aid could also be given to service hospitals when they were used as referral centres for health centres.**/ Provision of teaching aids and technical equipment were accorded the highest priority but non-technical equipment (such as beds, and laundry equipment) could be provided when it was clear that the government could not otherwise obtain it.

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*/ E/ICEF/288, paras. 23-28.

**/ A referral hospital normally serves from two to five health centres, which refer to it such patients as require more skillful medical treatment, either on an in-patient or out-patient basis.

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ENVIRONMENTAL SANITATION IS ADDED

In most developing countries infantile diarrheas, dysenteries, and other diseases related to unhygienic conditions constitute a principle cause of infantile mortality. Among young children diarrheas and parasitic infestations are an important cause of sickness. Moreover, other diseases, such as trachoma, are often associated with poor hygiene. It was clear that the control of these diseases required improved environmental sanitation, and by 1953 a number of countries were requesting that UNICEF provide aid for environmental sanitation.

In 1953 the Executive Board, upon recommendation of the UNICEF/WHO Joint Committee on Health Policy, agreed that UNICEF should provide aid for two of the key elements in environmental sanitation, namely the provision of safe water and the satisfactory disposal of excreta. Technical criteria were established by the JCHP which were subsequently given a more detailed interpretation by agreement of the secretariats of WHO and UNICEF to include the following conditions for aid to projects: priority would be given to environmental sanitation associated with MCH projects which UNICEF was assisting, but other environmental sanitation projects could be helped if they were part of a plan for the general development of health services in a region, or were considered a step in that direction; the projects should include as essential elements the provision of safe water and excreta disposal, health education of the public and community participation; the projects should not be merely a demonstration but should be planned from the outset to be progressively extended, and should include provision for training of sufficient personnel to make the expansion

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possible; the projects should be planned, supervised, and carried out by an adequate staff, including publich health officers, sanitary engineers, and sanitary inspectors; and aid to expensive programmes of water supply and sewage disposal of large towns and cities would be excluded.*/

By 1959 UNICEF had allocated almost $2 million for aid with environmental sanitation to 27 countries. Most of these were in the Americas (18 countries) where there had been considerable emphasis on integrated health services. In 1959 a progress report was prepared by the WHO Secretariat on the basis of which the UNICEF/WHO Joint Committee on Health Policy recommended revised criteria to guide future aid in this field. These criteria, which were accepted by the UNICEF Board, for the most part confirmed the main lines established in 1953 but with a few changes in emphasis.**/ Instead of favouring aid for sanitation projects which were part of UNICEF-aided MCH programmes, more emphasis was placed on aid for environmental sanitation integrated with general health services (including MCH activities with which, it was felt, sanitation schemes should be closely co-ordinated). Emphasis was also placed on UNICEF aid for training more sanitarians (including supervisory staff) as well as more training of other health personnel in the techniques of health education; more aid for improving sanitation in schools, health centres, and community centres; and more aid to permit a greater volume of safe water, and easier access to water, by providing more fountains and standpipes at public places in villages and small towns. Although the policy continued of assuring that both safe water and

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*/ E/ICEF/228, paras, 19-22; E/ICEF/243, paras. 38-40; JC12/UNICEF-WHO/4.

**/ E/ICEF/398, paras. 70-75.

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and excreta control were part of every scheme, UNICEF aid need only be given for one of these elements. The UNICEF policy of not aiding large scale public works for supplying water or piping water to houses was re-affirmed; UNICEF aid would continue to be concentrated on rural areas and smaller communities. At the same time there was a recognition that urban fringe areas had urgent sanitation problems and the way was left open for the UNICEF to present pilot projects to the Board for solving these problems if it could be done without entering into the field of public works. It was understood that UNICEF would not aid projects for which other sources of financing, such as long-term bank loans and bilateral aid were available.

Sharpening the objectives

Emphasis on quality and comprehensive services

The extension of services to new areas in countries which had not yet developed national coverage, rather than the elaboration of services in areas already covered, continued to be the main emphasis of UNICEF. The goal as stated by the Board in 1955 was to assure at least elementary services as widely as possible, at the same time planning of the development of supervision and training of personnel to raise standards.*/

It became increasingly clear, however, that even the expansion of a simple maternal and child health programme consisting of little more than midwifery services together with some health education and a few elementary public health services (such as vaccinations) and here and there some environmental sanitation,

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*/ E/ICEF/294, para. 40.

would necessarily be slow in many places. Considerable progress had been made, but now, however, more and more areas were being reached where the building of new centres, the training of staff to man them, and the financing of staff on an unaccustomed and continuing level, involving a large measure of local financing, was more difficult. Moreover, there was competition from other types of health programmes making insistent demands on the limited funds available for health. The point was being reached where the immediate objective needed to go beyond that of helping a large number of individual centres; a number of countries were already at a more advanced stage in their health organization, and greater emphasis needed to be placed on improving the quality of the services. A comprehensive programme ideally would comprise the full range of activities relating to the health of mothers and children, including prenatal and maternity care, care of the infant and pre-school child, school health, nutrition and educational activities, control of communicable diseases (through immunization and other means) and environmental sanitation.

Integration with basic health services

The WHO Expert Committee on Maternal and Child Health held its second session in 1955 reviewing the situation in the light of the unprecedented expansion of MCH activities since its first session in 1949. The Committee pointed out that all measures which improve the general public health will benefit mothers and children. But unlike other segments of the population mothers and children were exposed to the processes of reproduction and growth and development. Consequently public health programmes needed to include measures directed to these special needs. At the same time MCH services contributed to general public health

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because of the unique opportunities offered for health education, the prevention of illness, and the promotion of health. The popular and emotional appeal of a service for mothers and children made a particularly effective starting point for developing a later demand for a comprehensive health service. The Committee recommended that the main long-term objective should be integration of MCH with general health services while at the same time safeguarding that the special needs of mothers and children would be met.*/

In many places, however, MCH had moved ahead and there was, in effect, little in the way of general health services with which to integrate. An important new task was to assist governments to fill the void around these MCH centres so that services would be available not only to mothers and children, but in order to be really constructive also available for the members of the community of which they were a part. In some places, on the other hand, both MCH and health services existed. However, to a great extent they operated independently creating a situation which was both uneconomical and less effective than an integrated service.

Pattern of organization

It was apparent that health services should not be allowed to grow up ad hoc in a haphazard manner and that a short-term plan of say two to five years was needed in each country with definite targets within the broader outlines of a long-range plan. The new thinking about an organizational pattern which involves national, intermediate, and local public health administrative units was reflected in the Board's report on its session in March 1956 which stated:

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*/ World Health Organization, Technical Report Services, No. 115.

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"the organization of basic maternal and child welfare services necessarily varies from country to country. In general, however, UNICEF aid is now being increasingly directed toward establishing networks of village centres technically supported and supervised by intermediate health centres which, in turn, are under the overall direction of a district health centre and hospital. The primary emphasis is still on the village centre but UNICEF aid is also required at the intermediate and higher levels to ensure adequate training facilities, and supervision of the subordinate village centres."

(E/ICEF/316, para. 59)

Supervision

In order to effect the more rapid extension of services to the rural areas, large numbers of auxiliary workers had been employed who had only short preparation, consisting mainly in learning techniques rather than principles. It was clear that greater attention needed to be paid to the amount and quality of supervision. This meant greater emphasis on the training of professionals, capable of giving leadership to the programmes, not only at the national level but at all levels, and of giving technical guidance, stimulation, and encouragement to auxiliary workers.

Preventive services

It was becoming clear also that MCH needed to keep prevention as its principle responsibility. It was, of course, often impossible to make clear distinctions between preventive and curative services, and where illness was rampant and medical care facilities inadequate, it would be unwise to exclude treatment in MCH clinics. But attention needed to be given not only to the immediate illness for which advice was sought but mainly to the general health of the mother and child, the prevention of further illness, and the attainment of good health. By treating the disease, confidence was often established and co-operation secured for continuing preventive health supervision.

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Training in paediatrics and medicine

In 1959 in order to help meet the shortage of top-level supervision the UNICEF Board approved in principle for grants-in-aid to selected schools of medicine or public health, for periods of up to five years, to help them organize or strengthen the teaching of paediatrics (especially social paediatrics) and preventive medicine at both the undergraduate and graduate levels. The aid could help create a chain of paediatrics of preventive medicine through salary grants for the professor; the training of future professors through grants for the salary of assistants to the professor; equipment for the teaching hospital and urban and rural demonstration centres used by the school; stipends for one-year graduate training in paediatrics and preventive medicine for medical officers serving in the health services; and stipends for medical officers taking refresher courses.*/

Immunization and vaccine production

From the very outset the objective had been to encourage immunization against common childhood diseases (such as smallpox, diphtheria, pertussis, measles, tetanus, typhoid and paratyphoid) as a regular function of local health centres. UNICEF provided imported sera and vaccines. As time went on in a number of instances where the required technical facilities could be made available in a country UNICEF began providing aid to governments to produce their own sera and vaccines, thus ensuring for themselves a permanent supply for the progressive expansion of immunization activities. (This section to be expanded and completed in the light of the June 1965 Executive Board's discussion of the JCHP's recommendation on immunization programmes.)

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*/ E/ICEF/344/Rev. 1, paras. 27-31. Because of the shortage of specially trained teachers in paediatrics, UNICEF in recent years has financed several inter-regional courses to meet this specific need.

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School health

As MCH work progressed there was a growing interest in school health activities. Progress had been made in some countries particularly where school health was a direct responsibility of the MCH unit in the Ministry of Health or closely connected to it. In urban areas school health services, where they existed, were often administered independently. However with the move for integration there was a trend to include them in MCH projects receiving UNICEF aid.

Nevertheless when the WHO study was made in 1957 it was found that school health coverage was limited and progress was slow. The study pointed out medical inspections without the possibilities for follow-up and corrective services were of little value. On the other hand the schools by providing opportunities for children to experience living in a healthful environment, with practical education centred around the common health problems of the area, could break the chain whereby ignorance concerning health was passed from one generation to the next.

The study pointed out that the most important starting point for health authorities in developing a school health programme was the teacher and therefore health education in teacher training was important. Also important was the provision of sanitary environments for schools and teacher training institutions, the use of school feeding programmes and the development of school gardens for nutrition education. When MCH centres became well-established it was invisaged that they could assume responsibility for direct service to school age children as well as the younger age groups, but for the present this could not, practically, be an early goal.*/

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*/ See paragraphs ____ for a further discussion of school health and nutrition services.

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Specialized aspects

In the early days of UNICEF when medical supplies were made available to European countries a number of them received incubators and related equipment.*/ When UNICEF turned its main attention to developing areas no requests for this type of aid were brought forward.**/ since the care of premature infants, requiring specialized personnel and high per caput costs, was obviously less urgent in countries with only rudimentary health services and burdened with a high rate of endemic diseases.

Between 1951 and 1959, however, several requests were brought to the Board for aid to European countries***/ for demonstration and training centres in the care of premature babies. Although these requests were approved by the Board questions were raised about the costliness of such projects and WHO was requested to develop criteria on what constituted a good programme and prepare guide-lines as to a country's readiness to undertake it. The UNICEF/WHO Joint Committee on Health Policy considered this question in 1962 having before it the results of a study, which had been carried on for some time by WHO, and which had been reviewed by the WHO Expert Committee on Maternal and Child Health****/.

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*/ See paragraph _____.

**/ Except for the Philippines where aid was approved in 1954 for a programme in Manila.

***/ Austria, Poland, Spain, and Yugoslavia.

****/World Health Organization Technical Report Series, 1961, 217.

On the basis of the JCHP's recommendations the Board agreed on the general approach of UNICEF to aid to the care of infants of low-birth weight (premature infants) in the future. The key to saving the lives of small babies lay in prevention, including improved nutrition of the mother, prenatal care, and well-organized delivery services. UNICEF aid for these babies should be within the general framework of strengthened basic health services for mothers and children. As these services became established, simple measures for the care of small babies might be introduced. UNICEF aid would generally be in the form of simple equipment and aid for training. Elaborate equipment for specialized care requiring highly trained personnel would be given only to a teaching hospital with a well developed paediatrics or obstetrics department undertaking graduate and post-graduate training of physicians.

Aid to physically handicapped children

The same caution with which UNICEF has viewed aid for premature babies has influenced the Board's attitude toward special services for physically handicapped children which are relatively expensive and require highly professional staff. The major UNICEF contribution to the prevention of physical disability in children has been through its aid for long-term health programmes (including aid against disabling diseases such as yaws, leprosy, tuberculosis, and trachoma) as well as aid for nutrition programmes.

At the same time the UNICEF Executive Board has approved limited assistance to certain measures on behalf of handicapped children. A number of countries have begun to develop the core of technical services for the rehabilitation of the physically handicapped and UNICEF has given modest support to many of these.

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The UNICEF support is focussed on the support of training facilities in the country itself, for such basic skills as prosthesis and physiotherapy. In relation to training, UNICEF has also assisted a limited number of demonstration service facilities. UNICEF has also supported workshops for the local production of prosthetic appliances and for the production of Braille texts, as well as programmes for the vocational training of the handicapped. The projects which have been assisted have been addressed to common and relatively simple forms of disability, and can be alleviated through relatively simple and inexpensive measures, and which do not require technical skills which demand a sophisticated level of training. UNICEF has not assisted specialized services for those forms of physical disability which require advanced technical skills and very complex equipment which can be maintained only in a sophisticated institutional environment. For similar reasons UNICEF has considered it preferable to support out-patient services rather than residential institutions.

Main guidelines are established

A series of specific emphases required to move in the direction of improved quality of services were set down in 1957 when, at the request of the UNICEF/WHO Joint Committee on Health Policy, a comprehensive review was made by the WHO Secretariat of the status of jointly-assisted maternal and child health programmes*/. The main purpose of this report was stated as being not to "note progress and to count gains but to discover weaknesses and any aspects of the work which require strengthening."

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*/ E/ICEF/347.

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The report pointed out that while the major effort so far to extend at least rudimentary services into rural areas as rapidly as possible and to train staff, especially auxiliary workers, constituted substantial progress in many countries, coverage was still very unsatisfactory, and even in those countries where it is more extensive, there is great need to improve the quality of services. In most of the programmes the child over one year of age received very little attention.

Since it was not possible to attack all the lacks at once with equal emphasis, priorities needed to be established in terms of the local situation both in planning the programmes and in training staff. Assistance needed to be geared to the particular stage of development of a country, considering both the immediate and long-term goals and the economic capacity of the country to maintain new services. The report emphasized that increasingly, the programmes coming to UNICEF for aid should be of the type designed not only to meet immediate needs but to lay a sound basis for building comprehensive and continuous services.

From the standpoint of administrative structure, the WHO report pointed out that more encouragement and help should be offered to Governments by WHO and UNICEF for:

(a) Provision of qualified technical leadership and supervisory services effective at all levels;

(b) Integration of MCH services into general health services, at the same time ensuring that the special needs of mothers and children were met;

(c) Co-ordination of MCH services with community development, school health services, and with social welfare and other departments serving mothers and children.

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In terms of activities, the report made a number of specific suggestions designed to:

(a) Re-orient programmes away from concentration on midwifery to include emphasis on care of pregnant women and on child care, especially for the pre-school group. Continuing services from infancy through at least the second and third years constitute a goal for major immediate emphasis. In this connexion paediatric education for doctors and nurses need to be extended and improved, and more training in child care need to be incorporated in the preparation of midwives and auxiliary workers;

(b) Give emphasis to training of all categories (physicians, nurses, midwives, traditional birth attendants and other auxiliaries) and increased attention to professional training of teaching and supervisory personnel;*/

(c) Give more emphasis to child nutrition, including nutrition education of mothers, and the increased distribution of milk to priority groups in countries where protein malnutrition was prevalent;

(d) Use schools more effectively to carry on health education, including adequate training of teachers in health, and provision of sanitary school environments;

(e) Engage in pilot studies to improve the health of children living in urban slums.**/

The main problems as set forth in 1957 in the WHO report, and the emphases it recommended to improve the range and quality of MCH services have not changed substantially since that time. Another WHO report two years later stressed again the importance of integration of MCH in general health services, the importance of more and better supervision, the importance of training (including especially

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*/ The report pointed out that the weakness of many programmes was in part a reflection of the lack of paediatric and/or general public health training of national personnel.

**/ For a discussion of UNICEF aid to urban projects, see paras. _____.

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paediatric training, training in nutrition for health personnel and training midwives in child care), and need for immunization programmes to become a routine part of services for infants and young children.*/

On the other hand if progress was slow it was also usually steady; because of their roots in the local community, health services, unlike some other programmes, often remain relatively unharmed by political upheavals and problems at the central government level.

There has been a steady upward trend in UNICEF support for basic health services not only in absolute amounts but also relatively.**/ Nevertheless, it is clear that a great deal remains to be done not only qualitatively but in geographical coverage as well. For example, in 1962 the Executive Director pointed out to the Board that with few exceptions, UNICEF-aided countries had not yet succeeded in establishing adequate nation-wide coverage of even the simplest health services.***/

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*/ E/ICEF/398, paragraph 67.

**/ In the five-year period 1952 to 1956 the average annual UNICEF allocations amounted to $2.6 million, constituting 24 per cent of programme allocations. In the next five year period, 1957 to 1961, the average annual allocation was almost double, amounting to $5.18 million, constituting 28 per cent of all programme allocations. For the three year period 1962 to 1964 allocations for maternal and child health more than doubled again averaging about $10.8 million annually and constituting about 35 per cent of all programme allocations.

***/ E/ICEF/449/Add.1, paragraph 31. As another example of the time required to build up services, in one country in Asia which had received UNICEF aid for MCH for eleven years, even the simplest health services were still not reaching more than half the rural population.

Recent Board interests

In recent Board discussions of UNICEF aid for health service, interest has been displayed in preserving the identity of UNICEF's objectives in this field, in encouraging a clearer delineation of the relationship of maternal and child health to basic health services, and an approach which would not only be comprehensive from a health standpoint but from a wider point of view.

Some Board members while fully supporting the importance of integration, have cautioned against aid by UNICEF which did provide safeguards to assure that direct services to mothers and children would be retained in the process. They, therefore, tended to urge the assignment by WHO of more MCH advisers in the field, and to particular projects in which UNICEF invested considerable sums, whenever possible.

The relationship of maternal and child health to basic health services has been an important question over the years.*/ At the request of UNICEF it was dealt with at the UNICEF/WHO JCHP session held in March 1965 and discussed at the Executive Board in June 1965. (This paragraph is to be completed to reflect the discussion and conclusions on this subject at the June 1965 session.)

In line with general thinking in the Board on the best use of UNICEF aid**/ the view has been expressed that the most effective programmes are those which not only include MCH integrated with general health services but also provide co-ordination between such integrated services as agriculture, nutrition, social welfare and public works, or, as in certain community development programmes,

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*/ See paragraphs _____ above.

**/ See paragraphs _____.

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provide an integration of all of them into a single multi-purpose programme. The co-ordination of such multi-purpose programmes not only among government departments but between these departments and semi-official and private programmes was also felt to be desirable.

This interest for a more comprehensive approach fits in quite well with the increasing activities of WHO in national health planning and its desire to encourage this as part of broader economic and social planning.

When UNICEF was established in December 1946 its path of action was clear: as its first priority, it was to continue the work of UNRRA in aiding war-devastated countries, mainly in Europe, to carry on supplementary child-feeding programmes. But when in 1951 UNICEF shifted its main emphasis to the developing countries, the problem became more complicated. Every analysis of child needs emphasized the extent and serious consequences of malnutrition, which was a major cause of infant and child mortality and bore most heavily on the early stages of life - the pregnant woman, the nursing mother, the weanling child. It was obvious, however, from the moderate funds at the disposal of UNICEF, the enormous numbers of children involved, and the limited financial and distribution facilities of most governments, that mass supplementary child-feeding programmes such as had been conducted in Europe were not practical. With some doubts about the results, the Board agreed to provide milk for some demonstration school feeding programmes in Asia and Central America, with the hope that the initial stimulus would lead to workable programmes which could be expanded later.

An important new element, however, entered the picture in 1953 with the availability of U.S. surplus skim milk powder at a considerably reduced cost (2.5 cents per lb including freight).

In 1954 the cost of surplus skim milk was reduced to 1 cent, and in 1955 it became cost-free. UNICEF would be involved only in the payment of freight. There was general agreement in the Board regarding the value of continuing to assist demonstrations of supplementary feeding for infants and children, and the use of surplus foods for this purpose was considered appropriate.

In the meantime, the Board had noted differences in the nutritional objectives of supplementary feeding through MCH centres, and through schools. Stress was laid on the importance of nutrition in the crucial post-weaning and pre-school ages. Distribution through MCH centres made it possible, on a selective basis, to use milk powder as "medicine" to treat individual cases of malnutrition as part of the regular health activities. Criteria for the issue of milk through health centres gradually became refined. The issue of /Whole milk[1] was restricted entirely to infants under one year of age who could not be adequately breast-fed. Skim milk could be distributed, on the judgment of the doctor, nurse, or midwife in charge of the health centre, to any child or pregnant or nursing mother requiring it.

Although school feeding was recognized as a convenient and generally economical means for governments to reach comparatively large numbers of children through a central point, it was stressed that it was of less importance than the supplementary feeding of pre-school children. By the time they reached school age, children were better able physiologically to cope with adult diets. School feeding programmes would continue to be assisted only where sufficient local resources were available to run them satisfactorily; where there was a reasonable prospect of continuation in some form after the end of UNICEF aid; and where maximum help of local governments was available (.e.g. in providing fire-wood, utensils, and local foods). UNICEF was not interested

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1/ Until 19__ whole milk was purchased by UNICEF. After that date, however, it was decided in view of the high cost of whole milk (30 cents per lb) that UNICEF would distribute only such quantities as were donated. Many governments, on the advice of WHO, then began to distribute whole milk blended 50-50, or 40-60, with skim milk, in order that a greater number of infants could be served. Particularly Asian governments have continued to give very high priority to the provision of whole milk by UNICEF for distribution through MCH centres.

in assisting elaborate school-lunch programmes in capital cities at such a high level of sophistication that they could not be repeated in other less favoured parts of the country.

This priority for pre-school feeding was re-confirmed several times by the Board, particularly in 1956 when the survey of m child nutrition in Latin American countries performed for UNICEF ~~BY~~ by Dr. King showed that in some villages in Central America roughly one-third of the deaths among young children were caused by diseases in which malnutrition was probably a contributing factor, and in 1957 when the Chief of WHO's Nutrition Section pointed out to the Board that in the total field of maternal and child health malnutrition was perhaps the most important single problem.

In 1959 the Board reviewed a special report on UNICEF-assisted programmes of dry skim milk distributaón prepared by FAO, WHO, and UNICEF with the help of consultants (E/ICEF/385 and Cor. 1) together with a report by the FAO/UNICEF Joint Committee (E/ICEF/R.720, Section VI). The Board was pleased to note that according to these reports there was definite evidence of substantial health and other benefits derived by mothers and children from the distribution schemes. Distribution through schools, however, was still absorbing larger quantities than distribution to mothers, infants, and pre-school children through maternal and child welfare centres, notwithstanding the greater needs of the latter. Special attention should be given to the distribution of milk to children of pre-school age. The Board concurred with a ~~mm~~ suggestion by the FAO/UNICEF Joint Policy Committee that to the extent that the responsibility for school feeding programmes could be assumed by voluntary agencies, UNICEF resources would be freed for increased support to programmes for supplementary feeding of pre-school children and pregnant and lactating mothers. The Board authorized the administration to ask other agencies to take over the supply of milk for schools. Transfer should be undertaken only after careful analysis and after an assurance had been given that strict control would be maintained. As much as possible, distribution pro-

grammes should be associated with nutrition education and other activities to encourage lasting improvements in nutrition.

In March 1960, the Board further defined criteria for pre-school feeding, according priority specifically to: children, especially those suffering from protein deficiency; infants totally or partially deprived of mothers' milk; children in the weaning and post-weaning period; pregnant and nursing women.

For some time previous, various reports by nutritionists had accented the desirability of fortifying skim milk with vitamins. The removal of the fat content also removed the Vitamin A content. In many countries, Vitamin A deficiency caused great harm to the eyes, and a large percentage of complete blindness starting in infancy was attributable to this deficiency. In 1960 UNICEF undertook field trials in enriching skim milk with Vitamins A and D, and when these proved successful increasing quantities of the skim milk shipped through UNICEF were thus enriched.

Milk Conservation

In October 1947, the Board directed that UNICEF's attention be given to securing "the maximum amounts of safe milk for children out of indigenous production. The Board was concerned with the importance of assuring milk for children not just for the duration of the emergency feeding programmes, but continuously in the years to come. "The destructive effects of the war on dairy cattle and the inadequate facilities for processing and distributing milk present an opportunity to the Fund to render a type of short-term assistance in line with its emergency programme which will also have long-term benefits." (E/590 para 36).

In July 1948 the Board made the first allocations to provide equipment for pasteurizing or drying milk for plants in Europe in which all or part of the output would be used to continue child feeding on a permanent basis from local resources. The following conditions were set: assisted governments should formulate a sound general milk policy; objective of the distribution of equipment by UNICEF should be the exclusive benefit of children, pregnant and nursing mothers; the pla for distribution should guarantee as far as possible the continuation of the existing UNICEF feeding programmes.

As UNICEF turned its attention to underdeveloped areas, the possibilities for adapting its European experience in milk conservation did not appear bright, since in most countries there seemed to be no immediate prospects for the development of a dairy industry. Upon detailed expert examination, however, it became clear that the potentialiti were greater than oridinally assumed. In a number of tropical areas it was found that milk supplies for human consumption were low, not so much because of the inability to produce milk but because of the limiting factor of time in the collection and distribution of this perishable commodity. The common belief that milk production was ~~possible~~ economically possible only in temperate zones was re-examined. It was recognized that with lower milk supplies to begin with, less general knowledge about the value of milk in the diet, less experience within the countries, a hot climate, and a very low income per head, the element of risk was greater than it had been in Europe, and each proposed new project needed to be preceded by especially careful surveys and advance planning. The basic view-point dominating the thinking of the Board was the new mandate given to UNICEF to concentrate on projects of long-range value, and the realization that the temporary importation of milk did not offer a long-term solution to the child-nutrition problems of under-developed countries.

UNICEF embarked on a long-range programme of milk conservation which would continue to meet the needs of children.
In November 1950 the first allocation for a milk conservation project was approved (In the Americas); the first in the Eastern Mediterranean received an allocation in November 1951, the first in Asia in September 1953, and the first in Africa in September 1954.

To the early criteria developed for Europe for the provision of assistance to milk conservation projects were added others: plans of operation must incorporate the child welfare objectives which were the justification for UNICEF support; to ensure the continuation of these objectives, assisted governments must assume responsibility for local financing, administration, and development of the project as a state-sponsored enterprise. These basic criteria have continued to guide UNICEF policy.

The Board continued deeply interested in the progress of the milk conservation programmes. Delegations expressed their strong support for a greater emphasis on aid for milk conservation because it encouraged permanent and better use of local resources to attack the nutrition problems of children, and because of its valuable economic side effects.

The need was not merely for "insurance" measures against a possible future cut-off of donated supplies, but for a vigorous effort to organize local milk production and to ensure that clean, safe milk would be regularly available especially to the urban population and particularly the nutritionally vulnerable groups. Urgent and chronic malnutrition of women and children particularly in the overcrowded cities.

In September 1959 the Board undertook a lengthy review of a special report prepared by a team of FAO/UNICEF consultants (E/ICEF/384) together with the section of the FAO/UNICEF Joint Policy Committee report relating to it (E/ICEF/R.720 Chap. V). The Board's discussion was concentrated primarily on three major points: development of national milk policies in the assisted countries; the predominant importance of increasing the quantities of milk available for urban consumption and various measures for ensuring the distribution of milk at low cost to vulnerable and needy groups; the need for increasing technical assistance which is of greater importance as UNICEF assistance is directed more and more to countries in which milk processing is less developed. The Board adopted the following conclusions: the basic interest of UNICEF in milk conservation lies in the contribution it can make to better nutrition for children and mothers. Projects should be carefully integrated within the over-all objectives of a national milk policy. Adequate preliminary surveys are necessary for the develop[illegible] of sound projects. The objective should be the provision of a milk conservation [illegible] to serve as a demonstration and training centre for the country, to stimulate further dairy development in an orderly fashion. Special attention should be given to methods of reducing the price of milk to consumers of low income level, while still maintaining a reasonable return to producers. Milk drying should be looked upon as supplementary to other forms of processing. Training of local personnel is vital; aid would be provided to national or regional training centres and training courses.

Projects for the training of dairy staff have been consequently undertaken: mainly in India where major dairy-training schemes have been implemented; also in Africa, and through special inter-regional dairy training courses jointly sponsored by the governments of Denmark and India, and through in-plant training.

New marketing methods were noted: "toning" (mixing high-fat milk with reconstituted skim milk) was mentioned as a necessity to lower the price of milk for low income groups, also "standardization" (removing part of the butter-fat, which was subsequently made into higher-priced products), and bulk distribution at fixed times and places, and subsidizing the cost of milk for the neediest groups.

At other Board discussions (particularly in January 1964) it was emphasized that UNICEF's role in supporting milk conservation projects is pioneering and developmental. UNICEF does not assist milk schemes considered suitable for commercial investment, or which bilateral aid is available. UNICEF-aided plants are built on a scale to cope with an increase in milk production for up to five years from opening. Plants are planned to be financially autonomous, with provision for depreciation and sound capital growth. Because developing countries generally do not have budgetary resources to subisidze all the output for sale in districts of low income level, plants must sell to all sections of the community and for adult as well as child consumption. UNICEF's contribution is always less than one-third of the total. The sale of milk at prices varying according to fat content seems to be one of the best methods solving the dilemma of economic viability versus social policy.

The Board requested another review of the socio-economic aspects of UNICEF aid to milk conservation. This matter was reviewed by the FAO/UNICEF Joint Policy Committee in March 1965, and the report will be presented to the Board in June 1965

Protein-rich foods

In 1953, Board discussions began to stress the need for a wider approach to the problems of child nutrition. Whilst there was no doubt that milk was an effective preventive and therapeutic agent, there were many countries in which there was little hope of producing milk in sufficient quantities to warrant an attempt to establish a dairy industry. Inadequacies in transport and storage facilities, not to mention economics, further limited the ~~range~~ practical usefulness of milk in many areas of great need. Imported supplies of milk powder could not be relied upon to make any lasting impact. It had become clear that resources in addition to milk were necessary.

On the advice of a group of nutritionists and paediatricians at a meeting convened by WHO and FAO in July 1947, the major nutritional principle adopted was to limit UNICEF aid to the provision of supplementary foods of high nutritive value, especially foods rich in protein.

Thus, efforts began to be directed toward finding additional sources of high-protein foods that might be useful. In September 1953 the first allocation was made for equipment for a plant in Indonesia to produce a powder based on soybeans which could be reconstituted into a "milk" suitable for young children. In March 1954 funds were allocated to permit acceptability tests of fish flour, and in September 1955 for a fish flour plant in Chile. A basis was laid for systematic research and development of cheap local high-protein processed food sources by a $ 250,000 research grant by the Rockefeller Foundation in April 1956, and an allocation

of $ 100,000 by UNICEF to provide products for testing. In 1955 WHO had created the Protein Advisory Group*/ to advise UNICEF and FAO. In cooperation with these technical agencies, UNICEF set up a programme for the development, testing, and field evaluation of protein-rich foods and other supplements for infant and child feeding.

A number of criteria were evolved to govern the selection of food products that might help to meet this need: chiefly, that the foods selected must be available locally, or be capable of local production; that they must be within the economic means of the particular population group having the greatest need for protein, either to produce or to buy; and that they must have such nutritional values as to be effective protein supplements. Seven products were chosen for study on the basis of these criteria: fish flour, soy products, peanut flour, cottonseed flour, sesame flour, sunflower-seed flour, and coconut protein.

The Board continued to be deeply interested in the development of this programme, and received detailed reports in 1959 (E/ICEF/389), 1960 (E/ICEF/398), and 1962 (E/ICEF/463). The latest of these reports was that of the Fourth Session of the FAO/UNICEF Joint Policy Committee, which had decided that sufficient research and development work had been done to show conclusively that protein concentrates made from fish, groundnuts, cottonseed, and soybeans were suitable for child feeding. Emphasis should now

*/ In 1960 the PAG was reorganized to reflect broader tasks. It became a joint FAO/WHO/ UNICEF group consisting of 8 members jointly selected, to advise the three organizations on appropriate technical and ancillary aspects of the joint programme for the improvement of protein nutrition. The costs of the PAG's activities would be shared by the three organizations.

beplaced on getting such products into production and use. This would require widespread acceptability testing, the further development of industrial processes, the commencement of manufacture in the developing countries, and programmes of introduction and market promotion. The Committee considered that effort should be concentrated on the development of protein supplements and food mixtures for weanlings and toddlers.

With these decisions, the UNICEF-aided activities moved into the problem-solving field: the equipment and technology required for the production of various foods varied considerably; simplified procedures were needed; low cost packaging presented major difficulties. The range and complexity of the problems to be solved required efforts far beyond the resources that U.N. agencies alone could make available. Numerous groups were known to be developing an increasing interest in protein-rich foods, among them major commercial companies, government research services, and various foundations, many supported through bilateral aid. A concerted programme was planned (E/ICEF/P/L.370) for cooperative efforts in find solutions.

Collaboration with established commercial concerns was envisaged. It was particularly in the rapidly growing urban fringe areas, where families are denied the opportunity of producing any of their own food, and where malnutrition among children is generally high, that industrial processing of low-cost nutritive foods commended itself. Commercial concerns offered the best prospects for successful development, being best qualified by reason of their experience in the local procurement of materials, factory management, market development, and sales promotion.

Projects in cooperation with the World Food Programme were undertaken: in partnership with a government and a highly reputable firm in the food industry, using a food formulation that had been developed and tested in the country. The World Food Programme and UNICEF are supplying ingredients for the first two years, as a contribution to the cost of launching the product at a low price. The Board considered such projects as being of considerable potential importance.

In approving allocations of funds for further "developmental research" in January 1964, representatives on the Board noted that this was an essential preliminary to the launching of protein-rich foods. The approach through industrial application was commended, but the need was emphasized for a proper division of functions between UNICEF, FAO, and WHO, and for fullest possible use of qualified consultants and advisors.

~~Applied Nutrition~~

NUTRITION EDUCATION (Primary schools)

In September 1958 the Board approved a proposal by the representative of Pakistan that the Executive Director study the possibilities of UNICEF aid for primary education and present a preliminary report to the Board at the March 1959 session. This study was undertaken with the aid of UNESCO, and was reviewed by the Board in March 1959. Accent was on the inter-relation of children's needs. Some representatives were in favour of the recommendations to assist primary education: it was essential that UNICEF be ready to help the intellectual as well as the physical growth of children; social progress includi progress toward better health and nutrition was inhibited by ignorance and illiteracy. It was also important that Governments have latitude to choose among different types of aid related to the basic needs of children. Other representatives, however, were concerned that UNICEF's funds would be too greatly dispersed

in view of the large tasks ahead in the fields of child health and nutrition, and the commitments to malaria eradication. The costs of extending aid to primary education would be enormous, and UNICEF could contribute only on a minute scale.

There was general agreement that first priority on UNICEF aid should be for the completion of projects in which UNICEF was already engaged, but some representatives thought that if large resources were not available for primary education, more limited aid for the strategic element of teacher training would have long range value.

After extensive debate a Working Group was established to reconcile the various views. The Board adopted a resolution that "Considering that age-old needs of children arising from hunger, disease and ignorance are interrelated and that each evil is part cause and part effect of the others ..." UNICEF aid to primary education would be extended, but would be confined to improving the standard of teacher training in connection with UNICEF's traditional fields of interest, such as health, nutrition, hygiene, home economics, etc., also to primary schools */ in such fields in the light of developing needs.

*/ Earlier assistance to primary schools had been approved in March 1954 on the basis of a report (E/ICEF/249) entitled "Expanding UNICEF Aid to Rural Primary School Services. This approval covered assistance for school gardens, nutrition education in schools, and orientation courses for school teachers. Little advantage had been taken by governments of this type of assistance, and in September 1957 (E/ICEF/L.1123 para 8) the Executive Director had called to the Board's attention that this form of aid needed to be more systematic and comprehensive to be effective.

A few projects were implemented on the basis of this approval (notably Thailand, Kenya), but there was no wide expansion. In 1960, this policy was incorporated in the wider policy of aid to education.

NUTRITION EDUCATION

As a result of its comprehensive debate in April 1957 the Board concluded that there was "great need for additional practical action to improve child nutrition"

The Board requested the Executive Director to put forward a plan for possible courses of action, which was presented to the Board in September 1957 (E/ICEF/L. 1123). One of the recommendations was for expanded support to nutrition education of appropriate national personnel at various levels. In all developing countries, the first requirement for effective action in raising general standards of nutrition, and particularly that of the more vulnerable groups, is for improved and increased training of all categories of nutrition workers. The Sixth Report of the FAO/WHO Joint Expert Committee on Nutrition had pointed out that the failure on the part of governments to recognize the nature and magnitude of malnutrition was one of the reasons for the inadequacy of training of personnel in nutrition. Even where there was a general recognition of the nature of the problem, there must be a properly planned food and nutrition policy because this would decide the type of training and the numbers to be trained. In few countries did such a policy exist. Priorities for UNICEF aid to ~~increased~~ the expansion of ~~these~~ nutrition training were recommended as follows: (a) directorial personnel at the centre for planning, leadership and supervision; in this category were included medical nutritionists, agronomists, directors of home economics extension programmes, food technologists, biochemists, sociologists; (b) personnel at the intermediate level to direct and guide workers at the village level; in this category were included professional cadres - medical and public health officers at district or provincial level, graduate agriculturalists, home economists, nurses, teachers, community development or agricultural extension or sock workers, horticulturalists, experts in animal husbandary or fisheries, etc; (c) field level personnel - doctors, nurses, midwives, school teachers, social workers, community development workers, etc., perhaps also a special category of auxiliary personnel who might be called "nutrition workers."

The Board approved expanded UNICEF assistance to all these types of training. Aid would include stipends for students and, if necessary, national instructors; teaching aids; demonstration materials and materials needed for their local production; local language textbooks; transport where essential for field training.

On the basis of this approval, the training of national personnel has become one of the most important features of UNICEF-aided projects. The Board has agreed in general that it would not be useful to set rigid limits to the forms of aid for training. These should be adapted to local needs.

In order to interest and inform national policy-makers and planners on the subject of nutrition, UNICEF in collaboration with FAO and WHO has assisted the organization of special orientation seminars for groups of Ministers of agriculture, community development, health, education, planning, and economic development, and social welfare. (La Napoule, France, in 1962, and Gardone, Italy, in 1963. Major programmes of nutritional training at all levels on a regional basis have been developed in Africa and in Latin America.

APPLIED NUTRITION

At the same session in September 1957 (Doc. E/I EF/L.1123) the Executive Director, in response to the Board's directive to put forward a plan for possible courses of action in the important field of child nutrition, proposed assistance in several practical fields which, together, came to be known by the term "Applied Nutrition". These activities included:

- participation in country nutrition surveys by provision of equipment, supplies, and transport;
- assistance to the education of families in nutrition, with particular emphasis on the education of mothers and children;
- assistance to nutrition activities in the villages, to help people put into practice what they were learning from nutrition education; this would include aid to home, school, community, or cooperative gardens, fish culture, small animal or poultry raising, village kitchens and home food storage; demonstrations of food preservations; all, in particular where possible, as part of community development;
- supplementation of a staple food with a vitamin where this was the only practical means for the immediate control of a serious deficiency disease

affecting mothers and children.

All these fields of aid were approved by the Board in September 1957, with some additional safeguards: there should be joint planning in the country concerned between the U.N. agencies and the government, to ensure coordination of technical advice and assistance with the technical resources of the government; plans, teaching materials, and equipment should be approved by the appropriate technical agencies; the Board recognized a point made by FAO, namely that it would be profitable to embark on activities at the village level only when extension services or community development programmes had been sufficiently developed to provide a mechanism for educational work in the villages and communities, and for continuing and further expanding the activities started with UNICEF assistance.

Some representatives of the Board voiced varying degrees of reservation, with regard to UNICEF aid for fish culture and small animal and poultry raising. This might more properly be the responsibility of an agency other than UNICEF. Costs to UNICEF needed further clarification. The efficiacy of such measures was also questioned, particularly since trained persons to give appropriate guidance at all levels with few in numbers. Some representatives also expressered reservations in the enrichment of staple foods on the ground of difficulties in assuring a distribution system which would reach people who ordinarily do not buy, but grow, their own food. Such projects should be considered of a pilot nature. One delegation ~~xx~~ stated that it was unable to support approval in principle for these forms of aid.

In March 1959 the Board approved in addition (a) payment of honoraria for the use of national personnel in survey work in special cases (because some representatives thought this should be a responsibility of the government); also, strengthening of existing training facilities which would receive students from neibnouring countries.

By March 1960, 17 projects were being assisted. The Board approved $ 50,000 to permit the Executive Director to undertake interriong nutriton surveys as a basis for planning projects for which UNICEF aid might be requested.

for expanded nutrition & education
Total allocations/in 1960 were 4.7 percent of total allocations.

By June 1963, 58 applied nutrition projects were being assisted (24 in the Americas, 19 in Africa, 7 in the East. Med. and 5 in Asia, and 2 in Europe, and one interregional. There was general recognition in the discussions in the Pro. Com. and Board that the amounts of aid in this field available from UNICEF were small in relation to the vastness of the problem and that it was not an easy matter to delimit the areas of UNICEF support when interest was centered on long-range measures to improve the nutrition of children. Some delegations held that certain asepcts of aid seemed somewnat remote from the main objectives of UNICEF and were more properly the concern of other agejcies; on the other hand, some delegations expressed complete support for the present direction of UNICEF aid in this field. General satisfactorion was expressed with the increased cooperation among the several interested specialized agencies in developing project plans; some questions were raised regarding the division of responsibilities.

Applied nutrition projects generally were reviewed at the Fifth Session of the FAO/UNICEF Joint Policy Committee in April 1965. The conclusions and report (E/ICEF/510) will be reviewed by the Board in June 1965.

GOITRE

Endemic goitre is a food deficiency disease occuring in many regions of the world, in some of which it constitutes an important ~~nutritional~~ public health problem. Where soils are deficient in idiodine particaruly. Goitre is likely to have serious effects on the physical and mental development of children and, in the case of pregnant women, the mother's goitre may affect the child. Most effective and economical method of prevention is to enrich salt with ~~iodine~~ iodine. The Board was impressed by the fact that endemic goitre, which causes much suffering and economic loss, can largely be eliminated by relatively small expenditures. On

the recommendation of the JCHP at its May 1956 meeting, the Board approved in October 1956 UNICEF assistance to iodization plants.

One criterion of aid is that the Government is able, and undertakes, to control all salt distribution in the affected regions, so that iodization is effective and no un-iodized salt gets distributed.

Only three plants have been assisted (India, Thailand, Paraguay).

FAO/UNICEF Joint Committee

In March 1958 the Board approved this Committee. In October 1957, after approving aid for applied nutrition, the Board asked the Executive Director to consider with the specialized agencies concerned how best to achieve closer collaboration. Following secretariat consultations, the FAO Council in November 1957 voted to invite five Governments to send representatives to any Joint Policy Committee which might be convened jointly by the Dir. Gen. of FAO and the Executive Director of UNICEF. The Board voted to participate on the following basis: UNICEF to elect five Governments, members of the Board, to represent UNICEF on the Joint Committee, not duplicating the FAO nominations. Five alternates to be elected at the same time. Elections to be made on a yearly basis. Governments sl elected to nominate as far as possible UNICEF representatives who are now, or have been, members of the Board. List of representatives so nominated to be submitted to the Board for confirmation. Travel expenses of the UNICEF representatives on the Joint Committee to be borne by UNICEF. Terms of reference:

- to recommend general principles to be followed by FAO and UNICEF in jointly assisting governments, within FAO's sphere of competence, to improve the nutrition of mothers and children;
- to recommend to the Board and to the FAO Council type of country programm of interest to FAO to receive UNICEF support;
- to recommend and review from time to time general measures needed to

develop and coordinate the assistance provided by FAO and UNICEF, having reference to other aid including tnat of WHO;

- to receive evaluation reports and forward recommendations for furtner action to UNICEF and FAO;
- to recommend methods by whion assisted programmes may be more effectively coordinated with the U.T. technical assistance programmes;
- to review the manner in which FAO and UNICEF divide their efforts, and to call attention to duplication of functions;
- to make recommendations concerning any other matters of joint interest.

First session of the FAO/UNICEF Joint Policy Committee was reviewed by the Board in ~~Sxpxx~~ Maren 1959. Terms of reference (virtually as above) confirmed.

In October 1947, just after the first shipments of milk had been made to begin the supplementary feeding programmes in Europe, the Board turned to consideration of other fields in which there were urgent children's needs, and made certain policy decisions which had direct influence on the form that UNICEF assistance was to take. One of the most far-reaching of these was the decision to earmark a fund for the provision of supplies for medical programmes. The Chairman of the Board had informed the Programme Committee of the remarkable advances made in the use of BCG vaccination against tuberculosis, and of penicillin and the sulfa drugs against venereal disease. The Programme Committee recommended, and the Board endorsed the recommendation, that in making apportionments to governments from the fund for medical programmes, priority should be given to those governments wishing to take advantage of developments in medical science which had made possible the prevention of tuberculosis in children, and the eradication of venereal disease. This fund, initially $ 500,000, began the trend which by the end of 1964 had resulted in the allocation of $ 110,000,000 */ for a variety of disease control programmes throughout the world.

Main Policies

The disease control programmes so far assisted by UNICEF have been against:

Tuberculosis

Malaria

Treponemal diseases (yaws, bejel, pinta, syphilis)

Leprosy

Trachoma

Others (bilharziasis, filarial infections, typhus, etc.)

The evolution of policy in each one of these specific fields is dealt with in succeeding chapters. Certain general criteria, however, were developed ~~in the~~

*/ excluding emergency allocations and freight

in the early stages of assistance for disease control programmes. These had, as their primary objective, the improvement of maternal and child health. The long-term interest was to help countries establish networks of basic health services for mothers and children. It was clear, however, that campaigns to control or eradicate endemic diseases largely affecting children were a necessary first concern, since no health service could hope to build permanent preventive health benefits if its resources were constantly drained in the effort to treat chronic sickness. The range of diseases of public health significance was not large, but the numbers to be dealt with were vast.

In June 1951 the Board decided that mass health campaigns should aim to fight diseases affecting children. In this category were specifically included: tuberculosis, malaria, venereal disease, trachoma, and yaws. It was noted that the success of campaigns depends on the selection of a well-defined objective; the adoption of sound medical and health principles adequately publicized; the institution of an administration devoted to the task; the institution of proper coordination between national and international administrations; and the correct training of teams. These principles have continued to be applied in the consideration of aid for disease control. To the list of major diseases designated in 1951, only leprosy has since been added.

The Board and Programme Committee continued to review the progressive development of the mass campaigns. As early as 1952 it began to [illegible]

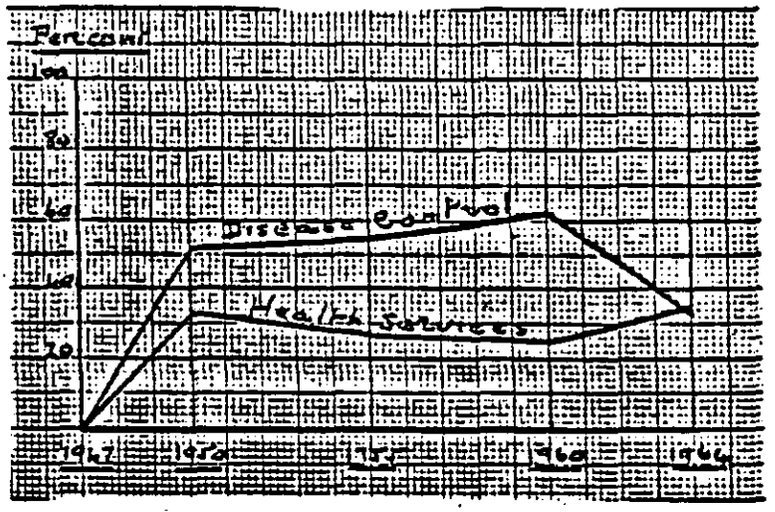
The tendency of mass campaigns to operate independently of other health activities has also been a matter for review in Board and Programme Committee discussions. Increasing stress has been laid on the inclusion of multi-purpose activities, usually at the stage of mass campaigns when the pressure of concentrated field work begins to lighten. Examples are: the use of yaws and leprosy workers for case-finding in both fields; of yaws workers for giving vaccinations against smallpox; of yaws and leprosy workers for the treatment of minor ailments, including eye diseases; of BCG personnel for the training health centre midwives and nurses in BCG techniques; of malaria workers for basic reconnaisance as to the location of planned health units, etc.

Liberalized policy on the assumption by UNICEF of local costs has been of very great assistance in the integration phases of mass campaigns and in the introduction of multi-purposes activities. It has permitted the essential short-term and orientation training of many types of personnel, which could otherwise never have been undertaken under governments' usually stringent delimitation of budget headings.

Financial Aspects

Until 1960, disease control programmes */ took a major part of UNICEF funds: in 1947-50 - 52 per cent of allocations to long-range programmes **/ in the African, Asian, Eastern Mediterranean, and Americas regions; in 1951-55 - 55 per cent; in 1956-60 - 62 per cent. It was not until the period 1961-64 that the ratio (when the ratio of allocations to basic health services rose to 35 %) for disease control dropped to 33 per cent.

Comparative ratios of allocations for basic health services were: 1947-50 - 33 per cent; 1951-55 - 27 per cent; 1956-60 - 25 per cent; 1961-64 - 35 per cent.,



Percentage of allocations for (a) Disease Control Programmes, and (b) Basic Health Services, as compared to total allocations (excl. emergencies and freight) in the periods indicated, to Africa, Asia, Eastern Mediterranean, and Americas.

One of the major reasons for the concentration on disease control programmes was governments' preoccupation with the problems that the "killer" diseases presented - problems which, by their overwhelming demand on meager existing public health services, and their detrimental effect on socio-economic life, were effectively blocking post-war reconstruction efforts. Coupled with this priority for disease control on the part of governments was the emphasis that WHO was giving to certain of the major diseases. Global and regional conferences sponsored by WHO, and an unusually large volume of technical assistance and advice made available to governments by WHO in certain fields, stimulated governments' efforts in those fields, and consequently the requests to UNICEF.

Major disease control programmes

This was particularly true of the anti-malaria programmes. Malaria had been named the No. 1 killer, particularly of children, and the discovery of

effective control methods by residual spraying, together with the emphasis placed by WHO on control programmes, led to a concentration of UNICEF funds in this field. In the first five years it was confidently believed that control would shortly be achieved and that there would be a declining call on UNICEF for assistance to malaria control programmes. Governments would "take over responsibility" after a few years of UNICEF assistance. There was therefore no cause to view with alarm the comparatively large amounts being allocated for malaria programmes - in 1951-55, 25 per cent of total long-range allocations, and 46 per cent of allocations for disease control, in the four regions.

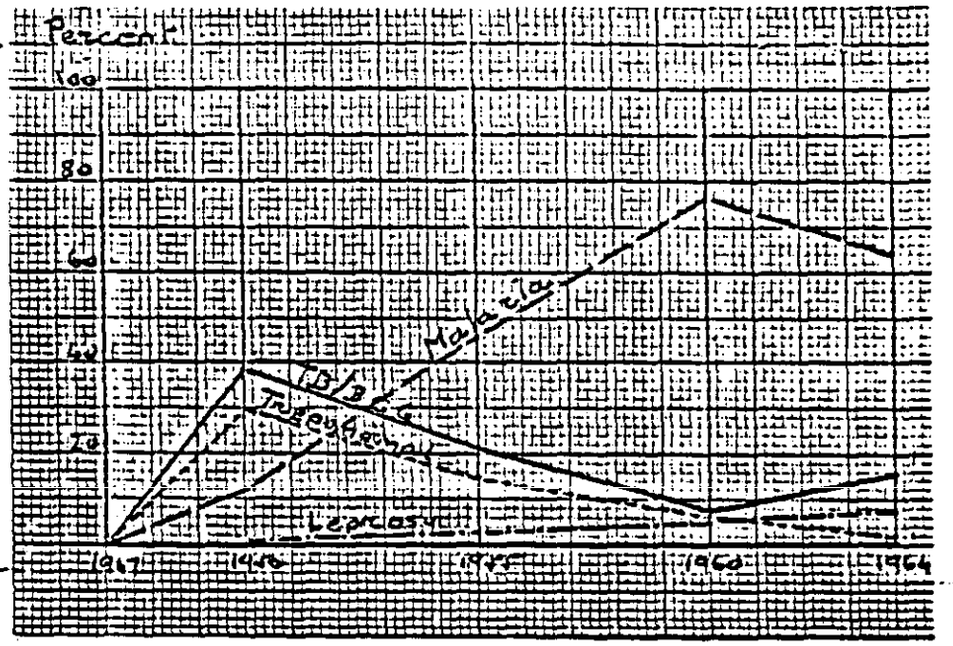
The discovery of vector resistance in 1954-55 destroyed these comfortable assumptions, which were replaced, however (in support of increasing allocations for malaria eradication) by a new assumption that eradication programmes only would only need about four years of assistance during the "attack" phase. In turn, this assumption too was removed when it became clear that eradication programmes would be prolonged, and that UNICEF assistance would be required beyond the attack phase, for the consolidation and surveillance phases. Although in 1958 the informal division of global funds available for anti-malaria work left UNICEF with ~~the~~ a smaller share of total responsibility (the larger going to U.S. Bilateral aid), and although various measures were adopted further to limit UNICEF's participation (e.g. the Board's decision to withdraw from programmes in which the possibilities of eradication were remote), nevertheless in 1956-60, 48 per cent of total allocations for long-range programmes, and 77 per cent of allocations for disease control, was absorbed by the malaria eradication programmes. In 1961-64, allocations for malaria dropped to 21 per cent of the total, but remained high at 64 per cent of allocations for disease control.

UNICEF's decision to give priority to programmes against tuberculosis, and the availability of technical aid in the implementation of BCG campaigns through Joint Enterprise, naturally accounted for concentration on BCG in the earliest

years. Before 1950, 100 per cent of allocations to Africa, and 70 per cent to the Eastern Mediterranean, were for BCG campaigns. For the four regions, BCG programmes in 1947-50 took 20 per cent of total allocations for long-range programmes. In the next decade, however, the ratio dropped as allocations for other programmes increased, and as the BCG mass campaigns progressively came to an end. Because of the major technical problems and the high per capita costs involved, other kinds of anti-tuberculosis work did not develop rapidly or widely, although governments' interest continued high. Since 1961, developments in domiciliary chemotherapy, particularly in Asia, have raised the level of allocations for anti-tuberculosis programmes.

The proportion of funds for treponemal disease control programmes has been relatively low. Only two regions, Africa and Asia, have had major problems and have conducted major programmes. Even though the larger programmes have been prolonged due to various difficulties (mainly financial and political), success is progressively being achieved and the demand for UNICEF assistance has declined almost to nil. Leprosy, the fourth of the major diseases in which governments have been interested, is important in relatively few countries and has taken a low overall percentage of UNICEF funds. Trachoma, although believed to be a widespread problem affecting children, has taken comparatively little money; governments do not appear to be giving priority to this disease. Other diseases have taken insignificant sums, for short periods without need for continuing support.

The trends in allocations to the four major categories of disease control programmes is shown in the following illustration:



Percentage of allocations for four major categories of disease control programmes, as compared to total allocations for disease control (excluding freight) in the periods indicated, to Africa, Asia, the Eastern Mediterranean, and the Americas.

MG.
8 April 1965

TUBERCULOSIS*/

When UNICEF turned its attention to developing countries it was clear that one of their most important health problems was tuberculosis. In developed countries, where living conditions were generally good, the death rate from tuberculosis had dropped dramatically as hospitals, clinics, and drugs for treatment became plentiful. Even in Europe, however, post-war conditions were causing an alarming increase in tuberculosis. In the developing countries, where living conditions were such as to favour the spread of the disease, and where facilities for medical treatment had never been adequate, the problem was assuming grave proportions. Although no age group was immune, children were particularly susceptible; if acquired in childhood, the disease was particularly liable to be fatal.

The approach through BCG vaccination

BCG vaccination**/had been used extensively in the Scandinavian countries since the 1930's; but mainly as a clinical rather than as a public health procedure. Early in 1948 UNICEF joined forces with the Danish and Swedish Red Cross and the Norwegian Relief for Europe in what was called the Joint Enterprise

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*/ This section is to be revised taking into account the discussion and decisions of the June 1965 Board session on recommendations of the JCHP.

**/ Children were tested to see whether they had tuberculosis, had previously been infected, or had developed natural resistance. Those who had not ("negative reactors" to a tuberculin dilution injected into the skin of the arm) were vaccinated. The expectation was that BCG vaccination would provide a considerable degree of protection (up to 80 per cent or more) for the most susceptible group of children and young adults. The exact degree of efficacy of BCG vaccination is not proved, and this has been the subject of discussion in the Board and Programme Committee from time to time.

(or the International Tuberculosis Campaign) for the purpose of giving international aid to a demonstration of mass BCG vaccinations.*/ After the Scandinavian partners completed their commitments UNICEF aid for BCG campaigns continued and was expanded under the technical direction of WHO.**/ The ultimate goal was the integration of BCG work into a permanent TB control programme, and of the latter into general public health activities, but until such measures could be built up in the developing countries, BCG vaccination was the only effective means within their financial, technical, and staffing resources of attacking (if only in part) the problem of tuberculosis.

The UNICEF/WHO Joint Committee on Health Policy reviewed the progress of BCG campaigns at virtually every session, examining problems relating both to the administrative and technical aspects of the campaigns. Included were problems of supplying the campaigns with vaccine of satisfactory quality,***/ and the

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*/ The WHO Interim Commission informed UNICEF that it believed the programme would be highly useful, although WHO itself, because of its then temporary status, was unable to participate on the scale proposed. The technical direction of Joint Enterprise was entrusted to the director of Danish Red Cross anti-tuberculosis work, who was concurrently chairman of the Expert Committee on Tuberculosis of the WHO Interim Commission. During the life of the Joint Enterprise programme (1948 to mid 1951) some 30 million tests and 17 million vaccinations were performed in 22 countries.

**/ WHO was able to draw on the recommendations of its Expert Committee on Tuberculosis and its Expert Committee on Biological Standardization. In addition, a WHO Tuberculosis Research Office in Copenhagen undertook the analysis of the great mass of statistical data collected in the campaigns, and engaged in studies to determine the degree of efficacy of BCG vaccination. As in the case of other health programmes, UNICEF aid for individual BCG campaigns required the technical approval of plans of operation by WHO.

***/ Because of its perishability and short life, liquid vaccine had to be used within a few weeks of manufacture. UNICEF helped solve the problem of supplying vaccine for campaigns all over the world by providing equipment for BCG vaccine production laboratories in strategic places, from which vaccine could be air-freighted to countries within the region. WHO was responsible for verifying the satisfactory quality of the vaccine produced by these laboratories. In 1962 the provision by UNICEF of freeze-dried vaccine for selected areas was approved. Since its life is far longer than that of liquid vaccine, this meant that health centres, and teams in remote areas which could not previously be served, could be included in the programmes. Also delivery schedules could be much simplified and work thus accelerated. Because of the technical problems of production, WHO up to mid-1965 had not approved UNICEF aid for the production of freeze-dried vaccine.

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formulation of teams to assess the results of BCG vaccination, and the testing and vaccination techniques of the field staff.*/ In 1957, as the result of a review of accumulated field experience undertaken by the JCHP, the Board placed emphasis on the need to reorient campaigns to concentrate on the young age groups at greatest risk, to select those geographical areas in which the risk of infection was greatest, and in areas of high TB prevalence to repeat campaigns in a "second sweep" to vaccinate children who had earlier been missed and those who had in the meantime been borne.**/

In 1957 the JCHP expressed the opinion that in view of the evidence of the protective value of BCG vaccine, UNICEF should continue to give support to mass BCG vaccination. At the peak of the mass campaigns (1956-1959) approximately 3.5 children and adolescents were tested per month, and one million vaccinated.***/ After 1960 most of the campaigns had accomplished the objectives of their mass phase, and the integration phase began. In only a few countries, mainly in Europe, was it possible for successful integration to be achieved, with permanent health services providing for the systematic vaccination of children reaching the appropriate age-group, and for revaccination.****/ In most of the developing

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*/ WHO assessment teams were established for Asia and the Eastern Mediterranean, partly financed by UNICEF, for the purpose of overall evaluation. National assessment teams were established in virtually every UNICEF-assisted country programme for the purpose of evaluation and maintenance of field techniques.

**/ E/ICEF/353/Rev. 1 paras. 82-87.

***/ Only about one-third of the children tested in the mass campaigns were negative reactors eligible for vaccination; two-thirds were or had been infected with tuberculosis, or had otherwise developed resistance.

****/ There are as yet no clearly defined and generally accepted criteria for revaccination.

country programmes, only partial integration could be effected. The lack of adequate networks of health centres was a serious handicap. Frequently, moreover, such centres as did exist did not have the personnel and transport to take on the additional task. In some countries a small number of mobile teams were retained to carry on modified campaigns in selected areas.

In 1962 the UNICEF Board agreed that UNICEF could continue to support existing campaigns and integration activities, provided satisfactory technical and operational standards were maintained. With increasing emphasis on a comprehensive public health approach to tuberculosis control*/ vaccination programmes are being reoriented as a corollary of broader anti-tuberculosis activities, and are concentrating exclusively on the young child.

At the end of 1964 UNICEF was assisting BCG vaccination campaigns in 21 countries. Counting campaigns which had been previously assisted in some 30 countries, UNICEF-aided campaigns had tested some 405 million persons and vaccinated over 188.7 million. Of those vaccinated 77 per cent were in Asia, 12 per cent in the Eastern Mediterranean, and 5 per cent in the Americas.

Demonstration/training centres

Although UNICEF aid began with primary emphasis on BCG vaccination, aid was also provided for other anti-tuberculosis work.**/ In accordance with guide lines developed by the WHO Expert Committee on Tuberculosis, UNICEF aid was given for the establishment of TB demonstration and training centres which included

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*/ See paragraphs _____.

**/ In Europe UNICEF had provided X-ray and laboratory equipment, and streptomycin for the treatment of child TB patients.

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facilities for the diagnosis of tuberculosis by X-ray (both static and mobile units were provided) and by laboratory analysis. Each centre instituted a treatment programme in its immediate periphery. Between 1949-1954 UNICEF aid totalling nearly $1 million was approved for such centres in Asia, the Americas and the Eastern Mediterranean.

After some experience it became clear that the methods demonstrated and copies from clinical tuberculosis programmes in economically developed countries could not be transplanted to most of the countries requesting UNICEF aid because of totally inadequate funds at their disposal, acute shortage of medical personnel, and lack of public health service structures through which the populations could be reached. With the advent of inexpensive chemotherapy the programmes of these TB centres was modified.

The use of drugs

Interest and experience had gradually been building up in other approaches to the problem of tuberculosis. In 1954-1955 the discovery of several cheap and effective anti-tuberculosis drugs*/, their commercial production on a large scale, and the possibility that ambulant patients could be treated with them as successfully as those in hospitals, raised the hope that TB could be controlled in the community and not just in the hospitalized individual. The question was

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*/ Isoniazid (INH) is the chief of these. Because infectious TB cases may not be converted from positive to negative quickly enough through the use of this drug alone, and may develop resistance to it, so-called "companion drugs" are also used for the treatment of sputum-positive and cavitary cases. Experimentation as to the side-effects and patient-tolerance of these drugs continues, with special reference to their cost, consequently the possibility of using them on a mass scale.

examined in detail by the JCHP. WHO advised that special studies were required before support of mass treatment with drugs could be envisaged. Aside from the technical questions involved there were many problems of an organizational and social nature which had to be solved.

In the meantime, however, on the basis of recommendations by the JCHP, the Board at its sessions in 1955 and 1957 agreed that UNICEF should broaden its support of TB projects through the provision of drugs to TB centres for home treatment of tuberculosis, provided there was reliable diagnosis of cases and adequate domiciliary supervision of patients to ensure that the treatment would be correctly applied and continued for a sufficient length of time.

Pilot studies in the use of drugs

On the basis of JCHP recommendations, UNICEF aid was also approved for pilot studies carried on by some of the TB centres.*/ These were to be careful, scientifically controlled pilot projects which would have as their purpose the development of simple, inexpensive, practical, and effective methods of tuberculosis control, capable of being expanded on a large scale, in which home care and drug treatment would play an important part.

While awaiting the results of these studies and other research carried on by WHO, the Board in 1959 reaffirmed its previous decision that UNICEF should not assist the mass application of ambulant chemotherapy.

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*/ UNICEF aid was approved for two pilot projects in Africa (Tunisia and Kenya) which were the main study areas, and for five in Asia.

For the planning of the large-scale control programmes which might now become possible, there was a need, however, to measure the extent of the tuberculosis problem in various countries, and for this purpose the Board approved assistance for a number of national prevalence surveys.*/

The comprehensive approach

As the results of the pilot studies and other research became available it became possible to envisage a comprehensive approach toward controlling tuberculosis which would attack the chains of causation at critical points: measures to reduce the transmission of the infecting agent (chemotherapy); that would lower the early and late risks of primary infection (BCG vaccination) and the risk of already existing infection (so called secondary chemoprophylaxis). These measures, if they could be carefully co-ordinated and applied on a mass scale in accordance with local technical and socio-economic conditions, would form the basis for a national tuberculosis programme.

UNICEF aid for national pilot area projects was envisaged as the first phase of support for a step-by-step approach to country-wide tuberculosis control. Covering a representative area in the country, the national pilot project would constitute a testing ground in which the methodology of a national tuberculosis control programme could be developed, and personnel trained. Once this had been

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*/ Beginning in 1955 special teams were set up by WHO, with support from UNICEF, to carry out prevalence surveys in Africa, the Eastern Mediterranean, and the Americas. Five national prevalence surveys were also assisted. These provided data on the epidemiology of tuberculosis in some areas that had not ever been obtained before, and generally stimulated public and government interest. Nevertheless, the difficulties and limitations of prevalence surveys on a national scale came to be recognized through practical experience, and as the concept of national tuberculosis control programmes (see Paras...) developed, the measurement of the extent and distribution of tuberculosis came to be included as a function of pilot project areas, through investigation in limited but representative sample population groups.

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accomplished, gradual extension to communities outside the pilot area could be considered, provided that continuous guidance and assessment by the national pilot project could be maintained, the extension areas could operate at a constant level of efficiency, and the whole service could be operated as part of the public health structure. Aid for this approach was approved by the Board in 1959 and 1962.*/ By mid-1965 UNICEF was aiding such programmes in 30 countries.**/ In the period 1962 - 1964 the allocations for anti-tuberculosis projects, including BCG, averaged about $1.5 million a year.

Certain aspects now developing may have implications affecting UNICEF aid for tuberculosis programmes. It is becoming clear that an existing TB control service, whatever its stage of development, should concentrate its resources on discovering and putting under treatment as rapidly as possible the largest number of sputum-positive and cavitary cases, who are the source of infection. Moreover, the maximum use of existing resources requires the cheapest possible diagnostic and treatment methods, including possible greater reliance on diagnosis by microscopy rather than more expensive X-ray and diagnostic facilities.

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*/ E/ICEF/380 para. 50, and E/ICEF/454/Rev. 1, para. 123.

**/ Due to financial limitations, personnel shortages, and the operational difficulties of the programmes themselves, the evolution of such programmes must be expected to take a number of years. In only four countries (all in Asia) has UNICEF aid for extension been approved beyond national pilot area projects.

MALARIA

The period through 1954: Control

The early years of UNICEF coincided with a lively interest on the part of health experts with the public health possibilities of new insecticides, particularly DDT. Because they were effective, relatively easy to use, and inexpensive, control of insect-borne diseases now appeared possible. These diseases took a heavy toll in children's lives, and UNICEF became interested in helping with DDT, sprayers, vehicles, and other supplies. By the end of 1950, 15 countries in Europe, Asia and Latin America had received UNICEF aid in beginning residual spraying operations with DDT. While the programmes in Asia were designed specifically as demonstrations of the effectiveness of residual spraying in controlling malaria, those in other countries included as objectives not only the control of malaria, but also the abatement or eradication of yellow fever and typhus (Latin America) and fly-borne intestinal diseases (Europe). All reference to other insect-borne diseases was soon dropped, however, and emphasis in residual spraying was centred entirely on malaria. By the end of 1954, UNICEF allocations to malaria control exceeded $6 million for programmes in 34 countries.*/

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*/ Africa 9; Asia 4; Eastern Mediterranean 5; the Americas 16.

1955: The concept of eradication

In March 1955 the Board was informed by WHO of the alarming danger of malaria-bearing mosquitoes developing resistance to insecticides, thus appearing to make continued control by residual spraying impossible and negating the work already done. For the first time, the theory of eradication was put before the Board; the objective was not merely the reduction of malaria cases but the complete elimination of the disease through the total interruption of transmission.*/ A special report by the Director of the Pan American Sanitary Bureau/WHO Regional Office for the Americas to the UNICEF Board included a plea for UNICEF participation in an accelerated regional approach in the Americas.**/

Wherever malaria incidence was high it was one of the main causes of infant and child mortality, and where it was chronic it undermined the health of mothers and children and stunted physical and mental development. The Board agreed, in March 1955, that a very important opportunity was being offered UNICEF for a fundamental contribution to the welfare of children; it recognized however, that substantially increased aid for malaria eradication would mean holding back on other activities. On the basis of estimates of costs to UNICEF of $5 million a year for expanded aid in malaria work (as against $2 million allocated in 1954) the Board agreed to join WHO in a concentrated effort to transform control programmes into eradication.

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*/ It was also pointed out that eradication campaigns, which limited large expenses to a few years, would in the long run be cheaper than control programmes which required spraying indefinitely.

**/ E/ICEF/282.

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By the next year, however, more accurate estimates were available of the total population to be covered in the Americas, and cost estimates were also available of several new country eradication programmes to be started in the Eastern Mediterranean. The costs to UNICEF, it was clear, would be considerably increased. The UNICEF Board agreed to a ceiling of $10 million a year which would allow it to participate in the continental approach for Latin America*/ a comparatively smaller regional approach in the Eastern Mediterranean eradication programmes, in campaigns of several of the smaller Asian countries, and some pilot projects in Africa where the means for effectively interrupting transmission had yet to be found. As a result of a series of meetings between the secretariats of WHO, UNICEF, and representatives of the United States bilateral aid programme, which provided the major financial resources for the global malaria eradication programme, an informal division of financial responsibility came about. United States bilateral aid was concentrated in the larger Asian countries, with a share for some countries in the Eastern Mediterranean and Africa. WHO funds were used for technical personnel for research, and for some material and financial assistance to smaller countries in the Western Pacific part of the Asia Region.

In 1957 UNICEF allocations for malaria campaigns had reached $7.1 million constituting 45 per cent of all programme allocations for the year. In 1958 they were $7.9 million constituting 52 per cent of all programme allocations. By that time UNICEF was helping 21 malaria programmes in the Americas, 11 in the Eastern Mediterranean, 11 in Africa, and 6 in Asia - altogether 49 programmes.

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*/ The programme in Brazil was assisted by U.S. bilateral aid.

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At its 1958 session the Director-General of WHO pointed out to the Board that there was a short-fall of funds needs to pursue the eradication plan in the next five years and expressed the hope that UNICEF would continue its participation and even expand it. A number of Board members, on the other hand, were concerned that continued high commitments by UNICEF for malaria would hamper the development of UNICEF activities in other fields; they expressed the view that every effort be made to secure increased financial support for eradication activities from other sources. The Board agreed to have a thorough review of UNICEF aid in this field at its September 1959 session in the light of UNICEF resources and the balance between aid for various programmes.*/

The 1959 decisions

The Board's view in September 1959, based upon a technical appraisal by WHO, confirmed that there were a number of reasons - organizational, technical, and social - which were resulting in prolonging the duration of the campaigns and increasing their costs**/; however, WHO believed that neither the main principles nor the general lines of strategy required change.

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*/ E/ICEF/374, paras. 41-53.

**/ e.g. extension of spraying to parts of the country not inlcuded in the original plan; more houses to be sprayed than originally estimated; increasing use of chemotherapy in conjunction with spraying and surveillance; the need for an evaluation organization to be set up early in each campaign. Moreover, UNICEF commitments had been based upon the assumption that total coverage spraying in the individual campaigns could be discontinued after four years, and that UNICEF aid would be limited to those four years. It was now beginning to appear that in many cases four years would not suffice, and also that UNICEF aid would be needed beyond the period of spraying, in the surveillance and consolidation phases of the programmes.

The Board agreed that UNICEF should continue its aid for malaria activities and retain its $10 million a year allocation ceiling; however, it would limite its aid to campaigns currently being assisted under certain conditions, including the prospects of success in a given country from a technical point of view and the satisfactory administration and adequate financing of local costs by the assisted governments.*/

The high level of UNICEF aid to malaria projects continued to be a matter of concern to the Board. The point was made by a considerable number of delegations that although malaria was a serious scourge affecting children, work in this field should not continue to be UNICEF's main activity.

The 1961 decisions

These same concerns were voiced again at the Board session in June 1961 when UNICEF policy for aiding malaria eradication was again reviewed. While no member desired to prejudice or terminate aid to sound malaria programmes, a number of them repeated their belief that malaria eradication was less a primary task for UNICEF than other types of programmes, and that continued large expenditures for malaria limited the flexibility of UNICEF to meet new and increasing needs in other fields.

The Board reaffirmed the previously established allocation ceiling of $10 million a year. It agreed that UNICEF aid should be continued in countries where prospects for eradication were good, even though aid would be required for a longer period than originally foreseen. Negotiations would be entered into with Governments where programmes were not going well to ensure that they made

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*/ E/ICEF/391, Rev.1, paras. 51-72.

the necessary efforts to remedy financial, administrative, and organizational deficiencies of the programmes; if such efforts were not made, assistance would not be renewed. Where prospects of eradication appeared remote, UNICEF, in liaison with WHO, would negotiate with the government to obtain agreement either to suspend the campaign or convert it into a pre-eradication operation; UNICEF aid might be given for a limited period to such small programmes.*/

The Board decided that it would once again re-examine the question of UNICEF aid to malaria campaigns in 1963. Since the next policy session of the Board was postponed until January 1964, however, this re-examination did not take place until then.

Present policy

By the time the Board reviewed the situation in 1964, the financial effects of the 1959 and 1961 policy decisions were becoming apparent. Aid had been discontinued for some dozen control or pilot projects in Africa for which there was, primarily for technical reasons, no prospect for eradication; no commitments had been entered into for any large new programmes; and some of the campaigns assisted over a period of years were reaching the stage where less UNICEF aid was needed. In 1960 UNICEF had allocated $8.5 million for malaria, constituting 37 per cent of programme allocations. From 1961 through 1964 the allocations averaged in the neighborhood of $5.5 million annually which constituted about 17 per cent of the programme allocations.

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*/ E/ICEF/431, paragraph 95.

While some representatives expressed the hope that this downward trend would continue, others believed that UNICEF should be spending more annually on malaria than had recently been the case. The latter pointed out that protecting children from the ravages of malaria was fundamental to their welfare, and that attempts to eradicate malaria in a UNICEF-aided project in one country were unlikely to succeed as long as malaria flourished in neighboring countries. While a time limit could be applied to operations in a single country it could not be simultaneously applied to all countries. Some countries were just building up the necessary infra-structure, with UNICEF help, and would soon be ready for the first phase of an effective malaria campaign. It would thus be wrong for UNICEF to close the door to aiding them.

While this general point of view was accepted by other representatives, they pointed out that some specific safeguards were essential from the standpoint of UNICEF objectives. The international responsibility for malaria work rested with WHO not with UNICEF. There were some countries where malaria problems were so large that it would be quite beyond the foreseeable resources of UNICEF to give them adequate assistance. From the UNICEF point of view priority accorded to malaria eradication should vary from country to country in accordance with the relative urgency of malaria as a problem for children. While UNICEF should continue aid to projects where the countries concerned were carrying out their agreed-upon obligations, it should participate in new campaigns only if: it could do so without unbalancing UNICEF's overall programme; the country gave malaria a high priority in child health and consequently was prepared, if necessary, to forgo other types of aid; no other sources of financing were available; and the future financing of the project to its completion was reasonably assured so that UNICEF would not be expected to assume increasing responsibility.

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These points, in essence, constituted the policy adopted by the Board in January 1964. The Board also agreed that in countries which were not conducting malaria eradication campaigns UNICEF aid to anti-malaria work should be limited to strengthening basic health services. Where these services were giving special attention to malaria some specific UNICEF supplies for anti-malarial work could be given. The Board also decided that it was no longer necessary to fix a ceiling or a floor on annual allocations for malaria work.*/

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*/ E/ICEF/492, paras. 36-51.

Yaws

At its third session in April 1949 the JCHP considered a note prepared by the WHO Expert Committee on Maternal and Child Health recommending assistance for programmes to combat skin diseases of children, including yaws. Yaws was endemic throughout a "belt" encircling the globe, including most of the tropical countries. Particularly in countries affected by the war, the disease had become rampant because of the interruption of treatment facilities. Thepopulation exposed to this highly infectious disease was estimated by WHO at 200 million. In 1948, the U.N. Special Mission to Haiti had recommended an anti-yaws programme for that country, and the Parran/Lakshmanan report on the survey of needs in Far Eastern countries, which was considered by the Board in July 1948, had also recommended several anti-yaws programmes.

The JCHP endorsed assistance to such programmes, and in June 1949 the Board approved, authorizing the Executive Director to proceed with the formulation of plans of operation for Far Eastern programmes, three of which began field work in May 1950. In October 1949 the first anti-yaws programme in the Latin American region (for Haiti) was approved; in April 1951 in the Eastern Mediterranean Region; and in June 1952 in Africa. Since then, assistance has been allocated for a total of 39 country programmes, of which 17 are still in operation.

All programmes were planned in accord with the recommendations of the WHO Expert Committee on Venereal Diseases and Treponematoses, and were based on the use of penicillin, which had recently been demonstrated as far more rapid and effective in the treatment of treponematoses than the previously used arsenicals.

UNICEF's earliest allocations for yaws programmes were based on UNICEF providing penicillin for the treatment of mothers and children under 18 years of age, and the governments providing for all other persons treated. In view of the great difficulty governments experienced in obtaining sufficient foreign exchange to purchase penicillin, then extremely costly, UNICEF soon agreed to provide all the penicillin required by a programme on condition that the government increased its local currency expenditures for expansion of the programme by an amount equivalent to the expenditure it would otherwise have made on penicillin. This liberalization of policy was welcomed, and from 1952 all programme allocations were made on this basis.

Otherwise, UNICEF's policy on aid to yaws programmes has varied only in accord with changes in technical criteria that WHO made as experience increased and it became clear that eradication of yaws could ultimately be achieved. In the early days, several injections of penicillin were given to each patient, but by 1952 it became clear that one injection of a sufficient dosage would suffice, and on WHO's recommendation all programmes changed to the "one shot" technique, which reduced the requirements of penicillin. WHO progressively refined dosage and treatment schedules, particularly as to the prophylactic treatment of the entire population in districts of high incidence and difficult accessibility. As the campaigns developed and population coverage increased into the tens of millions, several programmes, in consultation with WHO, worked out modifications of field techniques to suit particular needs of the country. These and other changes involved adjustments in UNICEF allocations, which were progressively incorporated through the normal procedure of obtaining WHO's technical approval of each project recommendation before its presentation to the Board.

In the early years, WHO provided technical advisors for most country programmes, and WHO has continued to act as international coordinator. In this role, WHO organized the first international yaws conference which was held in Thailand in 1952. The results of this conference were included in a special report prepared by WHO, at the request of the Programme Committee, and presented to the Board in September 1953. The Board noted with satisfaction WHO's conclusion that, with modern methods of control, there was no reason why millions of people throughout the world should continue to be affected by yaws. Mass campaigns were being successfully organized and executed, and moreover frequently paved the way for acceptance by the people of other health measures.

After the second international yaws conference sponsored by WHO in Africa in 1955, special attention was drawn to tropical Africa as holding the largest remaining continental resevoir of yaws, and the Board in March 1956 endorsed planning for yaws work in Africa on a regional basis. In 1957 various reports placed before the Board noted specially the need of appraising results of yaws campaigns at various stages of their development in order that strategy might be reoriented as necessary; also that while the "consolidation" stage of a campaign in a specific area might be reached after two or three resurveys, the total number of areas to be covered in a campaign might be so large that the mass phase might take a number of years. The need for integration into existing permanent health services was several times stressed. Adequate arrangements for this were made as each mass campaign came to a close. In the largest campaign, integration was built in area by area, which the Board noted with satisfaction.

The Executive Director's reports continued each year to inform the Board on progress of the yaws programmes. A third international conference sponsored by WHO in Bandung in 1961 discussed strategy on dealing with "the last few cases" in many areas where yaws had been eradicated, and foresaw the eventual eradication of the disease throughout the world.

At the end of 1964, the total number of persons examined in the 39 country programmes assisted by UNICEF was _____ (total number of examinations in initial and resurveys: _____). _____ cases and contacts had been treated.

Present Policy on aid to yaws programmes.

The Board has continued to approve assistance to existing yaws programmes in accordance with WHO's technical criteria, conformity with which is assured by technical approval of WHO for each project recommendation prior to its presentation to the Board. No new programmes are envisaged.

Venereal Disease

Programme discussions undertaken with European governments in 1947-48 had pointed up a particular problem, aggravated by war-time occupation in many of the countries, concerning venereal disease in young mothers, passed on in congenital form to their babies.

When, in October 1947, the Board earmarked a fund for the provision of supplies for medical programmes, priority had been specified for governments wishing to take-advantage of developments in medical science which had recently made possible the eradication of syphilis.

Nine European governments requested assistance for VD control programmes. The requests were revieved by the JCHP at its second and third sessions in October 1948 and April 1949, and programmes were approved in accord with the principles set by an ad hoc committee convened by WHO for the purpose of reviewing the proposals.

Subsequently, allocations were approved for programmes in the Far East that had been discussed by Drs. Parran and Lakshmanan during their survey, and later for every region, to a total of 12. Of these only 4 were major programmes dealing solely with venereal disease; one of those is still being assisted in the last stages of a five-year take-over by Govt. The others programmes provided treatment for VD as part of a yaws control programme. In addition, some of the MCH programmes have included aspects of VD control.

Policy of assistance to VD programmes

UNICEF assistance has been concentrated on those aspects dealing with maternal and congenital syphilis.

UNICEF allocations

Allocations for yaws (including syphilis) have been as follows:

	Africa	Asia	East. Med.	Americas	Total
			(thousands of U.S.$)		
1947-50	-	1,667	112	320	2,099
1951-55	953	1,518	41	272	2,784
1956-60	1,087	1,468	138	61	2,754
1961-64	309	202	14	14	539
	2,349	4,855	305	667	8,176
Per cent of total allocations (excl. emergencies and freight) and adjusted by geographical regions	6	5	1	1	3

MG
5 April 1965

Trachoma and Related Eye Infections

In 1952 when WHO and UNICEF entered the field of trachoma control it was not without some misgivings. Although anti-trachoma campaigns were already in operation in some countries the approach had been largely of a clinical nature. There were questions as to the feasibility of large scale collective treatment since, while certain of the wide spectrum antibiotics were specifically effective in trachoma, frequent application (3 to 4 times daily) over long periods (2 to 3 months) was considered necessary to cure the average case. Moreover there was a paucity in most countries of basic epidemiological data on trachoma and associated eye infections and a shortage of opthalmologists with training or experience in public health work.*/ It was clear moreover, that work for the control of trachoma needed to be directed not only against the disease itself but also against related or associated conditions particularly epidemic conjunctivitis. The basic principles of trachoma control included case-finding and treatment of patients; national health education of the people, adapted to their particular conditions; destruction of possible vector agents and other measures for the improvement of environmental sanitation.

However the agencies agreed that the magnitude and the gravity of the problem justified provision of international aid, for a number pilot projects. Some of these projects include trials of mass treatment which, following various field studies might result in the development of effective control measures in relation to specific epidemiological conditions, to applicability on a large scale

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*/ It was clear that much research remained to be done and experience developed since there were important differences of opinion among experts on the etiology, epidemology, and therapy of trachoma.

and to the economic resources of the country concerned. It was estimated that some 500 million persons were victims of this painful infection, contracted mainly in infancy, which caused damage to the eyes and was the leading world cause of blindness.

The UNICEF Executive Board reviewed the progress made in 1956 and again in 1959 on the basis of recommendations by the JCHP which had had the benefit of progress reports by WHO on the projects and reports of the WHO Expert Committee on Trachoma.*/ Several types of treatment operations were being used depending in part on the prevalence of trachoma: treatment of school children (either all or on a selective basis); assembling the whole population at given places or by systematic house-to-house visits; mass case-finding and selective treatment; and contact-tracing and self-treatment on a family basis. In the search for effective but economical control, several methods of treatment were being tried including "intermittent"**/ rather than continuous treatment.

The WHO review of trachoma activities, which had been endorsed in the report of the JCHP, pointed out that participation of international agencies in projects should be subject to the following conditions: the carrying out of a preliminary survey with the help of a WHO expert; provision for a pilot phase; and the agreement of the Government to appropriate sufficient funds and provide personnel and other resources to continue the project after international aid ceased. The JCHP made recommendations regarding epidemiological research, field surveys, further training of auxiliary personnel, the development of methods for reaching pre-school children and family contacts and more remote areas where schools do not exist.

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*/ By 1958 eleven projects were being aided (3 in Africa; 3 in Asia; 3 in the Eastern Mediterranean, and 2 in Europe) and more than 3 million cases of trachoma and season conjunctivitis had been treated or were under treatment.

**/ This consisted of application of the ointment twice daily on three to six consecutive days each month for six months. In addition to simplifying the organizational arrangements and saving on staff, the requirements for antibiotics were very considerably reduced.

/...

It also recognized the need for programmes of environmental sanitation and health education as parallel activities, and the importance of estimating per caput cost in the evaluation of control programmes.*/ In conformity with the above criteria, the JCHP recommended, and the Board approved continuing assistance to anti-trachoma programmes.

No general review of policy with regard to UNICEF aid for trachoma control has taken place in the UNICEF Board since 1959, although in reviewing allocations for individual projects the UNICEF Programme Committee has on several occasions had statements from WHO representatives on overall developments in this field, including technical problems requiring research, and the reason why on the basis of experience, certain projects had been reorganized. In 1962 a WHO sponsored conference of opthalmologists and public health experts from Asia and the Eastern Mediterranean regions discussed, as one of the principal topics, the incorporation of anti-trachoma activities into general health service, and community development programmes.**/

While some encouraging progress had been made in developing a trachoma vaccine, a great deal of further research in the laboratory and the field is still needed before it will be known whether a vaccine can be produced which is safe, effective over long periods, and practically applicable to mass campaigns. Should effective immunization agents be developed it might open up large new approaches for combatting trachoma.

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*/ E/ICEF/R. 623, para. 6.3(b).

**/ This was the fourth inter-country trachoma conference organized by WHO since 1958. In December 1963 WHO sponsored a meeting of a scientific group on trachoma research to study the current status of research and advise on future studies.

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The main current criteria for UNICEF aid to anti-trachoma projects, reflecting the technical guide-lines laid down by the JCHP and the emphasis in aid set by the UNICEF Programme Committee and the Executive Board in approving individual projects may be summarized as follows:

- sufficient epidemiological investigation preparatory to the planning of a programme, to ensure no waste of money and effort;
- pilot trials of various treatment methods, to ensure adoption of the most economical method that will be effective;
- assurance of adequate leadership, national and international, for periodic epidemiological assessment, to ensure reorientation as and when necessary;
- assurance of adequate training facilities, and arrangements for health education particularly with reference to the environmental factors concerned.

The comparatively high cost and long duration of anti-trachoma projects necessitated a close examination by UNICEF, prior to their approval, of the following factors which are considered essential for the success of these projects:

- the extent to which public co-operation (particularly from teachers and community leaders) will be available, and the extent to which permanent health personnel can be used;
- consequently, the amount of government expenditure that will be required for payment of special personnel and facilities;
- dependent on these factors, and on the nature of the programme recommended by WHO, whether UNICEF can reasonably afford to assist, and whether the government can afford to support during and after the end of international assistance, an effective programme;
- in programmes leading eventually to self-treatment by the public, whether the government has the means to make available to the public anti-biotic ointment of a satisfactory quality at a price within the reach of the lowest economic classes.*/

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*/ This calls for purchase or local production by the government, and a subsidy from the government. UNICEF-provided ointment may not be used for the purpose of subsidized sale since under UNICEF's terms of reference all provisions made by UNICEF are for free distribution.

/...

Present position

UNICEF assistance has been allocated to a total of 18 trachoma programmes, of which 12 are still in operation (4 each in Africa, Asia and the Eastern Mediterranean). The cumulative total of cases treated since the inception of the first programme up to the end of 1964 is _____. In the period 1962-1964 allocations for trachoma control have averaged around $900,000 annually.

At its fifth session in April 1952, the JCHP, at the request of the UNICEF Board, considered the question of assistance to countries in the supply of modern drugs for the suppression and cure of leprosy. The JCHP noted that while treatment of cases would be of undoubted value, emphasis should be laid on the importance of education, proper housing and general development of the level of life of the population. While assistance could be recommended in principle, it should be made clear to governments ~~inquiring about UNICEF assistance to leprosy control~~ that leprosy could not be controlled by the use of drugs known at that time. On the question of local production of such drugs, the JCHP noted that aid should not be given because intensive research work was going on in relation to a number of different drugs and allied products, and an expensive plant erected at that time might be outmoded very shortly.

In March 1953 the Board approved assistance to an African country for a leprosy control programme, but decided that no further projects would be approved until the subject had once more been reviewed by the JCHP. At its sixth session in May 1953, the JCHP accordingly reconsidered the question. A paper prepared by WHO informed the JCHP that a good deal of progress had been achieved in recent years, both in respect of better understanding of the situation of leprosy patients from the human and social point of view, and in respect of their treatment with sulfone drugs. While the exact magnitude of the problem was unknown, it was estimated that from 2 to 7 million cases of leprosy existed in the world, and that most of these cases were in the tropical and underdeveloped areas, where the disease was an important public health problem. Generally, leprosy was thought to be more commonly acquired during infancy and childhood than later in life. Modern leprosy control measures, primarily dealing with the protection of children, and including health education, early case-finding and diagnosis, adequate sulfone

therapy, organization of dispensaries and domiciliary care, home isolation and institutional treatment of selected cases, were helping to eliminate great obstacles to leprosy control. The JCHP recommended that international aid to governments' efforts to control leprosy could take the following forms (subject to determination in each individual case): supply of drugs; equipment for dispensaries for laboratory diagnosis and treatment of cases; provision of health education supplies and equipment; training facilities and fellowships; provision of personnel, including consultants to carry out surveys and help in the organization of anti-leprosy services; transportation for technical personnel; improvement of conditions in leprosaria.

In September 1953 the Board approved inprinciple UNICEF aid for large-scale modern leprosy control measures, the nature of the aid to vary in each individual case along the lineslaid down by the JCHP. In 1954 only one other small programme in Asia was presented for approval, but in March 1955 the Executive Director called the attention of the Board to a number of recommendations for leprosy programmes placed before it at that session. Experience in Africa had indicated that leprosy control projects could develop fast and successfully. The key element was concentration on ambulatory treatment by the simplest possible methods, to achieve widest possible coverage. The application of ambulatory treatment was removing fear of confinement, and experience in Africa was proving that when people had no reason to hide leprosy, they came forward eagerly for treatment, bringing their children who could thus begin treatment at an early stage. Most of the field work was being done by auxiliary personnel, supervised by leprosy control officers. The cost of ambulatory treatment in two African programmes was proving to be far less than that of segregation: for the cost of running an agricultural colony for 2,000 patients, one government found it could treat 20,000 by the out-patient method. In general, segregation was being considered only for a few selected

patients. While it could not be assumed that methods successful in Africa would work everywhere (e.g. in other countries it might be necessary to put more effort into case-finding and the examination of contacts), it appeared likely that UNICEF aid could be effectively used.

At that session of the Board (March 1955) 6 more leprosy programmes were approved, for a total of 8 (4 in Africa, 3 in Asia, and 1 in the Eastern Mediterranean) By the end of 1958 UNICEF was assisting 18 programmes in Africa (virtually every country in west and equatorial Africa was conducting a UNICEF/WHO-assisted programme) and the number of programmes in Asia had risen to 5.

By March 1959, trends in leprosy control had crystallized and were definitively stated in reports to the Executive Board by the WHO Chief Medical Officer on leprosy and by the JCHP. The efficacy and lack of toxic effects of sulphone treatment had made practicable mass ambulatory treatment by auxiliary medical personnel, without the use of compulsory segregation. The aim of leprosy control campaigns should be: the finding and recording of all leprosy cases; regular treatment of all cases to reduce the reservoir of infection and prevent fresh infection; protection of healthy individuals exposed to infection by direct contact; social reintegration of leprosy patients, and the physiotherapeutic and surgical rehabilitation of cases with curable disabilities. The planning of programmes required: a preliminary survey in countries or areas where inadequate data about the prevalence and distribution of leprosy existed; pilot projects in which the medical and auxiliary personnel for expanded programmes could be trained; arrangements for progressive integration with existing public health services, both for continuation of treatment and for surveillance of arrested cases; arrangements for periodic assessment of the results of the campaign. Research was continuing as to improved treatment media. Special measures to protect children should include repeated examinations of children of leprosy patients. Studies to determine the value

of BCG prevention and chemoprophylaxis of child contacts were being carried out. The need to modify legislation in regard to leprosy had been stressed at recent international conferences on leprosy. Special efforts were needed toward the social, economic, and physical rehabilitation of leprosy patients.

In 1960-63 the attention of the Board was called to increasing stress being laid on the need to ensure regularity of treatment. Treatment, particularly of lepromatous and border-line cases, had to be extended over several years, even after the patient had become bacilli-negative. Patients were likely tofall off in attendance and drug-taking. This was presenting severe problems in every programme. In subsequent reports by the Executive Director attention was drawn to increasing evidence that the organization and supervision of programmes had to be strengthened to ensure regularity of treatment for a sufficient length of time.

In June 1963 the Programme Committee suggested that since many of the leprosy campaigns had been in operation for many years, they should be thoroughly reviewed as to their value and efficiency.

The JCHP at its February 1965 session reviewed a comprehensive report by WHO on world-wide progress of leprosy programmes. The JCHP's report is being presented to the Board at its June 1965 session.

Present Policy on Aid to Leprosy.

UNICEF policy on aid to leprosy control programmes has emphasized the following points:

(a) case-finding and ambulatory treatment;

(b) progressive integration with existing public health services;

(c) as usual, conformity with technical criteria as evolved by WHO, ensured through technical approval of WHO for each project recommendation prior to its presentation to the Board. (In recent years, the main technical

criteria have been maintenance of the regularity of treatment at an adequate rate (or efforts to raise it to an adequate level), and adequate population coverage during case-finding, including contact tracing tracing and examination, which relates mainly to children).

(d) progressive closure of sanitaria and leprosaria, to release national funds for expanding ambulatory treatment programmes, and measures taken by governments for social and economic rehabilitation of leprosy cases released from segregation;

(e) progressive revision of legislation where national laws previously required the segregation of leprosy cases;

(f) strictly limited assistance for rehabilitative surgery, since this involves mainly adults.

The conclusions of the JCHP in February 1965, which the Board will review at its June 1965 meeting, recommend continued assistance to leprosy control programmes pending the recommendations of the WHO Expert Committee on Leprosy to be held in the second half of 1965.

Present Position of Leprosy Programmes assisted by UNICEF.

By the end of 1964 UNICEF had allocated assistance for a total of 39 programmes, of which only 2 had been completed. Of the 37 operating programmes, 22 are in Africa, 8 in Asia, 6 in the Americas, and 1 in the Eastern Mediterranean. The first of these programmes was approved in 1953.

According to a WHO estimate at the end of 1964, of an estimated 8.5 million cases throughout the world, 2.8 million were registered, and 1,8 million were receiving or had received treatment in varying degrees.

Patients reported to have been treated or under treatment in the 37 UNICEF-assisted programmes at the end of 1964 totalled: _____.

UNICEF allocations to leprosy programmes have been as follows:

	Africa	Asia	East.Med.	Americas	Total
	(thousands of U.S. Dollars)				
1951-55	357	18	23	18	416
1956-60	1,677	484	-	251	2,412
1961-64	1,619	1,024	70	68	2,781
	3,653	1,526	93	337	5,609
Percent of total allocations (excl. freight and emergencies, and adjusted according to geographical regions)	10	2	-	0.5	2

Bilharziasis

At its eleventh session in October 1958 the JCHP reviewed a document prepared by WHO entitled "The present situation of Bilharziasis and Review of Bilharziasis Control". The magnitude of the problem, and its particular importance to children as principal victims, were noted. The disease is caused by a parasite living in the blood vessels. Aquatic snails are the intermediate hosts, and the infection is acquired by man through contact with snail-infested waters. A WHO expert who attended the March 1959 session of the UNICEF Board pointed out that bilharziasis, widespread in Africa, the eastern Mediterranean, some countries of Latin America and the Western Pacific, was recognized to be second in importance only to malaria as a parasitic disease. Some 150 million persons throughout the world were suffering from it, and incidence was increasing, due to new irrigation schemes and the concantration of populations in newly irrigated regions. The disease damages various organs of the body, affects the physical and mental development of children, and greatly diminishes the strength and economic capacity of adults. The JCHP, considering some success in control operations reported by WHO, recommended UNICEF participation in WHO-assisted activities in instituting pilot projects in countries where bilharziasis due to certain types of snails (Schistosoma japonicum, S. haematobium, and S. mansoni) was prevalent. The need for coordination of activities between public health, irrigation, public works, agricultural, fishery, education, and other relevant authorities was emphasized; also the value of environmental sanitation measures and health education. International assistance should follow principles established by WHO.

In March 1959 the Board approved in principle UNICEF aid for projects as outlined by the JCHP.

Only two project recommendations have been presented to the Board and approved, one in Asia (completed), and one in the Eastern Mediterranean (operating);

Filarial Infections

The JCHP at its thirteenth session in March 1962 considered a report on filariasis (Wuchereria and Brugia infections), which are of great socio-economic importance in many tropical areas, certain types of which are often contracted in childhood. While some control measures had been found effective, there were still many obstacles, and much more knowledge needed to be acquired. The JCHP recommended UNICEF assistance for a few surveys and pilot control projects aimed at providing attitional knowledge. These would be in the nature of field investigations.

The Board in June 1962 accepted this recommendation of the JCHP.

Only one project, in the Western Pacific Region, has been presented and approved.

Typhus

Two projects were approved in Nov. 1949 for Latin America for the control of typhus by dusting affected populations with DDT powder. The approval was recommended by the Medical Sub-Committee and formed part of the general recommendation for approval of insect-control programmes. Two similar projects were later approved for Asian countries. All were successful. All are completed.

Brucellosis

Two programmes were approved for European countries in 1948-49, on the recommendation of the Medical Sub-Committee, as part of the general allocation for medical programmes in Europe.

Mycosis

Two programmes have been approved, both in the Eastern Mediterranean; one is completed, one is operating. They were approved as part of general child health activities, to meet particular problems in these countries, and involved no policy decisions.

At its third session in April 1949, the JCHP considered a report by WHO on the status of penicillin plants erected in five European countries with assistance from UNRRA. In some cases, these plants were already out-moded and needed supplemental equipment. The WHO report suggested that, in view of the value of promoting penicillin production in countries where it did not then exist, in terms of the importance to children of control of venereal and other diseases, the JCHP might wish to advise UNICEF to consider requests from the countries concerned for the necessary supplemental equipment. The JCHP so recommended, with the proviso that the Executive Board of UNICEF should itself determine the propriety of such assistance from the point of view of UNICEF's general policy. In July 1949 the Board considered the matter and authorized the UNICEF representatives on the JCHP to concur in the use of funds for thisspurpose from the $ 1 million UNRRA grant to WHO (which had been made on condition that the entire amount should be used for programmes approved by the JCHP for the benefit of children).

At its fourth session in May 1950, the JCHP considered two papers by WHO on the production of insecticides and of antibiotics. With regard to insecticides, the Secretary General of the United Nations, in a report to the Economic and Social Council in May 1949, had drawn attention to the fact that the manufacture of the basic insecticidal substances was concentrated in a few countries possessing large chemical industries, but that the full production from these was not being used because of the lack of funds or of foreign currency in the countries where the insecticides were not produced, but where they were most needed. In view of the great importance of programmes using residual insecticides in reducing infant mortality and in improving the health of children, WHO proposed that the JCHP examine the principle of UNICEF contributing funds for

the establishment of plants for the production and formulation of insecticides, ~~formulations~~.

With regard to antibiotic production, the WHO document referred to the first meeting of the WHO Expert Committee on Antibiotics (April 1950) which had noted that the methods of manufacturing antibiotics had become standardized, that capital outlay was not great, and that the same equipment with some modification could be used to manufacture many antibiotics. The Committee had recommended that WHO do everything possible to assist governments in obtaining essential equipment for the construction or expansion of plants. In view of the UNICEF Board's approval of provision of equipment for the European plants, WHO requested the JCHP to consider the principle of UNICEF undertaking requests from other governments in modernizing or expanding existing plants, or initiating new plants.

The JCHP approved both these proposals.

In December 1950 the Board was informed of a proposal received from WHO under which UNICEF and WHO would jointly assist the establishment of selected production plants, WHO providing the necessary technical aid, UNICEF providing imported equipment, and the governments providing buildings, locally available materials, and staff. Governments should firmly commit funds in national currency to cover all necessary expenditure, the funds to be provided against an agreed time schedule; and internationally accepted processing methods and to exchange knowledge with other production centres, all of which should be available as training grounds; and make satisfactory commitments regarding the use of the product of the plant.

On the basis of this proposal, a recommendation for the construction of an antibiotics production plant in India was approved by the Board in December 1950. In addition to the general criteria proposed by WHO, the Board specified that after the plant achieved production, penicillin to the value of the UNICEF contribution must be distributed free of charge to Indian children in accordance

with a plan to be agreed upon between the government and UNICEF.

In May 1951 the Board examined in principle the question of expenditures for capital investments. In order to provide safeguards, the Board decided that in addition to the basic principles governing UNICEF assistance generally, each proposal for UNICEF assistance for local production programmes should be examined on its merits, and should take into account certain factors:

- the benefits of the project should mature within a reasonable time;
- the benefits should accrue predominantly to mothers and children, and should continue to be available to them at or below cost;
- assistance should be restricted to items not locally available;
- the supply of raw materials should be ensured;
- the project should be financially and administratively sound; related to the country's permanent programmes of child health and welfare, and to its economic development; be approved by the appropriate U.N. department or specialized agency; and be within the means of UNICEF.

At the December 1951 session the Board engaged in further debate on assistance involving capital expenditure. Several representatives expressed strong reservations, and raised questions as to whether there were not more appropriate sources of financing than UNICEF.

Assistance was approved in 1951-54 for DDT production plants in two Asian countries, and for one in the Eastern Mediterranean, on the basis of no-profit-no-loss operation, all production to be used for public health programmes (primarily malaria control). Assistance was also approved in the same period for a second antibiotic production plant in another Asian country, and for expansion of two existing plants in Europe and Latin America, on the basis of free distribution to children of part of the production.

In discussion of these recommendations in the Programme Committee, representatives continued to express strong doubts, ~~as to whether this type of~~

On insecticides it was noted that the world supply situation must be taken into account; on antibiotics that the rapidity of new discoveries could quickly outmode production equipment. In particular, it was doubted whether this type of aid was appropriate for UNICEF, and whether the proposals fell within the criteria established in May 1951.

On these grounds, no recommendations of this nature have been placed before the Board since 1954.

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6.4.65

FAMILY AND CHILD WELFARE

Social Services for Children

UNICEF has been interested in social services for children from its earliest days. This interest was reflected in the assignment of child welfare advisers, seconded by the United Nations Bureau of Social Affairs, to the UNICEF European, Asian, and Central American regional offices, to be concerned with the "welfare" aspects of UNICEF-assisted programmes, particularly maternal and child health services.*/ There was at that time no concept of a separate field of social services which could usefully receive aid from UNICEF. Supplies and equipment, the only form of aid provided by UNICEF, was far less a critical item in welfare services than in feeding, milk conservation, basic health and mass disease control programmes.**/ It was not until it became possible to use UNICEF funds for local training costs that it became possible to conceive of individual social service projects on which the essential element, namely an acceptable quality of services by local staff, could be achieved and combined with some supplies and equipment from UNICEF which would serve to up-grade the quality of the services.

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*/ To encourage this the Board in 1951 decided to use the term "maternal and child welfare" instead of "maternal and child health".

**/ Most of the time of the child welfare adviser in Europe was devoted to receiving UNICEF supplies and equipment for the rehabilitation of physically handicapped children.

By the mid 1950's a new factor began to impinge itself upon the consciousness of the UNICEF staff and Board. It was the effect of social change in the developing countries on traditional ways of life. In many places where the change was rapid the individual lacked the protection and support of either traditional or modern patterns of social existence. This was especially damaging to children whose needs had previously been met through the extended family system and communal life. Social services were seen as necessary to repair or minimize the injurious effects of the transition. By some they were seen as having the additional role of providing opportunities for families and communities to adapt to, and learn better to cope with, the complex demands of modern life.

The UNICEF Board in 1959 approved in principle aid for social services for children on the basis of a special study on the possibilities for such aid prepared by a special consultant of the United Nations Bureau of Social Affiars.*/ The report pointed out that: there was an urgent need to improve the quality of care in many existing children's institutions; unless special measures were taken to develop other services there would be pressure to put more children in residential institutions; and there was a need for basic social services, of a preventive nature, which would help strengthen family life, improve the care of children in their homes, and keep the family together, such as day-care centres,

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*/ E/ICEF/377. The study had been requested by the Board the previous year, with particular reference to improved care of children in residential institutions and day-care centres as a possible beginning phase of a broader programme of child welfare and social services for children. E/ICEF/368.

neighborhood centres, family counselling and parent education services, youth clubs, and playgrounds. In addition all other community resources having direct contact with people (such as health centres, schools, churches, and home economics extension) should be used for education in family living and to help individual children with whom they come in contact. The quality of personnel was the most important consideration, and aid from UNICEF would have the greatest benefit if it were used in the first place to support the necessary development or expansion of training. The most important part of UNICEF aid would therefore be stipends for students and teachers. Priority should also be given to services which reach the more vulnerable age-groups, namely infants and young children. UNICEF supplies and equipment would be provided for institutions and services which serve demonstration and teaching purposes, or which there was assurance they would be used as part of a general plan for up-grading of staff and improving the quality of services.

As an over-all point of view regarding UNICEF aid for social services the report stressed that it would not be justified unless it were conceived of as a beginning towards a broader and more fundamental objective, namely that of assisting countries to develop well-organized national systems of social services which would help preserve and strengthen family life and foster opportunities for the health growth of the personality, abilities, and social habits of the child.*/

*/ E/ICEF/380, paras. 105-116.

Several problems, in addition to the shortage of trained personnel, influenced the development of projects. In most Governments responsibility for social services was not as well developed as in other fields, such as health, education, and nutrition. Although activity in this field by voluntary agencies was extensive and constituted a resource of great strength, it also made the question of coordination of national effort a more difficult one. Where voluntary agencies through the Government were the sponsoring bodies for projects, a number of questions were required to be worked out relating to the Government's role and the standards it should set: while private initiative should not be discouraged it was important not to set standards too low. In a number of places the first objective was not to induce greater local expenditures for social services but to produce greater benefits to children from existing expenditures, and this therefore required a different interpretation of the UNICEF matching principle.*/ In many places there was a tendency to be more concerned with remedial than preventive work; action necessary for a comprehensive social service programme might first require time-consuming social legislation. Because many of the projects necessarily involved health, nutrition, and educational aspects, co-ordination of these services was needed within the country and arrangements needed to be worked out to simplify arrangements between the United Nations Bureau of Social Affairs, which was the agency primarily responsible in the United Nations family, and the relevent specialized agencies. In order to secure all the necessary elements if international consultation and advice without duplication or delaying the preparation of projects.**/

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*/ See paragraphs _____ above.

**/ This question is discussed in more detail in the section on "UNICEF relations with agencies in the United Nations family".

Most of the initial projects approved by UNICEF were modest both in scope land cost, and the approach was experimental with no set pattern. As had been foreseen the major emphasis was on training but in some efforts were also made to strengthen planning and co-ordinating bodies.

In June 1961, following lengthy debate regarding the Executive Director's report of a survey of the needs of children in developing countries, the Board decided that the time had come to review the range of UNICEF aid with a view to broadening the fields in which it was operating, and opening new fields. (Action designed to meet the needs of children should depend on the judgement of the government of the country concerned, should be so planned as to form an integral part of the government's over-all programmes of social and economic development, and requests put forward by countries should come before the Programme Committee under its normal procedures, but new activities on the part of UNICEF should not be undertaken at the expense of activities that were being carried out successfully, nor should they result in fragmentation or dissipation of UNICEF resources and personnel.)

Among the ~~minimum~~ new or extended fields for which UNICEF aid would be considered, and for which the Executive Director was authorized to put forward recommendations to the Board, were activities designed to assist in preparing the child for adult life, including education and vocational training. ~~From~~ (Under an earlier policy decision the Board had agreed to extend aid only to the nutrition and health education aspects of teacher training).

Governments, apprised of this decision to broaden the fields of UNICEF aid, were quick to take advantage of the proffered assistance in the educational field. Within a year (at the June 1962 Board), 9 country projects had been approved, and by the end of 1964, 33 country education projects were being assisted, for which a total of $ 9.4 million had been allocated, plus 9 country projects in vocational training for which $ 1.3 million had been allocated.

By the end of 1964, in the course of consultations with UNESCO, ILO, FAO, and WHO in the development of the plans of operation for the country programmes, criteria for UNICEF aid to education had been considerably refined:

Since needs in education are vast, and since obviously UNICEF with limited resources must select the fields in which its aid can be most effective, the development of project recommendations for education programmes has been undertaken with great care. Some valuable sources of assistance in the preparation of project recommendations have been: the countries' own formulations of overall objectives and plans in accord with a series of regional educational planning conferences sponsored by UNESCO in the last few years; many country studies prepared by UNESCO; the reports of educational planning teams jointly supported by UNESCO and the regional Economic Commissions which have visited several countries in the last two years to assist the governments in projecting the costs of educational development at various levels; manpower surveys prepared by ILO; various reports and studies prepared by bilateral-aid groups.

In several instances, the project preparation fund has been used to reimburse UNESCO for the services of short-term consultants recruited to work with the governments concerned in the development of plans of operation for some of the larger projects recently approved by the Board. This has been particularly valuable. In other cases, joint visits have been made to countries by UNESCO and UNICEF regional staff to assist in discussing specific project plans with the governments concerned, and this too has helped greatly in the development of realistic plans. WHO, FAO, and ILO have been fully consulted in those aspects of the project plans which fall in their fields of competence, and care has also been taken to consult with other groups (U.S. AID, Ford Foundation, etc) which are also assisting the governments concerned. Several of the projects presented to the Board have represented undertakings in which the activities of several groups are complementary to each other.

The experience and consultation of the four years since aid to education was first approved by the Board in principle has resulted in a refinement of criteria for UNICEF aid along the following lines:

Aid to teacher training remains the most important need, both because it is a focal point from which aid can have a radiating effect, and because virtually every country study emphatically reveals an acute shortage of qualified teachers. In many countries, the same teacher must teach two or even three shifts of children in one day. In almost every country unqualified persons have had to be employed in an attempt to bridge the gap: the proportion of unqualified teachers is sometimes as high as two-thirds. These and other stop-gap measures result in poor teaching, which is ~~one~~ one of the most important causes of many of the ills afflicting the educational systems of developing countries, including very high percentages of "drop-outs" (children who drop out of school without completing the course, thus wasting the facilities that the countries are so hard put to it to provide), and of "repeaters" (children who must repeat a year's study, thus clogging the flow of pupils through the educational course). In almost every country a percentage (sometimes as high as 90 per cent) of primary school leavers cannot continue their schooling because of the lack of secondary school facilities, and this again is partly due to a shortage of secondary-school teachers. UNICEF aid as approved by the Board has aimed at improving both the quantity and

quality of teachers, including mainly: equipment for schools for instructors (teachers of teachers), teacher-training institutions, and the practice teaching schools attached to them; equipment and transport for supervisors of all types, particularly those of student teachers during their practice teaching periods; stipends or other local costs ~~[illegible]~~ (on a sharing basis with the government) for in-service or refresher training of instructors and of qualified and unqualified teachers. A very large variety of such short-term courses have been undertaken, including a correspondence course for one-year trained teachers to enable them to complete their training while teaching. Flexibility in this field has been one of the most valuable and helpful aspects of UNICEF assistance.

~~Secondary education (assuming that the basic elements of primary education already exist)~~

Secondary education has ~~[illegible]~~ next priority. The UNESCO publication on the "Elements of Educational Planning" notes that: "Economic expansion calls for ~~a~~ progressively higher and more varied qualifications .... this is increasing the importance attached to secondary education, no longer merely in its conventional role as a required course of preparatory studies for the university, but as a polivalent general education which will enable people to adjust to an evolving situation and ~~[illegible]~~ fill the very large number of posts necessary at the intermediate levels." W.A. Lewis says: "Failure to make adequate provision for secondary education is a major handicap to economic development. The products of secondary schools are the officers and non-commissioned officers of an economic and social system." In the contant of UNICEF's ~~[illegible]~~ graduates of secondary schools are the reservoir from which personnel will be drawn for the development of the health, education, and welfare programmes benefitting children and mothers which are the objectives of UNICEF aid.

UNICEF assistance to secondary education as approved by the Board has included mainly teaching equipment (plus assistance for ~~xx~~ training or re-training of teachers, as indicated above).

Both in primary and secondary education, the improvement of curricula is being emphasized. There is growing recognition that old-fashioned academic education provides insufficient preparation for most children. There is increasing accent on the revision of curricula to include practical education in such activities as agriculture and animal husbandry, manual arts, home economics, and industrial arts. The improved teaching of science has also been emphasized ~~xx~~ by UNESCO as ~~xxxxxxxx~~ essential to modern developmental aims. A high proportion of UNICEF assistance has been approved in the provision of equipment essential for the introduction or expansion of these types of teaching, mainly for teacher training.

Vocational and pre-vocational training. In the June 1961 policy decisions, the Board recognized specifically a need for vocational training in the preparation of the child for adult life, particularly where the children of rural parents were handicapped by a shortage of land and agricultural facilities. Other points at which vocational and pre-vocational training are valuable have been emphasized during the preparatory stages of project recommendations. The provision of such facilities ~~xxxxxxxx~~ helps to solve the problem of continuing education for primary school leavers ~~xx~~ where secondary education facilities are inadequate. Also, within the secondary education system, many countries are attempting to divert a larger proportion of students from the general education stream into the technical education~~xx~~ stream, to help provide the cadres of skilled technicians of which the countries are so badly in need. ~~xxxx~~ Vocational and pre-vocational training within a country may be the responsibility of the labour or social welfare authorities, but the needs as indicated above have resulted in an increasing interest by the educational authorities in including vocational

education within the educational system of the country. Much of UNICEF assistance in this field has been approved as part of an education programme rather than as part of a vocational training programme as such. An interesting sidelight is that there has been some emphasis on using UNICEF aid in this field for the training of girls, with accent on home economics, while for the training of boys bilateral aid has been used.

Other fields in which UNICEF aid has been requested are: (a) production of teaching materials, particularly textbooks, the dearth of which is a major problem in most developing countries. Some assistance has also been provided for the production of visual teaching aids. One or two countries are making a small start in local production of teaching equipment for schools, e.g. science teaching kits. (b) Libraries. Reversion to illiteracy is a real danger, particularly where attendance at school has been irregular and the degree of literacy acquired not great, and where writing and reading materials are rarely seen, e.g. in most rural areas. Some UNICEF aid has been approved for central library units to help increase the availability of library books, and also for the establishment of mobile libraries in rural areas. (c) Pre-school education. The generally under-developed state of such social welfare activities as day-care nurseries and crecnes has accented the need for pre-school educational facilities in some countries, and UNICEF aid has been approved mainly for the establishment of model kindergartens.

Fields in which UNICEF's resources are too limited for effective aid include general expansion of primary schools, and the provision of quickly-expendable materials. Teaching equipment for primary schools has been approved only where these schools are used for practice teaching by student teachers, or where pilot projects have been undertaken, e.g. "model schools" to be used for experimental or refresher-training purposes. Consumable materials (e.g. cotton cloth and thread for home economics projects)

have been provided only for the first year or two, to allow the governments time to include provision of these items in their budgets. Paper has been provided where there was a specific long-term need, e.g. in the production of textbooks, library books, manuals for teacher-training, correspondence course lessons, etc.

On an inter-regional basis, UNICEF has provided funds for fellowships (supplementing fellowships provided by UNESCO) for UNESCO training centres for educational planners and administrators. UNICEF fellowships have been provided under the conditionm that the fellows are connected directly with a UNICEF-assisted education programme.

COOPERATION WITH OTHER AGENCIES

The Principle of Cooperation

When in 1950 the Economic and Social Council decided to extend the life of UNICEF, one of the principles set was that the UNICEF Board "shall take all necessary steps to assure the close collaboration of the Fund with the specialized agencies and non-governmental organizations concerned with children, and to obtain from them the advice and technical assistance which it may require for the implementation of its programme." (E/1678, para 50).

This formally set down ~~x~~ one of the basic considerations on which UNICEF had worked from the beginning. In the earliest supplementary feeding programmes started in Europe at the end of 1947, the general technical principles governing the supply of protective foods were set ~~xxxx~~ for UNICEF by a Joint FAO/WHO Advisory Group of pediatricians and nutritionists. The decision in July 1948 to provide equipment for milk conservation occasioned the establishment of a Joint Fao/UNICEF Panel of Technicians to deal with the technical problems involved. Also in July 1948, the UNICEF/WHO Joint Committee on Health Policy was formed to advise the Board on medical programmes, and the Board in allocating funds to various programmes had set as a condition that the plan of operations should have the technical approval of WHO. In 1948-50, at the request of UNICEF, the U.N. Department of Social Affairs had appointed advisors to three of the UNICEF regional offices.

These cooperative moves had been taken in accord with the need felt by UNICEF for the technical advice of its sister agencies. On the basis of the Economic and Social Council's 1950 directive, the Board formally considered the matter of channels of cooperation, and confirmed as policy the position which had already been taken: UNICEF's function of providing essential equipment and supplies was complementary to certain functions of the specialized agencies, the U.N. Dept. of Social Affairs, and the Technical Assistance Administration, viz. the provision of technical advice and professional services to governments. UNICEF itself did not give technical advice. If Governments needed technical

advice and services in connection with projects for which they were also seeking supplies from UNICEF, their requests were referred to the appropriate agency. In addition, UNICEF needed the assurance that country plans for the use of UNICEF aid were technically sound, and for this assurance UNICEF relied upon the specialized agencies and the technical departments of the United Nations.

By the time these policy considerations were taken by the Board in 1950, it had already become accepted practice for the U.N. technical departments and the specialized agencies to have representatives participate in UNICEF Programme Committee and Executive Board sessions, and in the practical implementation of programmes, a number of channels of cooperation in the field had already worked themselves out. Over the years these channels have been sharpened and refined in practice, and ~~very~~ close and satisfactory (but not with all of them) partnership arrangements have developed.

Relations with WHO.

The formation of the UNICEF/WHO Joint Health Policy Committee was proposed by the First World Health Assembly, and approved by the UNICEF Board in July 1948 (E/901, para 57). At its third session in April 1949, the JCHP adopted formal terms of reference, (E/ICEF/151 Annex II), which were approved by the Board in July 1949 (E/1406 para 8).*/ These terms of reference included the provision that the Director-General of WHO would study and approve plans of operation for all health programmes falling within the policies laid down by the JCHP for which countries might request supplies from UNICEF.

By 1950, for the purposes of development of programmes in the field, WHO had appointed medical advisors to the UNICEF Directors in the regional offices at Bangkok, Paris, and Guatemala; in addition, an MCH advisor had been appointed

*/ Jack: it might be helpful to reproduce these in an annex, and to add a note on the present formation of the JCHP, representation, times of meetings, etc.

in Bangkok, and a public health advisor in the Paris regional office. */

A medical advisor (later two) were first appointed at UNICEF HQ in ____ **/.

With the establishment of the WHO regional offices, WHO's policy of progressive decentralization, and the gradual strengthening of the WHO regional offices to include at least one regional advisor in every branch of medical programmes, working relations between UNICEF regional offices became stronger and stronger. In 1952 a protocol for cooperation between the UNICEF regional office in Bangkok, and the WHO South-East Asia Regional office was worked out, which was extended later to all the WHO regional offices working with Bangkok. (I do not know if similar arrangements were made in the other regions, but I expect so). Smooth working relations have developed as follows:

- Budget information, particularly on advance-forecast budgets, is exchanged as soon as it is available, with mutual requests for comments. Both UNICEF and WHO regional offices are thus fully aware of prospective projects.
- Reports are mutually exchanged as soon as they become available.
- Consultation on a newly proposed project is undertaken as soon as possible. This usually starts in the field.
- WHO regional advisors, on their regular field trips around their countries, give UNICEF copies of their reports as soon as available, and whenever possible call at the UNICEF regional office either enroute to or back from their trip. In any case, they always call at the UNICEF field office, and field or regional office staff give them every possible assistance. Where possible, UNICEF regional staff trips are timed to coordinate with WHO regional staff trips, and vice versa. UNICEF regional and field staff always call at the WHO regional offices on their trips.
- By the time a programme comes to the stage of a Board recommendation, it is therefore already well known to the UNICEF and WHO staff, and a great deal of consultation has already taken place. UNICEF and WHO staff have collaborated in preparing the plan of operations. A copy of the Board recommendation is formally sent to the WHO regional

*/ The Bangkok posts were financed by UNICEF. All these posts were later abolished, but I cannot find out the exact dates of the abolishment. No doubt Admin. knows.

**/ Dr. Borcic was first in Paris. I can't make out what the arrangements were. No doubt you know, and can state if you wish.

director for approval (he is autonomous, except for a very few restrictions, where Geneva has the final say). WHO comments and/or provisos (if any) are conveyed to UNICEF HQ together with WHO approval before any project is presented to the Board.

- the plan of operations is formalized for signature as soon as possible after Board approval. This also is jointly undertaken, UNICEF sometimes preparing the final version incorporating all comments from WHO and the Govt., and WHO sometimes doing this. Signature is undertaken first by WHO and/or UNICEF, then by the Government.

  (Jack: I assume you will comment as necessary on HQ's relations with WHO, which I do not know).

  (Jack: I have said nothing about project personnel.)

- WHO has (most helpfully) arranged that copies of all reports of project personnel (except strictly confidential ones) are routinely made available to UNICEF direct. The only restriction is that UNICEF is requested not to quote from monthly reports, although we may quote from the quarterly reports)*/

- WHO project personnel work in very close association with UNICEF field staff.

In general, working relations with WHO are excellent and very closely cooperative.

Relations with FAO

After the constitution of the FAO/UNICEF Joint Panel for the planning and implementation of milk conservation projects, cooperation with FAO continued closely on milk conservation. FAO advice was available to UNICEF on supplementary feeding programmes through Rome, and nutritional consultants stationed in Geneva (to UNICEF Paris) and the Institute of Nutrition for Central America and Panama (to UNICEF Guatemala). Close cooperation was also maintained on the development of high-protein foods, through Headquarters technical staff. In September 1956, the

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*/ These are joint reports signed by the WHO senior team leader and his counterpart, but of course they are always prepared by the WHO staff.

first FAO advisor to UNICEF HQ was appointed.

In October 1957, after applied nutrition policy was approved by the Board, the Board asked the Executive Director to consider with the specialized agencies how best to achieve closer collaboration both in policy and in aid to governments in this field. In March 1958 (E/ICEF/368/Rev.1, paras 71-77) the FAO/UNICEF Joint Policy Committee was established. In March 1959 (E/ICEF/380, paras 78-84) its terms of reference were approved.*/

Field relations with FAO have developed more or less on the same lines as with WHO, but not so smooth and close because FAO is not decentralized. The FAO regional advisors are responsible, not to the FAO regional representative, but direct to their own divisions in Rome. They can do and say nothing without getting clearance from Rome first. Our best relations with FAO are purely on the field level, with their project personnel (reimbursed by UNICEF) who are theoretically restricted as the regional advisors are, but who often ignore all these restrictions and just work with us on a very close and friendly basis.

Relations with the U.N. Dept. of Social Affairs

(In E/ICEF/151 it says that child welfare advisors were appointed in 1948-50 to the regional offices in Paris, Bangkok, and Guatemala. But this must have been for very short periods. I don't even remember who the advisor in Bangkok was, in fact I don't remember any).

I leave it to you to fill in on this part, since you must know what developed, particularly in connection with the Alice Shaeffer report (which I understand you wrote) etc. etc. As far as I am concerned, relations with the Bureau are extremely difficult. They are so centralized that ~~nobody~~ none of them can move without clearance, and one or two people have to clear so many things that

*/ You may wish to reproduce the terms of reference in an Annex, and add a note as to the composition of the Committee, meetings, etc.

clearance takes a long time. In Bangkok, UNDSA staff are attached to ECAFE, and I suppose in other regions to the other Economic Commissions. They are as helpful as they can be, but with their operative, administrative, and budgetary restrictions, this is not much. As with FAO, their helpfulness in the region and in the field is in direct inverse proportion to the degree to which they are able or willing to ignore the restrictions placed on them by their HQ. and the degree to which UNICEF is willing to pay their travel.

Relations with UNESCO

Although UNESCO was from the beginning included as one of the specialized agencies with which UNICEF would cooperate as outlined in the first paras of this section, no close relation developed until 1954 when, as part of "Expanding UNICEF Aid to Rural Primary School Services" (E/ICEF/249) UNICEF aid was approved for nutrition and health education aspects only.

(I know that UNESCO was not happy about this, and considered the UNICEF Board was too restrictive, but I can't find any official references to this point of view).

Cooperation with UNESCO really began after the June 1961 policy decisions to include aid to teacher-training and primary and secondary education.

The first UNESCO advisor to HQ was appointed in September 1963.

At first cooperation with UNESCO was channelled only through Headquarters. Even when UNESCO started to establish regional offices (1960 or 1961 ? Mr. Opper will no doubt know), cooperation in the field was difficult because the regional offices were again highly centralized and the regional directors very restricted. There has been enormous improvement, however, and the latest directive from the UNESCO ADG to his Chiefs of Mission and Chief Experts and Field Experts (17 March 1965, attached hereto) is excellent. This directive is based on one that we developed with Dr. Rahman in Bangkok in 1962 and 1963.

It grows out of an education we gave to UNESCO in the field. (This is quite true) In general, the working relations with UNESCO have now developed along the same lines as with WHO. The Bangkok regional office staff is most cooperative.

Relations with ILO

ILO was also included from the beginning as one of the specialized agencies with which UNICEF would cooperate, but we have had not much to do with them, at least in Bangkok. In Bangkok, ILO has a Liaison Office with ECAFE, and we have worked with this office, but they have to clear on technical questions with the ILO Liaison Office in Ceylon. I believe there is also an ILO Liaison Office to the U.N. in New York, which is the one with which we work here.

Relations with U.N. TAB

We use UNTAB representatives every way we can in the field, particularly for the coordination of requests to EPTA, where we are paying for the personnel and we are anxious to get them transferred into the EPTA budget. Also, e.g. in Cambodia when we were anxious to have the Cambodians come to the Asian Institute, we asked the Resrep. to press the matter; in Indonesia for coordination with a Bureau that the government had which was supposed to corelate all foreign aid; in Laos as contact on the proposed education programme, etc. They are of value to us where we do not have our own office, and where there are no WHO or UNESCO or FAO personnel. It would be impossible, however, for us to work through the Resreps., as you can see from the foregoing. We do not need the Resreps for coordination with WHO, FAO, UNESCO, or ILO regional offices - it would just be adding another tier for nothing, and it would certainly burden the Resreps for no purpose. On the other hand, the Resreps or their staff certainly could not accomplish anything on our benalf. But we do use them, and they are very helpful, when we do not happen to have anybody on the spot, and where matters of coordination on EPTA are concerned.

A point you may wish to make here is that the Resreps do not have any bias on behalf of children - in fact, their bias is political and administrative.

last February (1965)
For instance, the Resrep in Laos (Mr. Galetti) cabled several times insisting that Mr. Bertrand of the UNESCO Regional Office in Bangkok and I should go to Vientiane to discuss an education programme, which ~~was all wrong~~. (turned out to be quite unsuitable.) The Government had no budget, no personnel, no teachers, and no idea of what they really wanted to do. It was just a sort of give-away that they wanted from us. But at a time when I was wildly busy (just before coming to New York) I had to take 3 days out and go to Laos on Mr. Galetti's insistence. And when ~~we~~ I got there, he insisted that ~~we~~ I should go and see a rehabilitation project that had just been started (rehabilitation for veterans) because "it would be very nice" if UNICEF would contribute something for children to that programme; ~~for children,~~ he was sure it would be fitted in. No idea of UNICEF terms of reference, priorities, objectives, or anything. He just wanted to make the U.N. ~~image~~ image as big as possible in Laos. It would be inappropriate to ~~Imagine~~ entrust the management of UNICEF affairs to people with that bias.

A.C.C.

You know far more about this than I do, and no doubt Mr. Heyward's information when he comes back from the latest meeting will be valuable.

Multiple Clearance.

A real headache. Since we are always the people who are anxious to get a programme implemented, and we have Board deadlines, etc., that we have to meet, we are always the ones who have to approach the agencies for their comments and technical approval. So the agencies all tell us what they think, and when their comments conflict (e.g. UNESCO vs. ILO, FAO vs. WHO), we have to try and straighten matters out and iron out differences, not only between the agencies, but also between each agency and the government. The Bureau is the most difficult of all,

because they do not take responsibility for their own comments. For instance, if WHO says that there is something technically wrong with a programme, they undertake to put it right. Thus a programme can proceed. But the Bureau says what is technically wrong, without undertaking to put it right; they hold up technical approval until it is put right. This naturally results in a state of programme paralysis. They regard "technical approval" not as a routine measure to ensure the soundness of a project within the bounds of possibility, but as a sacred function. They are Keepers of the Sacred Flame, or something.

I attach a few bits and pieces I dug out of the files foryou.

MG.

27.4.65.

REGIONAL DEVELOPMENTS

Europe

The first programme activity ever undertaken by UNICEF was a survey of children's needs in European countries made in April 1947 by Dr. Martha Eliot, Associate Chief of the U.S. Children's Bureau, on loan to UNICEF. Her report, confirmed by many others from the countries themselves and from other sources, of the appalling conditions of mothers and children in the war-devastated countries of Europe, led to the first emergency feeding programmes which at peak (1948-50) gave a daily supplementary meal to some 6 million European children; also to an emergency supply programme which provided to some 5 million children clothing and shoes processed by the countries themselves from raw materials provided by UNICEF.

Immediately after the beginning of these urgent emergency programmes, the Board turned to consideration of the principle laid down by the General Assembly that the ~~emergency~~ measures taken by UNICEF should be "so developed and administered as to utilize and strengthen the permanent child health and child welfare programmes of the countries receiving assistance." With this principle in mind, and at the same time taking into account priority factors affecting children and the technical assistance available from WHO and FAO, the Board approved major assistance to European countries in milk conservation equipment to help rehabilitate dairy industries; BCG programmes under Joint Enterprise; diagnostic equipment and streptomycin for child patients to aid the re-development of national anti-tuberculosis services; provisions for national maternal and child welfare services, particularly special needs such as transport for short-staffed health institutions, equipment for immunization, and the treatment of handicapped children and premature babies; supplies for anti-syphilis programmes, in view of the spread of venereal infection through war-time occupation, and the high proportion of young mothers affected.

Geographical Expansion

The needs of Europe were related to rehabilitation, and would decline progressively as the countries recovered. Representatives on the Board pointed out that in other parts of the world children's needs were as great, and of a longer-term nature. The Board had approved block allocations for assistance to China, Japan, and Korea in relief programmes, but at the same time the Board recognized the vast needs of children in other war-devastated Asian countries, many of which had only recently attained independence and were in the throes, not only of recovering from the destruction of war, but also of internal reorganization.

In October 1947 the Board approved a block allocation for Far Eastern countries other than China, and in the first half of 1948 delegated a team (Drs. Thomas Parran and C.K. Lakshmanan) to survey needs in these countries on behalf of UNICEF. On the basis of this team's recommendations, the first programme allocations for Asian countries were approved in July 1948.

In January 1948, the Ninth Pan-American Child Congress passed a resolution asking UNICEF to take into consideration the needs of children in the Americas. This led to consultations between UNICEF and several organizations with interests in Latin America, and to the delegation of Dr. R. Passmore as UNICEF's representative to discuss with Latin American countries the points at which UNICEF aid could best be made available. The first project recommendations for the Americas were approved by the Board in October 1949.

In the Eastern Mediterranean region, four BCG programmes had been implemented in 1948-49 under Joint Enterprise, and in August 1948 emergency

assistance had been allocated for mother and child refugees in the Palestinian crisis.*/ UNICEF personnel had been stationed in the area to help administer this aid. The office was gradually enlarged, and considerable country visiting was undertaken. In 1951, under the broader terms of reference assigned to UNICEF in 1950, long-term aid to Eastern Mediterranean countries began.

In Africa, the metropolitan governments then having authority had not approached UNICEF for aid other than for three BCG programmes implemented in 1948 under Joint Enterprise. In June 1951, under UNICEF's broadened terms of reference, the Board included a block allocation of $ 2 million for African countries in its target budget for the following year. The first project recommendations for Africa were approved in June 1952.

Needs

The needs of children in the various regions, as reflected in the reports reaching UNICEF, were essentially similar but showed regional characteristics. In Asia, the Parran/Lakshmanan report stressed that UNICEF's task would be very different from the one confronting it in Europe. The populations involved were enormous. The problems of hunger and malnutrition were chronic. Major public health diseases had become rampant because of the lack of medical services and medicines during the war. Malaria was the leading health problem and a major cause of death among children. Tuberculosis was spreading: where Mantoux tests had been performed, reactive rates showed up to 50 per cent of the children tuberculin positive at 6 years of age. Yaws was widely epidemic. Parasitic infestation contributed heavily to child morbidity and mortality. In many countries, the war had left virtually nothing of pre-war

*/ The provisions included milk and other foods for supplementary feeding programmes for about 500,000 mother and child refugees; equipment and supplies for medical programmes to control trachoma, syphilis, insect-borne diseases; a BCG campaign; pre-fabricated housing units for health centres, schools, and other community institutions. In 1951 the UNICEF-aided programme was merged with UNRWA activities, but UNICEF continued to support it financially until 1953. A total of $ 16.5 million was allocated 1948-53.

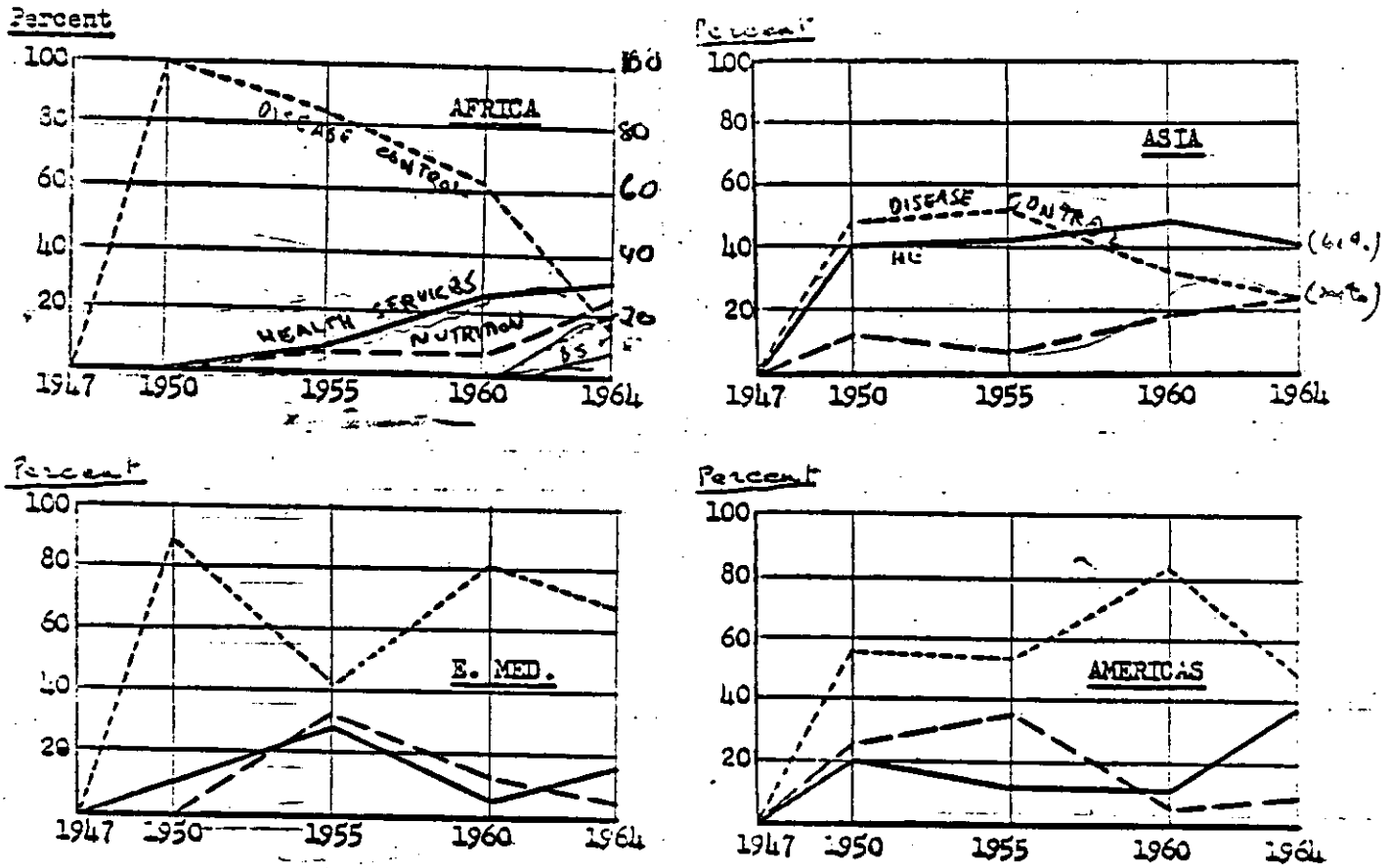
health institutions. Infant mortality rates were estimated at between 200 and 400 per thousand live births. In view of the enormous problems, UNICEF's limited resources, and the impracticability of attempting emergency impact programmes such as had been possible in Europe, the team had concentrated on discussing with Asian governments programmes which would have both immediate and long-range results.

In the Americas, although most countries already had advanced social and health laws, they had been implemented only on a small scale, resulting in uneven distribution of existing child health institutions and services, and extreme variation in their efficiency and effectiveness. It was estimated that between one-half and one-third of the children died before reaching their fifth birthday. Of those who survived, the majority existed in sub-normal health. Insect-borne diseases and tuberculosis were major causes of child mortality and morbidity, according to the few available statistics, but many leading Latin American pediatricians regarded malnutrition as the most important cause of death among children. Although calorie intake was generally adequate, the high consumption of foods with little or no protein content, and the extremely low intake of milk, of which there was a grave shortage, were perhaps the most important factors adverse to child health.

In the Eastern Mediterranean, there was generally little or no development of health and welfare services for children and mothers. Malaria, tuberculosis, bejel, and other infectious diseases were widespread and took a heavy toll among the children. In Africa, malnutrition, the general lack of basic health services apart from hospitals, and a host of other problems deeply affecting mothers and children, were recognized as needing major attention, but the enormity of the problem that the endemic diseases posed, and the vulnerability of children to these diseases, overlaid all else.

Health Services, Disease Control, Nutrition.

Until 1960, assistance was concentrated in these three major categories. The following charts illustrate the flow of development in the four regions.



PERCENT OF TOTAL */ ALLOCATIONS TO EACH REGION TAKEN BY THE THREE MAJOR CATEGORIES OF PROGRAMMES IN EACH REGION

Health Services: ——— Disease Control: ----- Nutrition: — — —

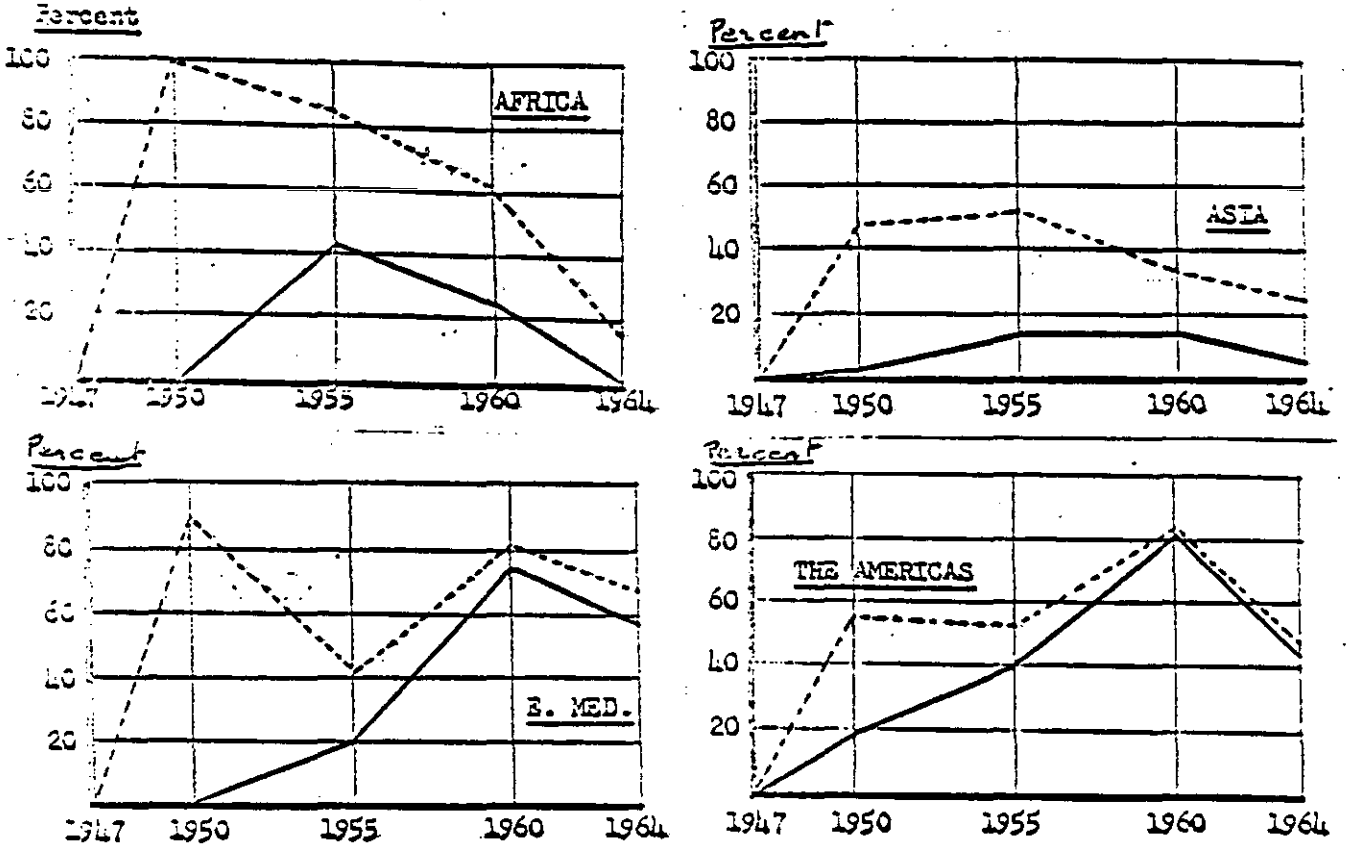
Disease Control

Although the comparative size of the problem of endemic diseases was greatest in Africa, in every other region governments were also primarily

*/ excluding allocations for emergencies and freight.

concerned with the overwhelming demand the major public health diseases were making on meager existing health services, and with the role they were playing in maintaining a state of chronic debility and reduced productivity of manpower among vast population groups. The urgency of finding a solution to these problems; the then recent discovery of effective means of combatting malaria and the treponemal diseases; the activity of WHO in these fields which, for the first time, was making widely available to governments expert technical advice and assistance; and the availability of material aid from UNICEF, all naturally combined in a rapid development of mass disease control programmes in every region on as wide a scale as the governments could undertake.

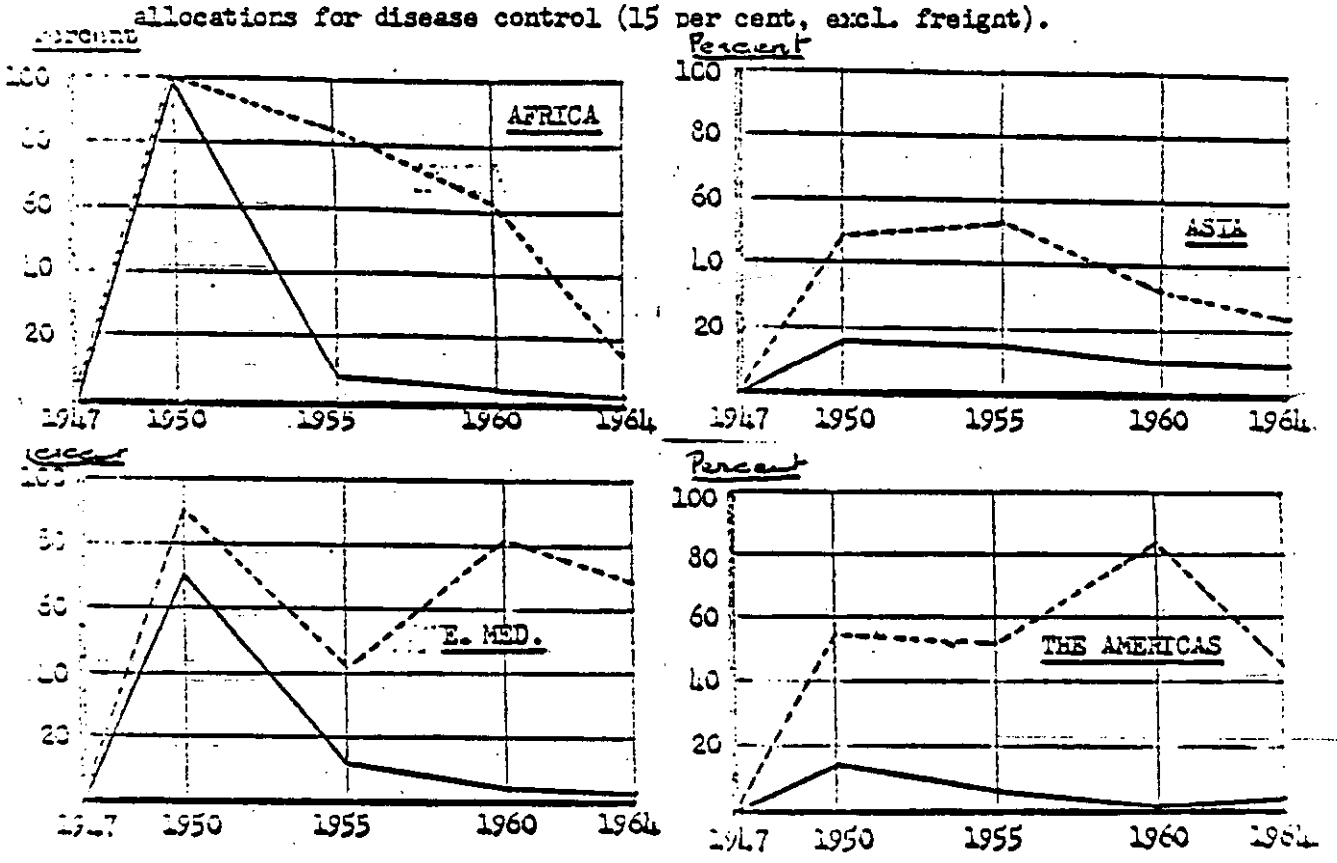
Malaria programmes have absorbed by far the major part of total disease control allocations (63 per cent, excluding freight):



PERCENT OF ALLOCATIONS FOR MALARIA PROGRAMES (_____) COMPARED TO PERCENT OF TOTAL ALLOCATIONS FOR DISEASE CONTROL (_ _ _ _) IN EACH REGION (excl. allocations for freight and for emergencies).

The comparative levels of allocations for malaria programmes were largely influenced by the fact that the informal division of financial responsibility for malaria eradication programmes which took place in 1958 left U.S. bilateral aid assisting most of these programmes in Asia, and UNICEF those in the Eastern Mediterranean and the Americas. In Asia; the decline in allocations after 1960 was accounted for by the decision of one government, which was conducting the largest UNICEF-assisted eradication programme in that region, to terminate international assistance. In Africa, the decline of malaria allocations after 1955 was due to the fact that, having been unsuccessful in finding effective means of interrupting transmission, the programmes remained as pilot projects. After 1960, for the same reason, UNICEF withdrew from all but one of the African malaria programmes.

TB/BCG programmes took the next largest proportion of UNICEF's total allocations for disease control (15 per cent, excl. freight).



PERCENT OF ALLOCATIONS FOR TB/BCG PROGRAMMES ( ) COMPARED TO PERCENT OF TOTAL ALLOCATIONS FOR DISEASE CONTROL ( ) IN EACH REGION (excl. allocations for freight and for emergencies)

Concentration of funds on TB in the period 1947-50 was due to the series of BCG programmes implemented under Joint Enterprise. Although considerable BCG work was maintained thereafter, the accent in most regions shifted to malaria. Development in Asia has been steadiest, particularly after 1960 when emphasis changed from BCG to domiciliary chemotherapy and the establishment of national pilot project areas. Although all regions are taking a small proportion of their disease control allocations for national pilot projects in TB control, only in Asia has there been development beyond the initial pilot areas. The number of TB patients under domiciliary treatment in Asian programmes is over 300,000 in 1965 (compared to about 2,000 in the domiciliary chemotherapy pilot projects in 1957-58).

The treponemal disease mass campaigns have taken about 7 per cent of total allocations for disease control (excl. freight). Major programmes have been operated only in Africa and in Asia. Success in these programmes has partially accounted for the decline in total disease control allocations to these two regions. Leprosy programmes have taken 5 per cent of total disease control allocations (excl. freight), again mainly in Africa and in Asia, and are continuing to take a relatively high proportion of allocations to Africa (7 per cent of total allocations to this region 1961-64). Trachoma programmes have accounted for only 2 per cent of total disease control allocations, and have been concentrated almost entirely in Asia. Allocations for other disease control campaigns, and for production plants (insecticides, antibiotics) have taken 8 per cent of total disease control allocations.

Basic Health Services

Although basic health service programmes were also undertaken from the outset in every region, the proportion of UNICEF assistance going into them has been considerably smaller than for disease control. They were more difficult to develop. Where mass campaigns used relatively small numbers of personnel, who were trained briefly to perform certain specific tasks, and paid under special short-

term budgets, basic health service programmes needed large numbers of personnel, who had to be much more carefully trained, and to employ whom payrolls had to be greatly and permanently expanded. Where mass campaigns needed little or no capital expenditure, basic health service programmes needed land, buildings, furniture, equipment. It was thus in the nature of these programmes to develop more slowly than mass campaigns, but the rate at which they did develop depended largely on the priority that they were accorded.

The comparatively high proportion of basic health service allocations for the Asia region was due to the strong accent placed on the development of networks, first of maternal and child health centres, and later of rural health units and other types of centres incorporating MCH. The Asian situation was distinguished from that of other regions by the very high population density of most Asian countries. The establishment of a health centre in almost any location made it immediately accessible to a comparatively large number of people, which not only made it worthwhile to establish the centres, but also created a demand for them which governments were eager to meet. Perhaps, also, Asia was more fortunate in having a larger reservoir of candidates for training than other regions. When other regions were reporting inability to fill training schools, Asian countries were reporting two or three candidates for every place.

A factor largely influencing the proportion of UNICEF funds absorbed in basic health service programmes is the scope of the programmes themselves. Where the development of basic health services is coordinated with community development, where improvement in environmental sanitation is undertaken on a wide scale, where a wide range of training is included (from the instruction of traditional birth attendants, to apediatric chairs in universities), programmes are able to absorb greater amounts of UNICEF assistance. Developments of this nature have taken place in all regions, but on a wider scale in Asia.

When the first project recommendations for Africa were put before the Board, no UNICEF representative had yet visited an African country. Initial

UNICEF assistance was in the context of the metropolitan governments' existing plans, and in accord with the needs as assessed by them. Their preoccupation with endemic diseases is reflected in the fact that in the first five year's of UNICEF assistance, only 7 per cent of total UNICEF allocations to Africa were taken for basic health service programmes. Development since then has been steady, but slow. The conflicting traditional influences left behind by metropolitan governments, and the multiplicity of social forms throughout the continent, which sometimes led to totally opposing concepts of what was normal in matters of parental responsibility for children, resulted in uneven development, and in an early and strong accent on activities aimed at the education of women (e.g. mothers' clubs) which were essential to pave the way toward acceptance of routine maternal and child health activities.

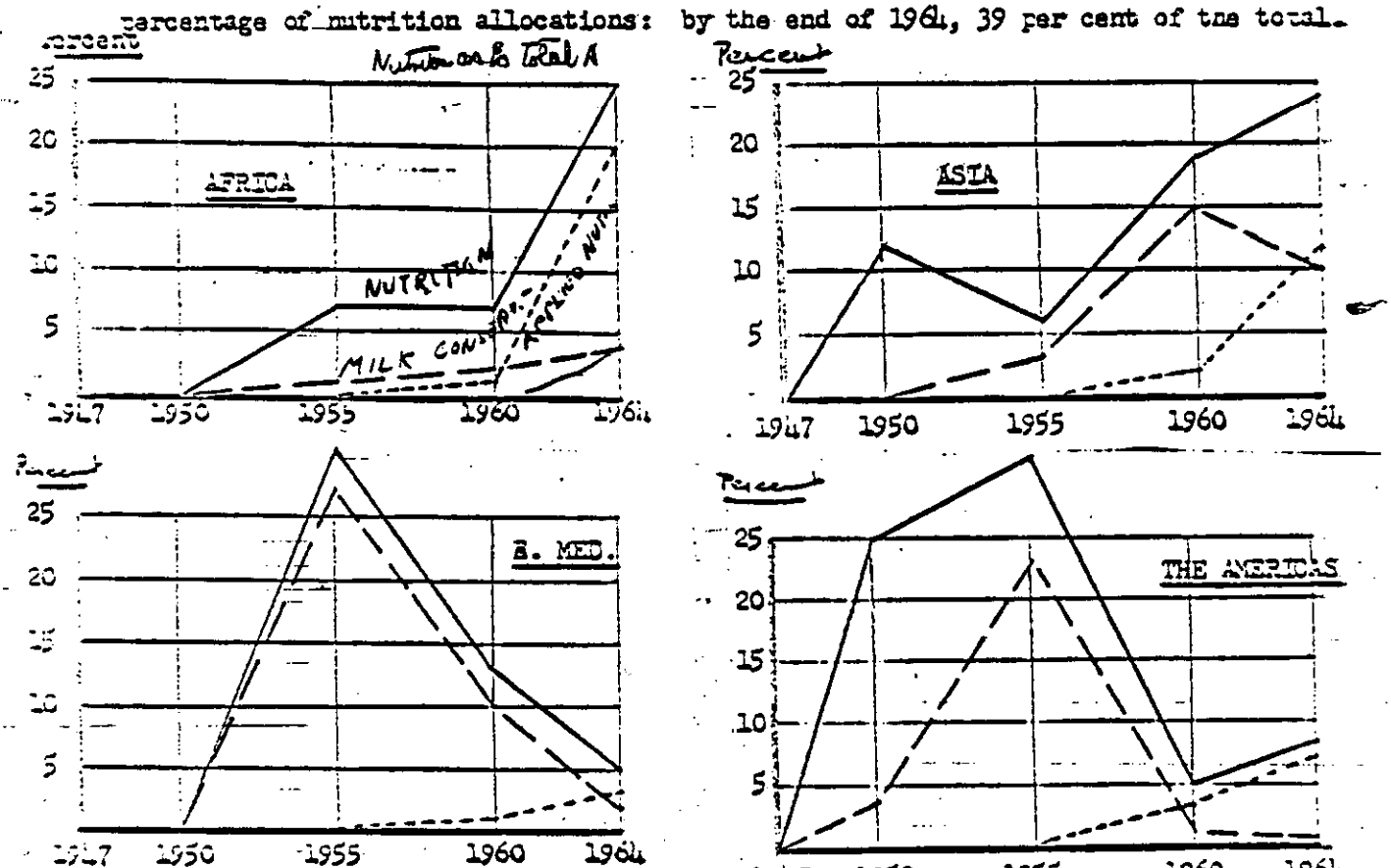
In the Eastern Mediterranean an important factor impeding more rapid development of basic health service programmes was the cultural and religious tradition forbidding the participation of women in public life. This made it particularly difficult to recruit trainee midwives and nurses, without whom expansion of MCH services is impossible. Public opinion has been hard to reverse, but the problem is being overcome. In Latin America the concentration of national funds in malaria eradication programmes left little or nothing for expansion in other health services, but after a period during which the basic health service programmes remained more or less static, there has been a sharp increase since 1960. The fact that in several countries there was no early emphasis on MCH activities and therefore no development of MCH in isolation from community health services, has meant that MCH is better integrated with comprehensive health developments in Latin America than in other regions.

Generally increased emphasis on basic health services began toward the end of the first decade of UNICEF assistance. The conclusion of mass campaigns emphasized the need for reasonably adequate public health structures on which continuing responsibility for surveillance could be devolved. Particularly,

a move in this direction has taken place in connection with malaria eradication. Imbalances between the development of MCH services and services for the whole community, pointed out by WHO, also encouraged increasing accent on comprehensive programmes. By 1958-59 Ministries of Health had had time to catch their breaths after the period of intensive post-war reconstruction, and began to develop national public health plans into which UNICEF-assisted basic health services programmes are fitting well.

Nutrition

Early development in every region was mainly in supplementary milk feeding programmes, but the policy begun in Europe of assisting the increase of indigenous milk supplies was soon extended throughout, and up to the end of 1964 had taken 44 per cent of total allocations for nutrition activities. From 1958 onwards nutrition education and applied nutrition programmes began to absorb an important percentage of nutrition allocations: by the end of 1964, 39 per cent of the total.



PERCENT OF ALLOCATIONS FOR ALL NUTRITION ACTIVITIES (_____), FOR MILK CONSERVATION (— — —), AND FOR NUTRITION EDUCATION AND APPLIED NUTRITION (- - - - - -), TO EACH REGION (excluding allocations for freight).

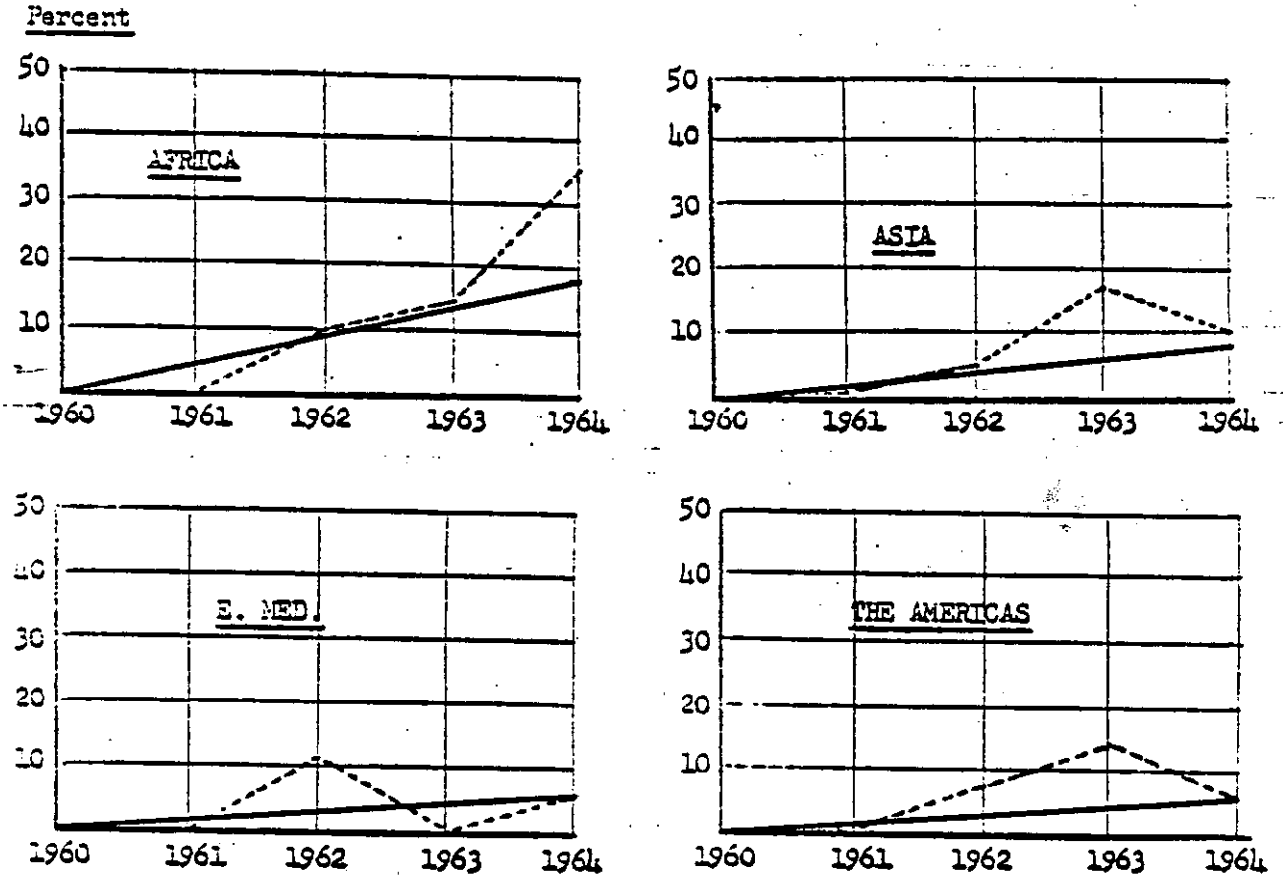
Africa, where programmes involving community activities enjoy comparatively easier acceptance, has taken a larger percentage of its allocations in applied nutrition programmes than other regions. Particularly intensive interest in agricultural development, which followed the attainment of independence by many African nations, has also contributed to this development. In Africa too, following the groupings of nations with similar language and traditional influences left behind by metropolitan governments, it has been possible to develop nutrition education on a regional level with comparative success. In Asia, developments in milk conservation, applied nutrition, and nutrition education, have been intense, but limited to one or two countries only. Many of the Asian countries aresetraditionally non-milk-drinking, and this has sharply confined the possibilities of milk conservation programmes. Several countries have expressed interest, but the potential supplies of liquid milk have not warranted the provision of processing equipment. Applied nutrition programmes have been undertaken only where machinery (such as community development administrations) exists for coordinating the several ministries involved.

In Latin America, from the outset, there was particular emphasis on nutritional improvements. A relatively high percentage of allocations for nutrition went into milk conservation plants, which were emphasized as providing an indigenous source of milk for continuing the early supplementary feeding programmes, but have contributed to the improvement of child nutrition on the whole. Nutrition education has also been developed on a regional basis, and applied nutrition programmes have been cited as valuable in establishing, for the first time, a closer link between rural communities and central governments. The existence in the Americas of several highly-developed institutes of nutrition has contributed to the general awareness of nutritional problems.

In the Eastern Mediterranean, apart from good development of milk conservation in a limited area, and some developments in nutrition education, there has been relatively little activity in this field.

Education.

In all regions, immediate interest was expressed in UNICEF assistance for education programmes.

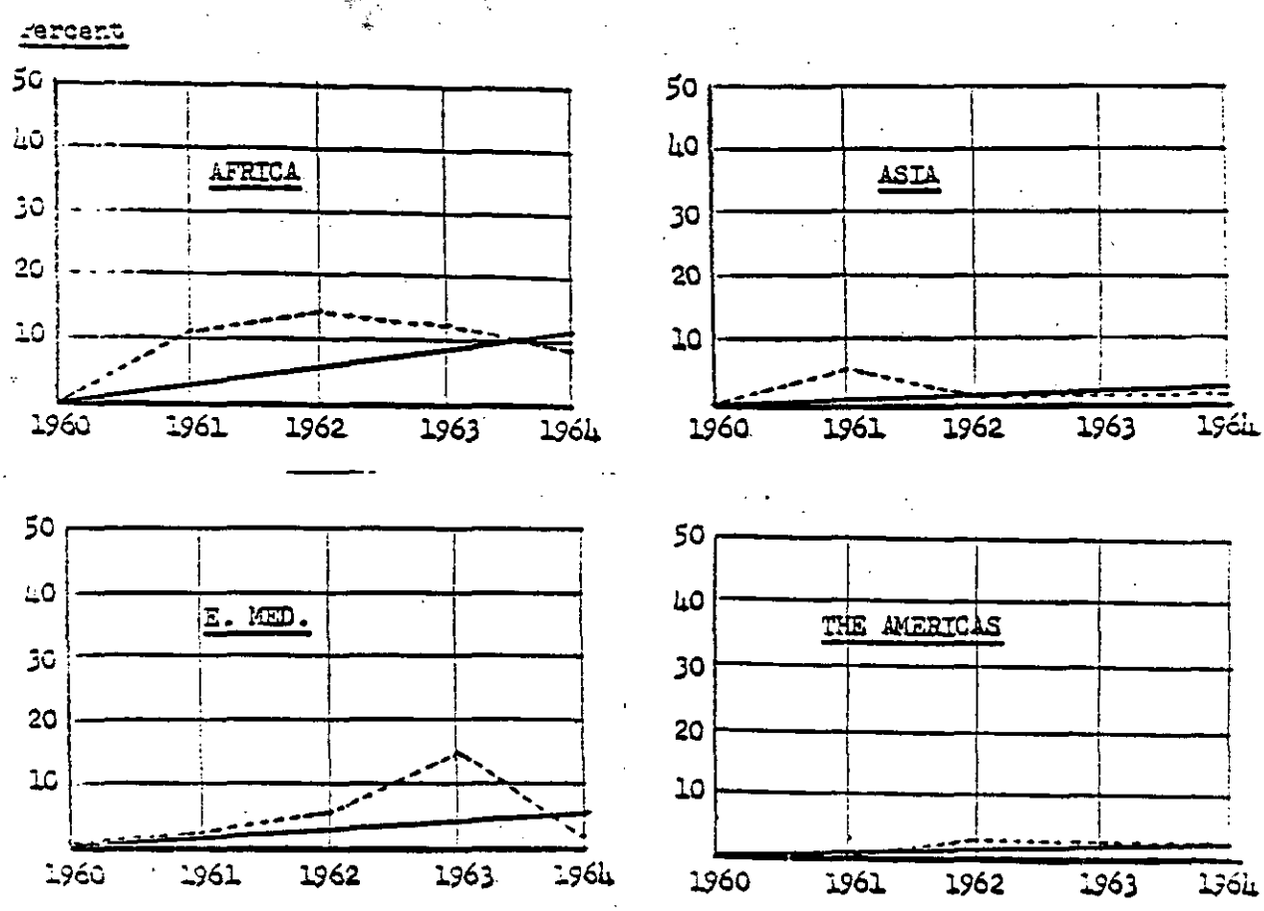


PERCENT OF TOTAL */ ALLOCATIONS TO EACH REGION TAKEN BY EDUCATIONAL PROGRAMMES. (Percent of total allocations 1960-64: Percent of yearly allocations:)

In Africa, after 1960, the importance of yaws as a public health disease had declined, and UNICEF had withdrawn from the malaria programmes. Nevertheless, the sharp change in emphasis exhibited by all the newly independent nations toward educational improvements was remarkable. Although it took a year or

*/ excl. allocations for emergencies and freight

two to develop the programmes, allocations sharply increased from 1961 to 1964, with the result that this region has taken a higher percentage of its allocations in education programmes than other regions. In the other regions, however, development of education programmes has also been rapid, and has been limited more by UNICEF's ability to assist than by governments' capacity to absorb assistance. Development has been primarily in the fields of teacher training and primary education, in accordance with UNICEF priorities. Only a small percentage of the allocations depicted in the graphs above has been for vocational training programmes as such, although the primary education programmes have contained a high content of vocational education as part of the strong accent on revision of curricula toward practical training.



PERCENT OF TOTAL */ ALLOCATIONS TO EACH REGION TAKEN BY CHILD WELFARE PROGRAMMES. (percent of total allocations 1960-64: Percent of yearly allocations:)

*/ excl. freight and emergencies

In this field, as well as in education, development has been most rapid in Africa, where rapid urbanization and its attendant social upheavals have created a particularly severe problem. In other regions, development of child welfare programmes is being hampered by two major obstacles: division of responsibility between various ministries, or where one responsible ministry has been created, the miniscule budget allotted to it.

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In October 1947, when the UNICEF Executive Board made a block allocation of funds for use in the Far East (other than China), many of the Asian countries had only recently attained independence, and were in the throes, not only of recovering from the destruction of war, but also of internal reorganization. Newly independent countries, with few trained civil servants, had enormous administrative problems to add to the financial ones created by blocked and devalued currencies, and falling world market prices for their chief export commodities. In many countries virtually nothing was left of pre-war health institutions, schools, equipment. In some countries, internal strife had succeeded war, and guerilla activities were preventing or nullifying attempts at reconstruction. The region as a whole presented the impression of a great booming confusion.

The UNICEF allocation was to be apportioned in accordance with recommendations of a survey team which the Administration had commissioned to visit Asian countries. The team consisted of Dr. Thomas Parran, former Surgeon-General of the United States, and Dr. C.K. Lakshmanan, Director, All India Institute of Hygiene and Public Health, Calcutta. The team visited thirteen Asian countries and presented its report to the July 1948 meeting of the Executive Board.

The report stressed that UNICEF's task in Asia would be very different from that confronting it in Europe, where "simple and measurable" child feeding programmes had been undertaken. "In most of the (Asian) countries visited, the problems of feeding - or expressed differently, of hunger, malnutrition, and even starvation - are chronic conditions. The populations involved are enormous ... with the limited funds at (UNICEF's) disposal, it is obviously impossible to attempt any large-scale feeding of hungry children." Apart from a few supplementary feeding programmes for selected groups of malnourished children and pregnant and nursing mothers that could be supervised by existing maternity and child health services, the team therefore concentrated on discussing with the governments concerned several

other "very sound lines of activity .. which should result both in the immediate and long-range improvement of child health and welfare standards."

The team reported that in none of the countries visited were there comprehensive statistical data, but fairly accurate estimates could be made of infant mortality rates, which were high, usually ranging between 200 and 300 per thousand live births. All the countries has urgent problems affecting children and mothers, which had been greatly aggravated by war and strife after the war. Malaria appeared to be the leading health problem in most countries, and a leading cause of death among children. Tuberculosis was another major problem; where Mantoux tests had been performed, reactive rates showed up to 50 per cent of the children tuberculin positive at 6 years of age. Syphilis had increased greatly as a result of the war and occupation. Yaws had become widely epidemic, because of the absence of anti-yaws remedies during the Japanese occupation. Parastic infestation in children contributed substantially to high infant and child mortality rates. Malnutrition, often in severe degree, was the usual rather than the unusual situation among children. Similarly, malnutrition often affected pregnant and nursing mothers, and the babies of such mothers had little or no chance for survival.

The report recommended to UNICEF certain specific programmes which the team had discussed in the countries visited. The criteria for selection of these programmes had been: (a) the priority accorded them by the governments concerned, and (b) their feasibility within the $ 3 million fund which the Executive Board had initially allocated for use in the Far East. The selection was varied, including: supplementary feeding programmes for selected groups; a fellowship programme for training abroad of nationals from several countries in several categories of health work - these nationals were envisaged as forming the nucleus of a teaching cadre after their return to their own countries; demonstration projects in malaria control; yaws control projects; provision of TB diagnostic equipment, equipment for

production of BCG vaccine and equipment and drugs for maternal and child health projects. (Parran/Lakshmanan report - E/ICEF/72 1 July 1948).

Pending the drawing up of plans of operation, and inorder that work in the Far East might start as speedily as possible, the Board in October 1948 approved the apportionment of funds from the block allocation for the award of the recommended fellowships. The number awarded eventually totalled 73. Arrangements were made with WHO for the selection and placing of the fellows, under the supervision of WHO in consultation with the governments concerned as to the fields of study. Most of the fellowships were in the fields of maternal and child welfare (public health nursing, nurse and midwifery tutoring, post-graduate pediatric studies for physicians), and tuberculosis. A few were specifically connected with the yaws and malaria programmes which were then in preparation. The programme was implemented mainly in 1949-51 and was completed by 1952. A follow-up study was maintained for two years after the return of each fellow in an attempt to determine the value of the programme. All except one of the fellows, were employed by their governments after their return in the field of work in which they had studied. All were reported to be working more effectively than before their studies, and a few were promoted to positions of influence. In general, however, the beneficial effects of the programme were limited, partly because no specific objective had been assigned to each fellowship, but mainly because studies in western countries in accord with advanced Western principles was found to be largely inapplicable in Asian conditions. The experience with this fellowship programme prompted policy decisions taken by the Board in 1950 (E/ICEF/155 para 7), and reconfirmed later at various times, that UNICEF's support of fellowships should in principle be limited to training within a region, and should usually be in direct connection with a UNICEF-assisted field programme. This policy has continued to prove practical.

In Asia, greater emphasis was placed on MCH programmes at an early stage of UNICEF assistance than in other regions. The first discussions by the survey team in 1948 included MCH equipment and supplies and, by 1952, 40 per cent of all UNICEF allocations had gone into such programmes. The proportion has continued to be high.

The development was similar in all Asian countries, closely following the technical recommendations of WHO and the evolvement of UNICEF policies, of which the governments were quick to take advantage. In some cases (e.g. the provision of transport for supervisory personnel) policy liberalizations were prompted by the needs of Asian programmes. (Check)

All programmes began with the expansion of networks of MCH centres. This fitted easily into UNICEF's early policy of giving priority to rural areas, and to the establishment of permanent services, of a feature which distinguished Asian problems from those of other regions: the very high population density of most Asian countries. The concentration of 80 to 90 per cent of the population in rural areas meant that a centre established in almost any locality was immediately accessible to a large number of people, and this not only made it worthwhile to increase the number of centres as rapidly as possible, it also created a popular demand which governments were eager to meet. The problem of most governments in expanding the number of MCW centres was not primarily capital costs for the construction of buildings - a feature of the Asian programmes was their flexibility in this regard. In general, buildings constructed by governments were extremely simple; where funds were not available, premises were rented; also, there was a striking willingness on the part of rural communities to provide premises at their own cost if government would appoint and pay a midwife. The main factor in the expansion of the MCH centre networks was in the staffing. Expansion was sharply restricted by the pace at which the training programmes progressed. Nevertheless, various interim solutions were found, and the number of new centres grew rapidly.

Among the solutions for staffing of centres were the short-term training of auxiliaries recruited in the districts in which they lived and would work after training, and the instruction of indigenous birth attendants who could work at extension points of an MCW centre. These personnel were placed under the surveillance of fully-trained staff who would regularly visit, in rotation, two or more work points other than their own.

This pattern, too, was easy to fit in with new developments in UNICEF's policy which arose mainly from a WHO report (E/ICEF - JC10/UNICEF-who/2) presented to the Board in 1957. This report reviewed the progress of maternal and child health activities and the related training of personnel, and stressed the need for integration of MCW services within a comprehensive public health network. There already existed in many Asian programmes the nucleus of the rural health centre/sub-centre pattern which subsequently emerged. Centres with better-trained staff were upgraded as rural health units, and those with less well-trained personnel became sub-centres. In countries where an adequate minimum of doctors could be assigned to rural health work, the number of rural health units could be geared to the number of doctors available, and the number of sub-centres under each unit multiplied to the maximum that one doctor could supervise. Thus, population coverage could be increased as much as possible.

By this means a few of the Asian countries have actually achieved total population coverage to an adequate degree. In most of the countries, however, this is not yet the case. Although, theoretically, the staff of a rural health unit might be able to reach the population group to which they are assigned, particularly with transport provided by UNICEF, in practice in most countries the curative workload continues so great, demanding the almost continuous presence of the staff at the central work point, for the people to whom that work point is accessible, that they cannot perform the preventive duties envisaged for them among their entire population group. Also, the extent to which field staffs are educated in a true concept of public health work is as yet not great.

Another important factor tempering the value of the health centre networks which have been developed is the quality of the services available. Only a relatively small percentage of the centres can offer more than pre- and pos-natal and obstetrical care, simple care of the infant and toddler, treatment of minor ailments, and perhaps immunizations. Continuing and increasing emphasis is being placed on improvement in the quality of services, particularly on support of centres by district referral hospitals and public health laboratory services, supervision and assistance through visiting clinics conducted by doctors or public health-trained nurse/midwives, etc.

On average, it may be true to say that in the Asia Region, at least simple health services are now available to perhaps 40 times as many mothers and children as when UNICEF aid first started.

Other features of the Asian programmes are worthy of note. The movement in three Asian countries to develop health services as part of community development has been the first major move in this field assisted by UNICEF. UNICEF assistance to country-wide environmental sanitation schemes integrated with rural health and community development also represents the largest UNICEF investment in this type of work.

As in other regions, however, although improvement in environmental sanitation is placed very high on the list of priorities for general improvement in health conditions, a large variety of problems facing developments in this field are proving extremely difficult to overcome. Two smaller environmental sanitation projects, envisaged in the very long term for expansion on a country-side scale presently being planned in phases with comparatively modest yearly targets, are having better success. The targets cover selected objectives: sanitation of a certain number of schools, health centres, etc. which are known to have the necessary prerequisites. Both plans include orientation training of sanitarians or sanitary inspectors already assigned, or shortly to be assigned, to the districts concerned. In summary, each year's operation is organized as carefully

and specifically as a pilot project, and this may eventually prove that in environmental sanitation work there can be no "country-wide expansion" based on the experience of a pilot project, but simply the multiplication of pilot-like projects, eventually covering an entire country.

UNICEF assistance for health services throughout the world is becoming increasingly involved in national health planning. In Asia, forward planning by UNICEF has been particularly useful, enabling Ministries of Health to envisage sources of funds several years ahead, and thus to include in their own budgets national funds that might otherwise not have become available, also to plan the use of total funds as rationally as possible. UNICEF funds have several times appeared in the financial schedules of Asian national health programmes planned over a period of several years.

The value of flexibility, of a broad delineation of UNICEF policies, has also been well demonstrated in Asia, enabling UNICEF assistance to be fitted in with exigencies peculiar to a programme or a country. A good example of this is the move in one country which has not yet formulated a national health plan toward starting the development of comprehensive rural health services, not through the existing rural health structure, but as an extension of a mass disease campaign in its final stages. Flexibility in the use of the UNICEF budget for that campaign has permitted the Ministry of Health to retain its own budget for the central organization created to operate the campaign. The continued existence of that organization has enabled it to use its own personnel to supplement the staffs of rural health centres in surveillance work, and this in turn has forcefully introduced to these staffs a concept of field work outside of their centres. The number of examinations, treatments of various minor ailments, and immunizations, performed by these rural health centre staffs since 1962 is in the millions, where very few were performed before. This in turn has encouraged short-term orientation training for the rural health staff; expansion and improvement of rural laboratory services, using the field laboratories established for the mass campaign

as a nucleus; and has finally led to a pilot project, which WHO is assisting, to study the shape and form that a comprehensive provincial rural health service should take, including continuing responsibility not only for the mass campaign concerned, but also for other mass campaigns, and for the eventual development, possibly, of tuberculosis control on a nation-wide scale, using the economical methods of case-finding by microscopy which are now being recommended by WHO.

Because the expansion of health centre networks was restricted mainly by the output of new graduates, UNICEF assistance to training programmes in Asia from the earliest days emphasized the establishment or extension of training institutions sufficient in number and quality to produce a continuing supply of personnel for MCH field services. Because in several of the larger Asian countries provinces or states were autonomous to a greater or lesser degree, training schools were generally established in a wide-spread pattern. This facilitated the recruitment of trainees in or near the places in which they lived and in which they would work after training; and largely eliminated the problem of trainees wishing to remain in the "big city" after graduation. Also, generally, Asia was perhaps more fortunate than other regions in having a comparatively larger reservoir of girls with at least primary school education from which to recruit trainees. When other regions were reporting inability to fill training schools, Asian countries were reporting two or three times as many applicants as there were places for training. Problems in recruiting trainees existed only in those countries where religious or traditional customs restricted the education and free movement of women, and these problems have now largely been overcome. Emphasis on basic training programmes drew down comparatively extensive technical assistance from WHO in the form of international tutorial personnel, and this permitted the re-designing of training curricula to fit special needs, and to include the elements of public health education.

This early start in Asia has meant that, in general, the region is now producing field service MCW personnel, while certainly not in numbers adequate to reach all mothers and children, at least in numbers that the permanent payrolls of the Ministries of Health are capable of absorbing. Early stop-gap measures in the short-term training of auxiliaries designed for a single type of service have now been almost entirely eliminated, and new graduates are adequately qualified for several types of service to mothers and children, including the elements of good nutritional education for mothers.

The comparatively rapid growth of field service MCW staffs in Asia created a reservoir of experianced personnel form which it was possible to recruit candidates for further training as supervisors, when WHO recommendations and consequent shifts in UNICEF policy began to emphasize the need for a supervisory cadre. With assistance from WHO, several countries established their own post-graduate schools for public health training. The Asia Region, therefore, is perhaps more advanced than others in this important field. A comparatively high percentage of field service personnel are under direct supervision of public-health trained nurse/midwives. It has also been possible to use the services of these personnel to strengthen the staffs of rural health units, particularly where teachers are scarce. A high percentage of UNICEF assistance to health services in Asia has therefore gone into the provision of equipment for training hospitals for training and demonstration centres, and rural and urban practice fields, not only for midwives and nurses, but also for health visitors, sanitarians, and other types of para-medical personnel.

In almost every Asian programme the instruction of indigenous birth attendants has been undertaken. In 1952 the WHO Regional Director for South East Asia stated in his annual report that "the desparate need is for a vast number of auxiliary personnel willing to work in rural areas." In commenting to the Board on this

statement, the Executive Director said that "an example of this shifting emphasis is the present requests(from Asian countries) for some 6,000 simplified midwives kits to be distributed to traditional midwives in rural Asia as rapidly as the trained midwives in the MCH centres are able to give them the elementary training and supervision necessary for proper use of the equipment". Since then about 20,000 indigenous birth attendants have been instructed in the Asia Region and provided with simple UNICEF kits. Many are attached to MCH sub-centres, but most on their own under more or less frequent supervision of qualified midwives, extending obstetrical care to perhaps a million mothers a year.

In Asia, UNICEF is also assisting refresher and orientation of all types, from public health seminars for medical and health officers at provincial or State level, to two-week basic orientation courses for sanitarians in rural health centres.

As in other regions, the liberalization of policy to permit UNICEF to assume certain local costs for training, including stipends for trainees and honoraria for teaching personnel, has been of enormous benefit, allowing the implementation of a great number of much-needed training projects which could otherwise never have taken place. This has been particularly valuable in the organization of training to eliminate obstacles to the progress of UNICEF-assisted programmes (e.g. orientation training of permanent rural health staff toward the assumption of responsibility for surveillance after completion of mass disease campaigns); to prepare the ground for expansion of programmes (e g. seminars in public health for provincial health officers); to accomplish specific objectives (e.g. workshops for supervisory nurse/midwives to discuss their problems, exchange views, and suggest solutions); to provide for maintenance of standards (e.g. refresher-training of midwives after three or four years in isolated field posts). The practical value of this form of assistance can hardly be exaggerated. In the Asia region, UNICEF has established the policy of sharing such costs with the

governments - e.g. UNICEF has paid stipends and the government has paid travel costs, or vice versa; UNICEF has supplemented government's per diem rates to raise them to a realistic level.

In the field of higher training, UNICEF's biggest investment in Asia has been in the development of post-graduate MCH training facilities at the All India Institute of Hygiene and Public Health. These are now being used by doctors and nurses from countries in both the Asia and Africa regions. Another major investment has been in the improvement of the pediatric departments of 51 medical colleges in India, and the preventive and social Medical Departments of 20 medical colleges, in India.

In summary, the development of health services and training programmes in Asia, with UNICEF assistance, has been comparatively rapid and widespread. Almost every UNICEF-assisted health services programme in Asia is part of a national health plan. It has been possible to a comparatively great extent to devolve upon existing permanent services responsibility for surveillance after the completion of mass campaigns. Continued expansion and development is foreseen based, as previously, on WHO recommendations, often with WHO technical assistance, and therefore automatically within UNICEF assistance policies.

Total UNICEF assistance to the Asia region in the field of health services and training has been $_____.

Problems of malnutrition are as great in Asia as in the other regions, but development of work in this field has been limited. The Parran/Lakshmanan report pointed out one of the main reasons for this: in terms of population, the problem is far greater in Asia than in other regions, and therefore far more difficult to remedy by simple means such as supplementary feeding. Another feature of the Asian situation, however, is probably a greater obstacle to improvement of nutritional status than any other: too many people are too often vitally concerned with

the immediate urgencies of obtaining enough food to eat, and are therefore even less receptive than normal to education about what kinds of food they should eat. The problem is one not only of lack of protein and other nutritious content in food, but of simple lack of calories. Another restrictive factor is that milk is not a traditional food in many parts of Asia. Indigenous sources of liquid milk are nearly non-existent in these areas, and they have therefore been unable to participate in UNICEF assistance.

In order to expedite the implementation of programmes in Asia, arrangements were made at the end of 1948 to appoint interim UNICEF representatives in several countries, in order that plans could be drawn up with the governments concerned for the supplementary feeding programmes. Quantities of skim milk were shipped early in 1949, for release as soon as plans had been finalized. By mid-1949, the first programmes were beginning. Although these programmes were difficult to start, not only organizationally but because milk was a new food, they soon grew important and became integrated as a part of other child welfare activities. In one country the availability of milk provided by UNICEF for school feeding was the basis of a nation-wide movement in the promotion of school lunch programmes, for which the communities and parent-teacher associations provided other foods which were prepared by older girls in the home economics classes, as part of their learning experience. A revolving fund was made available by the government, from which schools could borrow to start their school lunch programme. Several countries used school feeding programmes as a basis for nutrition education activities. In all countries, as the basic maternal and child welfare programmes grew, milk distribution through MCW centres became an important activity, and milk (with soap) was often the attraction which first drew mothers to attend the centres, and which later ensured their continued regular attendance.

At peak (1956-57) milk feeding programmes through all outlets in the Asia region were reaching 3 million beneficiaries per day (including 1.5 million in

the Korea school feeding programme which, although initially financed from an emergency allocation by UNICEF, was continued for several years). In 1964, after the turn-over of several programmes to voluntary agencies, in order to save freight costs for UNICEF, the programmes were serving approximately_____ (this represented a 25 per cent cut, due to reduction in the availability of milk from the U.S.)

The Asia Region has been the only Region taking large quantities of whole milk, at first purchased by UNICEF and later, after the policy decision that UNICEF funds should not be expended on whole milk (_____), from donations made to UNICEF. Whole milk has been distributed in strict accordance with the limitations set by UNICEF, only to infants under one year of age who cannot be adequately breast-fed. Upon WHO's recommendation, from 1957 most governments have issued the whole milk in a blend with skim milk, in order that the small quantities available could reach more infants. Most Asian governments place high priority on whole milk.

After the supplementary feeding programmes were initiated, the next development did not take place until 1953, when the first milk conservation project in the Asia Region was approved for India. Since then, UNICEF assistance has been provided to a total of 12 milk projects in India, of which 7 are in operation and the remainder should be commissioned within the next 2 years. India is a traditional milk-drinking country, and UNICEF assistance has been provided within the national scheme for organization of a dairy industry which was started in 1951, and which has been assisted by bilateral agencies to a greater extent than by UNICEF. The Indian programmes have been largely successful. UNICEF assistance has included major investment ina country-wide scheme for the training of all categories of dairy personnel. UNICEF allocations to two milk plants in Pakistan, another traditional milk-drinking country, have not yet borne fruit. Nowhere else in the Region has it been possible to formulate programmes for assistance in milk conservation. Though other countries have expressed interest, the possibilities of

increasing supplies of liquid milk to a level warranting the provision of processing machinery have been too small. In one case UNICEF has provided some milk collection equipment and transport to help increase indigenous production of liquid milk, eventually, it was hoped by the government concerned, to a point where UNICEF could help in milk conservation.

Pioneer work in the production of a protein-rich milk substitute food was done in the Asia region. An allocation for a soya-bean "milk" plant was made to Indonesia in 1953, the plant was operating within three years, reached full capacity by 1959, and was being expanded at the end of 1964. Although it was successful in producing a nutritious and acceptable, even popular, milk substitute for the feeding of young children, it was not successful in putting this product within the reach of mothers and children at the economic levels that UNICEF is most interested in assisting. Currency inflation which began shortly after the product came on the market obscures the total picture, but it is virtually certain that even in normal circumstances the cost of packaging the product (in tins) in a generally non-industrialized country, with generally unskilled labour forces, would have priced the product out of the reach of poor people. Other difficulties with regard to regular supplies of raw materials (mainly soy beans) of acceptable quality, and with regard to marketing channels could be satisfactorily solved. The Ministry of Health committed itself to purchasing a certain proportion of the production of this plant for free distribution through MCH centres, and this was looked upon as eventually replacing part of UNICEF-supplied skim milk, but costs rose entirely out of proportion to the budget set aside by the Ministry, and the term of the commitment had to be extended. It is not yet fulfilled.

Allocations have been made to India for two plants for the development and marketing of groundnut flour, and for a weaning food product. Work is progressing. Practical studies on infant feeding with soy-flour preparations have been carried through to a successful conclusion in another Asian country but the more difficult

tasks of production and successful marketing have yet to be undertaken. Studies with protein-rich rice fractions for human consumption are also being made.

Nutrition surveys have been supported by UNICEF in several Asian countries, with the main result of adding details to the already existing picture of gross malnutrition.

Applied nutrition projects have achieved wide acceptance only in India, where they have been connected with the national community development programme. Much was learned from the four initial State projects, which were successful in some ways, not in others. New projects were planned, taking account of previous experience. Stress has been laid on the importance of developing the projects as an integral part of community development. The implementation of such projects in every State on a nation-wide scale is contemplated. Even with the machinery existing in India of the community development programme to assist in the coordination of these multi-faceted programmes, implementation meets many obstacles. The only other Asian country which was interested in undertaking a like programme on a wide scale was Indonesia, where in one province machinery for coordination on a small scale similar to that in India existed in the form of a Nutrition Board, consisting of representatives of all governmental bodies. Here a promising programme was developed, in essentials along "traditional" applied nutrition lines, but interestingly tailored to suit a different cultural pattern. Insufficient experience as yet exists for comparison of the two approaches. The only other project in Asia is a small pilot project. Here the fact that in the country concerned there is generally a sufficiency of food was cited as a promising factor: it was thought that people with enough food to eat could more easily be interested in learning what foods to select. Comparative study may eventually show that this did have influence, but so far the most striking evidence connected with this factor is that the sufficiency of food has put financial support of nutrition activities low down on the priority scale of the government concerned.

Nutrition education in Asia has been conducted mainly through the applied nutrition programmes, in which it has been widespread on many levels. Most important are the three nutrition training centres established in India in connection with community davel pment and applied nutrition, which will continue to provide permanent means of educating leadership personnel, and should play a vital part in country-wide implementation of applied nutrition programmes. At other levels, training has been organized on a district basis to accomplish specific objectives, and has reached a wide range of people whose influence, however, does not spread much beyond the immediate vicinity or the immediate objective. Eventually, however, through a simple multiplication of the numbers of people reached through this type of training, nutrition education in subjects directly concerning each group's interests will become increasingly widespread.

Outside the applied nutrition programmes, efforts at nutrition education in Asia assisted by UNICEF have been in connection with nutrition survey, the establishment of nutrition boards or institutes (none of which have yet accomplished discernible results), and the inclusion of nutrition education in the training of various categories of personnel. Results are generally not assessable, except in one country where nutritionists trained in a UNICEF-assisted training school have been attached to MCW centres for practical field work. Here direct benefit to mothers and children reached through MCW centres has been discernible, but the wide spread of this type of programme would be exceedingly lengthy in terms of training a sufficient number of field nutritionists for the Region, and exceedingly expensive in terms of the governments employing them.

Total UNICEF aid to Asia in nutrition has been $_____.

Mass disease control programmes have been less important in Asia than in other regions in terms of the proportion of UNICEF allocations devoted to them.

In malaria, major assistance in Asia has been given by bilateral aid.

UNICEF's aid has been even smaller than the demand for it, on account of policies adopted by the Board which proved restrictive for Asia. UNICEF aid to Asia began, as a result of the Parran/Lakshmanan report, with allocations for small pilot projects in residual spraying in three countries, all of which proved highly successful. Assistance continued to control programmes in several countries, and included the provision of equipment for DDT plants in two countries, to provide continuing internal sources of DDT for residual spraying. The adoption of the policy of eradication, the availability of major bilateral aid for Asia, and the concentration of UNICEF aid for malaria in Latin America, resulted in a progressive division of responsibilities in Asia which left UNICEF assisting four eradication, and one pre-eradication programme. Assistance to the two larger eradication programmes was later terminated on account of decisions of the governments concerned, but a liberalization of UNICEF policy early in 1964 permitted UNICEF aid to be extended to another small eradication programme, and also permitted a one-time allocation for the bilaterally - aided programme in Pakistan, to help meet target time schedules. UNICEF assistance to malaria in Asia is presently limited to three eradication programmes, of which two are small.

Total UNICEF assistance to malaria in Asia has been $_____.

Major assistance to mass disease control programmes in Asia has been in the field of yaws eradication. The earliest allocations were made in connection with the Parran/Lakshmanan report in 1948. It took about two years to organize the first projects which went into operation early in 1950. A total of _____ country programmes have been assisted, covering all the yaws-affected areas of the Region, with populations estimated at about 100 millions at the peak of the programmes in 1956-58 (now about 165 millions). The Asian programmes included that in Indonesia, the largest single programme in the world. In the 15 years since the programmes started, yaws has been virtually eradicated from the region, except in the outer islands of Indonesia.

Total UNICEF assistance to yaws programmes in Asia has been $_____.

The greatest part of UNICEF assistance to tuberculosis control has been allocated to Asia. Earliest assistance began in 1948 with the activation of three country BCG programmes under Joint Enterprise, all three of which are still continuing as mass campaigns, one (in India) being the largest single campaign in the world. A total of _____ country BCG mass campaigns have since been assisted by UNICEF in Asia. On average, between 80 and 90 per cent of BCG work throughout the world shown in the monthly statistical records of WHO's Tuberculosis Research Office has been performed in Asia. At peak, (1957-58) 3 million tests and 1 million vaccinations a month were being performed. By the end 1964, the cumulative total of tests was _____ and of vaccinations _____. Apart from five campaigns still operating on a mass basis, the others have all been integrated with existing tuberculosis control or rural health services, four of the more important still reporting specifically on the number of tests and vaccinations performed.

With the increasing success of malaria eradication programmes in the Asia Region, tuberculosis began to be recognized as the foremost killing disease. UNICEF assistance to tuberculosis control in Asia began also in 1948 with the provision of X-ray and laboratory facilities for the type of tuberculosis control centre then recommended by WHO. A total of 12 such centres were assisted by UNICEF in Asia in 1949-53, and most were also assisted by teams of WHO international personnel who helped to develop demonstration programmes for case-finding and treatment in the periphery of the centres, and for training of national personnel. These programmes began to reveal very high incidence rates, and the attention of governments was increasingly drawn to the size of the TB problem, particularly in the urban fringe areas which were rapidly growing around all the larger cities and towns of the region, and in the more populous rural districts within easy communication of the towns where a great deal of movement to and fro made the spread of infection easy.

The exhorbitant cost of treatment, and the uselessness of diagnosing cases without offering treatment, were subjects deplored throughout the Region in the middle 1950's. When drugs for domiciliary chemotherapy were first recommended by WHO, five small trial projects were organized in Asia, but the early promise of this method of tackling the problem was obscured by the difficulty of employing and training a sufficient number of home visitors to supervise domiciliary treatment, even among the 1,000 (out of a projected total of 5,000) patients under treatment in the trial programmes.

In 1957 UNICEF assistance was allocated for the national TB control programme that India, the first country of the Region to do so, was undertaking. By the end of 1958 the details of the plan of operations had been completed, and the National Centre initiated. In 1961 the Executive Director reported to the Board that "the simple statement in the plan of operations that the target is to establish the (Indian) National Tuberculosis Institute and its field arms conveys no hint of the magnitude of the task which by the end of 1960 had been largely accomplished." In 1961 the training programme of the Institute was begun, and by the end it had trained 900 of the personnel who are helping to institute the individual State and district TB centres within the national programme, which aims at a TB centre in every district of India. The field work of the Indian National Institute was begun in 1960, and experience from it has progressively helped to solve a number of the practical problems connected with domiciliary treatment, and has thus promoted the expansion of programmes in the other countries of the Region.

Between 1957 and 1964 UNICEF assistance has been allocated to a total of 15 other country TB programmes in Asia, 7 of them major. The number of patients under treatment each year has expanded from the 1,000 in the trial projects of 1957, to over 300,000 in 1965. Every programme is being operated closely in conformity with the technical recommendations of WHO. The rapid development of some programmes prompted a liberalization of UNICEF policy in 1963 when assistance was approved, not only for the pilot projects themselves, but also for expansions to new project areas, provided that the personnel of those new areas were trained

and supervised by personnel of the pilot training and demonstration areas.

The WHO Anti-Tuberculosis Seminar held in Kuala Lumpur at the end of 1964 has prompted new thinking in the Region about new and more economical methods of case-finding by microscopy. This could mean faster expansion of national programmes, provided that it proves possible to strengthen health centre networks with the necessary additional personnel. They need be trained only simply, but proper surveillance of cases under treatment will call for meticulous organization and supervision if conducted mainly through health centres instead of by the highly specialized mobile teams. WHO's latest recommendations to concentrate treatment on sputum-positive cases, the source of infection, may lighten the problem of surveillance in terms of the numbers who need to be kept under close supervision. Continued experiments with effective and economical combination-drug treatments are being carried out in almost every programme.

Total UNICEF assistance for anti-tuberculosis programmes in Asia is $_____.

Although UNICEF assistance to leprosy programmes in Asia began only in 1955, it has grown rapidly. Assistance began with a pilot project in one country, and equipment for skin clinics in a second country which already had a programme but wished to expand it. The following year assistance to a third country, also with an existing programme, was allocated, and in 1957 India, with the largest leprosy problem in the Region, was included. A total of 7 country programmes are now being supported, with nearly 700,000 cases under treatment (of an estimated total of several millions). All projects are based on mass case-finding and domiciliary treatment, with a progressive disbandment of sanatoria. With earlier experience in other disease control campaigns of the difficulties of integration into existing health services, the leprosy campaigns are making a feature of progressive integration after the first mass case-finding surveys.

Total assistance to leprosy in Asia has been $_____.

Five trachoma programmes are assisted by UNICEF in Asia, two major. Assistance to the first programme in a country with a particularly severe problem, has continued

for ten years. Under a revised plan, control is expected to be achieved by 1968. Another programme has been activated in highly endemic areas only, a third is a slowly expanding pilot project, a fourth is still in the survey phase, and a fifth was terminated after two pilot attempts because the government gave priority to other projects. It appears that although trachoma is thought to be a widespread problem in Asia, governments have not given it priority for UNICEF assistance.

UNICEF assistance to trachoma in Asia totals $_____.

Venereal disease programmes in Asia have also not been given priority by governments. Only two major programmes have been assisted, with other small programmes forming part of maternal andchild welfare programmes and now terminated.

Assistance to social welfare programmes in Asia has generally followed the pattern of other regions, although diversified governmental responsibility has not been a problem of the Asian programmes. Each of the 10 countries to which assistance has so far been allocated has a ministry responsible for social welfare, although in most cases these bodies are relatively new, have not the stature of older ministries, and therefore have small, sometimes miniscule, budgets at their disposal. In several cases UNICEF assistance has had the beneficial effect of enabling the Ministry concerned to increase both its budget and its status because of the international commitments it has incurred through UNICEF assistance.

It is particularly in this field that UNICEF's liberalized policy regarding assumption of local costs for salaries of key personnel has permitted the founding of executive and administrative bodies without which many of the programmes could not have been operated.

Only one of the 10 assisted programmes has major aspects of professional training. In all others training is of the short-term orientation type, organized on a more or less ad hoc basis to suit particular needs. The more progressive programmes are making good advances in such fields as day care, community centres, youth clubs, etc.

Other programmes are mainly concerned with the improvement of institutional care. One programme is interestingly related to community development. Such advanced projects as foster care are generally still embryonic in Asia.

UNICEF assistance to child welfare in Asia totals $_____.

Asian governments have quickly and widely taken advantage of UNICEF's decision to include education in its field of assistance. Assistance to 10 programmes has been allocated since 1960. All emphasize teacher-training, and most include a re-orientation of curricula toward non-academic subjects. An interesting aspect is a small project for the local manufacture of science teaching equipment. Pre-vocational training, generally, has been included as a feature of the education projects, not as a separate subject in Asia.

Assistance to education in Asia totals $_____.

UNICEF's first assistance to Eastern Mediterranean countries was an emergency programme for Palestinian refugees which was approved in August 1948 at the urgent request of the Mediator for Palestine. UNRRA recommended to UNICEF that at least half of the residual funds it was then turning over to UNICEF be used for aid to mothers and children among these refugees, and as a result UNICEF allocated considerable sums of money for this emergency programme, which provided various types of foods and also medical supplies for control of syphilis, trachoma, insect-borne diseases, and a BCG campaign under Joint Enterprise. The average number of beneficiaries per year was 500,000 mothers and children. The programme continued under UNICEF administration until it was integrated with UNRWA activities at the end of 1951, but UNICEF continued to make allocations to it for two or three years thereafter.

In the Middle East the War had little effect on the condition of children and, except for the Palestine crisis, the attention of UNICEF was not directed toward this area under the emergency criteria of the Fund's early terms of reference. BCG vaccination campaigns were activated in four E.M. countries under Joint Enterprise, but it was not until 1950 that UNICEF assistance on a long-term basis was inaugurated, the first country receiving an allocation being Israel. This first programme was an MCW project, including supplementary feeding, drugs for epidemic control, and other medical equipment. Shortly after, a project for the control of bejel was approved for Iraq.

About Middle Eastern countries generally no investigations were carried out directly by UNICEF itself as to the needs of children. Information available from the UNICEF personnel originally appointed to administer the Palestinian refugee programme, and from WHO sources, was conveyed to the Board. It was stated that the development of health and welfare services for children was generally not far advanced in Middle Eastern countries, that there were serious shortages of trained staff and supplies; that malaria appeared to be the principal disease

and a chief cause of child mortality; that tuberculosis was a serious threat; that bejel and other infectious diseases were widespread and took a heavy toll.

In 1950/51 with the establishment of UNICEF offices in this region considerable country visiting was undertaken by UNICEF staff, frequently in conjunction with WHO officers, and there was a marked increase of activity.

The first MCW programme in Israel was followed in 1951 by two other programmes which concentrated on training of personnel. In 1952 three other countries started programmes, and UNICEF aid in basic health service programmes was eventually extended to a total of 11 countries. ~~Although~~ generally progress has followed the conventional pattern ~~of training~~ (expansion of number of centres, training of auxiliaries, increased accent on training as shortage of staff impeded progress, lat emphasis on integration of MCH with basic public health) there have been two or three features peculiar to the region. ~~Training~~ Perhaps the most important obstacle facing the region as a whole has been the religious and cultural traditi forbidding the participation of women in work outside the home. Although in the long run it is proving possible to overcome this obstacle, conservative public opinion has been stubbornly against posts for women in public life and has only reluctantly been ~~changed~~ reversed in many places. This has meant ~~initially~~ great difficulty in recruiting sufficient numbers of trainees for expanded training programmes, not only because women were reluctant or prevented from coming ~~of the reluctance of woman to come~~ forward for training but also because when they did come forward there were few who had the educational qualifications for training. Also, it was difficult to post them after they were trained, ~~and~~ All these obstacles meant that, in general, the E.M. region got off to a slower start than other regions.

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An interesting development in Egypt was the national plan to establish collective community centres which included health services (MCH, disease control, communicable disease immunization, etc), agricultural extension services, aspects of home economics, related nutritional activities, adult education.

In general, in the E.M. Region development has been slow in basic health services, although theoretically in line with latest technical recommendations of WHO.

Allocations to the E.M. Region for basic health services totalled $ 3.776 million at the end of 1964.

In disease control, although earliest emphasis was on BCG programmes, malaria soon took priority. As in other regions, the earlier control programmes switched to eradication in 1955-56. In ~~1955~~ Sept. 1955 a malaria sub-committee of the WHO Regional Conference resolved on eradication and asked WHO and UNICEF to provide maximum assistance. WHO special consultants, and a new WHO malaria advisor helped to crystallize plans, and a coordinated five-year eradication plan covering 7 countries was formulated in 1956. Major UNICEF assistance to ~~the Mediterranean area~~ the E.M. region in 1955-60 was in malaria, which took 75 per cent of all UNICEF allocations to the Region in this period. In 1961-64, with the successful conclusion of some of the programmes, the proportion dropped but was nevertheless 47 per cent of all allocations to the Region.

Total assistance to the E.M. Region in malaria was $ 17.585 million by the end of 1964.

There has also been considerable emphasis on TB/BCG in the E.M. Region. ~~Immunization~~ Earliest assistance was under Joint Enterprise for BCG programmes. 6 other countries also conducted programmes. Some countries were able to integrate, but others could continue BCG in a ~~limit~~ "maintenance" phase after completion of mass campaigns only with continued international assistance. In

In 1960 when ~~the~~ emphasis in TB control shifted to prevalence surveys, several countries began to reorganize BCG programmes with TB control in mind. A regional TB survey unit was approved for the E.M. Region, and UNICEF shared in the cost of a WHO regional TB survey team. Two or three countries also began their own prevalence surveys, with UNICEF assistance. Domiciliary chemotherapy experimental programmes were set up in ~~two~~ one or two countries, which later developed into demonstration and training pilot project areas. UNICEF is presently assisting such projects in 5 countries.

UNICEF assistance to TB/BCG in the E.M. region totalled $ 3.532 million by the end of 1964.

Although trachoma was frequently mentioned as a widespread affliction in E.M. countries, ~~[illegible]~~ control activities have been undertaken in only 4 countries of the region, and did not progress fast. Pilot project activities continued for several years before they were expanded somewhat.

Other programmes for bejel control, mycosis. No vaccine production labs.

Total for disease control to E.M. Region $ 20.864 ~~[illegible]~~ million by end 1964 (including DDT plant for Egypt).

Nutrition: comparatively good progress in training at various levels, but no applied nutrition programmes as such. Some school gardening and training of teachers, etc. School feeding began ~~[illegible]~~ at a later stage, but progressed well in several countries, including training of teachers and other foods provided by governments. Peak beneficiaries approximately 1 million, in 1956-59.

A few nutrition surveys assisted (but what good are these).

MCP: working party on milk problems convened in April 1951 with representatives from 5 E.M. countries. Total UNICEF assistance has gone to 13 plants in 6 countries

Excellent results. (See Davies' report).
nutrition
Allocations for MCH in E.M. Region: $ 3.919 million till end 1964.

Welfare: comparatively good. Training quite high-level and widespread. 8 projects. $ 428,000 up to end 1964.

Education: 6 projects, mostly primary teacher training. $ 666,000 up to end 1964.

Tech 2nd draft

The Ninth Pan-American Child Congress held at Caracas, Venezuela, in January 1948, passed a resolution asking the Executive Board of UNICEF to take into consideration the needs of American children. This resolution was brought to the attention of the Executive Board by the American International Institute for the Protection of Childhood, and considered at the Executive Board's March 1948 session. The Board instructed the Executive Director to consult with appropriate organizations in the Americas concerning the needs of children in the western hemisphere and the possibilities of implementing programmes to further their health and welfare.

Consultations were initiated with the American International Institute for the Protection of Childhood, the Pan-American Sanitary Bureau, WHO and FAO, and in the latter half of 1948 exploratory activities were set in motion. Chief among these was the delegation of Dr. R. Passmore of Edinburgh University as UNICEF representative to the Conference on Nutritional Problems in Latin America which was sponsored by FAO in Montevideo in July 1948. Following the conference, Dr. Passmore visited five Latin American countries, on the invitation of their Governments, to formulate recommendations to UNICEF.

Dr. Passmore's report illustrates the difficulties that confronted UNICEF in determining the points at which UNICEF aid, necessarily very limited, could best be made available in this area of 153 million population of whom 40 per cent were under 15 years of age. Dr. Passmore noted that statistical records, collected on a scale greater than the limited medical and technical staff could supply and therefore largely based on information provided by untrained persons, were

misleading. Also that it had been possible for most of the countries to implement only on a small scale their generally advanced and elaborate social and sanitary legislation. This had resulted in uneven distribution of the existing child health institutions and organizations, and extreme variation in their efficiency and effectiveness. Children's services were generally limited and their administration erratic. Where comparatively effective services did exist, they reached only small numbers of children, mainly in urban areas. These factors made accurate judgment of the state of children's health very difficult. High rates of illegitimacy (higher than 50 per cent of total births, according to some official records) were associated with a low standard of parental responsibility and were an important factor in child health and welfare.

Dr. Pasamore estimated that between one-half and one-third of the children died before reaching their fifth birthday, and that of those who survived the majority existed at levels far below normal physiological development and in sub-normal health. Recorded birth rates varied between 33 and 50 per thousand population and infant mortality rates between 100 and 200 per thousand live births. Mortality below 4 years of age accounted for as high as 43 per cent of total deaths in some areas. Major causes of infant mortality appeared to be pneumonia, congenital debility, diarrhoea and enteritis, convulsions, and premature birth. Major causes of child morbidity appeared to be

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intestinal parasites, tuberculosis, and insect-borne diseases (malaria, typhus). Tuberculosis particularly appeared to be a heavy cause of mortality, accounting in some statistics for as high as 10 per cent of total deaths. Manifestations of congenital syphilis were common in some areas. Food supplies were generally plentiful, and frank starvation in children was not common, but a grave shortage of milk was perhaps the most important factor adverse to child health.

Other visits were made to almost every Latin American country by several consultants from UNICEF, WHO, the Pan American Sanitary Bureau, Joint Enterprise, and the American International Institute for the Protection of Childhood. Consultations between UNICEF and the cooperating agencies continued throughout the latter half of 1948 and 1949.

As its 1949 session, the Executive Board made block allocations totalling $3.84 million to be apportioned for programmes in the Latin American countries on the basis of requests from the Governments concerned, and on the advice of the agencies with which UNICEF was consulting. At the November 1949 session of the Board, as the result of eighteen months of consultation and country visits, the Administration was able to present to the Board for approval programmes for 15 Latin American countries.

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The programmes were divided into three main groups: (1) projects for supplementary feeding of children, mainly through schools, to demonstrate the values of good nutrition and the techniques of effective administration; (ii) "impact" programmes against diseases constituting primary public health problems - insect-borne diseases, diphtheria, pertusis, yaws and syphilis; (iii) a beginning in basic health programmes, including the institution of a laboratory for the production of BCG vaccine to be used in BCG programmes throughout Latin America, a BCG demonstration project, a project for the creation of a mobile maternal and child health and dental care unit, and a project to equip certain children's institutions.

The deciding factors in this first selection of programmes were several. When the Board made the first block allocation for Latin America in March 1949, one of the earliest decisions taken by UNICEF and the consulting agencies was that the funds should be used for programmes that would be capable of developing rapidly and of yielding immediate benefits, and that would not need highly trained personnel. These priorities were logical in view of the uncertainty which then existed with regard to the duration of UNICEF's existence, and the obvious undesirability of spreading UNICEF's very limited funds too thinly, in view of the reports becoming available indicating many urgent needs and a generally acute shortage of trained personnel. It was also logical, within the priorities already established, to exploit the fact that technical advice and assistance were readily available in

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certain fields. Dr. Passmore was eminently qualified to advise governments as to the nutritional aspects of child health. Dr. Johannes Holm of Joint Enterprise was able to visit several Latin American countries to help them plan and prepare for BCG programmes. The WHO/UNICEF Joint Committee on Health policy at its session in April 1949, in accordance with the findings of the WHO Expert Committee on Maternal and Child Health, has recommended UNICEF assistance to the development of programmes in this field, and at the end of 1949 UNICEF delegated Dr. Leo Eloesser to visit Latin America as a consultant. The JCHP was also considering insect control programmes (at that time noting their value in reducing infant mortality by reduction of summer diarrhoeas), and this coincided with the facts that Latin American countries had a severe problem in insect-borne diseases, particularly malaria, and that WHO/PASB was able to make consultants available in this field.

Many reports have since been presented to the UNICEF Board setting forth the importance of the malaria problem in Latin America. In those early days, referring to the first control programmes approved for UNICEF assistance in the five Central American countries and British Honduras, WHO noted that insect-borne diseases had a long history of endemicity in these countries and that malaria was the most widespread and persistent, particularly in coastal regions. Spleen and parasite rates indicated

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75 per cent of the population were infected, and mortality rates per 100,000 ranged from 14 to 432, according to available statistics. Various studies had indicated a large variety of vectors, about which little was known. Besides malaria, typhus was important in highland regions, and the vector of yellow fever was known to be widespread in several countries.

In 1949 the PASB assigned to Central America three international experts to help prepare insect control projects, and in 1950 WHO regional consultants on malaria and Chagas' disease toured the countries. UNICEF supplies and equipment, allocated in November 1949, began to arrive in April/May 1950, and by July 1950 control operations by residual spraying had begun in all six countries. The total population protected after four six-monthly cycles of spraying was approximately 1.25 million. A report presented to the Board at the time (E/ICEF/206 - Oct. 1952) stated that statistical data on the results of the programme were meager and of doubtful quality, but that there was a widespread belief in Central America that the incidence of malaria had been reduced. Plans for the future, the report stated, included "the intensification of malaria surveys to determine the incidence of the disease and to provide a check on the day when residual spraying need no longer be carried out. In several isolated instances, there is evidence that this technique alone is not sufficient to control malaria in population centres. The reasons for this failure will be investigated....." In 1950-54 assistance for

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malaria programmes in 11 other countries was approved by the Board, making a total of $1.7 million for 17 country programmes. In 1954 the Programme Committee made a visit to three Central American countries, and in its report of the visit observed that UNICEF assistance had enabled the countries to expand control to the point of complete coverage of endemic areas, and that this in turn had made it possible for governments to make the necessary budget provisions to continue control from their own resources. Two countries had already taken over completely the responsibility for the cost of continuing control.

In March 1955, however, the Executive Director reported to the Board that experience in malaria control had pointed up the need for faster and more thorough measures, and that WHO was urgently re-examining the position. Several documents were presented to the Board emphasizing the danger of development of resistance to insecticides by malaria-bearing mosquitoes, and setting forth for the first time the theory of malaria eradication. A report by WHO (E/ICEF/232) on "Malaria Eradication in the Americas" included a request for UNICEF participation in an accelerated regional approach in the Americas. The subject was put on the agenda of the JCHP's next meeting, and following the JCHP's recommendations, the Board at its September 1955 session agreed in allocating assistance for malaria to give first priority to eradication programmes, and to support them for the entire period of spraying.

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WHO had already enormously increased its malaria staff in Latin America. During 1955 and 1956, a total of 50 international officers were assigned to assist in the reorientation of the Latin American programmes from control to eradication. The programmes were gradually consolidated, and by 1956 were being planned on a continental basis. The Executive Director reported to the Board that this move constituted "perhaps the largest coordinated continental planning in the history of public health". Since that time UNICEF aid has been allocated for a total of 23 country eradication programmes in the Latin America Region, covering50.5 million people (estimated at start of eradication in 1955) in affected areas and taking a total of $37.8 million from 1948 up to the June 1964 allocations.

The history of the Latin American malaria eradication programme is still being written, and is well known to the UNICEF Board. Generally, the time schedules originally anticipated were over-optimistic, and the requirement of UNICEF funds under-estimated. Administrative and organizational difficulties delayed the beginning of operations in several programmes, and "attack phases" took longer than the four years theoretically planned. Because of incomplete census figures, the total number of houses to be sprayed in many areas turned out to be greater than anticipated. Problem areas required additional spraying, and the number of spraying cycles in several places had to be increased. The development of resistance to dieldrin required a switch in insecticides. In general, the early ten-year estimate for completion of this continental eradication programme

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must now be lengthened and the estimate of total UNICEF funds required increased but no estimate can be made how much.

UNICEF's agreement to support the Latin American malaria eradication programme to its conclusion has meant that less UNICEF money has been available for the development in that Region of other types of programmes. More importantly, the government's decision to eradicate malaria has meant so great a concentration of national health funds that little, if anything, has been left over for new programmes. Several times in the first years after the inception of eradication, the Executive Director reported to the Board that the development of child health programmes in the Latin American region was limited more by the unavailability of resources than by the capacity of the countries to carry out, with international assistance, programmes to improve the health of children

Perhaps however, the conclusion may now be postulated that this was not so lamentably restrictive as it at first seemed. Experience in health work from all over the world, distilled in the policy papers and directives WHO has made available to UNICEF, has clearly pointed to the development of reasonably strong and widespread basic health structures as an essential prerequisite in order to coordinate and supervise health work, to maintain proper balance between curative and preventive services, to accept responsibility for continued surveillance after mass campaigns have been completed, and to serve as the basis on which new health programmes can most

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economically be developed. In the last category, perhaps significantly for Latin America, can be included the latest concept of anti-tuberculosis work through diagnosis by microscopy and domiciliary treatment based on general health centres.

At the end of the 1950s and in the early 1960s, the Executive Director first began to report to the Board that emphasis in health programmes in Latin America was changing from short campaigns and assistance to isolated institutions, toward comprehensive and elaborately planned programmes affecting the whole basic structure of public health. Malaria eradication, although not proceeding as quickly as had been anticipated, was already forcing a beneficial consolidation of public health activities. This trend has continued. It is generally anticipated that malaria personnel, after the conclusion of the campaigns, can readily be diverted to strengthening public health services. UNICEF experience in all Regions has been that most if not all previously assisted institutions or organizations find their place in a public health structure, if they do not indeed form the nucleus of it.

Thus, in the long run, it may prove to be the case in Latin America that mass anti-tuberculosis programmes, for instance, may develop more quickly, successfully, and economically after the conclusion of the malaria programmes than they could possibly have earlier, and delay in the start of such programmes (should they be undertaken, and should UNICEF assistance be requested and approved) will not have meant any real delay in the activation of effective work. Certainly, as technical policy on mass anti-tuberculosis programmes has evolved, delay in Latin America

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has meant for UNICEF a probably large saving since a number of mobile X-ray units would no doubt have been requested had mass programmes developed earlier, which presumably will no longer be requested in future since WHO is now recommending considerably more economical means of mass case-finding.

In Latin America, as in all other regions, UNICEF assistance to health services began mainly in the narrow field of expanding and improving obstetrical services. In a region where, in spite of official statistics, resident medical personnel were convinced that infant mortality rates in individual communities, ranged as high as 300 per thousand live births (King L.1028), this was not only a primary need but one in which development of simple remedial measures could be rapid, since high grade trained personnel were not needed, and capital expenditure was not great and could in many cases be met from other than central government funds. All that was necessary to extend obstetrical services to the mothers of a rural community were a small premises and a midwife, who could be trained in six months to handle normal births adequately. The cost of training was not great, since the UNICEF Board very early in its history recognized the burden being suddenly placed on government budgets by new training projects, and authorized assistance in the form of stipends in local currencies for the trainees. Teaching staff were available from WHO, to help in training cadres of teachers in the national programmes. UNICEF provided equipment and supplies for the new MCW centres.

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The early MCW programmes were planned along these simple lines, and 11 of them ($1.04 million) went into operation between 1950 and 1953. Some included elements of health education, and later of environmental sanitation. All included provision for training of staff, but at the lowest level of auxiliaries who could be rapidly trained.

In 1953 (Doc.E/ICEF/235) WHO presented to the UNICEF Board a review of MCH programmes in 15 countries, including 4 Latin American countries. The findings of the review were similar for all countries, and varied only as to degree. Many of the countries had established Divisions of Maternal and Child Welfare as part of the general health administration, and this augured well for the future. At that early stage, however, the Divisions were still generally in embryo and relatively ineffective. There was a distinct separation between work in urban areas, where direct access to and interest of central governments, as well as more money, were available, and work in rural areas where lack of adequate planning, lack of technical supervision, and shortage of trained personnel were the main regarding factors. It was already becoming apparent that hastily trained personnel could not be depended upon to maintain standards, and WHO noted that success would depend to a great extent on supervision. Not only were greatly expanded budgets and facilities for training and re-training needed, but also incentives for personnel to work in rural areas. Lack of home visiting in rural areas was a fundamental shortage. Ill-trained auxiliary midwives were able to give obstetrical care, but there was a glaring need for pre-natal care, which the programmes as then planned could not attempt to fill.

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The emphasis in MCH programmes was in a period of transition between 1954 and 1958. MCH began to be viewed within the context of a general public health programme. Simple training of auxiliary workers began to be supplemented by higher-level training of supervisors and instructors. Model MCH centres, to serve as training and demonstration centres for all types of medical and auxiliary personnel, were included in plans of operation. One or two programmes included the development of laboratory services to support public health activities. More emphasis was given to health education, particularly through the establishment of mothers' club, and to environmental sanitation as an integral part of the MCH programmes and also in separate programmes. Two new country programmes approved in March 1954 and September 1955 were planned on a five-year basis.

In 1958 the Executive Director reported to the Board :"In the Americas an emphasis toward integration of maternal and child welfare services within the general health services is becoming increasingly noticeable. In Brazil, the President of the Republic in a message to Congress had emphasized the necessity for more coordination within the public health services and the re-oriented MCH programme reflected that policy. In Mexico planning was commensurate with the possibilities of sound implementation, and the UNICEF-assisted MCH programme in that country, and in several others, reflected a pattern of strengthened administrative and technical supervision both from the State capitals, and from district and local

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health centres, down to sub-centres in small villages. In Colombia the approved MCH programme was the key-stone for a larger reorganisation of the country's public health service. In all other countries, the starts made were expected to provide a sound basis for extension. This trend still continues, in accordance with the continuing refinement of technical policy that WHO is promulgating in the 25 country programmes (total allocations 1948 - June 1964 $15,9 million) that UNICEF is now assisting in Latin America. In a recent report to the Board the Executive Director said that "after several years of cooperation with the Governments of the Americas, UNICEF aid has been a factor in promoting the basic health services in almost all countries, either as an integral part of the national health system, or in specially selected areas in relation to their needs and priorities. Another fact worthy of mention is the scale on which health personnel are now being trained, ranging from doctors to auxiliary and voluntary personnel, special emphasis being laid on the training of nursing staff and sanitary inspectors".

As in the other Regions, however, a caution noted by the Executive Director as early as 1958 must be borne in mind: "The implementation of the concept of national health plans is necessarily slow. Many of the countries are plagued by the problems resulting from a population growing faster than the food, schools, housing, trained personnel, or income available to them. In the health field, shortage of funds and of personnel, particularly full-time doctors to work in rural areas, hampers a rapid extension of services. The building-up of a sound public health structure calls

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for long-range planning, time, patience, and adaptation."

There has been no major development of health programmes concerned with specific diseases (other than malaria) in Latin America. Early mass campaigns against yaws and syphilis were comparatively quickly completed. A penicillin plan erected in Chile commenced production in 1956, and UNICEF assistance ceased. Six small leprosy programmes are continuing. UNICEF assistance to four projects for immunization of children against diphtheria/pertussis were provided with the basis for continuation by the supply of equipment for the production of the necessary vaccines and toxoids. Assistance in all these fields has totalled $1,7 million. Needs have presumably not been major, or the governments have not considered them to be primary, warranting special efforts which would take funds much needed in the malaria and other programme. Allocations for yaws programmes in two countries were turned back to UNICEF on the grounds that the governments found they could deal with the problem within their own resources and without mass campaigns.

In the field of tuberculosis, however, the interest earlier expressed has not been followed up. Although comprehensive statistics seem not to be available general evidence appears to indicate a serious problem. Since the early days of UNICEF assistance, a total of 20 BCG vaccination campaigns have been assisted, which are reported to have progressed well, some remarkably so. Vaccine is supplied from three production plants that UNICEF helped establish within the region. Beginning in 1960 the programmes

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were reported as being integrated with public health services, or at least devolved upon existing TB services , and 14 countries requested UNICEF assistance in TB prevalence surveys in limited areas, or in the establishment of TB pilot project areas, as then recommended by WHO. These projects are proceeding, one or two very well, but on their original limited scale. They have not been followed up, as in other countries, particularly after the discovery of cheap drugs for domiciliary treatment, by major development in national campaigns for diagnosis and treatment of TB cases on a mass scale. This lack of development in a field in which, it seems, a serious public health problem probably exists, may perhaps be attributed to the general tightness of health budgets while the malaria eradication programme is still being pursued.

The TB/BCG programmes have taken a total of $2,2 million of UNICEF funds from 1948 until the June 1964 Board.

In the field of child nutrition there has been constant emphasis in Latin America. Although meaningful statistics were non-existent, and the general availability of plentiful supplies of food was an obscuring factor, there was widespread belief even in the earliest days of UNICEF assistance, that malnutrition particularly of children was an important problem. In his 1948 report Dr. Passmore pointed out that the pressure of the people on the land was seldom high, and in consequence there was not the same shortage of food as in many parts of densely populated Asia. Few of the children in South America had faced actual famine conditions, and frank starvation was not common. In that respect, children of Latin America were in a better position than millions of children in Asia, Africa, and South East Europe. Dr. Passmore, however, postulated protein deficiency when

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be noted that a grave shortage of milk was perhaps the most adverse factor in child health, and this was confirmed in later studies and reports, particularly that of Dr. Charles Glen King (E/ICEF/L.1023) 1957). Dr. King's report noted that :"Although in certain areas of Latin America the estimated net calorie value of the food supply in 1952-53 was estimated as 2350 per day, compared with about 1600 in India, 2200 in Japan, and 3200 in Denmark, for the same period, the weakest spot in the entire food pattern is obviously in the excessive consumption of the starchy root crop, mandioca (manioc or cassava) by those with low incomes. Among infants, small children and mothers, the high intake of mandioca results in widespread caloric deficiency in parallel with protein, vitamin, and mineral deficiencies. The total protein content of mandioca is low and the nutritive quality is low..... There is no doubt of the widespread incidence of severe malnutrition among infants and small children. The type of protein deficiency represented by typical kwashiorkor is not uncommon, but a much more prevalent condition is represented by an onset of combined starvation, dehydration and diarrhea (marasmus, dystrophy). The resident pediotricians regard this result as primarily due to the high intake of mandioca and the extremely low intake of milk or other animal protein foods. Most of the official records have not identified kwashiorkor or protein deficiency (or other specific forms of malnutrition) as a specific entity, so it is difficult to arrive at valid conclusions regarding the cause of high infant death rates. Many of the leading physicians regard malnutrition as the most important contributing factor".

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The earliest programmes approved for UNICEF assistance in 1949 included 6 for feeding demonstration projects in Central American countries the objective of which was :"further examination, in close collaboration with the Governments, WHO, the Institute of Nutrition for Central America and Panama (INCAP), and FAO, of the ways in which the current programmes are related to long-term objectives of nutrition, health, and education, and can be carefully developed as initial phases of long-term programmes." Supplies consisted mainly of dried skim milk, with some other foods. The projects were planned as extensions of existing programmes, which reached a total of 16,000 beneficiaries in these countries prior to UNICEF assistance, mainly through schools. There was considerable difficulty in getting the programmes organized, but by early 1952 they were all operating more or less efficiently, and reaching nearly 300,000 children, 90 per cent through schools. (This number of children was about half the total school population of the countries concerned, and about a quarter of their total school-age population). The number of supplementary feeding programmes increased rapidly until in 1958-59 UNICEF was providing skim milk powder for 25 country programmes with a target of 1.5 million beneficiaries per day 60 per cent through schools and the balance through MCH centres. The programmes diminished after that because of the decrease in availability of skim milk powder from the U.S. Government, and in 1962-63, in order to save freight costs, UNICEF was able to turn over responsibility for continuation to bilateral or voluntary agencies. UNICEF is now providing for only about 137,000 children in a few small programmes in the Carribean area.

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Although the supplementary feeding programmes themselves were considered to be of importance, in direct benefits to the children and mothers who were reached, their particular importance was in stimulating interest in nutritional problems. A wide variety of people - teachers, community leaders, parents, medical and auxiliary personnel, etc.. - participated in their implementation, and the popular interest aroused served as an additional stimulus to the governments. At the end of 1952, the Executive Director reported to the Board that at least one government was legislating to establish a Nutrition Division within its public health administration, others had established Nutrition Councils, and all then participating in feeding programmes had undertaken additional activities in nutrition. In 1954 the Executive Director observed (E/ICEF/L.555 Add.1) "It is gratifying now in 1954 to observe in a number of countries that government-supported child feeding programmes have become an established part of public welfare policy. In seven countries UNICEF is assisting in the establishment of milk drying and pasteurisation plants. In all of these countries the first step was the development of feeding programmes with UNICEF milk. The second step has been the establishment of facilities for collecting, conserving, and distributing milk from local resources to replace the imported supplies.

UNICEF assistance up to now has been allocated for a total of 12 milk conservation plants, of which 10 were commissioned between 1955 and

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1964, one is shortly to be commissioned and the twelfth (approved in June 1964) is expected to be in operation by early 1966. The usual difficulties attended the commissioning of these plants - financial shortage which held up erection, shortage of trained technical and managerial personnel, inadequate local planning, political changes, and natural calamities such as floods and earthquakes. The most successful of the plants succeeded in bringing UNICEF equipment into operation within three years of the date at which the Board approved an allocation; in other cases the time lag has extended up to ten years. An important factor in delays was the early emphasis placed on these plants as providing for the replacement of imported supplies of dried skim milk when these should no longer be available, in order to continue the supplementary feeding programmes. When imported supplies of milk remained available longer than expected, the Governments concerned tended to view the commissioning of the milk plants with a certain lack of urgency.

Nevertheless, by early 1965 the ten operating plants were all producing, and were supporting welfare feeding projects for children, involving government expenditures substantially in excess of the value of the donated equipment. It is patently clear, however, that in the Americas as everywhere else, the expansion of dairy projects will have to be part of a rounded agricultural development policy with appropriate priorities and providing for essential legislation. Various technical studies and conferences mainly organized by FAO have indicated that

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the problems of Latin America are common to those of dairying in other tropical areas - low average yields per animal, unproductive animal husbandry practices, and generally unfavourable climatic conditions. More technical training of dairy personnel is needed, more and better extension and demonstration work, and better credit facilities for proper organization of milk producers. References were made however, to the beneficial influence of the FAO/UNICEF-assisted milk plants in Brazil and in Honduras have had on local milk production.

The development of indigenous protein-rich foodstuffs has also had considerable attention in Latin America, but as in other regions progress appears to be dependent on factors other than funds, mainly suitable low-cost processing popularization, and marketability at a cost within the reach of the lowest income groups. As early as 1951, reports were reaching UNICEF of experiments with indigenous foodstuffs being performed by INCAP in Central America, and by other Nutrition Institutes in Brazil, Chile, Ecuador and Peru. In 1955 UNICEF approved an allocation to Chile for the establishment of a plant to process fish flour. Acceptability tests had indicated good possibilities, but in 1965 the plant is still having difficulties with too slow production processes, combined with a shortage of fish. Experiments continue with the use of this fish flour in bread, but there is not yet enough production to test the idea on a wide scale. Allocations have also been made more recently, to

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Brazil for testing and establishing commercial marketing channels for a weaning mixture for pre-school children and also for equipment for the development of other types of protein-rich food. Little progress can yet be reported.

Applied nutrition programmes when introduced in 1957, won immediate acceptance in Latin America. The Latin America Regional Conference on Nutrition Problems held in Montevideo in July 1948 had foreshadowed such programmes in one of its recommendations urging "the development and improvement of nutrition in selected demonstration areas by the cooperation of experts in agriculture, animal husbandry, sociology, education and medicine". In 1957, the visit of Dr. Charles Glen King had served as a renewed stimulus, and the Executive Director reported to the Board that year that in Latin America thought was being given to greater emphasis on milk channelled to the pre-school child, on exploration of ways to use local high-protein foods, on training in nutrition of all types of personnel, direct nutrition education, and planning to reach the villager directly and help him to produce and consume more nutritious food.

Applied nutrition programmes for 17 Latin American countries have been approved since 1957. The earliest reaction was something like dismay at the complications involved in coordination at all levels of personnel of the Ministries of Agriculture, Health and Education, who had never before worked together. The following year, however, the Executive Director reported that the expanded nutrition projects were meeting

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with rapid success. "There is a constant gap between the social aspirations of the countries a nd the resources of the government budgets aimed at satisfying them....Latin America as a whole, as is well known, is subject to fluctuations of prices in agricultural products and raw materials. Too much emphasis is placed on the cash crops - cotton, sugar, cacao and coffee - and too little is produced for direct consumption by the families in the villages. The United States or European type of small farm which is almost self-sufficient as regards the basic food requirements is almost unknown in Latin America. Rural communities are isolated from central governments, contribute little to the fiscal revenue, and receive little from the national budgets. Mass health campaigns have been the first health services to be extended to rural communities, but too many villages are not under public health supervision, and are deprived of decent schools and trained teachers. Expanded nutrition activities have not yet performed any miracle but they have, for the first time, created a pattern of administrative coordination involving education, agriculture and health services at various levels, including that of the community itself... These activities have to some extent relieved the isolation in which the villages lived."

As the primary objectives of individual projects, however, come within sight of accomplishment, a big question is raised: future growth of each project lies in the same realm as the future development of milk resources - a realm of combined economic and technical development beyond the resources or terms of reference of UNICEF to assist.

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Nutrition training is another basic field in which Latin American countries have interested themselves. In 1960 a team of FAO and WHO nutritionists visited various countries to study the needs, problems, and possibilities of nutrition training. A comprehansive report (E/ICEF/429) was presented to the Board in June 1961, following its recommendations, and several programmes have been developed both in a country and on a regional basis, covering nutrition training at a variety of levels including training of nutrition specialists, agricultural engineers, nutrition programme planners, and nutrition education of social workers and home economists. Development has suffered from an acute shortage of trained supervisors, and from lack of coordination between the education, agriculture, and health authorities. These programmes, too, look to the future rather than to immediate widespread benefits. Much will depend on government's ability to solve current problems, and in future to employ trained personnel at remuneration adequate to keep them in their jobs, to create posts for the high level personnel in which they can have real influence, and to continue and improve the training schemes on a permanent basis.

UNICEF assistance to nutrition and nutrition training in Latin America from 1948 through June 1964 totals $7.55 million, of which $2.55 million was for milk conservation plants.

When UNICEF assistance in the field of social services for children was offered in 1960, advantage of the offer was immediately taken by

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several Latin American governments. Most of the countries, however, have as yet no effective legal and administrative machinery for dealing with social problems, and the UNICEF-assisted programmes broke down at several points mainly for this reason. They recovered after much effort on the parts of the governments concerned and international agencies, and have expanded to include training of existing employed and voluntary personnel, some higher-level training, the improvement of institutions and community centres, and some vocational training. A growing awareness is reported of the major problems created by high rates of illegitimacy, and consequent large numbers of abandones children and unprotected mothers. A regional meeting held in Santiago de Chile in 1962 recognized the gravity of the problems involved, and fixed common aims to be achieved in coming years. A seminar in 1964 stimulated a tangible advancement of the extent and quality of the programmes. Total aid to family and child welfare services so far amounts to $600,000.

When UNICEF's policy was liberalized to include aid to education, Latin American countries immediately took advantage of the offer, as did many in other Regions. 6 programmes have been approved between 1962 and 1964 ($1,9 million) which concentrate on teacher training, and fundamental planning. The problems in Latin America appear to be common to those of many countries in other Regions: too few schools, too few teachers, too little teaching equipment, a low quality of teaching, too few facilities for training teachers, too little money in education Budgets. UNICEF has yet to gain experience in the field of educational

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programmes, to study carefully at what points UNICEF aid can best be made available (since obviously UNICEF cannot possibly afford to give as much assistance as countries all over the world could take in aid to education), and to establish priorities.

AFRICA

UNICEF'S work in Africa has borne two complexions. In the opening phase it was characterised by the fact that metropolitan governments had authority in most African countries and territories, and this meant that the use made of UNICEF assistance was selective, in accord with needs as assessed by those governments, and in the context of their own existing plans. When the first project recommendations for Africa were placed before the Board in 1952, no UNICEF representative had yet visited any of the African territories. The recommendations were based on preliminary field work and contacts which WHO and FAO had established with metropolitan governments in the fields of health and nutrition. In commenting on those recommendations, the Regional Director for Africa pointed out that it was very important "for UNICEF to integrate its own efforts into the existing development programmes ... Metropolitan governments have, since 1946, made sizeable funds available for ten-year programmes aimed at the development of economic resources and the raising of living standards in Africa.. UNICEF and the Specialized Agencies are coming into contact with these territories when the programmes have already been laid down and pursued for 7 years out of the total 10. Therefore it is very important that we do not upset the planning which has already taken place. We must integrate our own efforts in relation to what has been worked out." (E/ICEF/224 and 240). He also commented that up to that time very little international aid had been directed toward the development of African territories, and that "long before the appearance of U.N. organisations in Africa, governments had been engaged in extensive research activities .. they prefer to await the results of their own research before they seek U.N. cooperation." (E/ICEF/240)

Emphasis in the first years was on mass disease control programmes, which took 82 per cent of all allocations made by UNICEF between 1952 and 1959. Governments were preoccupied with the problem of endemic diseases, which was of enormous proportions. Existing health services were able to deal with only a small proportion of the total load of curative work, and yet the burden was so great as effectively to prevent development on the preventive side. Apart from the health aspects, the role of the major endemic diseases in maintaining a state of chronic debility and reduced productivity of manpower was incalculable.

The remaining 18 per cent of the first six years' allocations was for basic maternal and child health and nutrition programmes, but the Board was informed that major development of these programmes was envisaged for a later time since considerable additional information was needed, plus experimentation to determine what types of services should be developed.

After 1960-61, when most African nations attained independence, the emergence of a definite trend of policy in the fields in which UNICEF is interested has naturally been obscured by the acute political and financial tensions inherent in the transition period. Also, the immensity of the problem of endemic diseases has been reduced. Nevertheless, it seems clear that emphasis will be given to UNICEF assistance in education, nutrition and community development, particularly in the sphere of women's education. In a 1961 report (E/ICEF/409/Add.2) commenting on Africa's "momentous year", the Executive Director said: "The strengthening of the economy of these countries is having first call on the attention (of the new governments). Africans everywhere aspire to a future which, they feel, must inevitably be of their own making. Priorities are therefore given to the use of mineral resources and to the expansion and improvement of agriculture. This, in turn, can only be assured if their educational systems are to be expanded. Throughout 1960 it has become increasingly clear that the emphasis in future development plans will be on education and on economic activities which will contribute to increasing the production potential of these countries." This is being substantiated by the increasing proportion of UNICEF allocations being taken by education and welfare programmes (an average of 40 per cent at the last three Board meetings) and by nutrition activities (an average of 27 per cent). Of the remainder, an average of 26 per cent has been allocated for basic health services, and 7 per cent for continuation of disease control programmes.

A third factor has played an important part in the flow of UNICEF assistance to Africa. At its March 1960 meetings, the Executive Board took certain policy decisions permitting flexibility in local "matching" criteria in order to enable useful projects to be started (i.e. the UNICEF contribution could, in the first stages, be larger than that of the government); providing funds for the employment of experts to help prepare project requests; and permitting the assumption by UNICEF of additional local costs, including the payment of salaries of key personnel. In taking these decisions, the Board recognized that there would be particular problems of administration and technical personnel in newly independent countries, and unless some solutions to these problems were offered, the amount of assistance flowing into these countries would

decrease for lack of project planning and supervision. This prospect at a time when the need was undoubtedly very great was of concern to the Board, and was the background to the decisions taken. It was not assumed that these decisions would solve the problems, but they have eased what might otherwise have been insurmountable difficulties in meeting the prerequisites for starting UNICEF-aided programmes.

First UNICEF assistance to Africa was allocated in 1948 when, in common with projects in other countries assisted through Joint Enterprise, three BCG programmes in North Africa were approved for UNICEF assistance. There was no further movement until in June 1951 the Executive Board approved a target budget for expenditure of UNICEF funds in the year mid-1951 to mid-1952, which included $2 million for Africa. In October of that year the Executive Director reported to the Board that the metropolitan governments having authority in Africa had been informed of their inclusion in the UNICEF budget, and that programme discussions had begun. In June 1952 the first project recommendations for Africa were put before the Board totalling $1 million, two-thirds of which was for mass campaigns against malaria, trachoma, and yaws, and one-third for milk feeding programmes.

For the first time, in these project recommendations, general information on the needs of African Children was put before the UNICEF Board. The population of Africa at that time was estimated at 198 million, and the population pattern was marked by high birth and death rates, resulting in a gross excess of people in the younger, dependent, non-producing age groups. The proportion of children under 15 to the total population averaged about 45 per cent (as compared to 21 per cent in several European countries). It was estimated that only 50 per cent of African children reached the age of 15 years. Infant mortality rates, recorded in limited areas, ranged between 200 and 350 per thousand live births. Mortality under the age of 4 years was thought to be heavily attributable to malnutrition. A joint FAO/WHO (Brock/Autret) nutrition survey in 1950-51 had led to the conclusion that there was widespread malnutrition in Africa, and that children were major victims of protein deficiency diseases, especially kwashiorkor. A WHO-sponsored malaria conference in Dec. 1950 had called attention to malaria as being highly endemic in widespread

areas, and another major cause of child mortality. Yaws and leprosy were known to be rampant. Tuberculosis, one report stated, was "liable to spread like wildfire at any moment" because of excessively rapid urbanization.

Geographic and climatic features presenting well-known obstacles; the great variety of customs, languages, and beliefs; the generally low economic level estimated at an average annual income per capita of $50 throughout tropical Africa; infestation with virulent diseases affecting both man and cattle; deficient soil and deficient methods of agriculture; extremely poor sanitary conditions; extremely low literacy rates; all contributed to the general picture of need. Poor communications, lack of transport facilities, and an acute dearth of trained personnel were mentioned as major obstacles to the launching of programmes.

A second group of project recommendations was presented to the Board for approval a year later, which included more countries for UNICEF assistance, but in the same types of projects. 50 per cent of the aid approved in the first year was for anti-malaria projects. Malaria was the major problem. According to WHO estimates, 90 per cent of the population of Africa was exposed constantly to the risk of malaria infection. It was estimated that between 200,000 and 500,000 African infants and children died every year from the direct effects of malaria alone. Mortality due to indirect effects of the disease, and the amount of morbidity due to it, could not be estimated, but according to limited health statistics available from some hospitals, up to 50 per cent of admissions in the age-group 0-4 years were diagnosed as malaria, and 20 per cent of recorded deaths in that age-group were attributed to malaria.

UNICEF assistance in malaria began in 1952 with $450,000 allocated for 6 projects, and by 1960 amounted to $4 million for projects in 15 countries. Although the population of these countries totalled approximately 135 million of the 170 million WHO estimated were exposed to malaria, only a small fraction were covered since most of the projects were designed as pilot projects. This continued even after the theory of eradication was introduced because it was not possible to find means of interrupting transmission. In 1959 (E/ICEF/386) WHO reported to the UNICEF Board that spraying with residual insecticides had decreased the amount of malaria, often quite spectacularly, but in none of the projects had transmission been interrupted after 3 to 4 years of spraying.

In 1963, WHO reported (E/ICEF/431) that comprehensive appraisal of the results achieved since 1953 showed that in forest areas total coverage with DDT residual spraying twice yearly, adequately supervised, could interrupt transmission. In upland hyper-endemic areas, three applications of DDT per annum, with single-dose distribution of antimalarial drugs, had also been shown to interrupt transmission. But in the open savannah areas interruption had not been achieved, due to various factors including exophily of the vector, movements of population, type of housing, and type of housing material employed. Where interruption had been demonstrated as achievable, the other requisites for malaria eradication (i.e. practical feasibility, and adequate administrative organization) had been absent. With the exception of the southern extremity of the continent, and of the islands of Mauritius and Zanzibar, it was considered that in all the other countries of the African Region the fundamental elements required for the proper setting-up and maintaining of a malaria eradication programme were inadequate. It was therefore considered advisable to plan for a preliminary operation (pre-eradication) adapted to the general social conditions and development status of each country.

A Policy decision adopted by the Board in 1959 and 1961 (E/ICEF/391/Rev.1 and E/ICEF/431) provided that where the chances of eradication appeared to be extremely remote, UNICEF in consultation with WHO should negotiate with Governments with a view to suspension of UNICEF aid. In accord with this decision, no further UNICEF aid was allocated for 14 of the 15 assisted projects. Assistance has been continued only for the programme in Zanzibar, which it was possible to organize as an eradication programme.

UNICEF assistance to Africa in malaria programmes up to June 1964 totalled $4.2 million.

Yaws was the second widespread endemic disease on which the governments elected to concentrate. Initial small allocations were made in 1952-1954 for three country programmes, but major allocations started to be made in 1955, after a WHO-sponsored yaws conference called for an offensive against endemic yaws in Africa on a continental scale. The conference concluded that Africa, with about 25 million cases of yaws, contained the world's largest reservoir of endemicity. UNICEF allocations for yaws programmes totalled $2.4 million up to the end of the June 1964 Board, the peak years being 1955 - 1960.

Programmes were assisted in 16 countries, all successfully. Unlike malaria, the means for rapid cure and prevention of yaws were to hand, and could be made available to entire populations with comparative ease. Highly qualified personnel were not needed. Short-term training of low-level personnel provided the field forces, and with these deployed and working the main requirement was for continuing adequate supervision and assessment. Some programmes developed faster than others, and some took considerable effort to put on their feet, but after twelve years of continuous work, the Executive Director is able to report to the Board that the disappearance of yaws from the African continent is in sight.

Two programmes in North Africa for the control of syphilis were included with yaws under the heading of "treponemal diseases", but there was no wide development in this field.

In leprosy, however, development was wide spread. Of the total of 10 million cases throughout the world, WHO estimated that one-fourth were in Africa. Starting with $50,000 for one programme in 1952, UNICEF has made allocations for leprosy programmes every year since then, totalling $3.6 million for 20 country programmes by June 1964. These have progressed less rapidly than the yaws programmes, because of the long period of treatment, but nevertheless _____ cases were under treatment by the end of 1964. The need for UNICEF aid will continue, but on a decreasing scale, for some years.

Tuberculosis was the fourth of the major diseases in which governments were interested in the early days of UNICEF aid, chiefly in the light of preventing the spread of the disease since it was regarded as an imminent rather than an existing threat. The early BCG vaccination programmes in North African countries were quickly terminated, and a few additional BCG and TB chemotherapy trial projects were initiated, but major developments were suspended pending investigations carried out by WHO (with support from UNICEF) between 1955 and 1960 through two regional teams which undertook prevalence surveys in a large number of areas.

Conditions in africa are in so great a state of flux, however, that in some cases the conclusions of a survey were no longer applicable shortly after it has been completed. The difficulty of measuring endemicity, lack of adequate national financing, and major obstacles in organization and staffing, have been responsible for the general slow development of anti-tuberculosis programmes. By the end of 1964 nine pilot projects were being assisted, of which only 2 were in a fairly

advanced stage of development. There appear to be no indications as yet of acceleration in this field. Governments are said to be focussing increasing attention on BCG, but this is as a corollary of the anti-TB methods recommended by WHO. Only two small BCG programmes are being assisted as such. UNICEF allocations total $878,000 to date.

Major interest in the control of trachoma was concentrated in Northern Africa. Programmes in three northern countries received much attention in the first five years of UNICEF assistance to Africa, and were largely successful. One programme in Ethiopia continues. UNICEF allocations total $770,000 to date.

These were the main fields in which UNICEF assistance was concentrated in the period before 1960, when (as stated) they took 82 per cent of total allocations. The reasons for their diminishing importance in UNICEF aid are partially due to UNICEF's virtual withdrawal from the field of malaria in Africa, and to the almost complete disappearance of yaws. Nevertheless, no new emphasis on other major diseases (e.g. tuberculosis) has grown to maintain the demand on UNICEF assistance to Africa for disease control.

The development of basic health services in the period before 1960 took only about 15 per cent of total UNICEF allocations in that period. The basic concepts of rural health services characteristic of the several country administrations then existing had a direct bearing on the form of UNICEF aid. Immediately after the war, the policy was to concentrate on the establishment of hospital services. Apart from the organization of measures against sleeping sickness, the possibilities open to post-war preventive medicine seem to have influenced public health planning only to a limited degree. Gradually, however, the financial burden of the ambitious hospital construction schemes began to weigh heavily, and there was a general realisation that existing training schemes did little more than meet current requirements, with no room for expansion. A trend began toward the development of basic health services outside of hospitals, and there appeared an awareness that such problems as environmental sanitation and health education of the public would need to be tackled if the general health level of populations was to be raised.

In the early stages of this trend came the mass disease control programmes, promoted by the emphasis WHO placed on malaria, yaws, and leprosy, and made possible largely through UNICEF assistance. Two years after the start of these mass programmes, the first allocations for basic health services in two countries were made. By 1956, UNICEF assistance had been allocated for a total of 9 country

programmes for development of health services. The Executive Director reported to the Board that during field visits that year, UNICEF representatives had noted a marked tendency on the part of African governments toward the concept of health services which had already been developed to an advanced degree in other regions, i.e. the concept of the rural health unit. The African rural health unit was conceived as performing curative services on a higher level than the previous dispensary system could have achieved; introducing the idea of active maternal and child health work both in terms of midwifery and of pre- and post-natal services; establishing cooperation with communal health activities; and, when properly functioning, accepting responsibility for continued surveillance after the termination of mass campaigns. That year, WHO appointed two regional consultants in MCH and this helped to expand the trend. In the field of training, several governments began expanding training activities focal points, where facilities for accommodation were adequate, teaching staff could cover a variety of training courses, andtraining could be exercised under direct supervision of the health authorities.

Development, however, was uneven. The traditions of the various governments having authority in Africa had a strong influence. Where British traditions existed, for instance, emphasis was on field activities rather than higher training. Where medical inspiration came from France, the opposite was the case. At the root of the problem was the fact that the great variety of social forms throughout the continent led sometimes to totally opposing concepts of what was normal in matters of family responsibility and the upbringing of children. In many places, before mothers could be persuaded to patronize MCH services, they had first to be persuaded to accept direct responsibilityfor their children, because in their traditional pattern of life it was the father or another person who was responsible. Preconceived animistic ideas as to the causes of illness, and the necessity for certain diets or practices at certain times, also presented extraordinarily difficult problems.

It was perhaps this aspect that led to the introduction in Africa of an earlier stage than in other regions of programmes aimed at the education of women. 15 per cent of the total allocations for MCW in Africa up to 1959 went to programmes of this nature. Generally, they took the form of mothers'

clubs organized by "natural" leaders who were given some elementary training. The clubs promoted various educative, recreational, and communal activities such as improved housing, better nutrition, personal hygiene, improved water supplies, and improved methods of caring for children. At the beginning, these clubs did little more than to satisfy the women's desire to learn home-making skills, but gradually they began to lead to real self-help schemes, in which the men pooled efforts with the women in building of nursery schools, community centres, protected springs and water courses, and other activities of community betterment. Activities in community development were furthered by visits from personnel of the Bureau of Social Affairs, and by a seminar organized by the Bureau and the Committee for Technical Cooperation in Africa South of the Sahara, in Ghana in 1959. When UNICEF's policy on aid to the development of family and child welfare services became more clearly defined, these programmes were shifted into a separate category, but it is interesting to note that in the earliest stage they spontaneously developed as part of MCW programmes, and they continue to be closely associated with them.

The numbers of MCW centres assisted in Africa were at first small, a total of 173 in 1954. All programmes included schemes for training of auxiliary personnel, mainly midwives, but it proved difficult in the early years to recruit a sufficient number of trainees to meet targets. In 1956, however, candidates for training began presenting themselves in increasing numbers, and in 1958 and 1959 the number of centres to be equipped by UNICEF rose sharply to about 1,200. The Executive Director reported to the Board that in Africa the health of mothers and children was beginning to be viewed in the realistic context of community development, environmental sanitation, and nutrition. Planning for UNICEF-assisted African MCW programmes had been co-ordinated within the framework of the general public health programme of the area concerned. In certain areas notable improvements were being recorded: in Northern Nigeria, for instance, reduction of malaria had halved the rate of premature births, and it was noted that the weight of babies born to mothers free of malaria was strikingly greater than those of malarious mothers.

As the plans of operation for the earliest programmes were fulfilled, (1960-61), they were reappraised and re-oriented according to the new concepts. Programme recommendations put before the Board since 1961 have all reflected

the pattern of expansion of field services through main and sub-centers. Development is steady, but slow. Apart from the major financial handicaps which prevent more rapid development, a lack of supervisory personnel in the middle echelons appears to be more of a practical obstacle to expansion in Africa than in other regions. An acute shortage of doctors is a complaint common to all Regions, but whereas in other Regions it has been possible at least partially to fill this gap by using numbers of well-trained supervisory nurses and midwives at provincial or district level, in Africa this has not been generally possible.

Apart from the emphasis on the education of women previously mentioned, the African programmes have contained other features peculiar to them. There has been comparatively greater development of mobile services than in other regions, due partly to the necessity of reaching large numbers of nomadic peoples, and partly to the strong development of mobile teams for specific disease control programmes. Where these mobile teams have been the first to bring health service to remote areas, a reverse of the usual procedure has evolved: instead of being disbanded after completion of the mass campaign, and the work of surveillance devolved upon static units, mobile teams have continued work and have assumed additional functions ordinarily performed by static units. Health education, and the local development of educational materials, was also given more emphasis in Africa than in other regions as an integral part of MCW programmes.

Environmental sanitation projects have developed in Africa as part of the general development in the public health field, and also as a corollary of other health programmes. Interest has been accelerated by the particular attention given by WHO to this type of work, and by comparatively large numbers of WHO technicians who have been made available for demonstration projects and for the training of health officers. As in other regions, however, it is anticipated that it will be difficult to progress beyond the demonstration phase in most countries, shortage of funds being not the only deterrent. Public education, the difficulties of installing and maintaining pumps, and other factors common to all Regions are present in Africa perhaps to an even greater degree.

In Africa, the health training programmes have been good and largely sucessful at the lowest level of auxiliary personnel, lacking at the middle

level of supervisory field personnel, and again good at the highest level of university training. At the latter level, training has tended to be organized on a regional basis, in East Africa for English-speaking peoples, and in West Africa for French-speaking peoples. UNICEF first entered this field by assisting in the establishment of a Chair of Paediatrics at Makerere College in 1958. In 1964, this college became part of the newly established University of East Africa, and its Medical Faculty (consequently, also the Dept. of Paediatrics) is scheduled for considerable expansion. The work of this Dept. has been extended beyond college walls by several of inter-country seminars in child health. At the same college UNICEF is assisting in the establishment of a two-year course to provide leadership training in social services and community development. At the University of Ibadan, a post-basic nursing education course is being established which should eventually help to fill the need of supervisory field personnel. In West Africa, French-speaking countries participating in public health seminars held in cooperation with the University of Dakar, with some assistance from UNICEF.

UNICEF assistance in the field of health services totals $8.4 million up to the end of the June 1964 Board.

One of the earliest emphases in UNICEF assistance to Africa was on malnutrition. In 1951, at the request of FAO, UNICEF provided small quantities of skim milk for tests of its value in combatting kwashiorkor in Central African countries. Among the first group of project recommendations placed before the Board in 1952 were three supplementary feeding programmes for extension of these test projects, which had proved very successful. They were, however, extremely difficult to organize efficiently. Reports to the UNICEF Board in the early years of UNICEF assistance to Africa stress the ravages of malnutrition among African child populations, the interest in nutritional development work, and at the same time the difficulty of organizing the three small supplementary feeding programmes which had been approved. It was not until three years after their inception that they were operating more or less efficiently, serving fewer beneficiaries than originally planned, but proving once again the efficacy of skim milk against kwashiorkor. In spite of this, however, the difficulties of packaging, transporting, and distributing the milk in view of climatic factors and generally poor communications were a major deterrent to a large development of supplementary feeding programmes.

Some school feeding projects were undertaken, but the greatest number of beneficiaries reached were through the MCW centres, where (as in other regions) the distribution of milk and vitamin capsules first attracted mothers to the centers, and later helped to assure regular attendance.

Several other interesting developments took place in the nutrition field, however. Perhaps chief among these was the wide spread of very simple nutrition education through the mothers' clubs in the mothercraft/homecraft and women's community development programmes. A great number of mothers were thus reached, with immediate and direct benefit for many babies, and some value for the future since awareness of the importance of good nutrition was awakened. Other programmes for nutrition education through schools, home economics, school gardening, and nutrition training of health staff, were introduced early in UNICEF'S operations in Africa, and all attested to the interest of the countries in their nutritional problems. In 1960, most of the countries which responded to UNICEF's suggestion of a study of the Needs of Children placed malnutrition among the problems needing priority attention.

It was not until the applied nutrition programmes were introduced, however, that there was important expansion in the nutrition field. In 1961-64 _____ per cent of UNICEF's allocations went into such programmes. Difficulties of coordination and cooperation of several ministries were perhaps even more pronounced in Africa than in other regions, but response from the communities has been remarkably good. Conferences organized by FAO for the French-speaking countries in 1962, and for the English-speaking countries in 1963, helped to further the programmes, to consolidate results, and to encourage the formation of constructive nutrition policies generally suited to African needs and capabilities.

Nutrition education has developed to cover a wide field in Africa, at all levels. Education through schools, including not only the training of pupils but also of teachers, has been emphasized particularly in those applied nutrition programmes in which the Ministry of Education was the strongest of the three participants (the others being Health and Agriculture). Teaching of mothers, health personnel, and various other groups ("cadres") continues through a variety of projects, including a series of seminars. Textbooks on nutrition with specific reference to African problems are being issued. University-level teaching is being implemented through collaboration with

the University of Paris for French-speaking countries, and through the establishment of a Faculty of Agriculture at the University of East Africa, for combined teaching and field study in agricultural extension and human nutrition. Africans are also participating in the inter-regional nutrition training programme in London and Ibadan. The continued growth of nutrition education programmes, wherever they may be introduced, is looked upon as a valuable investment for the future.

Experience with milk conservation in Africa indicates a good potential, sharply limited at present by lack of financing and trained personnel, and difficulties of efficient organization. Four milk plants have been assisted by UNICEF in Africa. Where there was previous experience and organization, the programme developed quickly and successfully. Not only was milk made available for welfare feeding, but the whole local economy of the areas concerned was stabilized to a point where it was not necessary for the government concerned to organize measures for the relief of distress, as it was necessary for other large sectors of the rural population. In other countries, progress has varied but is not discouraging. Africa is not limited, as are many Asian countries, by pressure on the land, which is so intensively cultivated for human food that there is little possibility of increasing cultivation for cattle food. Improved agricultural methods leading to improved feeding of cattle, organization, administration and training will all need to play their part in a real development of milk processing in Africa. Organized training for various categories in dairying, milk collecting, etc., has started with FAO/UNICEF assistance in Kenya.

Interest has also been expressed in Africa in the development of protein-rich foods, mainly groundnut flower. Here, too, it seems that there may be possibilities of real expansion. In the atmosphere of rapid and drastic change that characterizes Africa in this era, change in food habits may be less difficult to achieve than in other regions. One UNICEF-assisted experiment in Senegal was held up by the discovery of ground-nut aflatoxin, but is promising. Experiments with another weaning food, also using groundnuts, are satisfactory in the laboratory. But there is no experience as yet in commercial marketing of either product.

Assistance for nutrition and related projects in Africa to date totals $5.8 million.

In the field of child welfare, development has also been comparatively wide in Africa. As in the nutrition programmes, most satisfactory progress

has been made where the community is directly involved. The mothers' club movement, previously mentioned, has been outstandingly successful in several areas. In one country, the women's clubs have developed to the point of a government-recognized national voluntary organization. There is considerable training of community development workers for the promotion of this and similar activities at village level. Some high-level professional training of social workers has also been developed, but as in other regions this movement must be slower since the period of training is considerably longer, candidates for training fewer since they must have higher qualifications than trainees of lower level, and the effect when trainees have graduated and been employed in government service must be less spectacular since it is less discernible. Projects of direct social services for children are mainly urban and, as in other regions, confused because of divided responsibility between several Ministries. Lack of funds is, of course, a major obstacle. Reports indicate that for the immediate future village-level development is likely to take precedence and to be more rewarding. Total UNICEF aid in the field of social welfare/community development/mothercraft and homecraft to date amounts to $1.7 million.

Much has been said about national planning in Africa, the general lack of sufficient analysis in the formulation of the plans, and the fact that so much of the financing is envisaged from outside sources. Nevertheless, almost every plan gives priority to the development of educational facilities, and a comparatively large percentage of internal budgets, as well as of bilateral and international aid, is devoted in the national plans to this purpose. UNICEF aid for education projects was sought on a wider scale as soon as UNICEF's policy was widened to include them. In general, these are practically oriented to priority needs: teacher training, and the revision of curricula to include practical teaching for every-day life. As in the case of all regions, there is not yet sufficient experience in this field for useful observation. UNICEF allocations for education programmes in Africa to date total $3.2 million.

Annex ___

Note on UNICEF Programme Terminology

UNICEF programme terminology has changed several times. In 1951 the Executive Board decided that UNICEF would concentrate on two broad classes of programmes, "maternal and child welfare" ~~xxx xxxxxx~~ (which included mass health campaings as well as maternal and child health) and "child feeding" (which included milk conservation programmes) (E/ICEF/178/Rev.1, paras.22-23). In practice as aid for mass health campaigns became increasingly important it was treated as a separate programme category and UNICEF aid for "maternal and child welfare" was largely synonomous with what WHO called "maternal and child health". However, UNICEF retained the title of "maternal and child welfare " since it wished to emphasize without developing a new programme category the social welfare side as well as the purely health side of the services to be provided mothers and children.

In 1958 the UNICEF Board decided that the term "basic maternal and child welfare servids" should replace "maternal and child welfare services" (which was now conceived of as a broad term describing the objectives of all categories of UNICEF aid) and defined it to include, in addition to the usual maternal and child services environmental sanitation, and specialized programmes for physically handicapped children and premature babies, "child welfare services through channels other than a health department, such as a community development or social welfare department" (E/ICEF/368/Rev.1, para.32). In 1959 UNICEF approved a new field of aid called "social services for children" and established, taking this into account. One major classification was "Health Services" which included "basic health/maternal and child health" (drawing no distinction between the two, but recognizing that some projects would have more integrated services than others)

environmental sanitation, handicapped children and care of prematures. "Disease control" was a separate classification which included malaria eradication and control, tuberculosis control including BCG vaccinations, yaws/VD control, trachoma control, leprosy control, others. Projects for social services for children were included under a classification of "Family and child Welfare Services", Together with mothercraft/homecraft projects. At a later stage aid to community development projects (where they were not a direct part of health or applied nutrition projects) were classified under Family and Child Welfare as were special "Urban projects." The "Nutrition" classification included child feeding, applied nutrition,*/ milk conservation, and other high protein food development.*/ Two new major categories "Education" and "Vocational Training" were added as a result of the June 1961 Board decisions broadening the scope of UNICEF aid.**/

As a result of the classification

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*/ Originally called "expanded nutrition" and then "nutrition education and related activities".

**/ E/ICEF/398, para. 64.

**/ See paragraphs _____.