Chapter 7

The Gender Dimension

From the moment of its own birth, Unicef accepted as a matter of course that the well-being of children was inseparable from the well-being of those in whose wombs they were conceived, at whose breasts they were suckled and in whose care they traversed the dangerous passages of early life. The primacy of the mother in a child's well-being was regarded by all child development specialists as axiomatic, and Unicef was anxious from its earliest days to assist women, especially those who were poor or disadvantaged in some special way, in their maternal roles.

To embrace maternity within the concept of public health was one of the early Unicef's central tenets. Some of its most important postwar assistance in Europe and later in the developing world was for the training and equipping of midwives, both the white-coated variety and the village 'auntie' who supervised childbirth in traditional settings[1]. The midwifery 'kit' for the TBA (traditional birth attendant)—hygienic gloves, clean razor blade, forceps, gauze, scissors and other essentials for delivery—was a standard Unicef item, updated and replenished over the decades. Unicef also promoted low-tech gynaecology and paediatrics, or MCH (maternal and child health) services, which were still embryonic in the early 1950s in most countries of the ex-colonial world.

Within a very few years, Unicef also began supporting women in their socially delegated, as opposed to biological, maternal roles as the upbringers of children. Mothers' clubs in Brazil and Egypt were seen as conduits for health and nutrition education and home economics; in India, day care provided an opportunity to feed and stimulate the young child and release mothers' time for other responsibilities[2]. In the 1950s and 1960s, the range of domestic activities Unicef assisted was widened to include 'mothercraft' and 'homecraft'

in countries such as Kenya. Here, as in many other ex-British colonies, the women's movement of the day was fashioned after the needlework and cake-baking conventions of the imperial alma mater. In West Africa, women were a prime target of *animation rurale*, a popular thrust of the worldwide community development movement.

As awareness rose about the heavy domestic load carried by many women in the rural third world, support for their role as hewers of wood and drawers of water was added. Clean water supplies close to home reduced the time and energy women spent on supplying the household's utilities, as did fuel-efficient stoves. Milk production, poultry-keeping and vegetable gardening could all be seen as support for child nutrition if they were carried out by women in a family labour context. And if women collectively pursued these activities on behalf of the community, this was applauded as an adjunct to their nurturing role. As the 1970s dawned, basic services schemes—soon to become the centrepiece of Unicef's 'alternative' approach—began to rely heavily on women volunteers as their front-line care-in-the-community workers. They were trained to become 'health promoters', 'village-based workers', 'handpump caretakers'—the outer arm of primary health care (PHC)[3]. And within urban basic services programmes, activities for and with women—to reduce the difficulties of raising children amidst urban squalor and brutality, to ease their lack of access to water and other utilities, and to help them earn money and organize for community improvement—were absolutely central[4].

The movement for women's rights that gathered momentum in the early 1970s concerned itself with the situation of women from a very different perspective. Far from seeking greater support for the safe accomplishment of maternity and domesticity, women were refusing to be defined by these roles and were demanding equality with men in other spheres of life. Their protest was against entrenched male domination of power, property, pay, educational and job opportunity, and the discriminations and disadvantages women suffered in these contexts. These discriminations were concomitants of their political and economic dependence on men, which in turn was based primarily on their role in reproduction and family care. Now they were insisting on gender equality as a right independent of maternity and child-raising—activities that, in the industrialized world, no longer occupied the long drawn-out and pivotal role in many women's adult careers that they had customarily held[5]. So determined were women activists to avoid being legally and socially defined by their reproductive organs—over which modern contraception had dramatically increased their control—that emphasis on other-than-motherhood and non-wifely roles was a distinguishing characteristic of the movement.

There was no permanent organization in the United Nations system for women as there was—by a historical quirk—for children. As some of the new champions of the women's cause began in the early 1970s to seek international linkages, they looked to Unicef for help. But they were disappointed. Not surprisingly, given the radical climate surrounding 'women's liberation' and the contemporary lack of recognition that low status of women interacted with poor family well-being, there was deep resistance within Unicef—male-dominated, as were all bureaucracies at the time—to the idea that an organization created in the name of children should be concerned with women in capacities other than child-bearing and -rearing[6].

This view was legitimized by the reality that changes in laws affecting women's status and the articulation of policies to promote equal gender opportunity would have little immediate effect on the lot of women in the developing world with which Unicef was most concerned. The kind of disadvantages experienced by women caught in the trap of poverty, illiteracy and unremitting toil were not easily susceptible to the passage of laws. 'Basic services' to improve a woman's and her children's health, relieve her worries and reduce her domestic drudgery seemed to Unicef at this time more appropriately 'liberating' for most such women, though the degree to which these services depended on the willingness of women to give unpaid service in pursuit of goals that did not necessarily mesh with their own was widely underappreciated. Some in positions of responsibility at Unicef believed that opening up women's horizons and granting them access to the workplace would distract them from their domestic roles and thereby lead to child neglect. Although no statistics, then or since, have ever been produced to support the idea that the children of women who are educated, employed and fairly paid suffer commensurate health and nutritional disadvantages—invariably the opposite is the case—this attitude has often since seemed teflon-coated[7].

Gradual conversion to the idea that women might have a significant role to play in development was inspired initially less by the movement for women's rights than by the mounting panic about population growth and the growing pressure of human numbers on planetary resources[8]. In the lead-up to the first World Population Conference in 1974, those who had managed to think of the women of the third world only as the mothers of its children began to view their child-bearing activities in a new and alarming light. Women were suddenly important because they were the progenitors of all the human statistics that were preoccupying planners with their future requirements for health and education services, jobs and housing, and jeopardizing economic development by their unprecedented profusion. Modern contraception, the technological

response, was mostly designed to inhibit female, not male, fertility. Therefore the potential mothers of the next generation must be persuaded to bear children 'responsibly', in numbers and at intervals that would not overwhelm either their own or their State's fragile resources. On the question of what went on in the womb of a woman living in the third world countryside or in one of its shanty towns, the protagonists of women's rights and of development had, for the first time, found themselves on common ground.

This was the reasoning behind the appointment in 1974 of Unicef's first 'family welfare adviser' ('family welfare' was a contemporary euphemism for 'family planning') with a brief that explicitly included 'programming for women'[9]. The position was initially financed by the UN Fund for Population Activities (UNFPA). This continued until 1976, when Unicef decided to institutionalize a post for its senior policy specialist on women's affairs (though it was not prepared to call her that until 1983). In 1975 came the first UN International Women's Conference and the launch of a Decade for Women, 1975-85. These events played a critical role in boosting Unicef's commitment to women, both in terms of programming for 'women in development' and in terms of female advancement within its own ranks. In turn, this made Unicef more sensitive to the way in which a core of influential women thinkers were speaking up on behalf of women in the developing world and recasting perceptions about their role in economic life[10].

Up till the mid-1970s, women in the pre-industrial communities of Africa, Asia and Latin America had not been perceived as making any significant contribution to the family economy. Assumptions about the distribution of tasks within the household had echoed the norms of middle-class industrialized society—namely, that family resource procurement was carried out largely or exclusively by male breadwinners and that anything women might additionally earn was pin money for the purchase of extras. In many parts of the world, these assumptions were highly flawed. The domestic load carried by many third world women had been noticed as consuming time and energy that could otherwise have been spent on mothering. But when the workload was examined and described from a quite different point of view, it turned out to be not really 'domestic' at all, according to norms operating in most Western societies, but economically highly significant.

In Africa, women undertook almost every task connected with growing and processing food, including planting, weeding, hoeing, harvesting, winnowing, tending small livestock, milking all milkable beasts, storing crops and pounding, grinding and sieving them into cookable ingredients. Out of a 16-hour day, around 11 hours were spent on these tasks[11]. Women were responsible for

between 60 and 80 per cent of agricultural work, 50 per cent of animal husbandry, all food processing and almost all the market-place trade in household food[12]. In Asia and Latin America, their agricultural burden might not be as heavy, but even the most casual inspection showed that nowhere was it light—even in a country such as Bangladesh, where rural women were secluded from society. In Africa, women produced most of the family food supply[13], and they also had to provide—not just manage as in industrialized societies—supplies of water and fuel. And when families from a peasant background migrated to town, women normally had to go on providing household utilities, even though they could no longer draw upon the natural environment, and buckets of water and bottles of kerosene now had to be paid for with cash.

On top of these responsibilities came other household maintenance and subsistence tasks. Many African women were expected to repair and replaster the family hut annually; in most pre-industrial societies, women manufactured household items: clothing, baskets, mats, charcoal, salt, rope, pots and kitchen utensils. In societies where female seclusion was not the norm, women regularly traded their production surpluses of these items as well as vegetables and food snacks in the 'informal sector'—the only context for engagement in commercial life open to them. Since everything to do with children's upbringing was traditionally left to women, many used the fruits of these transactions to pay the costs of schooling, and medicines if their children were sick. The 'breadwinning' male typically produced only one half of household income[14], and he rarely assumed tasks in support of his partner's domestic work, which invariably included waiting on him, his parents and other relatives.

Where women's work was so central to the household economy, it was unrealistic to compartmentalize women into two quite different creatures—the (economically significant) worker functioning outside the household, and the (economically insignificant) dependent home-maker and child-bearer—and engage with only one of them. In most of the third world, such a division was entirely artificial. The long obsession with economic production as the gauge of development, and—even more important—its definition as something with a monetary value in an officially recognized national or international market had obscured the fact that all the functions required of a woman in traditional society, including bearing and raising children for the family workforce, were economically important. Women's work had been marginalized in standard development analysis mainly because women did it and therefore—the presumption went—it did not count; since it was marginal, the circular argument continued, no one need bother to count it[15]. But once the full scope of

women's role in the household economy began to be appreciated, it became clear that any effort to help women as mothers would be handicapped by a failure to take into account the entirety of their roles. A woman who had to hoe a field or ply a trade to keep her family afloat could not waste time on skills such as embroidery and cake decoration—those typically taught in contemporary home economics courses. Even mothercraft lessons on subjects like bathing the baby had to be considered contextually, with the cost in energy and time of collecting, and heating, the water taken into account.

By the time 1980—the mid-point in the Decade for Women—had been reached, a great deal of effort had gone into a new analysis of the situation of women in the developing world[16]. Although there was still resistance in Unicef to picking up the cudgels on behalf of women qua women, the resistance was at least beginning to crumble: in the report prepared for the Mid-Decade Women's Conference in Copenhagen, recognition was given for the first time in a Unicef document to the fact that women were individuals in their own right, and that instead of trying to separate out their roles as child-bearers, nurturers, domestic workers and managers, Unicef should address their multiple roles—as wives, mothers, economic providers, citizens and leaders—in totality[17].

The need for something more than 'women's projects' was also beginning to be recognized. In some programme contexts—water and sanitation, for example, and urban basic services—there was already an important degree of recognition that women's involvement was central to programme implementation. Not only would their special needs have to be considered, but women would have to be allowed to express those needs to programme designers and managers and take part in decisions such as where a handpump should be placed and how its upkeep should be paid for; or which women in an urban neighbourhood should be regarded as eligible for business loans or help with school fees[18]. The projects that Unicef had initially supported under the rubric of 'homecraft' because they taught handicraft or horticultural skills were now reclassified as 'income-generating'. Networks of women's clubs and associations were given advice in marketing and business skills: their capacity to yield viable income was now seen as a more serious, less peripheral matter[19].

But there was another side to the analysis of women's impact on development: the effects of its impact on them. Evidence was beginning to show that the changes that modernization had wrought in the landscape over the past two decades had tended to increase, rather than relieve, women's drudgery. Population growth had meant a heavier pressure of people on the land, which made it harder to grow enough food, further to walk to gather fuel and water,

and longer to fill the pot from the trickle of water in the well. It also swelled the casual workforce, increasing the difficulties faced by landless or land-short families and swelling competition in the informal sector. Seasonal agricultural work was harder to come by, impelling menfolk to migrate to the city in search of a living. Although this brought occasional remittances from afar, marital bonds tended to loosen and families fragment. As the world entered the 1980s, a growing number of both urban and rural families were depending on women as their sole or main provider. Women were losing the security provided under traditional marriage and social systems, and at the same time they were working longer hours and life was becoming more expensive and harder.

This was because most of the opportunities offered by development had gone the way of the few, and these few were mostly men. Agricultural development tended to mean cash crops, crops that could be sold by a national marketing board to pay the national import bill. Cash was for the male heads of household, the supposed providers, so agricultural extension workers visited the men, not the women, with advice about hybrid seeds, tools and fertilizers. One study in Africa showed that women—despite their vital role in food production—received less than 10 per cent of extension contacts[20]. Improved technology, training courses, credit to set up a mechanized mill or processing business were automatically appropriated by men. Those who set off for town, or were drawn into the labour market by mines, factories and the industrialization process, gained a precarious entry to the 'modern' world while their womenfolk languished back in the rural home. Women were being left further behind, losing status rather than gaining it. 'Development' was playing a trick on women: it augmented their role in the economic life of their families while failing to include them in its benefits.

The 1980s was the decade in which not only Unicef but the whole network of international development institutions was forced to come to a reckoning with the way 'progress' was treating women.

When the 'child survival and development revolution' was launched in late 1982, the paramount contribution of mothers to child well-being was given due recognition. Not only did growth monitoring, oral rehydration, breastfeeding and immunization require mothers' full understanding and active participation, but GOBI in its fullest form had two 'F's suffixed: food supplementation (later changed to food security) and family planning; a third 'F'—female education—was added in 1983. These were the other three predeterminants of major improvements in child survival, according to the

group of experts advising Jim Grant. Thus the total 'child survival and development revolution' package was supposed to consist of GOBI-FFF, even though the three 'F's were never given equivalent weight.

These 'F's were an acknowledgement that there was a close link between the social aspects of a woman's situation and her family's condition. This had first been revealed by analyses of the disappointing results of many of the family-planning campaigns of the 1970s, notably the massive promotion of contraceptive technology and sterilization in India. Women in most poor societies did not step forward with alacrity to swallow pills, be fitted with IUDs or terminate their child-bearing possibilities. In large parts of the world—all of sub-Saharan Africa and much of Asia—a woman's status, her own sense of her value and her role in life were intimately associated with her child-bearing career, especially with the number of sons she bore[21]. Unless it was clearly in the family's interests—interests guarded by husbands, fathers and mothers-in-law—she was not likely to curb her reproductive behaviour. Besides which, the unlettered mother regarded child-bearing—its products and its intervals—as something over which the Almighty rather than the human will presided.

However, in some Asian countries—for example, in Sri Lanka, Taiwan and Thailand, and in Kerala state in India—family planning had proved relatively acceptable. These were all places where women's educational attainment was high in relation to their socio-economic status. And as demographers began to correlate drops in the birth rate with women's state of learning, child health specialists followed in their wake. A World Bank study of 1980 showed that each additional year of a mother's schooling reduced the chances of her newborn child dying in infancy by 9 chances in 1,000—even when key differences between families, such as income levels, were taken into account[22]. Thus, increasing the number of years spent by girls in school from—for example—three years to nine could reduce high infant mortality rates (above 100 per 1,000 live births) by as much as 50 points.

The reason for this very important sociological connection between women's education and improved child survival was not difficult to detect. Women who were better educated were likely to buy, and prepare, better-quality food for their children and to know how to handle common childhood ailments. Not only had they gleaned such information in school, but the experience of learning had imbued them with a sense of individuality and powers of choice. An educated woman was a woman with a belief in her ability to take decisions on her own, a woman inclined to step out from under the heavy layers of fatalism that had characterized her mother's and grandmother's attitudes to life and break the mould of ingrained and unquestioning submission, and a

woman whose opinion and actions deserved—at least potentially—the respect of her husband.

Although the contribution that women's education could make to child survival was acknowledged in the rhetoric of the 'child survival and development revolution', in the campaign's early, fundamentalist phase no serious emphasis was given to expanding programmatic support in this area, or indeed in other 'women in development' contexts. Unicef's annual expenditure on formal and non-formal education, for example, was $36 million in 1987, compared with $40.4 million in 1983[23]; during the mid-1980s, while expenditures on child health shot up, this category of assistance remained virtually static. In the run-up to the International Women's Conference in Nairobi in 1985, Unicef echoed the latest jargon of women's rights by talking about the need for 'women's empowerment'. But in reality, there had been a retreat to a position in which women were perceived as important because of their role in infant and young child nurture. When Jim Grant talked about 'empowering' women[24], he cited—with his extraordinary capacity for single-mindedness—the need to provide mothers with the necessary knowledge and motivation to monitor their children's growth, use ORT to treat diarrhoeal illness, breastfeed and take their infants to be immunized. The presentation of GOBI as a formula for women's empowerment caused some anguish among senior women in Unicef. Grant did redeem the analysis a little by suggesting that knowledge in such important child health contexts could give women confidence to do more for themselves in other spheres of life[25].

As for access to family planning—one of the three 'F's affixed to GOBI and a quintessential element of women's rights—here Grant ducked the issue entirely. He wanted Unicef to have no part in promoting contraception either on grounds of women's reproductive rights or for the sake of population control. At the same time, he wanted to avoid criticism that Unicef was advocating the saving of millions of children's lives without appearing concerned about the extra numbers of mouths to feed that this would necessarily entail. On the connection between child survival and fertility, Grant took a very particular line: 'Fewer child deaths means fewer births'. According to this logic, child survival was itself a means to reduce family size—despite the obvious truth that more children surviving in one family could not mean that the family would be smaller. This apparent contradiction was explained by a phenomenon known as the demographic transition: a country with high mortality and high fertility rates had first to reduce mortality before parents would be convinced not to have 'spare' children to offset those who would die young; once mortality rates had dropped, a reduction in births could be expected to follow[26].

Although no demographer could prove a causal effect, there was an observed connection between declining infant mortality and declining fertility, and the pace of fertility decline accelerated once infant mortality rates had dropped to below 100 per 1,000 live births[27]. By emphasizing this 'family planning' effect of the 'child survival and development revolution', Grant had reversed the usual formula, whereby family planning was regarded by WHO, UNFPA, the World Bank and the leading international population and family planning NGOs as important because it contributed to child health and survival, not because child survival contributed to it. In Grant's scenario, Unicef was contributing to fertility decline because child survival was a kind of delayed-action contraceptive—although he would not have used those words.

This was, for example, the theme of Unicef's contributions to the 1984 International Conference on Population in Mexico City[28] and to the Better Health for Women and Children through Family Planning Conference in Nairobi in 1987[29]. It was popular neither with the international health and family planning community nor with those active on behalf of women's rights. Besides adopting this line for reasons of strategy—which was to repeat child survival messages under any and every umbrella—Grant was determined not to let Unicef become overidentified with advocacy of family planning because of the controversies surrounding contraception and abortion. These controversies were reflected in the contrasting views held by different members of the Unicef Executive Board, by official bodies in countries where Unicef had programmes, and by governmental and non-governmental donors Grant was naturally anxious not to offend. Whatever his personal convictions on the subject of family planning, he therefore did his best to keep his 'child survival and development revolution' away from this contentious arena. He wanted to keep child survival squeaky clean.

In 1985—the last year of the Decade for Women and the year of the culminating international conference on women—Unicef's Executive Board reviewed its programmes and policies towards women for the first time since 1980. The paper lamented: 'The reality that women are the key actors in the child survival strategy has not yet been internalized throughout Unicef. This factor, together with the current weak linkages between women's socio-economic programmes and the child survival and development revolution, has led to a depreciation of the significance of women's socio-economic standing in relation to child health activities. Recognizing the important role women play remains a challenge for Unicef.'[30] Although the policy review explicitly pointed out the need to improve women's socio-economic status per se because of the

knock-on effect this would have on social development and on child well-being, the fact remained that this was a challenge that a Unicef obsessed by child survival was unwilling to face.

Some senior policy and programme staff still believed in their heart of hearts that there was a dichotomy between the interests of women and the interests of children, and that direct support for the former would siphon away resources from the latter[31]. However, given the growing international influence of the women's cause, and the increasing presence of women in senior Unicef positions, the pressures—from the Executive Board, from some Unicef country offices and from UN and other partners—began inexorably to mount.

Although there was little backing from headquarters throughout most of the 1980s, the decentralized character of Unicef came to the rescue of 'women in development'—as for other programme areas not embraced by the 'child survival and development revolution', such as water and sanitation and urban basic services[32]. Activity went ahead in the field as a result of pressures felt on the ground and therefore reflected in the country programme.

Much pioneering work was under way in Latin America, and Unicef country offices wanted to play a role. In 1976, in the wake of the first International Women's Conference in Mexico in 1975, the Unicef Regional Programme on Women in Development for the Americas and the Caribbean was set up in Bogota, Colombia. In time this became a dynamic venture with a respectable impact on women's programmes in the region. It began by undertaking studies, situation analyses and workshops at the national and international level, and followed up with assistance to women's projects in several countries: Bolivia, Ecuador, Mexico, Peru, and others[33].

In 1982 a major evaluation was undertaken, as a result of which the programme was upgraded. (By this time, the Unicef Regional Office for the Americas and Caribbean in Bogota was headed by a woman Director, Teresa Albañez, an ex-Minister in the Government of Venezuela.) Instead of being seen as project 'recipients' with all the welfarist connotations that implied, women were henceforth to be regarded as 'participants' in projects and partners in development. Two lines of programme action were identified: support for basic services and support for economic activities. In the latter context, there was a determined rejection of the old 'homecraft' approach, which had never seriously addressed the issue of women in poverty[34]. In Eastern Africa, where the women's programme was also strong and where the Regional Director was also a woman (Mary Racelis), similar thinking was afoot[35].

As a result of the recession and debt crisis of the 1980s, the predicament of women already disfavoured by the development process was progressively worsened. If adjustment negatively affected children, it did so partly because of its impact on women's and household income, as well as because of cuts in health, education and social services—which themselves threw back onto women an increased nurturing burden. The debt and adjustment crisis that descended on Latin America after 1982 disproportionately affected women who were already poor[36]. Both their numbers and their degree of poverty grew, while at the same time the survival of almost one third of the entire population of Latin America and the Caribbean came to depend on their statistically all-but-invisible labours, as well as their social contributions in the absence of service care[37]: care for the sick, for example, in families that could not afford a doctor's fee or hospital visit; child-care services, growth-monitoring sessions, literacy groups, community kitchens and other mutual support.

By the end of the decade, 86 million women in the region were estimated to be living in absolute poverty, of which 40 per cent were 'heads of household'[38]. Both culturally and economically, women had been relegated to marginal and underpaid occupations; their entrenched disadvantage in terms of education and the employment market meant that many had to fall back on commercialized versions of domestic work, in which low pay and instability of employment reduced their situation to near-servility. (Some solved these problems by entering prostitution.) A Unicef-sponsored study in Argentina found that women's incomes had dropped to a level less than half that of men; in Jamaica, the proportion of households dependent on women had risen to 45 per cent, and 40 per cent of these were in the lowest income group. Typically, women in poor Latin American environments were working longer hours—an average of 13—at lower wages than they had done a decade before[39]. Where many commentators talked of the 'feminization of poverty', Unicef in Latin America began to argue not only for 'adjustment with a human face', but for 'adjustment with a female face'.

At the same time, support for women's economic activities in the region was stepped up. The 1982 evaluation had showed that where women remained the beneficiaries or quasi-employees of what were essentially handicraft projects, the termination of start-up financial assistance quickly led to project bankruptcy. Genuine commercial viability, personal growth and eventual autonomy for women 'participants' needed to be built into the conception of a project if any real and sustained increase in income was to ensue. Experience suggested that credit, with the skills to handle personal savings and finance, had to be the mainstay of any long-term programme to improve women's economic situation

in such a way as to improve their families' well-being. The main difficulty was that conventional banks and lending organizations were not prepared to give loans to people who were poor, let alone to people who were both poor and female.

In Colombia, Unicef set about breaking this log-jam by persuading various state agencies to handle lines of credit for various networks of women's groups if Unicef itself first established a guarantee fund. One programme set up in the very poor southeast sector of Cartagena in 1983 through the Centro de Desarrollo Vecinal 'La Esperanza' (the La Esperanza Neighbourhood Development Centre) worked with women street vendors whose previous means of credit was from usurious 'financiers' charging 10 per cent interest a day. Under the scheme, they joined solidarity and savings groups and received low-interest credit and support. In 1984, Unicef signed an agreement with the National Vocational Training Service (SENA) to systematize the programme and replicate it throughout the country. By 1987, 225 solidarity groups with 750 members had been established and 10,000 family members had benefited indirectly[40].

By 1985, the experiences in Latin America and others elsewhere were encouraging Unicef to talk about 'infiltrating' women's issues into mainstream national programmes, 'emphasizing activities that are both income-saving and income-generating'[41]. The most striking example of a nationwide programme to help women overcome their lack of access to resources was the Grameen Bank of Bangladesh, set up in the mid-1970s by Professor Muhammad Yunus of Chittagong University. Yunus wanted to prove to himself and his students that those normally shunned by institutionalized moneylending—the rural poor—were entirely 'bankable'. In 1976, he set up a credit scheme for local villagers in which the only eligible applicants were the very poor: those with almost no land—less than 0.5 acres—and almost no possessions. Grameen had a policy of no collateral, relying instead on membership in local groups and peer pressure to guarantee loan repayment. Loans might be given for a milch cow, a food-processing device such as a rice-husker, poultry and even home improvements such as a handpump. The success of this experiment attracted support from external donors, and by 1985 the Grameen Bank had over 220 branches serving 170,000 borrowers in 3,600 villages across the nation[42].

Unicef was a keen supporter of Grameen, providing funds to help train women 'branch managers' and group leaders, and helping integrate motivation for child survival activities and family health improvements into local group pursuits. The bank focused increasingly on women savers: they came to constitute 89 per cent of Grameen clients, and their repayment rate on a cumulative

loan disbursement of around $185 million (1990) was an extraordinary 98 per cent. Average per capita income in borrowers' households rose by over one third[43]. These results, obtained in a Moslem country where women were in purdah, therefore did not play a visible role in the market past the age of puberty and had been erroneously assumed incapable of commercial undertakings, did much to change attitudes—not only in Bangladesh but around the globe—towards women as efficient users of credit. Grameen inspired a number of similarly modelled user-group savings and credit schemes for women in countries as diverse as the Dominican Republic and Nepal.

Although a growing number of Unicef programmes of cooperation were actively involved in pursuing the cause of women as a coterminant of child survival, the Executive Board remained far from convinced that there was a real organizationwide attempt to give efforts on behalf of women what had been internationally established as their due[44]. Instead of leading the field for women, the UN's organization for children now appeared to be dawdling in its rear, still regarding 'women in development' as some kind of extra, not as central to everything Unicef was about. Senior women policy advisers began to feel that things had reached a nadir. In 1986, Board members expressed their concern; the result in 1987 was an implementation strategy agreed by the Board to make sure that policies already laid down in 1980 and 1985 became fully operationalized. The review was not supposed to make policy so much as to make policy stick.

The 1987 policy paper spelled out uncompromisingly that Unicef regarded women's development as integral to the social and economic mainstream. Women's needs were to be considered not only in the context of bearing and raising children but in the whole range of their interconnected roles. The woman vendor of pots and pans was to be given the same consideration as the woman at the antenatal clinic, the woman bringing her child for vaccination, the woman in the literacy class and the woman community worker: they were all the same woman. Not only should programmes cease to compartmentalize women's roles, but the whole logical process of examining women's developmental role should be reversed. Women were not in some ghetto of their own; they were a part of every picture. Therefore within each programme and sector, women's roles needed to be analysed, and the inequalities stemming from gender had to be made a target of affirmative action. From then on, every Unicef situation analysis and country programme must fully incorporate the gender dimension, and programme staff should be gender-trained and gender-oriented systematically so as to help this come about. Programmes that favoured women within the health, education, agricultural, labour, housing and water

and sanitation sectors could support a holistic strategy that addressed nurturing, poverty and equity issues at the same time.

In subsequent years, the Executive Board sternly asked for annual updates on the implementation of the 1987 strategy. The abandonment of 'women's projects'—seen as an essential conceptual leap in redefining Unicef's approach—needed to be carefully monitored; there was justifiable fear that in the more recalcitrant field environments it might lead not to the mainstreaming of women in the development process but to their convenient oblivion. And still there was a sense in many parts of the organization that the forward-looking policy was barely connected with its actual realization. However, it was not so much the nagging of the Board as the arrival into view of a hitherto unnoticed person that finally propelled the genderization of Unicef forward. This was the 'girl child'.

For every 100 female babies delivered into the world, at least 105 males are born[45]. The female human being is more biologically durable, and the surplus of boy infants is nature's way of balancing the sex ratio in the population. Ordinarily, the number of surviving girls soon overtakes that of boys; if given the same degree of care and nurture throughout the passage of infancy, childhood and adolescence, females should outnumber males and live longer.

Yet there are parts of the world where this male-female rebalance never occurs; where, instead, human intervention—in the form of girl neglect—favours the survival of males. In India, for example, there are only 957 females aged 0 to 4 years for every 1,000 males in the population, although official statistics indicate that 112 males are born for every 100 females[46]. Preference for sons is most marked in South Asia and the Middle East, where many traditional proverbs attest to the undesirability of daughters: in Bangladesh to have a daughter is described as 'watering a neighbour's tree' because the benefit of her upbringing will accrue to someone else. But the evidence of relative discrimination is by no means confined to those regions. In Colombia, 75 deaths of boys between the ages of 1 and 2 occur for 100 deaths of girls; in Mexico, 86; in Senegal, 99. Only in some countries of Africa, the Caribbean, and Central and Latin America is there equal preference for girls and boys[47].

Cultural attitudes stressing the value of sons against daughters are so much a normal part of traditional codes that they were long simply taken for granted. That they might significantly influence parental behaviour towards the health and nurture of the young girl began to draw scientific attention only in the mid-1980s. The impact of son preference on child well-being was first docu-

mented by Unicef in the Middle East and North Africa, where a series of country studies described the cumulative disadvantages suffered by girls from birth until age 14, by which time many were married and about to precipitate a similar cycle in their own offspring. Discrimination began with the lack of enthusiasm—even insults—greeting the birth of a girl, the mother's early abandonment of breastfeeding to attempt another pregnancy, the girl infant's extra susceptibility to diarrhoeal and respiratory infections, and her relative lack of food and clothing[48].

This analysis was important not only for its findings but for the setting of indicators to guide the collection of gender-sensitive data about child survival and development—an aspect of the necessary ingredients of the CSD revolution that up to this point had been ignored. It also illuminated the discriminatory predicament of girls not only in their earliest years—from birth to five years of age—but until the mid-teens. The concentration by Unicef on child survival on the one hand, and by WHO and others on 'safe motherhood' (see later in this chapter) on the other, had led to a serious neglect of the young girl and adolescent by researchers. Concern about the girl child implied, therefore, not only a gender approach to childhood but concern about the whole period of childhood, including the precocious onset of maternity. In the Middle East, this typically occurred to the girl-woman, married off in adolescence.

In the late 1980s, similar concern about the girl child began to be expressed in the Indian subcontinent, largely by women's rights activists. There were increasing reports of girl infanticide in states where dowry prices had become inflated, and of the use of amniocentesis tests for foetal sex determination and the subsequent abortion of unwanted female embryos. The use of modern gynaecological techniques to support age-old son preference raised a hue and cry, and in 1988, Maharashtra's state legislature became the first to ban the use of prenatal technologies and techniques for this purpose[49]. However, the publicity given to this extreme form of discrimination against girls helped bring to light other more insidious discriminations. Studies showed that, especially in lower income groups, malnutrition tended to be both more common and more severe among girls than boys; that girls were breastfed less often and taken less frequently to the health centre when sick[50]. In the Punjab, one study among underprivileged children showed that 50 per cent of girls were seriously underweight for age compared to 15 per cent of boys[51].

In 1988, the South Asian Association for Regional Cooperation (SAARC) declared that 1990 would be the Year of the Girl Child. In 1990, they declared 1991-2000 the Decade of the Girl Child, and proposed an SAARC Plan of Action incorporating appropriate recommendations from the World Summit

for Children Declaration[52]. With Unicef assistance, Bangladesh, India, Sri Lanka and Nepal set about compiling gender-disaggregated data on children and developing a profile of the comparative situation of girls. With the exception of Sri Lanka, there turned out to be a consistent pattern of discrimination in parental and health service care in every country, combined with an extra household working burden and a lack of schooling compared with boys.

In Bangladesh, for example, it was found that twice as many girls aged between one and two years suffered from nutritional wasting as boys. The report coolly stated: 'A poor family with many children just cannot give everyone as much food as is wanted and the girl has to sacrifice for her brothers.' When it came to schooling, girls were similarly disadvantaged. Only 10 per cent of girls aged 10 to 14 years attended school, compared with 23 per cent of boys. In spite of laws restricting child labour, the participation of girls in paid work had increased, while that of boys had declined; meanwhile, a great deal of girls' work, whether paid or unpaid, was in domestic households other than their own, which was invisible in official statistics[53]. A Unicef-assisted study in Nepal found that girls spent almost twice as many hours a day working as boys, and that by age 10, 7 per cent of Nepalese girls were married; 40 per cent were married by age 14[54]. In Bangladesh, by age 15, 20 per cent of girls had borne their first child[55].

From 1989 onward, Unicef became an important advocate for the girl child, including the gender perspective on childhood in its annual reports to the Executive Board on the implementation of Unicef's 'women in development' policy[56]. In industrialized countries, where that part of the women's movement concerned with such issues had begun to regard Unicef as a reactionary force, its pioneering role in adopting the cause of girls did much to re-establish its credentials as an organization concerned about gender inequality. In its turn, Unicef's advocacy did much to persuade the women's movement that they should engage with children's concerns from this much neglected direction: so concerned had some women's activists been to avoid typecasting in maternal roles that they had overdistanced themselves from the children's cause[57]. The genderization of childhood coupled women and children together in a new kind of way. The recognition that discrimination against the female sex had to be fought from before birth and throughout infancy and childhood added a new dimension to the campaign for gender equality.

Meanwhile, in a number of Asian countries, public education initiatives supported by Unicef set out to persuade parents that girls were as valuable as boys. The most striking of these was the development in Bangladesh of a cartoon series for Asia-wide distribution based on the adventures of a small girl

called Meena. The Convention on the Rights of the Child was beginning to spawn a number of national and local fora to promote children's rights and review existing legislation relating to childhood protections, and these mechanisms were useful contexts in which to affirm the childhood gender equality called for in Article 2. In 1990, Unicef published a booklet: *The Girl Child: An Investment in the Future*. The wide currency this publication enjoyed among NGOs, partner organizations, Unicef National Committees and others indicated that here was an issue that had captured the public imagination. Within Unicef itself, many who had not been committed to women's rights within the context of development happily embraced the rights of females in the context of childhood.

If the true scale of gender imbalances in nurture, nutritional well-being and health care provision were being systematically revealed for the first time, the differentials in educational access had long been noted—and deplored because of the correlation between a woman's lack of schooling and her family-planning and child-care behaviour. During 1989, preparations were under way for the International Conference on Education for All, sponsored by UNESCO, UNDP, UNICEF and the World Bank, to be held in Jomtien, Thailand, in January 1990. This helped to refocus Unicef's attention on educational disparities suffered by girls: two out of three of the world's 300 million children who were not in either primary or secondary school were female, as were two thirds of the world's 960 million illiterates[58]. From this point onward, closing the gender gap in education re-emerged as a Unicef concern, and increased resources were dedicated to education as a category of assistance (see Chapter 8).

But 'girl child' issues did not stop at questions of equal access to family care, health and education throughout the whole infancy and childhood period. Girls as compared to boys were doubly in need of special protections because of their extra physical and sexual vulnerability. Their perceived inferior status not only laid them more open to exploitation, but they were also more vulnerable to its consequences. The Bangladesh Decade for the Girl Child Action Plan stated: 'Disadvantages facing the girl child are compounded by an apparently increasing incidence of violence against girls and women, such as abduction and rape, assault, kidnapping and immoral trafficking. Despite the existence of laws and penalties, social attitudes towards women's status seem to permit these behavioural aberrations.'[59] Similar phenomena were occurring in Nepal and in the northern provinces of Thailand.

On the one hand, women's activists were struggling to bring an end to practices that constrained women's opportunities, self-awareness and participation in society: early marriage, and practices that protected an adolescent girl's

chastity by enforcing her seclusion (purdah) or sealing her genital area (circumcision). On the other, these systems of girl protection were vanishing under the pressures of 'development' and nothing was being put in their place. All over the developing world, the growth of a rich, mobile, industrialized middle class had created new types of moneyed demand; the simultaneous creation of a pauperized underclass produced the corresponding supply of vulnerable young people. Poverty and rapid urbanization were eroding behavioural codes and forcing girls to venture out to work. They were young, sexually mature, undereducated and ill-prepared for adult life, and their options were limited. They entered the world of earning without the necessary preparation or resources to negotiate their path through the minefield of adult exploitation. The result was a foregone conclusion. According to the Norwegian Government: 'Every year, one million children are either kidnapped, bought, or in other ways forced to enter the sex market.'[60]

Gradually, under the rubric of the Convention on the Rights of the Child, Unicef began to expand its advocacy role in relation to issues affecting girls and women under the age of 18 in contexts that had previously been taboo. No fewer than 14 Articles in the Convention covered special protection, of which 8 specifically or indirectly covered sexual and other types of exploitation. Given their prominence in the Convention, and the emphasis they commanded within the child rights lobby, an organization that wished to maintain its position in the international vanguard for children could no longer neglect the issue of children involved in sexual trade. The context in which Unicef initially became involved—as in other child protection issues—was that of 'street children'. In Kenya, in the Philippines, in India, in Brazil[61], in almost all countries where increasing numbers of children were working and living around market-places and shopping malls, some proportion of the children were girls. These girls, often runaways from violent homes and sometimes from sexually abusive stepfathers, were easily seduced, or reduced, into selling sex to make a living. Given that the returns were infinitely higher than for selling flowers or chewing-gum, once they had started prostituting themselves, it was extremely difficult for them to stop.

In the Philippines, Brazil, Bangladesh and a number of countries, Unicef began to network with NGOs, assisting the process of capacity-building and financing research. In Thailand, where under-age prostitution was of a high order of magnitude and the sex industry very commercialized, Unicef embarked on a special programme related to children and teenagers in prostitution. The Police Department believed that there were 400,000 prostitutes altogether throughout the country, of whom around 40 per cent were below

the age of 16 (1992)[62]. This figure indicated not only the very high number of young girls in prostitution—160,000—but the high preponderance of teenagers in an industry in which youth and freshness command a high premium. That premium had now become enhanced in the era of AIDS: Thai men, a high proportion of whom visited prostitutes as a form of entertainment, were now seeking out younger girls in the belief that they were less likely to be HIV-infected[63].

The young employees in the bars and massage parlours of Bangkok and Thailand's resorts all came from the poor provinces in the north and north-east, whose inhabitants were hill-tribe people. Traditionally, girls from these areas were expected to provide economic support to their families before they were married, and the modern way to do this was to go to town to earn[64]. Private agents functioned as middlemen between poor rural parents and placements for their daughters in the country's booming tourist and entertainment industry. Recruiters offered parents 'advances on wages', and their poverty and their value system enabled them to accept this money without feeling that they were 'trading' their children in a morally reprehensible exchange[65]. NGOs, many of them religiously motivated, took a different view, and staged rescues of young girls effectively enslaved in brothels. This helped to create international notoriety around the issue.

After strong NGO campaigning, the Thai Prime Minister announced in 1992 that child prostitution would be eliminated and set up a special task force to carry out this policy. Since that time, Unicef has been actively engaged in a programme designed to prevent the mass entry of hill-tribe girls into the commercial sex industry[66]. Reading materials, videos and radio messages in hill-tribe languages have been introduced into primary schools to familiarize girls with the hazards of prostitution, suggest job alternatives and explain their rights. Unicef has also assisted the 'Daughters Education Programme', a residential leadership training centre for post-primary girls from villages where recruitment agents for the sex industry are highly active. The girl scholars become change agents in the communities they come from, helping to transform the social and economic conditions to which girls like them would otherwise become victim.

Commercial exploitation was only one framework within which Unicef was by the early 1990s actively beginning to address the risks posed by sexual activity to young teenage girls. Almost everywhere in the world, the age of first sexual encounter has recently been declining. Precocious sex frequently leads to early motherhood: in the Caribbean, for example, 60 per cent of first babies are born to teenagers, many of them unmarried. It also poses the age-old problem

of sexually transmitted disease, whose potential threat to health and life have been dramatically multiplied by the advent of AIDS. Sexual and reproductive health, especially in teenagers, became therefore the lens through which Unicef in the late 1980s began to refocus its attention on its very earliest historical female concern: women's biological role in reproduction.

For the first time, in 1989 *The State of the World's Children* published a specific set of statistics about women: an indication that the pressure to heighten Unicef's attention to womanhood was gaining ground. The statistics illustrated gender disparities in life expectancy, literacy and school enrolment, and women's access to family planning and maternity services.

Their most striking feature was that, of all disparities between life chances in the industrialized and developing worlds, the widest gap was in rates of maternal mortality. Of the 500,000 women who died from causes related to pregnancy and childbirth every year, 99 per cent were in the developing world. Well over half the deaths occurred in Asia, where every year over 300,000 women died, most of them in Bangladesh, India and Pakistan. Of those remaining, 150,000 were in Africa, where a woman's lifetime chances of dying of pregnancy were 1 in 21 as compared with 1 in several thousand for women in Europe[67]. As significantly, 25 per cent of maternal deaths were among teenagers[68].

The causes of these deaths were identical to those that had made childbirth a risky, even life-threatening, undertaking for women in the industrialized world not so long ago. They included haemorrhage, infection, toxaemia, obstructed labour and complications following unsafe abortions[69]. As many as 200,000 women were estimated to lose their lives annually as a result of illegal abortions—a reflection of unmet need for family planning[70]. In the modern world, antibiotics and obstetric technology had reduced the risk of dying from childbirth to almost zero for women within their reach. However, for many millions of women in the developing world, supervised delivery in a modern maternity ward with drugs and emergency care on hand was beyond the bounds of possibility.

In some African and South Asian countries, up to two thirds of women—especially those who lived in the countryside—still gave birth in the privacy of their own or their mother's home with only the village 'auntie' in attendance. This *dukun*, as she was known in Indonesia, *dai* in India and Pakistan, *matronne* in French-speaking West Africa, belonged to one of the oldest professions known to humankind. Her skills were passed down through many generations,

and she usually learned at her mother's side how to tend a woman in labour and bring her baby into the world. Although the traditional birth attendant might be capable, her instruments were crude and her hygienic standards not the highest; more important, if something went severely wrong, she might not be able to see mother and child safely through their joint moment of jeopardy.

Ever since the 1950s and 1960s, Unicef had supported the training of traditional birth attendants (TBAs) and provided trainees with basic midwifery kits. Instead of treating her as an illiterate crone to be swiftly displaced by a fully trained alternative, Unicef had confirmed the TBA's importance in birthing, but had attempted to add 20th-century knowledge and public health equipment to her armoury. During 1977-86, training had been given at Unicef expense to some 250,000 TBAs[71]: this form of cooperation in maternal and child health (MCH) services was still a prominent feature in a large number of country programmes. But improving the TBAs' performance was not always easy: many were unused to learning in a classroom setting and without persistent supervision easily reverted to old habits. Many countries in Asia and Latin America were therefore now developing a new, better-trained auxiliary midwife cadre. China—the cradle of so many public health innovations—had made spectacular progress in reducing maternal mortality by promoting three 'cleans': a clean surface for the mother in labour, clean hands and clean cutting of the umbilical cord.

Unicef also supported the distribution of iron folate, vitamin A and iodine in antenatal and postnatal clinics to improve maternal health and nutrition. These supplements—the first 'F' of GOBI—helped to reduce the incidence of low birth weight (affecting 22 million babies a year[72]) and fortified women physically for the stress of pregnancy and breastfeeding. Mainly because of their heavy workload, around two thirds of all pregnant women and one half of all other women in the developing world suffered from anaemia. This lowered their resistance to disease and increased their fatigue and their chances of miscarriage. The reduction of micronutrient deficiencies was therefore an important element of better maternal health[73].

In early 1987, the 'Safe Motherhood Initiative' was launched by WHO with strong backing from the World Bank and support from other UN agencies. This emphasized a number of strategies for reducing maternal mortality. Although over one third of pregnancies in the world could be considered high-risk simply on grounds of age, only around one half of women in the developing world made one or more visits during pregnancy to a health facility[74]. Screening out the high-risk cases and advising such women to give birth under professional supervision would help to reduce obstetric emergencies. Other ingredients of 'safe motherhood' were to increase the use of family planning

services and to reduce the prevalence of sexually transmitted diseases (STDs), especially HIV. The Initiative set the target of reducing the maternal mortality rate by half by the year 2000, a target reconfirmed at the 1990 World Summit for Children.

During the early advocacy of 'safe motherhood', Unicef supported most strongly those parts of the package that had the greatest bearing on child survival. Apart from regular contributions to TBA training and MCH, this largely meant an increased emphasis on immunization with tetanus toxoid: 750,000 infant deaths were annually attributed to tetanus soon after birth. With all the emphasis on *childhood* vaccination, maternal vaccination still languished at 30 per cent. Unicef's other focus remained that on 'empowering women to breastfeed'[75]. In the late 1980s, Unicef's support for 'safe motherhood' could still only be described as lukewarm. Gradually, the threat of HIV to young women, and the new consciousness of issues relating to the sexual exploitation of girls, pushed Unicef into a new appreciation of the need to promote reproductive health and to defend girls' and women's rights in this context.

Pressure from Unicef country offices in AIDS-affected parts of Africa and the Caribbean was critical to this process. In the very early stages of the worldwide AIDS epidemic, the threat to children appeared to come mainly from the risks associated with the use of hypodermic needles and blood transfusion, in immunization campaigns and hospital treatment. But in the mid-1980s, a special AIDS threat to mothers and children began to emerge. It transpired that HIV-infected women could pass on the virus to their baby in the womb or at delivery. Such children, born with an agent in their blood that thwarted the body's every effort to construct routine defences against infection, failed to thrive. By age five, almost all had died[76]. To begin with, WHO calculated that the risk of maternal HIV transmission was 50 per cent; as studies accumulated, this was reduced to 30 per cent. This percentage still represented a very high risk to healthy child-bearing in places where infection was widespread.

Unlike in Europe and North America, in Africa, the Caribbean and Asia the overwhelming means of HIV transmission was by heterosexual relations. From the outset of the epidemic in Africa—where by far the highest number of infections were to be found—the number of female cases was equivalent to, or slightly higher than, the number of male cases. The highest concentration of HIV infection occurred in women at the height of their child-bearing years, usually between the ages of 20 and 29. Therefore, if the spread of HIV in women remained unchecked, it posed a significant threat to the continuing

gains of the 'child survival revolution'. Demographers calculated that young child mortality rates in seriously affected countries would rise by amounts estimated between 10 and 50 per cent[77]. Unicef estimated that before the end of the century, 2.7 million children would have died of paediatric AIDS, more than 90 per cent of them in Africa[78].

In 1988, at the prompting of the Executive Board, Unicef began to articulate at a policy-making level how it could contribute to the WHO-led global effort to combat HIV[79]. Already, some country offices had begun to engage in programmes to prevent the spread of HIV, especially among young women and girls. Uganda was the pioneering country. The subject of sex education in the classroom is one everywhere fraught with controversy. However, Uganda was willing to accept that the importance of protecting the generation yet to embark on a sexual and child-bearing career overrode all other considerations. With support from Unicef, in the late 1980s the Ministry of Education totally revised the science curriculum in primary and secondary schools. Teachers were trained in a new syllabus that included health education and AIDS prevention; classroom materials and extracurricular activities were developed. By the end of 1991, over 2,000 Ugandan teachers had been trained and 30,000 primary school textbooks produced[80]. Meanwhile, the Ugandan schools programme had become a model for others to copy. In Zimbabwe, an AIDS action programme for schools was introduced under the title 'Education for Life'. The first book off the production line in 1993 for Grade 7 pupils talked about friendships, sexuality, resolving personal conflict and how to live kindly towards yourself and others in a world with AIDS. In a number of countries, educational programmes tried to help schoolgirls learn how to say 'no' to sex.

Unicef programmes also attempted to reach children and teenagers who were not in school. Organizations such as the Undugu Society of Kenya, which catered to working children on the street, began to develop programmes for sexual awareness and self-protection. In the Caribbean, comic strips and videos targeted teenagers fond of partying and disco life. In Trinidad and Tobago, Unicef supported a six-part television series about AIDS called *Body Beat*[81]. In Thailand, hot-line services, including telephone and radio outreach, were set up for students. In Nepal, a theatre group toured villages throughout the countryside to provide entertainment with a strong anti-AIDS message. In Zambia, where a Unicef study showed that one quarter of all perinatal deaths in the country were a consequence of syphilis in the mother, Unicef supported a programme to increase awareness about STDs[82].

In some countries, Unicef also supported women shouldering the socio-economic fallout of AIDS: those taking in the orphaned children of daughters,

daughters-in-law, sisters or co-wives. Many such women needed income support, either by help with agricultural tasks or by jobs or credit for small business enterprises. Unicef's role was usually a coordinating one, helping bring together NGOs and community organizations involved in helping the AIDS-affected, backing them with materials and training, and acting as an intermediary with government departments and international donors.

As the epidemic progressed, and epidemiological knowledge of the reasons for HIV's spread increased, it became clear that—in Africa especially, but in the developing world as a whole—AIDS was a disease of the predominantly young and the predominantly female[83]. The age profile of AIDS tended to be younger in women than in men: HIV infection peaked in young women aged 15 to 25, and did not do so in men until age 25 to 35[84]. This was partly attributed to the physical immaturity of young women's genital organs, which increased the chance of the virus' transmission, a risk that compounded the relative ease of the male-female passage of infection. But much more influential were the social practices surrounding sexual relations and reproductive life. By the age of 19, 60 to 70 per cent of women in many African countries were married and respectably engaged in sex[85]. Meanwhile, those who remained unmarried and were continuing with their education—whether in Africa, the Caribbean or elsewhere—were members of a society in which urban and 'modern' life had had a profound effect on personal behaviour. One survey in Nigeria found that 43 per cent of schoolgirls aged 14 to 19 were sexually active[86]. The rises in prevalence of STDs, particularly among 16- to 24-year-olds, were causes of alarm to public health officials everywhere. This had a particular connection to the spread of HIV, because the presence of another STD increased by tenfold the chances of contracting the AIDS virus[87].

For many women in developing countries, the threat of AIDS was deepened by the social inequality between men and women. Women lacked control over their sexual lives and over the sexual lives of their husbands outside marriage. As well as forcing out into the open the neglected subject of sexual health, the AIDS epidemic prompted inquiries into sexual mores—inquiries that many found distasteful. It transpired that many African and Asian women had little negotiating power over sexual relations, and were conditioned to expect none inside or outside marriage. This meant that the vast majority were unable to refuse sex or demand the use of a condom. And the accepted pattern of sexual behaviour in men in certain cultures did nothing to improve matters. Those who demanded unprotected sex and had it with multiple, casual partners increased the powerlessness of women to protect themselves from HIV[88].

Girls who had embarked on an independent or semi-independent life—often because economic circumstances obliged them to earn—were particularly vulnerable. In Zimbabwe, HIV infection among 15- to 19-year-olds was six times higher in girls than in boys[89]; in street girls and women involved in sexual commerce it could be as high as 80 per cent. Even those in relatively sheltered situations were subject to sexual pressure. In Uganda and Zambia, schoolgirls were often enticed into sex by promises from 'sugar-daddies'—teachers or employers; in the Caribbean, peer pressure was as much to blame. All of these sociocultural discoveries reinforced Unicef's involvement in educational programmes for young people's and women's self-protection, not only by imparting knowledge but also by equipping them with the skills and with the acceptance that they had a right to negotiate the terms of their sexual engagements.

Its support for AIDS prevention confronted Unicef anew with its reticent attitude towards contraceptive devices—in this case, prophylactics, which could block the transmission of HIV. As a result of the AIDS crisis, contraceptives began to assume a new—or forgotten—role in STD control and public health. Condoms in particular were seen as an important means of physically preventing the spread of the AIDS virus. But Unicef was focusing its attention almost exclusively on trying to encourage behavioural change—abstinence or monopartnership. The case Unicef presented for its lack of emphasis on prophylactics stressed the fact that, in many countries of Africa especially, the supply of condoms could be erratic and their consistent use beyond the financial means of the average couple. Operational considerations were also a factor: Unicef did not want to devote the energies of its procurement system to becoming a leading world supplier of low-cost condoms (as it had for vaccines); it was willing, however, to act as a purchasing agent for them on a reimbursable basis if other donors could find no better source of supply.

The course steered by Unicef was a delicate and controversial one. In the background was Unicef's reluctance to be publicly associated with advocating the use of contraceptives for fear of becoming embroiled in religious and cultural controversy. At the same time, it was anxious to disassociate itself from the idea that it opposed their use as a self-protective or 'safe sex' measure. Although it was not willing to supply condoms itself for AIDS prevention programmes, it by no means decried their use or tried to prevent them from being mentioned in the AIDS awareness literature it was helping to spread.

Whether for family planning or for disease control, contraception was still implicitly a 'no-go' area in Unicef. But as the 1980s drew to an end, both the AIDS epidemic and growing activism over reproductive rights within the international women's movement were gradually forcing Unicef towards adopting

a public position on family planning. Over the decade, in spite of its place within the three 'F's suffixed to GOBI, family planning was barely mentioned in Jim Grant's annual *State of the World's Children* reports. This was in spite of the well-established contribution to child survival of reducing births in the categories of 'too young', 'too old', 'too many' and 'too frequent'.

The 'Safe Motherhood Initiative' had pointed out that spacing births at least two years apart, and avoiding pregnancies under the age of 18 and over the age of 35, could reduce maternal deaths by as much as 25 per cent. Spacing births also redounded to the health of a woman's existing and future children, as the international family planning and health community consistently underlined: a mother preoccupied by the birth of a new baby was less able to give a newly weaned child the necessary time and care that the vulnerable toddler required. Nevertheless, despite all the evidence that family planning services were a vital part of improved maternal and child health, Unicef only ever spoke of giving women the *knowledge* to avoid at-risk pregnancies; never did it speak of the low-cost technological means that would enable them to do so, nor except in the context of general support to MCH did it support family planning services. Not surprisingly, therefore, it was often criticized for not being sufficiently active in family planning.

Pressure on Unicef from certain members of its Executive Board and partner agencies in the UN system began to mount. In 1990, a number of delegates stressed that readily accessible family planning was an essential part of any strategy to improve maternal health, and sent a clear signal that they wanted more attention to family planning. In the 'Strategies for Children in the 1990s', a goal for family planning for the year 2000 was established: access by all couples to information and services to prevent unwanted and risky pregnancies. This goal was later reasserted in the World Summit Declaration and Action Plan. The Board also asked the Executive Director to submit to its 1992 session a report on its collaboration with the UN Population Fund; this led to the preparation of a Unicef policy paper on family planning for 1993. The position it outlined would provide the basis of Unicef's contribution to the International Conference on Population and Development to be held in Cairo in 1994.

An important indication that Jim Grant was now less reluctant to avoid the association of Unicef's name with any pronouncement on family planning came in the 1992 *State of the World's Children* report. This set out 10 propositions for a 'new world order' to favour children; one proposition was on 'planning births', which was described as 'one of the most effective and least expensive ways of improving the quality of life on earth'. For the

first time in more than a decade, the case for supporting family planning as a measure to improve maternal and child health and survival had been prominently spelled out in a Unicef document. The arguments were those consistently advanced over the years by UNFPA, the World Bank, WHO and leading international NGOs.

When the Unicef policy review on family planning was published the following year, it repeated the case in favour of family planning as an aid to maternal and child health[90]. The review added that reductions in under-five mortality and in fertility had a 'powerful synergistic effect': smaller family size improved the prospects of child survival, and improved child survival motivated couples to want fewer children. Unicef was, as usual, anxious to defend itself against the charge that child survival added to the problem of population growth, and underlined that support for MCH and family planning together could do more to solve the population problem than either activity by itself.

When it came to the specific actions Unicef proposed to take, however, the policy review essentially reiterated the existing contexts in which Unicef supported women and described these as constituting a family planning policy. These included the enhancement of women's socio-economic roles and status; support for mothers as bearers, breastfeeders and rearers of children; support for girls' education and female literacy; and the spread of information via traditional and modern communications channels. The emphasis was placed on Unicef's role in the 'improvement of knowledge' category, given its expertise in social mobilization and IEC (Information, Education and Communications). Support for actual family planning services 'integral to MCH' was mentioned, with the proviso that Unicef did not supply contraceptives and under no circumstances supported abortion as a family planning method[91].

The wheel had come full circle. Where in the early 1970s, Unicef enhanced its support for women's programmes as an adjunct to what was then called 'responsible parenthood', now it paraded its support for women's programmes as its contribution to family planning. Yet the fact that it had linked its name firmly with the issue after a long period of silence was welcomed in the international health and family planning community. It was even argued—as if Unicef were somehow responsible—that the holistic approach to population policy adopted at the International Conference on Population and Development in Cairo in September 1994 was closely in line with Unicef's own position. Whatever the record, the important point was that a real consensus had been reached and Unicef and its international partners in reproductive health were singing the same tune.

Meanwhile, Unicef was beginning to grasp the more awkward nettles of reproductive health, such as the exposure of young girls in prostitution to HIV and AIDS. In some of the worst-affected countries, notably Thailand, Uganda and Zimbabwe, concerns about the disproportionate impact of HIV infection and of AIDS' social damage on the young led for the first time in Unicef to serious policy-making concern with adolescent health at the international level[92]. Pro-active work in schools and the use of the media and youth organizations to spread sexual health awareness became part of the Unicef pro-child public health menu. If this happened *sotto voce* to begin with, in the wake of the 1994 Cairo Conference it received a real organizational boost[93]. Unicef was finally beginning to include sexual and reproductive health frameworks within the mainstream of its support to children and girls.

By the early 1990s, the importance of women's role in social and economic development had gained widespread recognition, not only on grounds of equity and justice but for much more hard-headed and practical reasons. Evidence had accumulated from all over the developing world that there was a close link between a country's commitment to the advancement of women and improvements not only in social indicators but in economic productivity and overall development advance[94].

Fortified with this extra ammunition, the international women's movement was increasingly managing to transcend the 'women's programmes' and 'women's issues' ghetto. Recognition was growing that gender was a fundamental organizing principle of society, and that profound inequities stemming from its application were inhibiting progress in every area of human life. This perspective began to emerge strongly on agendas other than the women's alone—in *Agenda 21*, for example, the product of the Earth Summit at Rio; and it dominated the international conferences on human rights at Vienna in 1993 and on population and development at Cairo in 1994.

The mounting visibility of the women's cause, and the prominence of the 'gender' framework within which governments and donors were now—theoretically at least—addressing all their policies concerning development and human rights, could not fail to rub off on Unicef. The Unicef medium-term plan for 1992 to 1995 identified the status of women and girls, their participation in development and their empowerment as a central focus of Unicef cooperation[95]. Without progress in these areas, the plan stated, the fulfilment of commitments made by governments in the World Summit for Children Declaration and Plan of Action would not be possible.

Such formulations in Unicef documents had become familiar to those who had fought long and hard to gain recognition for the centrality of women's disadvantaged status to the prospects for the world's children. Politically correct sentiments of this kind were expressed in policy documents galore, but their import had still not been internalized throughout the organization or its programmes, as the report of the 1992 Multi-Donor Evaluation of Unicef pointed out[96]. Although 'mainstreaming' of women's issues had been the key Unicef 'women in development' strategy since 1987, few of the necessary institutional changes and approaches to programming had been introduced, at least in the countries studied by the Multi-Donor team. Instead of being an antidote to the marginalization of women, mainstreaming had sometimes been used as a pretext for failing to allocate increased resources to gender-related action. Gender analysis was not being universally applied, and therefore the need for specific affirmative activity on behalf of women was not being revealed. Even programmes for the girl child—so prominent in Unicef advocacy—were conspicuous by their absence in the countries studied.

The Unicef record vis-à-vis women was undoubtedly patchy, but at the same time, partly because of organizational backing and partly in spite of it, the importance of the gender dimension in children's concerns had become much better appreciated, both inside and outside Unicef. By the early 1990s, it was being given more than token respect in sectoral programming in health, water and education; in situation analysis and data collection about children; in programmes for 'adjustment with a human face' and in programmes for countries in post-communist transition; latterly, also in schemes for emergency relief and rehabilitation. More offices were backing gender-based employment and economic studies; in some countries—the Dominican Republic and Zimbabwe, for example—legal reforms affecting women's property rights in marriage were on the Unicef country menu[97].

These changes had come about partly because Unicef had made efforts to increase the proportion of women employed in its professional categories and their representation at senior levels. By 1994, 39 per cent of professional employees in Unicef were female[98], a level above the one third targeted for the UN but still some distance from parity. Since 1987, one of the three Deputy Executive Directors (for Operations) had been a woman, Karin Sham Poo, who had done much to promote the greater representation of women in senior management positions[99]. In 1995, on the death of Jim Grant, Carol Bellamy was appointed as Executive Director[100]. Bellamy was only the second woman to be selected to head a major UN Fund: the first was Nafis Sadik of the United Nations Population Fund.

Not all the most striking Unicef initiatives on behalf of women—in programmes, in advocacy or within its management culture—could be attributed to women officers and representatives, but the necessary sensitization of the country office or headquarters department often could be. One such example was the attempt in Bangladesh to base the 1992 situation analysis and country programming strategy on the life cycle of girls and women[101], an approach that was later adopted for widespread use in Asia[102] and echoed in organizational thinking.

From 1993 onward, Unicef began to deploy a 'women's empowerment framework' in gender analysis workshops. This was a serious effort to overcome the organization's failure to internalize the gender dimension. Programme staff were taught to use an analytical hierarchy that allowed them to distinguish between welfarist activities that treated women as passive recipients; those that opened up their access to resources; those that promoted their participation in society; and those that enabled them to achieve parity with men. A policy review in 1994 in preparation for the 1995 International Women's Conference in Beijing elaborated further plans for Unicef's self-genderization and expressed the hope that 80 per cent of staff would have been trained in gender-awareness by 1995[103].

During the 1980s, Unicef had strenuously championed the techniques of social mobilization and 'empowerment' as a means of reaching child survival goals. In the 1990s, the challenge still remained of putting these techniques at the service of women for their own advancement. Women who were marginalized and refused equal opportunities were likely to fail in every role and in every area of their lives. If they so failed, women—who were half of the people—were bound to drag back their children and the rest of humanity with them. For years, Unicef had pointed out that child survival and development depended on 'women's empowerment'. Although in the mid-1990s it was still unclear whether Unicef fully understood throughout its fabric the real implications of such a statement, the signs that it was finally doing so were distinctly more promising.

Over one issue there was widespread agreement. If there was one key above all others that could unlock women's potential to transform their lives, that key was schooling. With education came not only knowledge and qualifications but the independence of spirit that enabled women to take their place in the world as fully fledged individuals and to resist male oppression and exploitation. The right to basic education was the theme of Carol Bellamy's statement to the 1995 International Women's Conference in Beijing[104]. This statement was as much a signal about Unicef's new level of commitment to education as

it was about its commitment to women. As the main mission of the organization, 'child survival' was now beginning to take a back seat, and 'child development'—not only physical development, but intellectual, psychological and emotional development—was steadily gaining ground.