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UNITED NATIONS

ECONOMIC AND SOCIAL COUNCIL

GENERAL

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UNITED NATIONS INTERNATIONAL CHILDREN'S EMERGENCY FUND

Executive Board

NOTES ON A VISIT TO SOME COUNTRIES IN ASIA

STATEMENT BY E. J. HEYWARD, DEPUTY EXECUTIVE DIRECTOR, UNICEF, TO THE PROGRAMME COMMITTEE, 30 APRIL 1951

Itinerary

I visited Thailand for twelve days, Burma for two days, India for ten days and Pakistan for four days. I also spent five days in Egypt, the main part of the time visiting the Eastern Mediterranean office of the World Health Organization together with Dr. Borcic and Mr. Egger.

Dr. Watt built up and directed a regional organization for UNICEF during 1949 and Mr. Keeny has headed that work since 1950. Illustrating the fact that considerable time is required for development of plans of operation and delivery of supplies by UNICEF, the fact is that a number of projects being assisted have not yet reached the state of full work and there will be much more to see in a year's time, nevertheless it is possible to draw a number of conclusions.

Public Expenditure on Health

One of the most important problems that must strike the visitor is the cost of projects. By this I do not mean so much the cost to UNICEF, which we are all used to considering, as the cost to the government of carrying on the project afterwards. Obviously, the Fund would wish to assist projects well adapted to the economic and financial possibilities of the country. Demonstration projects must be capable of having the methods demonstrated duplicated on a wide scale. Mass projects must at least reduce the problem to a scale where the government can afford to maintain control. In order to achieve these results the local recurring

/costs of

costs of projects must be judged in relation to the financial position of the country and the health budget. Perhaps the simplest way to do this is to look first of all at how much is the public expenditure on health.

In the countries I visited this was between ten and twenty cents per person per year. Approximate figures for three of the countries are as follows: In Thailand, 20 cents for the curative and preventive services of which 5 cents are spent strictly on public health, i.e. preventive services which include most of the types of project which are being aided by UNICEF.

In India the main expenditure on health is by the States, not the Federal Government, and therefore varies among them. 10 cents, however, is quoted as a general indication of public expenditure on health.

In Pakistan also health expenditure varies among provinces and reaches 30 cents per head per year in West Punjab. Expenditure on health in Pakistan is increasing rapidly at the present time. All of these figures amount to less than a half a day's wages for an agricultural laborer. In U.S.A. public expenditure on health approaches two days' wages for an unskilled laborer.

It is beside such figures as these that we have to put the cost to the governments of continuing malaria control, BCG vaccinations, maternal and child health services, the control of yaws, and any projects which may be started in nutrition. The extension over the country of malaria control and maternal and child health services alone, and on the simplest basis, would require the doubling or tripling of public expenditure on health.

It is obvious that projects which are costly to carry on have no chance of being widely applied in these circumstances. It is of interest therefore to look at the various forms of UNICEF assistance and see what chance of survival UNICEF-assisted projects may expect to have on the basis of cost.

/DDT for

DDT for Malaria Control

The extension of malaria control by residual spraying with DDT may be considered first because malaria is widely regarded as being the most important health problem in the area and it is certainly the one in which the governments and health services are most interested. It will be remembered that in 1948 UNICEF voted supplies for five malaria control demonstration teams, the personnel being supplied by WHO. One of these, in Thailand, did a very necessary job because that country had no Malaria Institute, though one is now to be founded to carry on and extend the sort of work that the team has been doing. This team demonstrated the organization of cheap methods of malaria control with DDT, which it has shown can cost less than 15 cents per person protected per year. About half the cost is for DDT and half for other costs, mainly labor.

Both India and Pakistan have well-established Malaria Institutes which quote costs of about 10 cents per year per person protected. In Ceylon, whose costs are reproduced in Document E/ICEF/R.152, Appendix I, the cost is 20 cents, but there insect control is undertaken as well as control of the malaria mosquito. This is always more costly because it requires more frequent spraying, but the Ceylon experience has also shown what a very large reduction can take place in general mortality and particularly in infant mortality, which in that country fell from 140 in 1946 to 87 in 1949, a result attributed mainly to the control of insects.

It can be seen, therefore, that the extension of malaria control by DDT which is the simplest and cheapest method yet discovered, would involve doubling public expenditure on health in many of the areas subject to malaria. Those are very large areas of the country. In the case of Pakistan, probably 60 million out of 80 million population inhabit malarious areas and need to be protected. In the case of India, more than 300 million need to be protected.

/ Nevertheless, the

Nevertheless, the governments are willing to extend malaria control over a period of years, because of its great benefits, and the enthusiasm that spreads from areas in which it has been undertaken. All the governments of the region are interested in getting international assistance in the form of further supplies of DDT. Burma, Thailand, Indonesia, Indochina are getting DDT from American assistance throug ECA. India, Pakistan and Ceylon, who are not getting ECA assistance, would be anxious to get additional supplies of DDT from UNICEF and would match UNICEF supplies with further purchases of an equal amount from their own resources.

I believe the Administration would be inclined to recommend these requests up to 1,000 tons of 50% DDT for 1952, at a cost of $ 1,000,000. At the present time it appears that a practical limitation is likely to be imposed by the narrow limits on the availability of DDT for export.

In addition to supplies of DDT the countries in this region are also interested in undertaking its manufacture. Recommendations are before the Committee for assistance to Ceylon and Pakistan for such plants. India has a request in preparation. These requests are recommended by the Administration for the same general reasons as we would recommend the supply of DDT to the extent that it becomes available.

These plants would come into operation in 1954 and therefore the need to import DDT continues fully for the years 1952 and 1953. Actually, the demand for insecticide can be expected to grow in India and Pakistan far beyond the production of the plants recommended. I am speaking only of the demand for public health work. The demand for agricultural purposes would remain a commercial demand, since it is agreed that the output of these plants would be used exclusively for public health.

It may be asked, is not malaria control a general public health problem, and should not UNICEF find something to contribute to of more direct benefit to children? Malaria is certainly a public health problem. I would like to return to this point

/again after

again after having reviewed the other types of requests likely to come before UNICEF in the future. Meanwhile, it can be said that malaria causes particular dangers to pregnant women especially on account of the anemia it causes and finds more victims among children than among adults. It causes more victims among children because their resistance is less, and while their health is weakened by malaria, they are also more inclined to fall victim to the other common childhood diseases. Malaria is therefore one of the outstanding problems of child welfare and in administration"s view is suitable for UNICEF aid even though other people are also to benefit.

However, as I have said, the governments seeking DDT would not ask for more than the additional quantities they would also buy themselves, so that UNICEF's contribution of DDT would be one half, and the cost of DDT itself being half the cost of the control, UNICEF's contribution to the cost of control would be one quarter.

In the case of contribution through DDT plants, UNICEF's contribution would b very much less. Its contribution to capital cost is less than half, and the whole cost of production year after year is assumed by the country.

BCG

We have seen that the cost of malaria control amounts to 10-15 cents per person, rising to 20 cents where insect control is also undertaken, and that this means practically a doubling of the health budget for malarious areas.

BCG vaccination against tuberculosis is much cheaper when established on the basis of local personnel. Recent experience shows that it costs between 2-4 cents per person tested. A mass campaign should test about half the population - the younger age groups - so this would amount to between 1 and 2 cents per head on the average of the whole population. This, however, is not a recurring cost every year. Once the mass stage has passed, a much smaller amount of work is required

/for vaccinating

for vaccinating the new-born and for re-vaccinations. Hence, from the point of view of cost, BCG vaccination is a very practical project. It is also one in which the governments of the region are interested because tuberculosis is one of their very important health problems.

BCG vaccination started first in India in this area with the establishment during 1940 of local production of vaccine with WHO assistance. During 1949 six international teams were working, since then $ 1.000.000 was allocated to India, Pakistan, and Ceylon through the J.E. in March 1949.

Nevertheless, until recently there was an unsolved problem which prevented the rapid extension of BCG vaccination. So long as doctors and fully-trained nurses were required to do the vaccinations, it was impossible to get many teams in the field. Dr. Johannes Holm has just spent two months in India, Pakistan and Ceylon, mainly in India, advising the authorities on vaccination by teams of lay vaccinators under medical supervision. These lay vaccinators are sanitary inspectors, smallpox vaccinators, compounders, etc. Work on this basis has now started in three areas in India and in Pakistan and in Ceylon. In India where this has taken the widest extension so far there are now 100 local teams in the field and the Indian tuberculosis authorities take as their target getting a further 200 teams in the field in 1952, and a further 200 in 1953.

UNICEF's main contribution would be transport. The vaccine is now being made locally and the personnel will, of course, be local. On this account, there may be future requests from India for transport amounting to about $200.000 in 1952 and again in 1953.

Owing to the importance which the supply of transport has assumed in UNICEF's aid to BCG, a standard has been developed for its use. Dr.Holm has recommended that transport should be provided to government teams which test on the average 15,000

/ persons a

persons a month, on the basis of one car to each team in rural areas and one car to three teams working in urban areas. This standard is based on working experience in India and Egypt and some other countries.

As a result of decisions taken by the UNICEF Board last November, as well as by other authorities, the Joint Enterprise will come to an end on 30 June, with WHO taking henceforward the responsibility for technical advice to governments. In the case of Egypt there is a request before the Board for an allocation to enable the same project personnel to stay on for another six months as WHO employees. We have had advice that a similar request may be received from India.

In Pakistan also there is interest and progress, though at an earlier stage of development.

TB Diagnostic Centres

The Fund has allocated $875,000 for TB training and diagnostic centres in six countries, the first of which are now just going into operation. The equipment supplied is to assist in diagnosis and the centres are also to assist in training T.B. workers. At the present time the plans of operation do not provide for treatment of the people diagnosed. Undoubtedly this treatment by the ambulatory or dispensary methods which are envisaged will impose considerable burdens of finance and organisation on the countries. Two countries expressed their interest in further equipment of this type and were informed that the Administration could not recommend further plans of operations unless specific provision was made for treatment as well as diagnosis. It was also generally agreed that it would be desirable to observe the working of the existing centres for a period to see if the equipment provided was actually the best type to duplicate elsewhere.

Maternal and Child Health Services in Rural Areas

Aid to maternal and child health services would be the form of assistance preferred by UNICEF, though as far as interest and planning by Governments in the region it seems not to have as high an immediate priority as malaria control.

With regard to the cost to the Governments of continuing such services, a project for which the Board has approved an allocation for the rural area of Chiengmai in Thailand will serve as an example. That is a plan on the simplest scale in which community midwives with some training in public health will be working out of rural dispensaries serving from 5 to 10 thousand people. The cost will be about 30¢ per inhabitant or 1 1/2 times the present level of public expenditure on health.

The Governments of the region have been informed that UNICEF is ready to help with simple equipment for additional maternal and child health centres and also with equipment for the training of people to man them. Plans already approved which have gone furthest in this respect are for Pakistan, where centres for the training of community midwives have been approved for Lahore, Karachi, Dacca and Peshawar. The centre at Lahore has recently begun work. A two-year's course is planned and the output of all the centres would be about 150 trained people a year for a country of 80,000,000 people.

Two difficulties prevent this work going more quickly. The first is financial. The Governments have to employ the people who are trained and this can build up to a heavy continuing commitment. The second is the difficulty of recruiting women ready to work in the villages. It is agreed that people should be recruited from the villages for training to go back to villages to work. It is not easy to find candidates with the necessary educational qualifications. There is also some conservatism about women taking this kind of work.

/Under this

Under this heading I would like to refer to the higher level training to be given out of the All India Institute of Hygiene at Calcutta. Training in maternal and child health work will begin in June 1952 instead of June 1951 as originally planned. The delay again is financial since the legislative authority took some time to agree to assume an obligation to maintain the training centre after the cessation of UNICEF aid at the end of three years.

Yaws

Extensive campaigns are being assisted in Thailand and Indonesia. The cost of penicillin alone for a treatment of a yaws case is about 75¢. The size of the present health budget makes clear how difficult it would be for the Government to finance extensive campaigns on this basis. However as a result of the present mass campaigns with UNICEF financial aid, it is expected that the number of cases remaining for control will be so much reduced that it will be financially possible for the Governments to maintain control.

Nutrition

Those then are the well-established lines of UNICEF assistance in the area. With regard to nutrition, the position to me is disappointing and baffling. The countries I visited have received surplus milk, and stocks will permit distribution until about the end of 1951. I cannot report however the same interest in nutrition and the possibility of carrying on supplementary child-feeding out of local resources that has been reported from Latin America. The reason may well be financial, because the small health budgets would already be strained to provide for malaria control and maternal and child health services, and it is impossible to carry on supplementary feeding without a considerable expenditure of money.

/It is

It is encouraging that at least three of the countries I visited, Thailand, Burma and Pakistan, have fundamentally sufficient food, and therefore a solution should be possible. In India the situation is more difficult because of a fundamental food shortage. At the moment, however, there are no plans prepared to a stage where it would be appropriate to ask for UNICEF assistance. Local foods such as eggs, beans and other vegetables are spoken of but there are no concrete plans. Nutrition education is recognized as being of great importance. As far as mothers and young children are concerned it is expected that the maternal and child health services will be the best means of giving this education. There may also be a need for some general nutrition education probably as part of health education.

India and Pakistan may refine fish-liver-oil, which they have, for child consumption and may ask UNICEF assistance in that regard. The rice-eating countries are trying out various means of dealing with beri-beri resulting from the overmilling of rice. Some countries might be interested in assistance in the manufacture of drugs for intestinal parasites. The FAO has consultants in Thailand and Pakistan who are working on nutrition. I believe that ways in which UNICEF can effectively aid improvement of child nutrition in this region have still to be found.

Trachoma

With regard to other types of request in which countries may be interested in the future, I should list first of all trachoma. India, Pakistan and the countries of the eastern Mediterranean and North Africa would be interested in aid in undertaking large-scale treatment of trachoma so soon as simple methods of mass treatment become available. The WHO has certain methods under study using some of the newer drugs, and recommendations may be available at the end of 1951, so that if all goes well requests of this type could be entertained in 1952.

/School Health

School Health

Burma particularly mentioned their interest in developing school health services and the position in other countries is similar. A number of countries are exploring what can be done by examining simple types of health assistance that can be given through school teachers, and without drawing on an extensive staff of medical personnel which does not exist.

Eastern Mediterranean

The countries of the eastern Mediterranean are interested in obtaining assistance from UNICEF with regard to improvement of their regular child health and welfare organization. There are before the Committee requests for maternal and child health services in two countries and various forms of aid to BCG in four countries. Further requests for this type of aid may be expected. Further supplies of insecticides are also greatly desired by this area and two countries are exploring the possibility of seeking UNICEF assistance for DDT production, namely, Egypt and Turkey. In the case of Egypt a lot of preliminary planning has already been done by the Government.

The indications that I have tried to give on the types of future requests should not be regarded as meaning that requests will not necessarily be made in other fields. I have spoken of plans which I was able to find as being seriously discussed. There may also be further ways in which UNICEF can bring effective aid.
