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UNITED NATIONS CHILDREN'S FUND

EXECUTIVE BOARD

SPECIAL MEETING ON THE SITUATION OF CHILDREN
IN ASIA WITH EMPHASIS ON BASIC SERVICES

SUMMARY RECORD OF THE 3rd MEETING

Held at the International Convention Center, Manila,
on Wednesday, 18 May 1977, at 2.30 p.m.

Chairman: Mrs. ALDABA-LIM (Philippines)

CONTENTS

The meeting was called to order at 2:40 p.m.

SERVICES BENEFITING CHILDREN IN RURAL AREAS

(a) "INTEGRATED HEALTH SERVICES PROJECT, MIRAJ, INDIA" (E/ICEF/ASIA/6) by Dr. Eric R. Ram (India)

(b) "SARVODAYA SHRAMADANA MOVEMENT FOR SOCIAL DEVELOPMENT IN SRI LANKA (E/ICEF/ASIA/8) BY MR A.T. ARIYARATNE (SRI LANKA)

(c) "BASIC SERVICES DELIVERY IN UNDERDEVELOPING COUNTRIES: A VIEW FROM GONOSHASTHAYA KENDRA" (E/ICEF/ASIA/9) BY DR. ZAFRULLAH CHOWDHURY (BANGLADESH)

(d) ANALYTICAL COMMENTS BY MR. ALI BIN ESA

(e) GENERAL DISCUSSION BY PARTICIPANTS

1. Mr. TILAKARATNA (Sri Lanka) said that the Sarvodaya Movement was warmly endorsed by his Government as it supplemented what the Government was seeking to do itself in such areas as rural development and education. Religion influenced the social development programme, for Sri Lanka was a small island where the impact of religion was unique: Buddhism there was not only a religion but also a philosophy and a way of life.

2. Mr. CHOWDHURY pointed out that the phrase "developing countries" was a misnomer which masked the real problem. As the Regional Director of the WHO South-East Asian office had stated, despite the efforts of overnments and WHO, the basic health needs of the vast majority of the population in the developing countries was still far from met in a satisfactory manner. Seventy per cent of the people in developing countries never consulted a doctor in their lives. Bangladesh was just one example among many. So-called "education" was one of the main reasons for the deterioration of services. The Planning Commission of Bangladesh had admitted, in 1973, that the literacy rate in the country was declining although the number of doctoral and master degrees had increased. The same was true in other countries of the region. Although the number of postgraduate degrees awarded by the University of Agriculture in 1973 had exceeded 200, the graduates actually had very few links with agriculture. Similarly, while the number of medical institutions had greatly increased over the past 20 years, less than 10 per cent of the population had access to clean water and health services. With regard to co-operatives, it had been noted, in 1974, that when a land-owning family formed itself into a co-operative, it retained exclusive control of land and equipment and monopolized capital, including government loans: in other words, it was merely rural capitalism in disguise. The same continued to hold true of the small farmers who were still not represented in the leadership of the co-operatives.

3. Manpower was the most important factor. Accordingly, attention must be given to the role of women who, chained by culture, ignorance, fear and poverty, were mere slaves. The welfare of children could not be dissociated from the welfare of their mothers. Recently there had been too much talk of overpopulation. That had diverted attention from the main problem, namely, poverty, which resulted in under-development. In that connection he pointed out that the death rate among the landless was 300 per cent more than among the landowners. Nutrition was a problem, for 60 per cent of the population was undernourished. So long as that was so the underdeveloped countries could not be

expected to progress. Ninety per cent of the health budget of Bangladesh was spent on 6 per cent of the population and the wealthy were in that 6 per cent. The percentage might be slightly higher in other countries but the situation was basically the same.

4. The services problem was compounded by outside agencies. Bangladesh was a good example: whereas the Government had wanted to go ahead with an integrated programme, it had been forced, under pressure from the World Bank, to divide its Health Ministry into two, one dealing with health and the other with family planning. Accordingly the population control programme had been introduced without a true understanding of village life and had not been successful. Since only some 10 to 15 per cent of the population could be reached through the rural medical centres, an attempt had been made to bring health services down to the village level. A group of doctors had decided to set up a paramedical programme which would involve women in development and emphasize preventive medicine. Paramedics were young village women with 0 to 10 years of education and trained in basic health and hygiene, immunization, nutrition, antenatal and postnatal care, normal delivery and family planning. They could also perform tube ligation operations. They worked hand in hand with the traditional birth attendants, older women who were therefore more influential in the community and quite willing to co-operate, since the paramedics did not threaten them, since they continued to undertake normal deliveries, calling for the paramedics only when complications arose. As a result of the programme, the birth rate, death rate and overall population growth rate had fallen considerably, all thanks to community involvement.

5. It was the paramedics who had questioned the wisdom of traditional antenatal clinics, pointing out that, since only a certain percentage of pregnant women were in the "at risk" category, it would be more efficient to identify such women and have paramedics give special attention to them rather than to require all women to attend the clinics.

6. Slides showing the delivery of basic services with reference to Gonoshasthaya Kendra were projected.

7. Turning to the subject of water, he pointed out that the technology for fixing water pumps was sometimes not passed on by the Government, so that many pumps were inoperative.

8. Education, too, was important, however, school attendance among the children of the poor was low, for reasons that were known to all. Accordingly, paramedics also helped to organize village schools, with the assistance of other young women. Those schools, which taught basic reading and writing, were controlled by the villagers themselves, not by a far-off government official. The teachers were more understanding too, and when children did not attend during harvest time because they were helping their families to harvest, they were not marked as absent. Such schools should also teach the children why their fathers did not own land. Until that type of education was provided there was little likelihood of progress.

9. The UNICEF paper entitled "Basic Services for Children in Developing Countries" was excellent. However, while the document advocated community involvement, and an integrated approach, other United Nations agencies were channelling resources into specific family planning and malaria control projects. WHO was supporting the establishment of four medical assistant training centres, situated in towns and designed to equip graduates to meet the needs of London rather than Bangladesh. Graduates of

(Mr. Chowdhury)

such schools would have 12 years of schooling and 98 per cent of them would be men even though, in order to have access to the villages, health workers had to be women. That being so, the community could not be involved unless such institutions were transferred to the rural level. Government officials and workers must be willing to implement the programme in an integrated fashion, involving the community, or the UNICEF idea would not really serve the people. Unless land reform and other far-reaching social measures were adopted, there would be no solution to the problems. Moreover, the middle-class men and women who represented Bangladesh at conferences obviously would not take a strong stand in support of social reform since that would be contrary to their own vested interest. So long as agencies accepted the claim that calls for such reforms constituted interference in national sovereign affairs, such integrated programmes would not be implemented.

10. Mr. BROINOWSKI (Australia) asked to what extent the idea that women should be used as the intelligent beings they were had gained acceptance and whether there were any social phenomena, such as religion, hindering its acceptance.

11. Mr. CHOWDHURY replied that the Government was interested in using women to encourage family planning. However, women continued to be paid different rates from men for the same work. Religion was not really a barrier, for social attitudes were changing rapidly.

12. In response to questions from the Nepalese representatives, he said that there had been no failure so far among the 2,500 sterilization operations performed by paramedics in the past three years. The paramedics had had to seek the doctor's help 20 times and the doctors themselves had had to seek the help of other doctors 6 times out of the 500 operations they had performed. There had been two cases of eclampsia. When toxaemia was not treatable at the local level, patients were referred to the main health centre. The first group of paramedics had been trained by a senior doctor. Later groups had been trained by other paramedics, but all were tested by a doctor prior to starting their duties.

13. In response to a question from Mr. Wahabsadah (Afghanistan) he said that the traditional birth attendant, being an older woman, had great influence in the community. The birth attendants continued to deal with normal deliveries after being instructed on certain procedures and warning symptoms for which to be on the alert. Paramedics were trained for a period of 6 months to 1 year. They were not doctors' assistants but in a class by themselves.

14. In response to a question from Mr. Hasan (Pakistan), he said that the previous Minister of Health, himself a doctor, had threatened to take him to court upon learning of his activities. However, the present Minister actively supported the paramedical programme. Paramedics did not assist the birth attendant in normal deliveries; they were called only in cases of obstructed labour.

15. Dr. HIRSHMAN (World Health Organization) agreed with Mr. Chowdhury that medical assistants should be trained in the area in which they were to serve. However, the programme of WHO and UNICEF were invariably formulated in consultation with the Governments concerned. He therefore wished to know whether any success had been achieved in persuading Governments to adopt the kind of approache outlined in Mr. Chowdhury's paper.

(Dr. Hirshman)

16. Secondly, he asked why the water-seal latrines were considered impracticable even if water was available. Was the problem a cultural one and what was the alternative to that kind of latrine?

17. Mr. CHOWDHURY replied that it was difficult for Governments of developing countries to refuse offers of assistance from such organizations as WHO since the needs of those countries were so great and the representatives of international organizations were regarded as experts. However, the Government of Bangladesh had decided that the training of rural health workers should take place in the rural areas.

18. As to the impracticability of water-seal latrines, it was necessary to take into account the cultural attitudes of the population. The amount of water required to flush the water-seal latrines was excessive, with the result that people did not use them. It would be better to provide latrines which required a maximum of two or three litres of water for hand-flushing.

19. Mr. GONDWE (World Food Programme) said that integrated development should of course, take into account the environment of the target population. Mr. Chowdhury's ideas might be perfectly suited to Bangladesh , but other countries might have to adapt them to their individual situations. It was true that international organizations had in the past provided assistance which had been unsuited to the real needs of the recipient. In many cases, however, it had been the Government concerned which had requested the specific kind of assistance provided. International organizations were not in a position to refuse requests from Governments when the latter seemed to have a clear idea of what they wanted. He therefore sought Mr. Chowdhury's views as to how international organizations should respond when they received requests from Governments which they considered to be at variance with an integrated approach to development.

20. Mr. CHOWDHURY said that, except for those that were socialist, Governments of developing countries rarely had the courage to reject the advice or the money offered by donor organizations. Moreover, because of their often precarious situation, developing countries sometimes accepted kinds of assistance which they did not actually need. Bangladesh, for example, had never refused assistance from the World Food Programme even in years of good harvest because of its fear that a food emergency migh recurr at any time in the future. International organizations therefore had a responsibility to take such attitudes of developing countries into account when making offers of assistance.

21. Mr. HAQUE (Bangladesh) said that he had an open mind regarding the ideas advanced by Mr. Chowdhury in his paper but that the basic question was whether they were practicable or feasible in the conditions prevailing in developing countries, particularly in Bangladesh. Bangladesh was one of the most densely populated countries in the world and its situation was particularly acute, as demonstrated by various demographic indicators. For example, whereas in developing countries as a group, an average of 26 per cent of the population was in the 0-15 age group, the figure for Bangladesh was 46 per cent. Moreover, the country's general mortality and infant mortality rates were well above the average for developing countries. The spectrum of diseases occurring in Bangladesh included malaria, TB and leprosy, and malnutrition and vitamin deficiencies were prevalent among children. The Government had recognized the need for radical change and, accordingly, had adopted an integrated health policy. The country had been divided into 356 Tana areas and grass-roots basic medical care was being provided on an experimental basis in 150 of them. Rural health centres, each staffed by four medical doctors, 20 paramedics and five public health nurses, had been established for each 200,000 persons. Each had a sub-centre for every 20,000 persons. The subcentres were staffed by paramedics and a family welfare worker was assigned to each for every 4,000 inhabitants. Community participation was ensured through a village voluntary health squad, which had one member for every 500 persons and was responsible for environmental hygiene, first-aid and applied nutrition.

22. In order to improve the reliability of health statistics, the Government had established a system of under-five clinics where every child under five years of age was examined once each month. So far 576 such clinics had been opened and the examinations carried out in them had revealed a high incidence of otitis, diarrhoea, scabies and other skin diseases, anaemia, malnutrition and parasites.

23. The Government had also established a committee to study the country's health situation and determine whether Mr. Chowdhury's suggestions might be further implemented.

24. As to preventive health activities, the Government, with UNICEF assistance was installing shallow tubewells which would supply water to 160 persons. In the under-five clinics, a voluntary organization known as the "Mothers Club" had been established and was being used as a means of attending to the health problems of women and encouraging the practice of birth control. In addition, the "Mothers Club" instructed women on the foods which provided the vitamins and minerals needed by their young children.

25. Under a new system, medical students were required to complete six months of their under-graduate training in rural health centres.

(Mr. Haque, Bangladesh)

26. The Government viewed the participation of women in health activities as essential and had reserved 20 per cent of all government jobs in that sector for them. The situation in Bangladesh would not be changed radically overnight but the necessary steps were being taken and gradual improvements were being made.

27. Mr. THEDIN (Sweden) welcomed Mr. Chowdhury's paper as a constructive attempt to dispel illusions about the provision of health services in developing countries. The part of the paper dealing with the drinking water programmes which were a very important part of UNICEF-assisted activities in Bangladesh, was particularly interesting.

28. The Swedish International Development Authority (SIDA) had recently been criticized because its programmes did not benefit the poorest segment of the population in Bangladesh and at a recent meeting of the SIDA Board he had cited the UNICEF water programmes in Bangladesh as an example of assistance which did reach the poorest members of Society. It came as some surprise, therefore, to learn that the hand pumps installed with UNICEF assistance were usually situated in the compounds of the wealthier people. That situation was a challenge to UNICEF, whose aim was constantly to improve its programmes. He sought Mr. Chowdhury's views as to what UNICEF could do to improve its water programmes in Bangladesh.

29. Mr. CHOWDHURY said that the water programmes of UNICEF in Bangladesh were valuable and that, although they benefited mainly the rich, they did reach many poor persons as well. They could be improved by adopting the objective of providing one hand pump for every 160 persons and by requiring each individual to contribute a nominal amount towards the cost of the pumps. In addition, poor village women should be trained to maintain the pumps, thus ensuring that the pumps would be kept in working order and enhancing the position of women in their communities.

30. Mr. ALI BIN ESA said that the three case studies which had been presented (E/ICEF/ASIA/6, 8 and 9) reflected the desperate efforts of conscientious development planners to devise suitable new models and strategies for improving the quality of life of specific target populations, especially the poor in rural areas. In each of the three studies reference was made to the inadequacy of basic services coverage in rural communities. The causes had been identified as poverty, hunger, malnutrition, over-population, rural capitalism, disease, landlessness, illiteracy, non-functional education, cultural attitudes that were unfavourable to women and children, an over-centralized and un-coordinated administration, and a lack of motivation on the part of public administrators and extension workers. Furthermore, all three projects stressed the importance of community participation and the "integrated approach" and they were concerned with improving the implementation of development projects.

31. Each of the projects described in the three case studies had apparently been successful in its own right. The problem for development planners was to determine how those projects might be expanded or adopted to other countries and situations.

32. In his paper (E/ICEF/ASIA/9), Mr. Chowdhury dealt not only with health services but also with the inter-relationship between health and other sectors, especially agriculture and education, in rural community development. Mr. Chowdhury emphasized better delivery of basic services through the careful selection of health personnel, including paramedics. Great importance was attached to the "sense

(Mr. Ali Bin Esa)

of belonging" in the community centre. Mr. Chowdhury also stressed the need for greater co-ordination between the United Nations and other funding agencies in carrying out projects and programmes. In that connexion, Malaysia's experience in launching its applied nutrition programme and the "Green Revolution" was perhaps relevant. The original plan had been to implement each programme separately; it had been realized, however, that close co-ordination between the two was imperative.

33. In his paper (E/ICEF/ASIA/6), Dr. Eric Ram focused on the co-ordination of health services only. Such an approach, although restrictive, was perhaps the most pragmatic first step which could be taken in any given sector, bearing in mind the multitude of agencies concerned with development. One of the problems Malaysia had encounted in carrying out the "Green Revolution" had been to ensure co-ordination among the many agencies concerned, each of which had its own identity and independent source of funding. The Miraj project described in Dr. Ram's paper aimed at ensuring co-ordination through training, a revised workload, an improved functional work system and better supervision. An attempt was also made to provide a detailed outline of duties for administrators at the village level and an evaluation of the project's impact had already been undertaken.

34. The Sarvodaya Shramadama Movement in Sri Lanka constituted proof that a development project would be successful only when there was community commitment, involvement and participation. The Movement focused on basic services and stressed self-reliance and wholesome personality development; to that end, it made extensive use of the existing religious institutions. In an era of conflicting cultures in Asia, such an approach should be given more serious consideration by other countries and by the funding agencies

35. How then could the experience derived from those three projects be used to improve the planning and formulation of implementation strategies? Firstly, in view of the complexity and elusiveness of development gains, both short-term and long-term plans must be formulated. Long-term plans should be designed to fight poverty and promote meaningful education, while short-term plans should cater for the basic needs of women and children so that they could enjoy physical and material well-being. Those basic needs could be met by providing such services as those described in the UNICEF booklet "A Strategy for Basic Services" and those advocated by the Sarvodaya Movement, both of which must be given top priority.

36. In operational terms, priority meant political and administrative commitment implying the need to review overall planning strategy on a regular basis, to review financial allocation and, finally, to review personnel management in terms of staff ratios, the content of staff training programmes, and staff security and remuneration. Such a review also involved the reorientation of senior officials in the central agencies. In that connexion, he was extremely concerned at the rigid specialization of such officials and at the lack of inter-sectoral coordination, which was not clearly demonstrated by meetings of the specialized agencies, where participants were always drawn from only one specific area of development planning.

37. In setting priorities for basic needs, national Governments must also have access to the necessary basic information and data in order to plan and implement their programmes. Such information was not always readily available. Similarly, effective co-ordination machinery was required in order to monitor the progress of individual programmes. In his own country, for example, district action

committee comprising elected representatives of the people and heads of departments co-ordinated project implementation at the district level. All programmes had to be referred to those committees, which in turn reported back to the central authorities on the progress of programme implementation.

38. The CHAIRMAN agreed that meetings of United Nations specialized agencies should attempt to embrace several disciplines. Top planners and planning Ministers should learn to consult with experts from all branches of development activity and, in particular, should try to ensure co-ordination between economic and social development programmes.

39. Mr. MANDE (France) said that the paper presented by Mr. Ram provided a highly encouraging example of community participation in health services. The project in question was so close to the programmes formulated by the Executive Board that it raised a number of questions with regard to UNICEF's role and its participation in the formulation and implementation of projects of that type.

40. He remarked that Mr. Ram's comments on midwifery kits had been most revealing : in all the years since such kits had been introduced, it was the first time that he had heard reservations expressed with regard to their use. He hoped that that did not mean that the Executive Board or field personnel were inadequately informed as to the use of such kits. At all events, it was clear from the discussion of Mr. Ram's paper that the whole concept of midwifery kits must be reviewed. After all, Dais must have good reasons for preferring to use the plastic delivery packs described by Mr. Ram in his paper. That situation raised a number of questions as to the exact nature of UNICEF participation in Mr. Ram's project.

(Mr. Ram)

41. In replying to a question from the representative of the Soviet Union, Mr. Ram had explained that he wished to see greater UNICEF participation in the supply of vaccine. The French delegation supported Mr. Ram on that point but wished to know in more general terms what kind of assistance UNICEF could deliver to projects of that type, which precisely implemented the action principles adopted by the Executive Board. It was difficult to contemplate direct UNICEF intervention, as it was a basic principle of UNICEF policy to act at government level, suggesting to Governments what projects they should implement. None the less, it was clear from the actual experiences described in the three papers that a decision must be taken as to how UNICEF assistance could be improved.

42. Ms. THAPA (Nepal), referring to the model for integrated health services described by Mr. Ram, asked whether the integrated basic health workers drawn from the pool of smallpox and malaria surveillance workers operated on a house-to-house basis. If that were so, according to her calculations the ratio of such workers to the population would be 1 : 113,000. In her estimation, such a workload was far too high.

43. Similarly, she wished to know whether immunization coverage was given on a house-to-house basis or in clinics. Further, as malaria field workers had been converted into integrated health workers, she wished to know what had been achieved by the malaria programme, as malaria had still nor been erradicated in the area covered by the project.

44. Finally, she had been struck by the strict demarcation between male and female integrated health workers and by the fact that only male workers had been chosen for family planning activities. It was surely preferable for female workers to carry out such activities as sterilization.

45. One of the main objectives of the integrated health services project had been to obtain a higher rate of acceptance of family planning activities, yet it was difficult to infer any measure of success on that score from the information provided by Mr. Ram.

46. While she strongly endorsed the practice of involving primary health workers such as Dais in integrated rural health services, she regarded the payment of 3 rupees per delivery as excessive. After all, the traditional birth attendants were already supported by the community as a matter of course. It would be difficult to apply such a costly practice on a wide scale. None the less, she welcomed the project's use of simple but effective technology.

47. The technical basis for Nepal's integrated health project had been derived from a pilot project carried out between 1972 and 1974. That project had integrated the services of five vertical health projects aimed at reducing fertility and mortality rates. It had also involved integrating information from five national vertical programmes. It had been evaluated by WHO and USAID as well as by the national Government.

(Mrs. Thapa-Nepal)

48. The tri-partite evaluation had shown that the project had provided effective fertility and mortality reducing services on a house-to-house basis at a lower cost than the vertical projects. The project had become part of government policy and, as the national programme expanded, manpower and other resources from various vertical projects were being integrated to provide a basic services infrastructure for the reduction of mortality and fertility rates. The various information systems from vertical projects were also being integrated.

49. The whole idea of the project was to introduce a co-ordinated approach to integrated health services. So far, the integrated approach had been adopted in thirteen districts and a further six districts would be involved in 1978. There was now an adequate infrastructure in those districts to ensure effective delivery of health services.

50. It would be a mistake to think that the UNICEF midwifery kit was not needed. In fact, it was especially necessary in countries such as her own. While a simpler kit was needed for traditional birth attendants, for whom the UNICEF kit was too sophisticated, the UNICEF kit was used by the assistant nurse midwives who supervised the birth attendants.

51. With regard to the role of UNICEF in supporting integrated health projects, priority must be given to determining what areas did not receive adequate UNICEF coverage. The question must also be raised as to whether the direct input from the specialized agencies was really beneficial. She recalled that UNICEF had initially been reluctant to provide disposable syringes for the vaccines administered to the under-fives as part of the basic health services project. The specialized agencies must learn to be more sympathetic to the needs of countries which were implementing such projects.

52. A more sympathetic approach was also required with regard to those countries' administrative shortcomings. For instance, the task of managing UNICEF-funded projects was greatly complicated by UNICEF demands for separate account keeping. As a result of the demands, many useful programmes never survived their encounter with bureaucratic procedures. She therefore appealed to UNICEF to reconsider its demands for separate account keeping and to rely on the system of each Government's Auditor-General.

53. With regard to the second and third papers, she felt that much could be learnt from the project described by Mr. Ariyaratne and that the project described by Mr. Chowdhury demonstrated the usefulness of simple but effective paramedical care and exploded a number of myths concerning the need for highly qualified medical personnel in rural areas.

54. Mr. DASHDOVDON (Mongolian People's Republic) pointed out that the whole question of services benefiting children was extremely relevant to many countries and not only to countries in Asia.

55. The Mongolian Government provided, extensive health care from birth. Pregnant women and working mothers enjoyed a whole range of benefits including paid maternity leave, job security, access to rest homes with nurseries and kindergartens and extra financial assistance in bringing up large families. All children came under medical control as soon as they were born and had individual medical cards. In rural areas, each medical unit was staffed by trained pediatricians, nurses and educators. Children of pre-school age were educated in kindergartens and crèches operated by the Government or by agricultural associations and units.

56. None the less, his Government was encountering a number of difficulties in meeting the needs of children, particularly in rural areas where the number of crèches and kindergartens was still inadequate. New crèches and kindergartens were being built with the assistance of students on vacation from universities and higher education institutes.

57. Mongolia had been co-operating with UNICEF, WHO, UNESCO and other international organizations for over 10 years. However, that co-operation represented only a small part of Mongolia's efforts to meet children's needs and his delegation hoped that the co-operation between his country and UNICEF would be developed further in the future.

The meeting rose at 5:35 p.m.