

Chapter 7

A Mother and Her Child

If the health and well-being of the child are at the heart of an organization's concern, then, however dramatic the impact of any mass campaign against disease, ultimately it must hold most dear the effectiveness of those parts of the health services which look after the expectant mother and her foetus; the mother in labour and at the moment of delivery; the mother and her newborn baby; and, with the co-operation of the mother, her small and growing child.

There are particular hazards associated with reproduction in women and with the growth of the child before and after birth for which special types of health and nutritional care are needed. And because of the love which every mother feels towards her child—and because of the hopes she and her husband, her parents, her inlaws and the entire family of Mankind entertain for their children's survival and future well-being—the time of pregnancy and early motherhood offer unique opportunities for influencing the kind of care a mother gives her child through the first risky months and years of life.

In postwar Europe, once the first moves had been made to get emergency feeding underway, Unicef offered help to ministries of health trying to rebuild and at the same time, improve the parts of their health services which catered to everything connected with conception, childbirth and the vulnerabilities of the foetus and small child. These were usually separate and self-contained branches of the medical world with their own practitioners and settings: gynaecologists, obstetricians, paediatricians; maternity wards, children's hospitals, and baby clinics.

In many countries, the immediate needs—needs met initially by UNRRA's much larger programme for restocking hospitals, clinics and laboratories—were still for drugs and other expendable supplies without which even rudimentary medical care could not be administered. But there were many other items—instruments, diagnostic tools, basic medical equipment—which were still in very short supply and were critical to the delivery of any acceptable standard of care in maternity and paediatric wards. Under the rubric of assistance to 'maternal and child welfare', Unicef took over from UNRRA the task of supplying items such as these to hospitals and clinics. Before long, the list began to extend to more sophisticated items such as

X-ray equipment and incubators.

When WHO came into formal existence in 1948, maternal and child health, or MCH, was designated as one of its top priorities. Its focus was narrower than Unicef's only by the use of the word health instead of welfare; Unicef wanted to be sure that social work among handicapped children and other activities extracurricular to health in its narrow sense were not omitted from its definition. But to all intents and purposes, the two organizations began to pursue the identical goal of helping build up permanent maternal and child-health services within their usual partnership: guidance from WHO's technical experts; material assistance from Unicef. During the next decade the partnership between the two organizations was extremely close, particularly out in the places where together and in close collaboration with local medical services and ministries of health, WHO and Unicef people wrestled as a team with the problems of developing programmes of MCH in the unfamiliar landscape of underdevelopment.

The most visible and tangible items in any MCH programme were the supplies. Medical supplies, both because of their range and because of the permutations of different designs and manufactured costs, presented much more of a challenge than the milk powder and cod liver oil capsules needed for supplementary feeding. Finding, packaging or having specially-manufactured the right therapy or equipment was as complex as meeting the specifications for milk plants—even though items like pills, thermometers and enamelware seemed a great deal less glamorous.

The requirements of the International Tuberculosis Campaign, followed by the other mass campaigns against yaws, leprosy, malaria and others multiplied by many times the complications and dimensions of the supplies procurement and shipping functions gradually taken on by Unicef under the guidance of WHO. The chief of Unicef's supplies operation during these years was Ed Bridgewater, a Canadian who had originally worked in the grain business and joined Unicef from UNRRA in 1947. Bridgewater and his staff quickly developed an expertise in medical procurement which eventually had an important impact on the niche the organization carved out for itself within the UN family.

As important as any medical consumable or diagnostic tool was the need to provide a high standard of training to all the kinds of professional personnel whose work impinged on child care. In the postwar phase, this mostly meant the retraining of people whose wartime experiences had cut them off from any contact with developments in their field, and even in some cases from performing in it altogether. In 1948–49, some 900 fellowships were organized for public-health workers, paediatricians, nurses and social workers on the strength of donations from Britain, France, Sweden and Switzerland. In 1950, Unicef co-operated with the French Government in setting up in Paris an International Children's Centre (ICC) with the idea that it would provide a permanent training, research and documentation

service for the best and the latest in the promotion of child health. Professor Robert Debré, the ICC's philosophical architect, had special views about what constituted the right kind of training for the well-set-up child-health promoter. He fused the specialization of paediatrics with the idea of public health in a discipline of which he was one of the key inventors: 'social paediatrics'. The social or preventive paediatrician not only knew how to care for mothers and children in the hospital ward, but also held 'well-baby' clinics and undertook other kinds of preventive maternal and child care in the community.

The early programmes or support for MCH in postwar Asia were almost a mirror image of forebears in Europe: 'shopping lists' of drugs, diet supplements, medical instruments, children's ward furniture, items expendable and nonexpendable, for clinical use and for training purposes, were drawn up in collaboration with ministries of health to replace those destroyed or worn out in the war, or which had never existed before it. Fellowships were offered for doctors, public-health workers and paediatricians; within the All-India Institute of Hygiene and Public Health in Calcutta a new centre was offered support similar to that given the ICC in Paris to provide postgraduate training in MCH, serving India and other countries in the region. But it was clear from the start that the scope of this assistance was inherently very limited, not to mention its minute quantity in relation to needs. In parts of the world where the permanent network of public-health services was embryonic, the immediate prospects of developing any extensive system of catering specifically for the health and welfare needs of mother and child were very dim.

An MCH service was a much more complicated affair than a mass treatment or vaccination campaign. For both a baby clinic, and for a vaccination, mothers might well line up with their small children under a tree or on a verandah in the expectation of some kind of health-promoting therapy; but there the similarities ended. Every pregnant mother and every child had to be treated as an individual case and their specific problems, actual or potential, identified. Only fully-trained professional staff were equipped to make this kind of judgement; the only service the lay worker or the auxiliary could reliably perform was to hand out whole milk powder to nursing mothers or carry out other straightforward diagnostic or preventive routines. Not only were professional staff needed, but they were needed on a regular basis; a pregnant mother needed several check-ups before giving birth, domiciliary or hospital care during labour, and her small child needed regular monthly check-ups thereafter.

In most Asian, American, and Mediterranean countries, eighty per cent of the people lived in the rural areas where there were few permanent health installations; some were hospitals and health centres set up courageously, but in a piecemeal fashion, by church and voluntary organizations, at a remove from the embryonic national health network. Unicef and

WHO set out to equip existing facilities, most of which were in the towns and larger population centres, to carry out pre-natal and baby clinics; and to set up model MCH centres for training and practical purposes. These were supposed to illustrate what a good MCH service meant; some performed valuable service in finding out which methods transposed well from more developed parts of the world and which did not.

Although Unicef might wish it to be otherwise, a relatively small proportion of its assistance went towards maternal and child welfare in the years following its reorientation towards the underdeveloped countries. This was seen as undesirable, and efforts were made to reverse the trend, particularly in Asia. But this was the era when disease control was widely regarded as the public-health priority, and the mass campaigns as the vanguard of permanent services following along more slowly in their wake. The campaigns were quicker and easier to mount than any service intended to be left permanently in place, and their instant results made them exciting and popular. The international organizations were carrying the banner of disease control higher every year throughout the 1950s; under these pressures it was unfair to expect hard-pressed ministries of health to divert more attention, and a substantially larger share of their budgets, to promoting MCH services and training workers in the various child-care disciplines.

Health budgets were small—minute in relation to needs—and under many competing strains. Lip service was often paid to their importance, but MCH was invariably a poor contender. Even where ministries were sincerely committed, the expense and the lack of trained personnel reduced progress to a snail's pace. Time was to show that the only chance of speeding up progress was to develop models for health care systems which incorporated MCH and looked and functioned very differently from most counterparts in the industrialized world.

Meanwhile, one of the first pieces of the maternal and child health jigsaws to be singled out by WHO's and Unicef's enthusiasts was the most obvious: the moment, place and circumstances of a child's delivery into the world.

The most risky moment in the natural course of a person's life is the moment of being born. The moment of giving birth—a moment which some women experience many times—is also fraught with risk. Before the advent of modern medicine, it was commonplace to lose either or both participants in their joint moment of jeopardy. In many countries, the death of mother or baby, or both, in childbirth or shortly afterwards was not uncommon in the postwar world, and in some of the world's remotest corners the same holds true today.

No society, however remote, however 'primitive', is without its maternity

service, even if it does not resemble the wardfull of obstetrical paraphernalia and personnel in which most modern mothers expect to undergo a confinement. In the 1950s, modern methods of childbirth were not even remotely available for the great majority of women living in Asia, Africa and Latin America; in many countries, especially in the countryside, this is still the case today. Their children come into the world in the privacy of their grandmother's or mother's humble home, with only the village 'grannie' or 'auntie' in attendance to help ease their passage: the *dukun*, as she is known in Indonesia; the *dai* in India and Pakistan; the *matronne* in French-speaking Africa; the *empirica* in Latin America. These were, and are, the 'traditional birth attendants' whose profession is one of the oldest known to Mankind: women who have passed down through many generations the mysteries of how to tend a woman in labour and deliver her baby safely into the world.

Many professional health practitioners and educated people used to classify the traditional birth attendant as a creature closely related to the witch: an illiterate crone who chewed herbs and brewed potions and whose superstitions and unclean ways were irredeemable. This school of thought believed that she must be displaced as swiftly as possible from her position as the village godmother, and mothers must deliver either in a hospital ward, or at home tended by a trained midwife. Her clients often saw the matter differently. They were deeply attached to the customs surrounding the birth of a baby, the careful protection and privacy in which the mother and her newborn child must be shielded. Even where an alternative was available, these were not lightly abandoned for the questionable advantages of being attended at a time of great stress by a stranger, especially away from home. The lack of importance the *dai* attached to particles of dirt lodged in her finger-nails or on the blade of the knife with which she cut the umbilical cord did not cause her clients anxiety: no connection was made with any later onset of a fatal sickness. If she had good hands and a soothing voice, if her knife was sharp and her movements deft, all would be well—God willing. If things went badly, then it was assumed that God, for some reason, was not willing. For the midwife's pains, she would take home a chicken, some fruits or a length of cloth for a scarf. Her advice, with that of grandmother or grandmother-in-law, would guide an inexperienced mother in how to nurse her child through the first risky weeks of life.

In the late 1940s, some progressive and pragmatic health practitioners, recognizing that the skills of the birth attendants were well-trusted and that in many places any version of the modern maternity ward was at least a generation away, began to advance the idea that the traditional midwives should be courted instead of discouraged from plying their trade. They were likely to command a clientele whatever the professionals thought of their methods. If they could be persuaded to add some notions of hygiene to their existing skills, and were linked to some kind of MCH supervision

and back-up, they could be co-opted into a relationship with regular MCH programmes. Not only could they then perform better their existing vocation, but they could summon professional help if a birth turned out to be more complicated than they could manage. They could also keep a track of pregnancies and births, informing the health centre, encouraging pregnant women to go for prenatal care and mothers to take their newborn babies for routine weighing and check-ups.

By the early 1950s, despite lingering scepticism, the image of the traditional midwife was already improving. Certain countries in Asia were starting to give some a weekly day of instruction or were persuading them to come to the health centre for a brief residential course. One way to help this process along was to provide a stock of the items they were teaching the midwives to use. A supply of medicaments and some better tools than the rusty old knife she currently used for cutting the umbilical cord would offer an enticement for *dais* and *dukuns* to join the training programmes, as well as improve their performance afterwards. Some modified versions of a standard midwifery kit had already been tried out in various places; on his return from China, Leo Eloesser started to experiment with assembling a range of items—sharp knife, basin, gauze, gloves, plastic sheet, bottle of antiseptic fluid—which could be supplied as a standard kit that the traditional birth attendant could carry in a canvas bag over the fields to wherever the woman in labour was waiting.

The kit was a simple but inspired notion. The product that resulted became eventually almost as well-known and as intimately associated with Unicef as powdered milk. Its final shape—not a canvas bag, but a cheaper and more durable aluminium box—and the final list of its contents was determined by Dr Berislav Borcic, with help from many WHO and Unicef colleagues. Borcic, with his long experience in China and other parts of the world, had a sharp eye for, and a strong disposition against, the complicated or extravagant medical accessory. With the help of friendly manufacturers enlisted by Ed Bridgewater and the supplies people, he pared the kit as close to the bone as possible: the total cost of box and ingredients was around \$12. Apart from the financial savings of standardization, the practical advantage of a pre-assembled kit—or what came to be a series of three standard kits designed for midwifery services of different degrees of sophistication—was the ease with which they could be ordered and despatched to destinations all over the world. Their contents could also be adapted according to the requirements of different health services.

The midwifery kits made possible an immediate expansion in Unicef's support for MCH services. The upsurge was most remarkable in Asia, where they became standard issue at the end of programmes to train several thousand *dukuns* each year in Indonesia and growing numbers of *dais* in India and Pakistan. One of the countries quick to make full use of Unicef's support was the Philippines, whose *hilots*—'old ones'—still

provided the backbone of maternity services in rural communities. When Philippine health authorities began to extend maternal and child-health services along conventional lines into the countryside, they found that the local women refused to have their babies delivered by fully-trained midwives in the MCH centres. The only way to tempt the mothers into starting to use the centres was to give the *hilots* institutional recognition via training and a midwife's bag, and hope that they would become advertisers for the centres' postnatal services. This strategy was farsighted and worked well; in time the local women began to overcome their original prejudices.

The *hilots* attended twelve weekly training sessions. They were taught about normal pregnancy and delivery, with special emphasis on the risk of infection, the need to sterilize the knife before using it to cut the cord, and how to tend the wound with antiseptic so that there was less risk of tetanus. They were also told to report pregnancies and births to the health unit, send pregnant women along for prenatal care and encourage mothers to take their young infants to its well-baby clinics. At the end of their training a ceremony was held, and they received their new kit in a neat tin box with 'Unicef' stamped on the lid. If something broke or ran out, the *hilot* was supposed to seek a replacement from the health centre. In 1955, when the programme had begun to move into its stride throughout most of the islands, the Unicef representative in Manila recorded that the 2000 *hilots* trained so far averaged one delivery a week; which meant that over 100,000 infants a year would be brought into the world with a better chance of survival for a cost of around \$20 for each midwife. As gratifying was their willing co-operation with the rural health centres, which they seemed not to perceive as a threat to their business. In some districts, *hilots* outside the programme had actually visited civic leaders to demand that they too be given training and a box of drugs and utensils.

The midwifery kit for the traditional birth attendant was just one small example of a process of refining and standardizing the supply of essential drugs and equipment for maternal and child services. This was not as easy as it sounds. 'Health centre' – as Sam Keeny frequently pointed out, and he made it his personal business to know – was a descriptor used indiscriminately to denote institutions engaged in functions so different in content and sophistication that it was almost misleading to think of them as generically related. The health-centre building could consist of open-air and a large tree, a bamboo hut with coconut matting walls and one tin chest, or a handsome brick structure with an operating theatre, wards with beds, and its own electricity plant. To reach the centre could require anything from a few minutes bus ride from a hotel in town, to a trek on foot along miles of paths, a boat ride upriver for several hours, or a steep mountain climb and a precarious scramble across a rope bridge. The staff in charge ranged from the auxiliary nurse-midwife proud of her competence at reading the labels on the bottles, to a fully-trained specialist at the frontier of

tropical paediatrics. This, then, was the 'health centre' which Unicef was trying to equip.

Supplies available from Unicef consisted firstly of expendables—cod liver oil capsules, basic drugs, iron tablets, vitamin A, and milk powder. These consumables were only supposed to supplement, not replace the provision of drugs and dietary extras by the health service, and then only for an initial period; but in many places they often consisted of the only supplies available. In practice therefore their function was far from supplementary; they were the only things more concrete than advice that midwives and nurses had to offer mothers who had often walked for miles with one baby on their back and another at the hip and lined up patiently for several hours on a crowded verandah.

These items increasingly came to be seen as an important draw, making of mothers a captive audience for talks on nutrition, or for preventive care such as a prenatal examination which they might not otherwise have sought. WHO gave technical advice about what should be supplied; this approach later led to the suggestion that health services depend on a basic stock of cheap 'essential drugs', and to the development of specific therapies for common complaints such as diarrhoea.

The range of possible items of equipment needed by health institutions from the grandest to the humblest was overwhelmingly varied, depending on the centre's staff, size and sophistication. To streamline costs and complications, lists of standard equipment were developed by WHO and Unicef to guide health officials and programme officers in drawing up 'shopping lists' as part of their MCH extension plans. Criteria emerged about what was reasonable and what was not; where a doctor was in charge, diagnostic equipment and even surgical instruments could be included; where midwives or nurses were in charge, the package was appropriately scaled down. Where an auxiliary nurse/midwife was expected to undertake home visiting and attend home deliveries, she might be provided with a bicycle; where a doctor ran an outreach programme of mobile clinics or subcentre supervision, a car or four-wheel-drive vehicle could be provided. Refrigerators—kerosene, gas, or electricity—were needed to keep vaccines fresh and other perishables from spoiling in hot temperatures; the specifications of every centre and the kind of service it was capable of running had to be known in order not to make mistakes over such critical factors as the existence or otherwise of a power supply.

Quite elaborate safeguards were set up to keep a check on what kind of health institution received what kind of equipment, and how well or badly it was put to use. Inevitably, stories abounded about refrigerators with the wrong specifications, the vehicle of a make for which no spare parts were available in the country, the equipment which was locked in a cupboard and brought out only for inspection by visiting officials. There were also the centres where staff were so overworked that equipment was used long

past the time when it should have been replaced; and others whose feedback enabled designs to be modified so as to make equipment more durable and better suited to its functional setting. One of the problems was how to set up a reporting system which was thorough, but which was not too complex, costly or time-consuming to carry out. On the basis of the information gathered, a great deal could be learned not only about whether the co-operation of WHO and Unicef was used and useful; but about what kind of ailments were most common; which staff in outlying places needed more supervision, or more training, or perhaps a promotion; which modest subcentre deserved upgrading, and which was serving no good use at all. These procedures, developed co-operatively with the authorities, were often incorporated into government practice.

Meanwhile, Unicef's own supplies operation outgrew its facilities in the basement of the UN building in New York. In 1962, it moved to special warehousing premises and packaging facilities in Copenhagen at the invitation of the Danish Government. There, as UNIPAC (the Unicef Procurement and Assembly Centre), it remained, expanding its operations more than tenfold over the next twenty years. As an instrument for the improvement of maternal and child-health care around the world, and a service to many other UN and non-UN organizations, UNIPAC became a phenomenon in its own right.

The other side of the maternal and child-health care coin was personnel. Shortage of staff, and of the wherewithal to pay the costs of training and employing them, was usually a greater barrier to the penetration of services into the rural landscape than any shortage of supplies and equipment. But in the early 1950s, there were still strong limitations on what Unicef could offer ministries of health to overcome this problem.

It was still widely held that funds donated for international humanitarian purposes could not fittingly be spent on doing anything to further people's expertise; furthering expertise was the domain of 'technical assistance'. An exception had been made after the war to allow students to be sent overseas to undertake courses of advanced study that, because of the wartime hiatus, were not available at home. In these cases other international considerations applied—considerations of healing international wounds, making desirable international exchanges, and how to make use of contributions in nontransferable currencies. But in order to do something so self-evidently sensible as pay for the training or in any way remunerate nurse/midwives for the day-to-day services they rendered to village women in Pakistan or Burma, Unicef had first to whittle down entrenched and outdated ideas.

The argument against such a use of funds was ideological: the development of national resources—personnel or other—was a matter for national

budgets and national planners, using whatever technical advice and extra financial investment they could negotiate from international partners. Humanitarian goodwill was only for the 'mercy mission' or its equivalent; it could not be used for something which was by its very nature ongoing and had nothing to do with a hiatus due to war or other emergency. Humanitarian donors—both governments using taxpayers' money and private individuals making charitable contributions—are as fussy about what happens to their money as any investor in business enterprise. They expect a certain return, and they are suspicious when it is difficult to measure in straightforward ways. In the case of a training programme, it was, and is, difficult to quantify exactly how the training of one person has benefited others supposed to live better as a result. Donors tend to prefer (it has taken many years to wean some of them away from such preferences) the reassurance of concrete actions like malaria control or feeding schemes; they like results which can be counted: milk rations, sprayguns, drugs, bicycles, baby scales—and kidney basins ordered, delivered and put to use. The problem in the 1950s—and in some places it is still the problem in the 1980s—was that without people properly trained to carry out the programmes, the equipment could be ordered and delivered, but could not be put to use. Not ordering it and not delivering it seemed an equally bad way of helping improve maternal and child health.

At that time, while ideas about international co-operation in the postwar world were still crystallizing and the philosophy of 'development' was yet to be fully articulated, attitudes about international humanitarian effort were still dominated by narrow definitions of welfare for the indigent or those dispossessed of some part of the physical or mental equipment human beings need to lead a 'normal' life. Remnants of such notions still persist; they are a holdover from an era in which humanitarian aid and social development were regarded as two quite separate and unconnected areas of human endeavour. During the 1950s, alleviating human distress and advancing human progress gradually came to be perceived as inextricable from one another. As both the intergovernmental and voluntary humanitarian organizations enhanced their experience of working with people in different economic, social and cultural circumstances, it became clear that no useful effort to do something 'humanitarian' could escape the implications of doing something 'developmental'.

At the beginning of the era in which Unicef began to wrestle with problems of underdevelopment, the stock on its metaphorical shelf fell within quite a narrow perceptual range: nutrition called for milk; health for disease control and MCH services. Gradually, the limitations of this stock-in-trade became obvious. Unicef offered 'material' rather than 'technical' assistance; at its best it not only went looking to see what was happening to the milk rations, cotton swabs, and enamelware delivered to the health centre out in the rice paddy or perched on the mountainside but also

ruminated constructively on what it had seen. Because of this, its arguments for breaking away from convention and getting involved in new fields of activity were pragmatic, and ultimately unanswerable.

The most serious bottleneck, in every area, was the lack of trained personnel to carry out programmes. It was originally to help develop MCH that Unicef began to push out the frontiers of its assistance for training. A series of decisions were taken during the 1950s—decisions inched through the resistance of certain major donor countries—on what kind of manpower development in underdeveloped countries could be supported in the cause of improving child health. These decisions had the full backing of WHO. In a very important sense, they paved the way for Unicef's evolution into a very different creature than the one it was at its inception.

The first step came in 1952, when Unicef adopted the policy of meeting the training costs for 'auxiliary' health personnel. This category excluded personnel receiving professional training at a school or college; it included those who had little formal schooling but who, on the basis of a short training course, were expected to play a vital role at the furthestmost tip of the health services: traditional midwives, nursing assistants, sanitary inspectors, lay vaccinators and other members of mobile teams. Such training courses did not need to be long in duration nor expensive, but instructors and trainees needed stipends to make it possible for them to travel to the place of training and stay away from home for a while. This decision was the crack in the door; it led to Unicef's entry into a wide range of health-training assistance, for it soon became obvious that low calibre staff could not augment the health services on their own. What was more, if no-one followed them back to the villages to see how they were doing, it was impossible to judge whether their training had had any effect, let alone improve upon it. In 1954, it was agreed that Unicef might defray the regular MCH training costs of professional nurses, midwives, and public health workers, as well as the costs—travel and stipends—of giving auxiliaries supervision.

In 1957, another considerable leap was taken in the area of more senior professional training. It was agreed that grants-in-aid might be given for periods of up to five years to help establish departments of child health in teaching institutes in parts of the world where these were few or nonexistent. One of the outcomes of this decision was the establishment of a Unicef chair in Paediatrics at Makerere University in Uganda. This was ably filled by Derrick Jelliffe, an English paediatrician who quickly developed an international reputation in child nutrition. By the end of the decade, still in close co-operation with WHO, Unicef had become involved in almost every aspect of health training related to maternal and child care in the underdeveloped world, providing at one end of the scale stipends worth a few dollars for members of the ancient profession of midwifery; at the other, grants and fellowships designed to create an élite of health pro-

fessionals to head the evolving MCH services in their countries.

By this time, a new theme was emerging, one that was to dominate health service development throughout the next decade and beyond. All efforts to improve the health of the entire community, including disease control campaigns, should embrace MCH; and MCH should embrace activities other than the strictly medical for the overall improvement of family life. Assessments of MCH progress had begun to show that too many nurses, midwives and public health workers were not extending the concept of MCH as far as WHO and Unicef had hoped. The numbers of health centres equipped and the numbers of personnel trained were mounting; but their impact left a lot to be desired. Too many so-called MCH activities were isolated from any other public health service and their scope often did not extend beyond routine maternity care.

The effort made to support MCH was too haphazard; more should go into setting up networks of MCH services which themselves were part of larger health-care networks. Somehow, more must be done, both inside the health centre and outside it, to reach mothers and children at all their moments of vulnerability. MCH must advance in a synchronized fashion with disease prevention, health education, nutrition, and public hygiene. Such ideas had implications for the training curricula of MCH workers, the contents of kits, the structures in which MCH was carried out— even the very nature of MCH itself.

Meanwhile, the health and well-being of the mother and her child could also be influenced from other directions. The MCH clinic might be the most obvious place to find Unicef's target customers congregated and ready for tangible assistance, but it was not the only one. In quite a few parts of the world there were also women's mutual support groups, such as the ones in Brazil which had been encouraged to take up mini-dairying. These networks belonged somewhere in between the traditional and the modern worlds; the idea of the mothers' union, of which they were in some places a copy and in others a deviation, was imported by the missionaries; but it was an idea that fell on fertile ground in places where there was a strong tradition of mutual help between women of a kin, caste or an age-set. It was among the women of Africa south of the Sahara, the last major part of the world to become a beneficiary of Unicef assistance, where this form of co-operation began.

In the early postwar years, the colonial powers did not welcome UN overtures to become involved in the parts of Africa where they were the responsible authorities. In the years when African aspirations for political autonomy were growing, Ralph Bunche and other senior UN officials concerned with non-independent territories were anxious to prepare the ground for the UN's future role in what was destined to become an array of new,

and struggling, independent African states. In the early 1950s, Bunche began to sound out WHO, FAO and Unicef on their willingness to offer, and the colonial powers on theirs to accept, a modest amount of technical and humanitarian assistance. Britain, France and Belgium responded positively.

Unicef opened negotiations with Paris, Brussels and London in 1951. The first allocation for Africa south of the Sahara—milk powder and medical supplies worth \$1 million—was despatched to destinations in French and Belgian territories in Western, Northern, and Equatorial Africa, and Liberia, late in 1952. Unicef at this stage was woefully ignorant about the 'dark continent', no Unicef programme person having yet set foot on its soil. This shortcoming was soon remedied by Charles Egger, director of Unicef's European headquarters in Paris, in whose domain Africa fell in the light of the need for close contacts with the metropolitan authorities.

Egger, a young and ebullient Swiss who had first served Unicef in postwar Bulgaria, was seized with enthusiasm by the idea of shaping a programme in what seemed like a vast, mysterious and virgin land. The first Unicef representative to live and work in Africa was another Swiss, Dr Roland Marti. Marti had served the International Red Cross for most of his career, was a veteran of arduous assignments, and brought to his interminable safari a conviviality which did much to make Unicef welcome throughout the continent. Marti arrived in Brazzaville in September 1952, was given a corner of the WHO regional office out of which to work, and worked from the outset in closest co-operation with colleagues from both WHO and FAO.

As always, Unicef's instinctive reaction in any place where it was offering assistance for the first time was child feeding. Brock and Autret's FAO/WHO sponsored study on 'Kwashiorkor in Africa' had recently appeared, and they had specifically singled out skim milk from milk-surplus countries as a remedial strategy. But the attempt to mount protective feeding programmes for the under-fives in various corners of French Equatorial Africa and the Belgian Congo was not an entirely fruitful experience—except in terms of lessons learnt. Little account had been taken of the distances which had to be travelled in Africa, the lack of roads, the fact that most people did not live in convenient clusters of dwellings in settlements akin to the notion of 'village' or 'hamlet', but in homesteads scattered far and wide throughout the bush. The complications and expense of distributing rations on a regular basis, and the difficulty of reaching the children most in need, made nonsense of giving out powdered milk as a kwashiorkor preventive.

There were other more banal but just as important reasons why milk powder made little impact on nutritional deficiency in rural Africa—reasons which made Marti laugh at his own and others' naiveté. The instructions for reconstituting milk powder demanded that it be heated,

and then rapidly cooled. But how, far off in the bush, was a large cauldron of milk, brought to the boil only after hours of heating over a brush fire, to be rapidly cooled? The women waited in the mornings for the milk to heat, and in the afternoons for it to cool. After a few sessions, bored and fed up and obliged to return to work in their fields, they stopped coming. Charles Egger described these results diplomatically to Executive Board delegates in New York: 'It may be necessary to reconsider certain elements', he reported, given 'the simplicity of existing facilities'. In due course, the milk powder was sent to schools, and to hospitals and health centres as a medicine for the specific treatment of kwashiorkor patients. Milk had a very limited application to the amelioration of child health in most of Africa.

Throughout the 1950s, by far the largest proportion of Unicef's modest assistance in Africa went to disease-control campaigns, particularly to schemes intended to prepare the way for malaria eradication. In the early 1960s, when WHO had reported that only in a few upland areas of Africa had it proved possible to kill enough malaria-carrying *Anopheles gambiae* mosquitoes to stop malaria transmission, almost all these projects were abandoned. The campaigns against yaws were much more successful: the susceptibility of yaws to penicillin made it very much easier to attack than malaria, particularly as any regular follow-up was so problematic.

Africa turned out to have a much larger reservoir of yaws than originally anticipated: twenty-five million cases, mostly in the West. Campaigns were mounted in Nigeria and in French Equatorial Africa, reaching a peak of three million treatments in 1958. In French territories the campaigns were carried out with a high degree of efficiency by the French Army's mobile epidemic disease units. The other targeted disease was leprosy. By the early 1960s, sulphone drugs had transformed the prospects of leprosy patients by ending the need for segregation and reducing the stigma attached to the disease. The missionaries looked after most of Africa's leprosy victims, and indeed were the only source of medical care in many parts of the vast hinterland.

In Africa south of the Sahara, more absolutely than anywhere else, programme models originally designed for circumstances of temporary social breakdown were hopelessly inadequate. Many believed that the deadweight of endemic and epidemic disease which cursed large parts of the continent—smallpox, typhus, yellow fever, sleeping sickness, river blindness, bilharzia, blackwater, as well as malaria, yaws, and leprosy—had to be tackled before anything else. Even though results were not always encouraging, disease control was one of the few options open in a part of the world where the only pervasive system of health care depended on self-employed practitioners dispensing a mixture of herbal concoctions, magic, ritual and promises of supernatural intervention. Except for the missionaries' brave little hospitals in the bush, it was nearly impossible to

find a functional health centre running any kind of MCH service outside the towns.

If the French authorities relied on the army's mobile teams for public health in the African countryside, the British both in West Africa—Gold Coast and Nigeria—and in East Africa—Kenya, Uganda, Tanganyika—had a different approach, envisaging the gradual spread of permanent services run by locally-trained and locally-stationed African health personnel.

When Unicef programme support for Kenya began in 1954, midwives and sanitary inspectors were spending some part of their training visiting rural communities and giving talks and demonstrations. As yet, almost no effort had been made to improve the skills of traditional birth attendants: even that kind of programme, however simple the course and relatively inexpensive, required an existing MCH service to give the training and follow it up with supervision. Training schools turning out the kind of professionals and auxiliaries needed for MCH were gradually increasing their number and the range of their curricula, but they were still very few and far between. In French West Africa, Dakar had a school for African midwives; but the French tended to concentrate on giving a high level of sophisticated training to medical personnel, almost invariably in institutions in France itself. Unicef's first contribution for MCH in French West Africa was in 1958, when the authorities in Senegal decided to transform their midwifery programme into full-blown MCH and give it a much wider spread.

The paucity in Africa of academic training institutions offering any grounding in paediatrics or courses in the public health subjects most strategic to the well-being of children was the main reason for Unicef's decision in 1957—a decision endorsed by WHO—to offer fixed-term grants-in-aid to medical colleges and university faculties. The chair in Child Health at Makerere was the most striking outcome of the new Unicef policy; other grants were made to institutes in Dakar, Senegal, and Ibadan, Nigeria. The work undertaken at these institutes, particularly at Makerere by Jelliffe and his team, helped begin the process of shedding the ethnocentric attitudes which afflicted social development policies in Africa—a process which, in the 1980s, is still far from complete.

Until teachers and students working in Africa itself began to develop a body of professional knowledge and experience about the way different societies bore and raised their children, the vacuum in child-health policy, personnel and practice could not be properly filled. This entailed studying family life, health and diet, in a wide range of different settings. In large parts of Africa, the life style of the people was shaped by the environment in a way that people living in a consumer society find hard to imagine. Responses to problems of health or nutritional deficiency suited to nomadic pastoralists living in the desert or semidesert were not applicable to settled agriculturalists living scattered in the plains; their diet and health problems

would differ again from those of close-knit societies living among the verdant greenery of cooler highlands. In colonial times, these differences were more often studied by anthropologists than by public health officials. Now times were changing.

In the absence of rural health centres and MCH services, the search for other organizational entities in which to put across to mothers information about child care, nutrition, domestic hygiene and family welfare, led Unicef to the women's groups. While traditional associations—among women circumcised in the same group, among the market women of western Africa—existed in many parts of the continent, the first formally-constituted women's movement to achieve recognition and support from what were then the colonial authorities was in Kenya. In 1956, Unicef offered assistance to the women's group movement in Kenya and to that in Uganda the following year.

The Kenyan movement for the progress of women—*Maendeleo ya Wanawake*—was established in 1951 to provide training for the leaders of women's clubs. A handful of these had sprung up at the initiative of rural women whose husbands had received some training in community development. But, as happened elsewhere in Africa, the real forcing ground of the women's movement in Kenya was the political struggle for freedom. Between 1952 and 1955, the years of the Mau Mau uprising against white settlers occupying the ancestral land of the Kikuyu people, thousands of women lost their husbands and fathers, and with them, their right to land, to occupation, even to legal existence as individuals. Shaken out of the set pattern of life by circumstances beyond their control, the women of Kenya began to demand something of a world which was offering change to men—training, education, jobs, money—but was leaving them in age-old servitude as men's appendages. *Maendeleo ya Wanawake*, by providing leadership and a co-ordinating structure, channelled what was essentially a grass-roots movement born of personal and economic hardship into a network of associations trying to improve the lives of members in many different ways. In five years the movement took off among rural women all over the country; by 1956, there were 500 clubs with a membership of over 30,000. Some clubs defied the law and bought land to farm co-operatively. Many hired themselves out to large farmers as contract labour, cutting grass and harvesting produce. The income they earned was used on a rotating basis between members, often for home improvements. A tin, or *mabati*, roof in place of thatch was the heart's desire of many, and as tin roofs began to dot the landscape, the groups became known as the *mabati* women.

In 1956, when Unicef first supported the women's club movement in Kenya, its assistance for training in mothercraft and homecraft reflected an idealized image of women's lives and ways of rearing children which had little connection with the realities of rural Africa. It was taken for granted

that a demand for classes in cooking, nursery care, sewing, knitting and handicrafts—the typical occupations of the mothers' union or women's guild in the Western world—were the principal reason why African women were clamouring for training and material assistance. At an elementary level, the need to educate women was beginning to be recognized; if they remained trapped in a fatalistic predetermined world, bound by the unchallenged authority of fathers, husbands and mothers-in-law over every aspect of their lives, then they would not embrace change, and therefore would not consider improving the way they raised their children and managed their family affairs. The same perspective also recognized the need to engage them in society, and to encourage in them qualities of independent judgement. But the vital part African women played in growing, harvesting and storing the family's food supply was only very vaguely understood, as was the amount of time and energy they spent on gathering fuel and collecting water, tasks as essential to the functioning of the household as any performed by men. Gathering sticks from the bush and loading them on one's back did not deserve attention in the standard text on 'homecraft'. Nevertheless, whatever the narrow perception of women's needs as mothers and homemakers which then prevailed not only at Unicef but also throughout the humanitarian community, the enthusiasm for supporting them was an enlightened step forward which, in time, opened the door to a broader view of the role of women in development.

Both the women's group movements in Kenya and Uganda were promoted under the rubric of 'community development', an approach which had developed a considerable following by the end of the 1950s. These were to be found among the policy makers in countries other than those in British East Africa: India, for example, whose rural administrative structure was refashioned in 1959 specifically to help community development along; and also in the circles where international assistance policies were shaped. 'Community development' was an approach with great appeal, particularly among those who thought of themselves as reformers and progressives and who were frustrated by the agonizingly slow pace at which conventional methods were transforming underdeveloped rural economies and—or—improving the lot of the rural poor.

The coming of community development marked a new chapter in ideas about poverty and underdevelopment, because its philosophical and practical characteristics distinguished it from any approach that had gone before. Its starting point was the growing realization that the problems of low productivity, hunger, ignorance and ill-health, were interlocking, particularly among those experiencing them; and therefore that they required a multidisciplinary response.

The multidisciplinary response demanded new things of people taught to refine and concentrate their attention on applying their own programme speciality and on leaving things outside their competence to the professional

attention of others. The problem with trying to improve the well-being of the rural poor from one direction only was that in the absence of other programmes or services, the good to be had was often promptly nullified. A nutrition lesson about the proteins in legumes or fish or eggs was not useful where no such foodstuffs were grown or found on sale at a reasonable price in the market; by the same token, a cure for malnutrition was useless if the child went home to the same starchy, protein-deficient diet. Doctors needed to concern themselves with nonmedical matters, like the food supply and water source; agriculturalists needed to think not only about crop varieties, seeds and fertilizers, but also about diet and health; educators needed to think of how to put all these things across to those who ought to be able to put such information to good effect. Community development tackled the family's and community's many different problems in tandem, usually by a team of people from a number of different government departments: local government, health, education, agriculture, forestry, public works, social services.

Not everything could be tackled at once, and no order of priorities was pre-defined from country to country or district to district; according to the ideal model, each team was supposed to establish their own. This element was associated with the other major novelty of the community development concept: a glimmering of recognition that the people on whose behalf schemes were devised were not simply their passive recipients, but had views and energies of their own to contribute. One piece of Unicef literature of the time commented: 'The community development process brings with it a new kind of vitality because it utilizes the felt needs of people'. The observation came from a review of the experience gained in supporting the women's groups movements in Kenya and Uganda. It conveyed the idea that people's sense of needing something was a resource to be harnessed; it did not suggest that their needs were other than self-evident – which meant in effect that they were defined by others. But at least the idea was admitted that they did have a sense of their needs, and that it could be important.

In Kenya the *Maendeleo* movement would not have spread so quickly – more quickly than any output of trained 'leaders' could possibly 'co-ordinate' – if it had not corresponded to something the women keenly wanted, even if they did not articulate their needs in terms of knitting and cooking lessons. To understand this was to move away from the one-dimensional view of poor people in underdeveloped countries as helpless and pathetic victims, and to begin to see the task of helping them as something other than a process of rhetoric and imposition, at the end of which they would have accepted something devised for their own good by someone who had never thought of asking their opinion.

Within Unicef, while there was no opposition to supporting mother-child welfare via the novel route of women's groups, there was some doubt about

whether an organization dedicated to the well-being of children should become involved in a process so detached from their specific needs as community development. The viewpoint was similar to that which saw disease control as the polar opposite of MCH, arguing that the only right and true Unicef pursuit was an activity directly focused on the child. Community development, by definition, did not distinguish between age-group, sex, or between the needy and the not-so-needy; in fact it was a great deal more of a catch-all even than disease control because a main part of its inspiration was economic rather than social. But evidence was accumulating in favour of thinking 'community' as well as 'child'. Studies of recent declines in foetal, infant and early childhood mortality showed that improvements in child health had as much, or more, to do with measures affecting the family and community generally as they did with efforts to impinge directly on the health of mothers, infants and children themselves.

Disease control, a cleaner environment, better housing, the chance of education and an increased food supply, played as important a part as maternity care, vaccinations and supplementary feeding in lowering the death rates of the under-fives.

A policy to promote children's welfare could not be devised and carried out in isolation from a policy to promote the well-being of the family as a whole. A set of baby-scales could not do more for a child than a bumper harvest in the family granary; a vaccination could not take the place of better housing on land distinguishable from the municipal garbage dump; a daily cup of nourishing milk was not a substitute for a supply of bacteria-free drinking water and a place where human ordure could be hygienically contained. Nobody disputed that a mother and her child faced special health risks and needed special attention; but if those requirements were held as the one-and-only sacrosanct destination of assistance divorced from their economic and social context, results were bound to be disappointing. The tunnel vision which insisted on seeing the child's well-being as somehow separable from that of family and community mitigated against the child . . . just as every untreated family and community member in a campaign against yaws or malaria was a potential source of re-infection for the child. The overall condition of family and community had a decisive effect on the child's present health and future prospects.

Well-reasoned as such a position might be, it took some years for Unicef as a whole to find it convincing. Where the expansion of MCH services was a specific ingredient of a community development strategy, as in India from 1956 onwards, Unicef was delighted to support that particular ingredient; but mother-and-child welfare was the beginning and end of the story. Gradually, however, Unicef became less cautious and began to see the benefits of the strategy as a whole for mother-and-child health. In the language of the time, the techniques of community development delivered a 'psychological shock' which broke the fatalistic bonds imprisoning people

—mothers being the operative people from Unicef's point of view—in custom and superstition and enabled them to take their first steps towards a more enlightened sense of who they were and what they were capable of doing. When Unicef began to support *animation féminine* in Senegal in the early 1960s, it had come around to the point of view that the 'psychological shock' was what counted, the spark that ignited women's interest in doing things together to solve common problems. That what many of the groups did together was to run crèches for children whose mothers were busy with agricultural tasks during the planting season was thoroughly pleasing; but the fact that the women themselves had made the choice, not the authorities or the supporting international donor, was an important evolution.

If the tantalizing promise of community development was that it could reach into households and families, arouse an appetite for change, promote productivity and release people from ignorance and ill-health, there was one problem for which it seemed an ideally suited strategy: the attack on hunger and malnutrition.

Ever since the early 1950s, FAO, WHO, Unicef and other partners in international co-operation had been trying to unlock the puzzle of how to do more for the hungry and malnourished child. Hunger and malnutrition epitomized the condition of underdevelopment in a way that nothing else could do. The misery they induced in the small child was the impulse that conjured not only Unicef but literally hundreds of bodies with similar purposes into existence.

Yet assuring the hungry and malnourished child enough to eat, not just today but every day, turned out to be the most complex of all the things these organizations were trying to do. As each new initiative deplored the failures that went before, it gradually went through a process of discovering that the presence of food on a child's metaphorical plate or in their family's metaphorical larder depended on an endless multiplicity of factors which, however frequently they were re-arranged and re-interpreted, always ended up in one configuration: poverty.

Only when poverty ended would the threat of hunger and malnutrition finally vanish; but in the meantime the hungry child could not wait. For an organization such as Unicef the puzzle of what to do about the hungry and malnourished child was, therefore, how to find ways of tackling some of the many factors— food quantity, food quality, food storage, food preservation, food preparation, food consumption, knowledge and skills in all these areas— without first solving the problem of poverty.

The discipline for addressing the combination of these factors was nutrition. One thing that WHO, FAO and Unicef had been trying to do from the early 1950s onwards was to boost the image of nutrition itself. Nutrition was described in many a UN document as 'the bedrock of health',

without which no sweeping prophylactic campaigns against disease and no maternal and child welfare activities would have much effect. Yet for all the rhetoric, nutrition was normally treated as an insignificant kind of subject, associated in the public mind with dieticians and vitamin pills. Depending on academic fashion, nutrition was passed around from the medical practitioners to the agriculturalists, to the social workers, to the economists; but wherever it landed—often half in and half out of many places at once—it tended to occupy a back seat.

With the advent of the new ideas of the late 1950s—‘community development’, ‘multidisciplinary responses’—nutrition finally came into its own. Hunger and malnutrition were the classic problems requiring a package of interlocking ingredients delivered by a combination of different players.

As far as Unicef’s assistance was concerned, nutrition had already moved through the gamut of milk conservation, social welfare, MCH, school meals, education, dairy development and food technology. In 1959, a new kind of nutrition programme won approval: the actual cultivation of the protein and vitamins—in eggs, fish, fruits, green leafy vegetables—which the small child so badly needed. Support for ‘applied nutrition’ placed a heavy emphasis on training professional and auxiliary workers in how to balance carbohydrates with proteins, vitamins and minerals. Nonetheless its accompaniment—support for growing the ingredients in gardens, ponds and poultry houses—met with resistance from those who believed that agriculture was an economic activity and had little to do with helping children. The logic of applied nutrition was, however, inescapable: if Unicef funds could support the blending of legumes or fish into a manufactured weaning food, then why not the local cultivation of the legumes or the fish so that the mothers could do the blending themselves.

The community development pattern launched in India during the second Five-Year Plan (1956–61) provided applied nutrition with its test tube. In 1960, the year after India introduced a new administrative tier—the community development ‘block’ of around 100 villages—an experimental nutrition programme began in 240 villages located in thirty-two blocks of Orissa State. A communal poultry unit, school vegetable garden and fish ‘tank’ were planned for every village; poultry hatching units and veterinary services were provided at block level. Among the many items which Unicef provided were tube-well linings and hand pumps for water supplies, garden tools and seeds, poultry incubators and fishing nets. The community development staff of Orissa drew upon agricultural, fisheries and animal husbandry extension services, as well as education, health, and public information services, to help co-ordinate activities. This programme, which became a national blueprint for tens of thousands of Indian villages, provoked considerable excitement both within India and internationally from nutrition’s growing band of professional enthusiasts.

Whatever else the school and village council might decide to do with the

produce, some part of the fish, eggs, fruits, pulses and green leafy vegetables planted and nurtured in ponds, hutches and gardens was intended for a nutritious extra daily meal for the community's under-fives. Here was the classic pattern of support to supplementary feeding: a short-term investment intended to set in motion a long-term activity.

Many of the villages were already recipients of skim-milk powder from Unicef, so the idea of organizing a special meal for the children was not unfamiliar. As the gardens began to yield, the milk powder was to be replaced by local ingredients. From the point of view of the villagers, the difference was important: the milk powder simply materialized, but chickens would not lay nor gardens grow without effort from themselves. The fact that they could produce a surplus and make a profit was an incentive to make the effort; but there were questions about whether it would be a sufficient incentive and, if it was, whether the attraction of profit might not deprive the under-fives of their special portion.

The Orissa nutrition schemes were cajoled into existence with little difficulty: the response of many villages was spectacular. Local landowners gave land, the schools planted gardens, and the village—often the youth club—dug fish tanks. The poultry houses, initial stock of hens and feed and the salary of an attendant were paid for by the local government until such time as the units became self-supporting. But the critical factor in the success of the Orissa experiment was the involvement of the women—their women's clubs—the *mahila samiti*—the women village workers, the auxiliary staff known as *gram sevikas* working in teams in each block. The *mahila samitis* saw to it that food from the gardens and poultry units was used for the preschool children; they also began to take an interest in the importance of nutrition, dropping some of their old resistance to certain types of food and introducing different menus into the meals in their own homes. When visitors saw children of different castes sitting and eating together in the *balwadis*—the preschools, and the crowds of enthusiastic women of all ages attending training camps, they felt that they were truly witnessing the erosion of social and psychological fetters. In 1963, Unicef agreed to support an expansion of the programme in several other Indian States, and in subsequent years repeated its support. The story of applied nutrition in India had only just begun.

By the end of the 1950s, at the end of the first decade of international effort to come to terms with the endemic condition known as underdevelopment, and on the threshold of the first official development decade, great changes were in the air. In Africa, the tide of independence was running strong; in the Western world, a new and optimistic era was about to open in international relations; in what was becoming the international development community, new links were being forged across disciplines and sciences, and between them. The whole field of social and economic co-operation was opening up. In November 1959, Maurice Pate wrote a letter to around

100 of his staff seeking their views in answer to a question: *Quo Vadis?*. Unicef was in a process of metamorphosis. In the era of 'development', what role should it try to play in improving the well-being of a mother and her child?

Main sources

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