

CF/HST/MON/1988-010

UNICEF IN ASIA

**A
HISTORICAL
PERSPECTIVE**

**UNICEF HISTORY SERIES
Monograph X**

(200p + ob)

THE AUTHOR

WAH WONG, who joined UNICEF in 1953, spent most of his 31 years with UNICEF in Asia. Beginning as programme assistant in the Asia Section at New York Headquarters, he served as assistant programme officer in the Asia Regional Office in Bangkok (1955-1963) and as programme officer in what was then West Pakistan in Karachi and Lahore (1963-1969). From 1969 to 1975, he was Chief of the Eastern Mediterranean and North Africa Section at Headquarters. From 1975 to 1980 he was the UNICEF Representative to the Philippines and South Pacific Territories. In recognition of his services to the cause of children in the Philippines, the late General Carlos P. Romulo, Minister of Foreign Affairs, conferred on him the Order of Sikatuna. Beginning in 1981, he served as the Zone Office Representative for Middle and North India. He retired in 1984.

Born in Vancouver, Canada, he graduated from the University of British Columbia and took his Master's degree at the University of Washington, where he had a brief teaching stint as lecturer in political science. He also worked as a summer research assistant at the Carnegie Endowment of International Peace just prior to joining UNICEF. He holds a Ph.D. degree in International Law and Relations from New York University. He is currently a consultant to the Canadian UNICEF Committee as well as serving as the subscription agent in Canada for Asiaweek magazine.

Copyright United Nations Children's Fund. June, 1988.

The opinions expressed in this publication are not necessarily those of UNICEF.

UNICEF IN ASIA - A HISTORICAL PERSPECTIVE

	<u>page</u>
Preface	vii
 THE EARLY YEARS: 1947-1950	 1
Introduction	3
China: 1947-1950	3
:Criteria for allocating aid: how much for China?	4
:Feeding programme for China	6
:Non-discrimination: helping both sides in China	7
:North China: simple training courses for primary health care workers	8
:Representation of China on the Executive Board	11
:Return of unused balance for China	12
:Representation of China on the Executive Board - a reprise	13
Asia (other than China): 1947-1950	14
:Parran/Lakshmanan survey mission	14
:High infant mortality rate (IMR) and malnutrition in Asia	14
:Block allocation for Asia -- and the principle of non-discrimination	15
:Administrative organization for Asia	17
:Plans of operation	17
:Non-discrimination: Indonesia; Indo-China	18
:Japan	19
:Korea	19
:Criteria for allocating more aid to Asia	20
:Reconstitution of the UNICEF Executive Board	21
Summary	21
 THE MASS CAMPAIGN ERA: 1950-1960	 23
Introduction	25
UNICEF allocations: from Europe to Asia	26
An exhilarating decade for UNICEF in Asia	26
:The role of Sam Keeny	27
:And the Asian village	27
BCG vaccination against tuberculosis	28
:Operational problems	28
:BCG accomplishments in Asia	29
:With miles to go	30
Anti-yaws campaign	30
:Early and quick accomplishments in Asia	31
:Indonesia: a success story	32
:Multiplier effect - success in yaws as an entry point	33

	<u>page</u>
Anti-malaria programmes	34
:Should UNICEF support programmes benefiting adults as well as children?	34
:Malaria demonstration projects in Asia	35
:Large bilateral support for malaria in Asia	35
Fight against malnutrition	36
:Supplementary skim milk feeding	36
:Search for indigenous solutions to malnutrition problem	36
Maternal and child health (MCH)	38
:Linear expansion of MCH centres	39
:Training of MCH personnel	39
:All-India Institute of Hygiene and Public Health, Calcutta	40
:Pediatric training at medical colleges	40
:Training of indigenous midwives	40
:MCH: from linear expansion to network of health services	41
Emergencies	42
Summary	43
 THE TRANSITION YEARS: 1960-1970	 45
Introduction	47
From supply to planning: the beginnings	47
:UN Declaration of the Rights of the Child	48
:Survey of children's needs: prelude to country approach	48
:UN's First Development Decade	49
:Bellagio Conference on Children and Youth in Development Planning (1964)	49
:Bangkok Conference on Children and Youth in National Development	51
:National conferences on children and youth	52
:The example of India	53
:National development plans	53
:The example of Indonesia	53
Organizational changes	54
:Two regional offices for Asia	54
:South Central Asia Regional Office (SCARO) in New Delhi	54
:East Asia and Pakistan Regional Office (EAPRO) in Bangkok	55
:Country offices	55
:And sub-offices	55
Executive Board session in Bangkok, January 1964	56
:Focus on Asia	57
:The unity of children's needs in Asia	58
Maternal and child health (MCH) services	59
:MCH assessment	60
MCH and family planning	60
:UNICEF Board — and family planning policy	61
Water and environmental sanitation	62
:Excreta disposal	63

	<u>page</u>
Disease control	64
:BCG vaccination	64
:TB detection by sputum microscopy	65
:Leprosy control	65
:Burma leprosy: another success story	65
:Trachoma control — and success in China (Taiwan)	66
:Other diseases	67
Nutrition	67
:Difficult beginnings	68
:Applied nutrition projects	68
:Child malnutrition report	68
:Some progress in Asia	69
:Goitre control	70
:Weaning food project: Saridele	70
:Milk conservation programmes	70
Education	71
:Towards a flexible policy on education	72
:Pakistan	72
:South Pacific	72
:South Central Asia Region — and India	73
:In perspective	73
Social welfare	74
Programme recommendations, the country approach, and area concentration	75
:The birth of "noted" projects	75
:Programme recommendations and country approach	76
:Integrated approach and area concentration in Asia	76
:India - precursor to integrated approach and area concentration	77
:Local procurement	77
:Non-supply assistance	78
Emergencies	79
Summary	80
 THE MATURING YEARS: 1970-1980	 83
Introduction	85
Country programming	85
Relations with technical and other agencies	87
Commitments and allocations for Asia	87
Basic Services concept: the beginnings	88
Basic Services: the missing link in development	89
:Community participation: a vital component	90
:And the multiplier effect in the "package" concept	90
:Basic Services: reprise at 1976 Board session	91
:General Assembly's second endorsement of Basic Services approach	92
Special Meeting on the Situation of Children in Asia with Special Emphasis on Basic Services: Manila, May 1977	93
:Some Asian perspectives on community participation	95
:The Philippines: Project Compassion	96
:The multiplier theory in practice	97

	<u>page</u>
UNICEF Board session, Manila, May/June 1977	99
:UNICEF as a connecting bridge for Government and community	100
Alma Ata Conference on Primary Health Care (1978)	101
From sectoral programmes to Basic Services	101
From Basic Services to area development and convergence of services:	
the India experience	102
:India - Integrated Child Development Services	102
- Social Inputs in Area Development	103
- Urban Basic Services	104
- Development of Women and Children in Rural Areas	104
Urban development	105
Water and environmental sanitation	106
:Hard-rock drilling for water in India	107
:India's Mark II handpump	108
:Handpump maintenance	108
:Environmental sanitation	109
:Other water supply projects in Asia	109
:Bangladesh rural water supply - and a revolving fund	110
Women in Development	112
Regional women's project in Asia	113
:Pakistan	113
:Thailand	113
:Philippines	113
:Other women's projects in Asia	114
Education	115
:Female illiteracy	115
:Link between infant mortality rate and level of female illiteracy	115
:Female literacy: two steps forward, one step back	116
:Functional literacy: what is relevant content?	117
:Some gains in education	117
:Burma and the conquer of mass illiteracy	118
:Government and UNICEF inputs for education	119
:Non-formal education	119
Nutrition	120
:Breast-feeding	121
:Changing hospital practices in breast-feeding: the Philippines experience	122
UNICEF and the disabled child	124
:"Reaching the Unreached" through low-cost intervention measures	125
:Emphasis on locally available resources	126
Mass disease campaigns	126
Emergencies	128
:India, Pakistan, and Bangladesh	128
:The agony of Indo-China	128
:And natural disasters	129
International Year of the Child (IYC)	130
Summary	131

	<u>page</u>
THE CHILD SURVIVAL AND DEVELOPMENT ERA: 1980 --	133
Introduction	135
Kampuchea: a "loud" emergency	135
For the "silent" emergency: a child survival and development revolution	136
:Low-cost, high-impact measures	136
:The Asia response	137
:South Asian Association for Regional Co-operation (SAARC)	137
:Association of South-east Asian Nations (ASEAN)	138
:Political will -- plus concrete achievements	138
:Social mobilization in Asia	138
:Over-emphasis on immunization and oral rehydration therapy?	139
:In practice - a balanced approach	140
Global priorities and focus for the 1990s	141
:Priorities and focus for the 1990s: Asia	141
:And the importance of country programming	143
Poverty -- and a new regional focus	143
:From Asia to Africa	144
Criteria for allocating UNICEF resources	144
:Infant mortality rate (IMR)	145
:A new index - the under-five mortality rate (U5MR)	145
:The U5MR - and its challenge for Asia	145
:The U5MR - and its link to female illiteracy	146
Some concluding thoughts	146
 NOTES	 149
 STATISTICAL TABLES	 175
I. UNICEF expenditures in Asia from inception through 1985:	
By main categories of programme activities	177
II. UNICEF expenditures in Asia from inception through 1985:	
By countries	178
III. Number of personnel receiving stipends in Asia	179
IV. Number of institutions in Asia receiving supplies and equipment	180
 INDEX	 183

- vi -

Blank Page

This monograph attempts to provide some highlights of UNICEF in Asia over a time-span of some 40 years, beginning with the early years (1947-1950). China was the first country in Asia to receive UNICEF aid, carrying out a pilot project in basic health care which eventually influenced the development of the "bare-foot doctor" scheme. The early years were also characterized by a debate on criteria for UNICEF aid to individual countries and regions at a time when assistance to Europe was being phased out.

The section on the decade of the 1950s surveys the mass campaigns in Asia against tuberculosis, yaws, and malaria, and describes UNICEF's efforts in the difficult field of child malnutrition, as well as in the development of a maternal and child health network. The key role of Sam Keeny, Asia's Regional Director in this period, is highlighted.

The section on the decade of the 1960s is described as a "transitional" period because UNICEF was adding to its mandate a planning responsibility for children, along with a new concept of the "whole child", country programming, and area concentration, all of which the countries in Asia applied in the context of their own programmes.

The decade of the 1970s is described as the "maturing" years: UNICEF was acquiring the confidence and assurance which comes with long experience, tempered with a flexibility and adaptability with which UNICEF has always been closely identified. It is in this period that the concept of Basic Services was developed, resting as it does on the bed-rock of community involvement and participation -- a concept which Asia is now implementing in a variety of new ways.

The present decade, the 1980s, may well be known as the Child Survival and Development Era, precisely because of the major emphasis being given to the Child Survival and Development Revolution within the context of basic services and primary health care. However, the decade is not yet over, and any attempt at a summary would obviously be premature. Some major developments to date, and a few concluding thoughts, are set forth in the last section.

In preparing this monograph, the author has drawn heavily on the Executive Director's General Progress Reports to the UNICEF Executive Board, and the progress reports submitted by the two Asia Regional Offices in Bangkok and New Delhi to the Executive Director.

These have been supplemented by the informative companion series of monographs prepared for the UNICEF History Project, covering such subjects as water (Martin G. Beyer), education (H.M. Phillips), and women (Virginia Hazzard); by two excellent books on UNICEF by Maggie Black (The Children and the Nations) and Judith M. Spiegelman (We Are the Children); by several invaluable memoirs and other relevant materials; and by the author's own field experience in Asia, enriched by years of formal and informal exchanges of information with government officials, his UN/UNICEF colleagues, and above all, with the many friends in the private sector who are dedicating their lives to working for the underserved in urban and rural areas.

Wherever possible, some general background information has been provided to introduce events in Asia. The Bellagio Conference in national planning in 1964, as a prelude to the national conferences which were held in a number of regions, including Asia, is one example; another is a summary of the UNICEF Board and General Assembly decisions on Basic Services as a back-drop to a review of the rich experience in Asia with community involvement and participation. Indeed, some of that Asian experience in basic services and other fields have served as useful inputs for the other UNICEF regions.

This monograph is part of a series of regional papers produced for the UNICEF History Project, consisting of: Europe, by Burhan B. Ilercil; the Americas, by Kenneth E. Grant; Africa, South of the Sahara, by Michel G. Iskander; and the Middle East and North Africa, also by Iskander.

Because the Asia region is so vast, the time period of three or more decades so packed with events, and the documentation so voluminous, the very act of selection means that this monograph is necessarily limited in scope and coverage. It would be highly presumptuous of the author to claim otherwise. A more appropriate title, therefore, might have been: "UNICEF in Asia: A Singular Perspective".

Grateful appreciation is extended to all those who took the time and trouble to read this in draft form, and who provided many useful comments and suggestions for improvement. While it would be imprudent to try to name them all, for fear of any inadvertent omissions, a special word of thanks goes to Mr. Jack Charnow, head of the UNICEF History Project, who made this all possible.

That deadliest constraint of all -- time, or rather the haste with which it slips by us -- has regretfully meant that many shortcomings remain, for which the author accepts full responsibility. He hopes that, possibly from the vantage point of the year 2000, another UNICEF staff member will write about UNICEF events in Asia in the last two decades of the present century, as well as providing a more comprehensive and historical perspective on the decades covered here.

This is dedicated to the author's wife, Vivian, who gave up an administrative and teaching career to accompany him, for better or for worse, on his various UNICEF postings; and to their two sons, Warren and Michael, who were born abroad, and who will always have international roots.

THE EARLY YEARS: 1947-1950

- 2 -

BLANK BACK

Introduction

William Blake in his Auguries of Innocence puts it well:

Every Night & every Morn
Some to Misery are Born.
Every Morn & every Night
Some are Born to sweet delight.
Some are Born to sweet delight,
Some are Born to Endless Night.

Many of the children born in Asia during World War II were born to Misery, Endless Night -- and early death, victims of man's inhumanity to man. Yet, even while the destruction and chaos of the war was going on, an institution was born to ameliorate some of that suffering -- the United Nations Relief and Rehabilitation Administration (UNRRA), an organization which was later to pass on that part of its commitment to children -- and some badly needed funds -- to this new UN agency called UNICEF, the United Nations International Children's Emergency Fund. Its title was later shortened to "United Nations Children's Fund", although the acronym "UNICEF" was retained because of its high recognition factor.

Sir Robert Jackson, in his informative foreword to Maggie Black's history of UNICEF, has described in eloquent terms the tremendous achievements of UNRRA, which fell into three project areas: the survivors of the concentration camps; the displaced persons; "and, above all, the children".¹

Most of the children aided by UNRRA were in Europe, but not all; less well-known perhaps is the fact that UNRRA also worked in three countries in Asia: China, Korea, and the Philippines. The emergency programmes for Korea and the Philippines were relatively small, but UNRRA's programme in China was its largest anywhere: \$517 million over a three-year period beginning in November 1944.² Much was accomplished, but the civil war that continued on after the end of World War II meant that the people had had no respite from an interminable cycle of internal strife, external conflict, and internal strife for many weary decades.

Against this dark background, the history of UNICEF in Asia began in China -- the first country in Asia to apply for UNICEF assistance (March 1947). It was not until the summer of 1948 that UNICEF aid was extended to other countries in Asia.

* * *

China: 1947-1950

The children of Europe and China, said the Report of the Third Committee to the UN General Assembly of 9 December 1946 which recommended the establishment of an International Children's Emergency Fund, were not only deprived of food

for several years, but had lived in a state of constant terror, "witnesses of the massacre of civilians and of the horrors of scientific warfare, and exposed to the progressive lowering of standards of social conduct". The urgent problem facing the United Nations was how to ensure the survival of these children. The next few years -- 1947 to 1950 -- "would be the critical period and, upon the success of the international assistance proposed will depend to a large degree the future of the children of Europe, and of China, and thus the future of the world".³

China was also named as one of the 25 original members of the UNICEF Executive Board in General Assembly Resolution of 11 December 1946 establishing UNICEF -- the only country in Asia to serve on the Board in the early years.

:Criteria for allocating aid: how much for China?

Barely three months after the creation of UNICEF, the Government of China, with the help of personnel from the China Office of UNRRA, submitted a request to UNICEF dated 3 March 1947 for \$150 million, in cash and supplies, for a three-year programme of child welfare. As Perry Hanson, long-serving UNICEF staff member who began his career in China, has recorded in his study for the UNICEF History Project on the early history of UNICEF in China, the newly-appointed first Executive Director, Maurice Pate, replied that UNICEF was in its nascent stage and had no funds of importance. In any event, UNRRA supplies were still flowing into China; "therefore it would be some later date before we start in China".⁴

The result was that UNICEF placed no staff at all in China during the whole of 1947 (nor in any other Asian country), and discussions about possible UNICEF help for projects in China were conducted in a preliminary way with UNRRA personnel and with Dr. Berislav Borcic, Chief of the WHO Mission in China (later UNICEF Deputy Executive Director for Programmes).

Meantime, the programmes in Europe during the first year of UNICEF's existence developed rapidly. Dr. Martha Eliot of the U.S. Children's Bureau, a highly respected pediatrician who was later to serve for many years as a member of the U.S. delegation to the UNICEF Executive Board, visited a number of European countries as a UNICEF technical consultant and reported to the Programme Committee in June 1947, when UNICEF's initial funding was still uncertain.

Nevertheless, to expedite matters as soon as funds did become available, the UNICEF Secretariat prepared a six-month feeding programme for 3,163,000 beneficiaries in 10 European countries and China, at a cost of \$8 million, or roughly half the expected initial U.S. contribution. A table was presented showing individual country allotments, based on the Secretariat's best estimates of the relative needs of malnourished children in those countries, thus setting the stage for UNICEF's first debate on the criteria for allocating aid.

China's share was estimated at 580,000 beneficiaries, or 18 per cent of the total. The Chinese delegate stated that "there had been more war victims in Asia than in the whole of Europe. The majority of child war victims were to be found in Asia and of these again the majority of sufferers was in China.

China would apply for one-third of the whole fund". This prompted the Canadian delegate, Mrs. Adelaide Sinclair (later to become UNICEF's Deputy Executive Director for Programmes), to declare that she "did not think that the Committee could accept the principle of allocating one-third of the total available supplies to any one country".

After further debate, the United Kingdom delegate suggested a compromise which the Programme Committee (and, later, the Executive Board) accepted, raising slightly the total number of beneficiaries from 3,163,000 to 3,250,000, and increasing China's share from 580,000 to 700,000.⁵

This was not acceptable to China. In September 1947 the Chinese delegate tried a new approach, presenting statistics which indicated the unevenness of a unit allocation for 12 European countries and China. It appeared that, while the great majority of the European countries were receiving a unit value of \$4.60-\$4.70 per child, China was receiving the lowest -- \$2.52. The Chinese delegate, in asking the Programme Committee to reflect on these figures, was careful to avoid using the population argument ("since it was far too great"); rather, he said, it was more a question of having a "single standard of aid" that could be followed as closely as possible.

This unit value argument, while certainly persuasive, may not have been the only major factor. It would appear from the discussion that China's high infant mortality rate (IMR) -- i.e., the number of babies dying up to one year of age per thousand live births -- appeared to be a very important consideration, as can be gleaned from the following remark of the United States delegate:

"Miss Lenroot (United States) repeated that she greatly appreciated the material which showed the very high death rates and thought that a person should be sent to China to work out a programme. The increase recommended might be raised so that something should be begun at once. The figure might be brought up to \$3,500,000...."

Since the original figure of 580,000 beneficiaries represented, in dollar terms, an amount of \$1,763,000, this suggestion would double China's allocation. And, indeed, that was what the Programme Committee finally recommended -- and the Executive Board approved -- for China in the latter part of September 1947.⁶

Thus, the statistical homework of the Chinese delegate paid off in terms of a much larger allocation. But clearly this ad hoc method was not the most satisfactory way to proceed, and the UNICEF Executive Board had already decided, in June 1947, to adopt the following criteria in allocating assistance to countries:

- a) The proportion of undernourished children in each country;
- b). The number of homeless and orphaned children in each country in need of care;
- c) The capacity of a country to meet its own needs out of its currently available resources;

- d) The extent and duration of deprivation of the children of each country experienced during the war;
- e) The extent of wartime destruction of children's institutions in each country;
- f) The extent to which other international relief supplies are available for the same or similar purposes.⁷

These criteria, however, were either too emergency-oriented or too general to survive the passage of time. They were invoked in 1949 by a Board member who argued for a greater share of UNICEF's resources for Asia and less for Europe; thereafter, these criteria were mentioned very infrequently, if at all, in subsequent discussions by the Board.

Eventually, in 1970, UNICEF selected two specific criteria for allocating its assistance: population, and GNP per capita. It was not, however, until 1983 that this was formally augmented with a third and most significant yardstick, the infant mortality rate (IMR) -- number of children dying before the age of one year per thousand live births -- a measurement which China had raised as early as 1947 along with several countries in Europe.⁸

:Feeding programme for China

Securing an allocation from UNICEF, large or small, is one thing; spending it wisely and well is quite another, as China discovered. In the weeks and months following the approval of \$3.5 million for China in September 1947, a number of proposals and counter-proposals were developed, reviewed, amended, and rejected, during which time the political and military situation in China was changing rapidly and dramatically. This only served to heighten the sense of anxiety and frustration at UNICEF's inability to come up with an acceptable proposal.

Not until April 1948 -- over a year since China first applied for UNICEF aid -- was it possible for the Programme Committee to approve, under a delegated authority from the Executive Board (in the interests of speedy action), a plan of operations for a feeding programme of \$1 million. This would take place in six cities (Shanghai, Nanking, Tsingtao, Peiping, Tientsin, and Canton) for a six-month period, with a target of 45,000 infants and 215,000 children and pregnant and nursing mothers.⁹

By now many of the hapless children and mothers were approaching Endless Night. The infant mortality rate in cities was estimated at 150; in villages, 200. In the worst areas the problem "is not one of under-nutrition but of actual starvation". Also, children "were left on the streets and were given away by their own parents who had no way of feeding them".¹⁰

The amazing part is that a UNICEF-assisted feeding programme did indeed take place, beginning in September 1948; and that it did succeed -- as the Executive Director was later to report to the Board -- in reaching, at its peak in December 1948, over 36,000 infants with whole milk and 119,000 older children with rice (instead of skim milk) under extraordinarily difficult circumstances.¹¹

Hanson cited three reasons why most of the 702 UNICEF-aided feeding centres were able to keep going throughout the period of military take-over:

"First, in none of the cities was there a protracted battle for its control, so that the pattern of civilian life was not greatly disrupted. Second, the centres were under the day-by-day management of local committees not directly connected to the leaving government; and the UNICEF Field Representatives also remained. Third, all centres were issued UNICEF supplies from the central warehouses to last for about a month."¹²

Sadly, as supplies ran out, it became impossible to carry on. Representations to the new authorities were unsuccessful, and the feeding programme came to an end in the fall of 1949.

:Non-discrimination: helping both sides in China

When the Programme Committee in April 1948 presented its report to the Executive Board on the plan of operations for a feeding programme in China, a long discussion ensued, focussing on the issue of enlarging the list of six cities to include areas not under the control of the Government. The final outcome was to uphold UNICEF's principle of non-discrimination and willingness to help on all sides of a civil conflict — a policy which UNICEF has followed to this day, despite the often very delicate political problems and enormous practical difficulties, not to speak of dangers, inherent in implementing it.

Initially, the Chinese delegate reacted very strongly to a proposal to add several cities not under the control of the Government. What transpired in the next few days is not on record, but a week later, on 28 April 1948, the Chinese delegate read a cable from the UNICEF Office in Nanking which stated inter alia that "For aid of children, adolescents, pregnant and nursing mothers in communist area, Chinese Government will provide equivalent amount in Chinese national currency.... Methods of supervision and control of aid... in communist areas must be the same as those practiced in other areas".

The Australian delegate, E.J.R. Heyward (who later became UNICEF's Deputy Executive Director for Operations) thereupon proposed that the Board note "with pleasure" the proposal by the Chinese Government for a specific allocation to the "northern" areas, and allocate \$500,000 for use in such areas as soon as a satisfactory programme could be worked out.

After more lengthy debate, this draft resolution, with some revised wording as proposed by Heyward himself, was approved in the afternoon session of 28 April 1948 by a vote of 10 to 1 (China voting against), with 9 abstentions.¹³

It was now up to Dr. Marcel Junod, recently-appointed Chief of Mission for UNICEF in China, to implement this allocation. Dr. Junod, a veteran of the International Committee of the Red Cross before joining UNICEF, was able to secure agreement for a UNICEF team to go into Communist-controlled areas for on-the-spot discussions with the Chinese Liberated Areas Relief Administration (CLARA), on what kind of programme should be pursued. Now he had to form a team to do this.

Serendipitously, there was in China at the time Dr. Leo Eloesser, a renowned thoracic surgeon who had first come to China in 1945 (at the age of 63) under UNRRA auspices, and who had quickly realized that, whatever his lofty titles as "specialist in thoracic surgery and dean of medical consultants for UNRRA in China" might indicate, they had little to do with the needs of the Chinese people. He had gone into Yen-an in North China on a teaching assignment for WHO, and had worked there for five months in a hospital (named after the well-known Canadian surgeon, Dr. Norman Bethune) tucked away in a small village with no outside communications. That had proved to be a valuable experience, providing him with an insight into conditions in rural China that would otherwise have been unobtainable.

Dr. Eloesser had been reflecting on how China's vast population could be served. He was convinced that what the people needed was not more medical doctors, who tended to concentrate in the coastal towns and cities, but large numbers of persons to carry out simple prevention -- to vaccinate and immunize against smallpox, typhoid, cholera, diphtheria; to teach simple hygiene by boiling drinking water, disposing properly of sewage, and killing off harmful insects; assisting in childbirth, and teaching infant care. Dr. Eloesser was also convinced that it should be possible and not too difficult to train large numbers of "ordinary" people to do these things. And he had discussed these ideas with Dr. Junod and others, including in particular Dr. Su Chin Kwan, Central Commissioner of Health for the Chinese Liberated Areas Relief Administration (CLARA).

Thus, when Dr. Junod received word of the \$500,000 allocation for North China, he asked Dr. Eloesser whether he would like to go to there to put his ideas into practice. Dr. Eloesser accepted with alacrity. The other member of the UNICEF North China Field Team was Perry Hanson, formerly with UNRRA in Kaifeng, West Shandong and Tianjin, and the last UNICEF staff member to leave China on 2 May 1951.

:North China: simple training courses for primary health care workers

When the Eloesser/Hanson team in July 1948 proceeded to North China, the country was in extreme turmoil. Newton R. Bowles, Chief of the Asia Section at UNICEF/HQ (who had served with UNRRA both in Washington and in China through 1947), visited China in mid-1948 and wrote that "This is a most inopportune time to undertake health and welfare work in China. The civil war dominates everything".¹⁴

But nothing would deter Dr. Eloesser. An abandoned Trappist monastery was located as the site of the new health training school. A teaching staff was assembled. Discussions about the course content proceeded, punctuated by frequent air raids and the need to tend to the wounded. An agreement was reached between UNICEF and CLARA, spelling out their joint cooperation for the sake of children (known as the "Shijiazhuang agreement"), which Hanson carried back to Dr. Junod. The curriculum, for a first course of 20 trainees for about 3 months, would be kept simple, consisting of (a) sanitation and communicable diseases; (b) first aid and treatment of injuries; and (c) midwifery.

The daily schedule, as described by Dr. Eloesser in a delightful paper on his China experience, would be spartan: "A wintry reveille at 5:30; then setting-up exercise; classes to begin at 7 and continue until 12 noon with a half hour for breakfast and 10 minutes rest period in between the hours. Afternoon classes to begin at 1 and continue until 6 with a half hour for dinner at 6:30. Taps at 9:30".¹⁵

While all this on-the-ground planning was going on, the draft plan of operations was working its way through the bureaucratic procedures. First, the UNICEF/WHO Joint Committee on Health Policy (JCHP) — established in mid-1948, and representing the Boards of both agencies — reviewed the draft, after which the Programme Committee approved it on 19 November 1948. The Board acted swiftly, clearing the document on the same day — "subject to approval from the Government of China". Fortunately, the Government did give its approval on 23 December 1948, and this was duly reported to the Board by the Executive Director in January 1949.¹⁶

The training course had already begun in the last week of November 1948. Of the 20 students, 11 were males and 9 were females. Three of the students had had 4 months at medical schools, which Dr. Eloesser found to be a mistake: "their level was too high, they were disappointed at having their medical careers interrupted. They considered digging latrines and killing lice less useful than cutting out an appendix and certainly less noble". On the other hand, there were three sturdy farm wives: "they read and wrote with effort; arithmetic was beyond them; they never learned to read the dial of a blood-pressure sleeve; but what they lacked in literacy they made up in intelligence, force and forthrightness".

After six weeks of lectures and practical demonstrations, the students early in January 1949 were sent out to do field work. Their preparatory activities included making posters, preparing speeches and statements, and holding mock village meetings to learn how to talk to villagers and village authorities. The three semi-literate women spoke forcefully and clearly; the former medical students used language over the villagers' heads. The trainees were assigned to villages in groups of 2-4 with very simple items (UNICEF supplies had not yet arrived) to perform vaccinations against smallpox and typhoid, help clean the village and, if acceptable, construct latrines. They also performed many other tasks, including health surveys, and were amazed at the frequency of tetanus of the newborn.

When the teams returned to the training centre and presented their reports, Dr. Eloesser was astonished to see what the short six weeks of training had been able to do for the group. But he also learned that future preparation would need to be more explicit and more detailed. He wrote to Dr. Su, CLARA's Health Commissioner, for a critique of the first course, and advice for the future.

Dr. Su felt that the students were being taught too little of too many things. Would it not be better to have fewer specializations — sanitation; communicable disease control; mother and child health (including midwifery); and first aid and treatment, with students taking only one specialization? After graduation, teams could be formed to go to the rural areas, each team to consist of 5 persons: one from each of the specializations and the 5th to be in charge of administration.

The defect in this approach was that knowledge would be limited, so that the five persons had to work as a team and not alone. Its advantages would be a higher level of trainees and many, many more workers. As for the defect, rotation training may be the solution: after working in the field for 1-2 years, they could have the opportunity of either learning more in their own specialization or taking something in another discipline. By this method of rotation training, the effectiveness of the workers would be increased. The goal, said Dr. Su, would be to train the largest number of village health workers within the shortest possible time.

All this would require a great deal of thought and organization, and Dr. Su in his letter to Dr. Eloesser said that "In regard to this working system and its development we all have no experience.... Beginning of this work has great influence both to the confidence of the working men and the realization of the others. So in China we have a maxim that is 'Beginning is difficult'".¹⁷

Looking back, who can say how much (if any) of this initial modest experience had influenced or help to shape the eventual development of China's well-known "barefoot doctors" programme? Certainly, in the 1930s, much pioneering work had been done in developing a rural health care delivery system, based on community involvement and participation, led by Dr. John Grant (father of the current UNICEF Executive Director) and his Chinese colleagues at the Peking Union Medical College, Drs. Ch'en Chih-ch'ien and Marian Yang. Their success was due in no small measure to Jimmy Yen's Mass Education Movement and the consequent excellent social preparation of communities at Ting Hsian, some 200 miles from Beijing.¹⁸ Even if Dr. Su had been aware of these activities, he may have felt it necessary to start at the "beginning", as he said in his letter to Dr. Eloesser.

In any event, a second course did take place, beginning in mid-1949, this time with 80 students; and with the training centre moved to T'ung Chow, a town outside Beijing, so that there would be proximity to well-established health and educational facilities and a bigger choice of trainees. The curriculum was changed in accordance with Dr. Su's perceptive observations, with instruction grouped into three specializations: sanitation (men), midwifery (women), and communicable disease (mixed). A fourth group on child care and nursery school techniques was added at the request of the Women and Child Welfare Association.¹⁹ Each senior teacher was assigned one junior teacher, chosen from the first training course at Shijiazhuang, so that a multiplier effect could take place of having more and more instructors for more and more courses.

This second course also went well. Its duration was extended from 4 to 6 months, partly to give more time for closer supervision of the students in the field. Again, lessons were learned. For example, the communicable diseases group found that the village people were not easily disposed to accept health education. It was therefore decided that in future courses all female health workers would receive midwifery training, a service which was readily accepted everywhere, to serve as the opening wedge to introduce, gradually, other health measures.

It was also found that short, practical courses for the "old-type" midwives (or granny midwives) in the rudiments of aseptic delivery technique was quickly reflected in a great reduction in tetanus of the newborn and in puerperal sepsis. In fact, two of the teachers -- Edith Galt and Isabel Hemingway, who were fluent in Chinese -- later co-authored UNICEF's first Midwifery Training Manual.²⁰

The Executive Board in November 1949 had the opportunity of hearing first-hand from Dr. Eloesser this unusual story of UNICEF's first involvement in the training of primary health care workers.²¹ Dr. Eloesser stressed that "Most communicable disease is preventable, and prevention of the ordinary forms of communicable disease, ordinary midwifery and ordinary care of the newborn demand no extraordinary techniques. It was thought that the necessary technical procedures could be learned in a few months by any person of ordinary intelligence". He went on to describe the two courses which had been held under UNICEF auspices. Then, in a prophetic comment which has been captured by Hanson, Dr. Eloesser said: "Whatever future UNICEF may have in China, these or similar courses will go on. I think that their value has been proven for countries totally or almost totally lacking in trained medical personnel."²²

Unfortunately and regretfully for UNICEF, it was not possible to remain in China at the time. Relations between UNICEF and CLARA deteriorated, to the bewilderment of the UNICEF staff. The Shijiazhuang agreement was abrogated at the end of December 1949. Dr. Eloesser later said that,

"In retrospect I recognize my dullness in not perceiving immediately that UNICEF's situation in China was an incompatible anomaly. How could China officially recognize and work with UNICEF, a United Nations agency, when the United Nations itself refused to recognize, let alone, accept, China? The fly, buzzing above the pudding, can see it and steer his course accordingly; once he's in the sticky mess, he's blind and halt".²³

:Representation of China on the Executive Board

The People's Republic of China did, however, as part of efforts being made in other parts of the United Nations, come very close to taking its seat on the UNICEF Executive Board in 1950.

There had been two attempts by some Board members in the first half of 1950 to seat the representative of the People's Republic of China (PRC), replacing the representative of the Republic of China, but in both cases the votes were not that close.²⁴

In August 1950, Chou En-Lai, Minister of Foreign Affairs, sent a cable to UN Secretary-General Trygve Lie, appointing a PRC representative to sit on the UNICEF Executive Board, and requesting that copies of his cable be sent to all Board members. This was done by the Executive Director, Maurice Pate, in September, along with copies of a cabled reply by Dr. Ludwik Rajchman, Chairman of the Board, who informed Chou En-Lai that he would support the PRC application (Dr. Rajchman was the representative of Poland on the Board).

There was also a cabled reply by Pate, diplomatically side-stepping this political issue and responding instead to other queries on supplies and personnel; and, finally, a letter by Mr. P.Y. Tsao, the representative of the Republic of China, to the Executive Director.²⁵

The UNICEF Executive Board met on 27 November 1950 to consider the matter. After a lengthy debate in the morning, the Chairman put to the vote "his recommendation that the credentials of the representative of the Central People's Government of the People's Republic of China should be recognized, so that he might sit as the member of the Executive Board for China". The vote was 12 in favour, 12 against, with one abstention.²⁶

In accordance with the rules of procedure, the Board at its next meeting (on the afternoon of the same day) met again on the same issue. After hearing a representative of the UN Legal Department speak on the question as to whether a delegate whose credentials were being contested could nevertheless vote (the answer was yes), the Board took another vote, with the same result: 12-12, with one abstention. As a consequence, the motion was rejected.²⁷

It was very close.

A few weeks later, on 14 December 1950, the General Assembly passed Resolution 396 (V) to ensure that the UN specialized agencies and "other organs of the United Nations" (such as UNICEF) would follow the General Assembly's decisions on such matters.

Thereafter, although the Chinese representation issue was raised at the beginning of a number of subsequent Board sessions, all such attempts were routinely overruled through a motion to adjourn debate on the matter.

However, the non-recognition of the People's Republic of China (PRC) by the United Nations, and the non-seating of the PRC on the UNICEF Executive Board, did not mean that China could not receive UNICEF aid. Pate, deeply committed to the principle of non-discrimination, and aware that a large balance of some \$7 million still remained on UNICEF's books for China, wrote to Chou En-Lai on 29 August 1951 to say that UNICEF, "from the very nature of its work, is an entirely non-political organization. It has extended assistance up to now through the governments of countries to children in over sixty countries and territories, and in all geographical areas. Whether a government is actually represented in the United Nations or not has no bearing on the extent of UNICEF assistance. As a matter of fact, UNICEF has furnished supplies to eleven countries whose governments are not represented in the United Nations".

There was no reply.

:Return of unused balance for China

After the difficult fight in 1947 over the first allocation to China of \$3.5 million, further amounts had been approved by the Executive Board in quick order (\$2,947,000 in 1948 and \$2,500,000 in 1949, for a total of \$8,947,000), covering such items as more food, and cotton padding for children's garments (UNICEF shipped some cotton which had to be held in Hong Kong, and had also appointed a textiles expert to assist in this project).

In addition, there was a large package of proposals, totalling \$4.9 million, including more health training patterned along the lines of the North China experience (which drew many favourable comments); tuberculosis control, and kala-azar control (an infectious disease with a high fatality rate), which was going through the laborious clearance procedure for health projects: first, review by the Programme Committee's Medical Sub-Committee; then, the UNICEF/WHO Joint Committee on Health Policy (JCHP); and, finally, the Programme Committee and the Executive Board.

However, by the time the JCHP was able to consider this proposal in April 1949, political and military events in China were making it all redundant: the Chinese Nationalist Government was (temporarily) in Canton, and the Red Army was poised on the northern banks of the Yangtze River.²⁸

So, in the end, the package of proposals, even though it had been cleared in principle ahead of time by the Programme Committee and the Executive Board, was never implemented. There were no further food shipments, so the feeding programme gradually finished distributing all its stocks. The cotton shipped to Hong Kong never did reach China, eventually to be diverted to Europe.²⁹

The medical and training supplies intended for the health workers courses arrived too late for the first course at Shihjiazhuang, but some of the items were eventually sent there as well to the People's Health Workers Training Centre at T'ung Chow, where the second course was held. Other medical equipment were sent to several hospitals in Beijing, including the National Vaccine & Serum Institute in the Temple of Heaven. UNICEF supplies for nurseries and kindergartens in North China were allocated to 52 such children's institutions.³⁰

UNICEF staff were gradually withdrawn and offices closed. The large \$7 million balance of unused funds for China was eventually returned to UNICEF's general resources in two instalments,³¹ with Pate informing the People's Republic of China each time. Each time, there was no acknowledgment or reply.

:Representation of China on the Executive Board - a reprise

Jumping ahead some twenty years later, the issue of China's representation on the Executive Board came up again in the 1970s -- this time with quite different results.

The People's Republic of China (PRC) was admitted to the United Nations in October 1971 by General Assembly Resolution 2758 (XXVI). This action also meant that the PRC replaced the Republic of China³² on the UNICEF Board for its unexpired term -- until 31 July 1973. However, China for various reasons decided to assume membership in the various UN bodies on a gradual basis, and as a consequence did not immediately take her seat on the UNICEF Executive Board.

Meantime, as a result of some quiet diplomacy, Newton R. Bowles, Deputy Director of the Programme Division (and formerly long-serving Chief of the Asia Section) was invited to Beijing in October 1978 for the first exploratory discussions about re-opening UNICEF's programme in China. A full report was prepared. This led to the first pledge by the People's Republic of China to UNICEF's general resources of \$200,000 in 1979.

In April 1979, a first study tour of programmes for children in China was organized with the collaboration of the Chinese People's National Committee for the Defence of Children and the All-China Women's Federation. Senior government officials from Bangladesh, India, Nepal, the Philippines, Sri Lanka and Thailand, who were directly responsible in their own countries for multidisciplinary children's services, participated in the study tour, and the exchange of information and learning experience which took place was an outstanding example of the principle of technical cooperation among developing countries (TCDC).³³

It was altogether fitting that James P. Grant, who succeeded Henry R. Labouisse as Executive Director in 1980, and who was in charge of UNRRA activities in the liberated areas of China in the immediate post-war years, should attend his first session of the Board in May 1980 -- the same session at which China resumed her seat on the Executive Board.

The Basic Agreement with the People's Republic of China was signed in Beijing in June 1981, soon after the (re-)opening of the UNICEF Beijing Office in February 1981, with Ralph Eckert, a highly-respected veteran UNICEF staff member, as the UNICEF Representative.³⁴

* * *

Asia (other than China): 1947-1950

When the Executive Board in September 1947 approved the enlarged allocation for China of \$3.5 million, it also set aside \$1.5 million for Asia, other than China, as a provisional allocation. Because of an improving financial situation, the Board was able to increase this amount to \$3 million at its April 1948 session.³⁵

:Parran/Lakshmanan survey mission

Promptly thereafter, in May/June 1948, a team consisting of Dr. Thomas Parran, former Surgeon-General of the United States, and Dr. C.K. Lakshmanan, Director of the All-India Institute of Hygiene and Public Health, Calcutta, carried out a survey for UNICEF of children's needs, visiting "the Philippines, Hong Kong, Singapore, Malay Federation, North Borneo, Sarawak, Brunei, Indonesia, Indo-China, Siam, Burma, India, (and) Pakistan" (it was not possible to visit Ceylon because of travel delays).³⁶ The team was also able to complete their report in time to have it discussed at the Programme Committee's meeting in Paris on Sunday, 4 July 1948.³⁷

:High infant mortality rate (IMR) and malnutrition in Asia

There were two major findings with regard to children and mothers in Asia in the post-World War II period. First, despite the lack of vital statistics, fairly accurate estimates revealed a very high infant mortality rate (the number of children dying up to one year of age per thousand live births) in almost all of the countries visited, as borne out by the following figures:

Table I

Infant mortality rates for selected countries in Asia
(taken from country Annexes of Parran/Lakshmanan report)

Burma	300
India	150.9
Indo-China	353
Malayan Federation	102
Pakistan	184.6
Siam	99.8
Singapore	87.3

Secondly, "malnutrition, often in severe degrees, is the usual rather than the unusual situation among children. Similar malnutrition often affects the pregnant and nursing mother, making it impossible for her to suckle the infant. Since milk is scarce or entirely unknown, the babies of such mothers have little or no chance for survival".³⁸

The survey mission, faced with enormous populations in the region on the one hand and limited UNICEF resources on the other (the allocation of \$3 million for Asia would have worked out to about one cent per beneficiary); and considering also the weakness of the infrastructure, concluded that the usual type of UNICEF large-scale feeding was impossible. It recommended that UNICEF should instead focus on projects designed to control specific diseases seriously affecting mothers and children (tuberculosis, yaws, syphilis, and malaria); some limited feeding where malnutrition was extreme; and training of personnel. The mission's report also suggested country-by-country breakdowns for 80% of the \$3 million, with the balance of 20% to be held as a reserve for later action.

:Block allocation for Asia — and the principle of non-discrimination

Most of the mission's recommendations were accepted since, as Dr. Ludwik Rajchman, Chairman of the UNICEF Board, commented at one point, the Programme Committee "was impressed by the extraordinary scope (of the) report and the balance in which the proposal had been framed".³⁹ With adjustments in some of the individual country figures, and eschewing the mission's suggestion that part of the block allocation for Asia be reserved for later disposition, the Executive Board in July 1948 approved all of the \$3 million for the following country allocations as recommended by the Programme Committee:

Table II⁴⁰

Block allocation for Asia: approved country breakdowns

Burma		\$ 150,000
Ceylon		100,000
India		750,000
Indo-China: French controlled	\$200,000	
Not under French control	<u>100,000</u>	300,000
Indonesia: Dutch controlled	<u>500,000</u>	
Republic controlled	<u>300,000</u>	800,000
Pakistan		250,000 .
Philippines		300,000
Siam		100,000
United Kingdom Territories		<u>250,000</u>
Total:		<u>\$3,000,000</u>

As can be seen from the above table, the Board endorsed the mission's recommendation that funds be earmarked for those parts of Indo-China and Indonesia not under government control, thus upholding -- as in the case of China -- UNICEF's basic principle of non-discrimination.

The Parran/Lakshmanan report had also emphasized the urgent need of training health personnel. Accordingly, the UNICEF Secretariat recommended in August 1948 approval of \$214,000 for a fellowship programme to be administered by WHO, including two fellows in malaria from Thailand for whom clearance had already been obtained.

The Programme Committee endorsed this proposal. However, because the Executive Board at that moment was seized with the Palestine refugees issue, and it was not known when the Board would be able to schedule its next regular session, Board approval of the fellowships was obtained by mail poll.⁴¹ Thus, the two Thai fellows who took a nine-week study course at the Malaria Institute in New Delhi, in the summer of 1948, were UNICEF's very first beneficiaries in Asia, other than China.

As for the other fellows, their selection and placement had to await the arrival of UNICEF and WHO representatives in the region. Eventually, of course, the fellowship programme did get implemented, and successfully, with a total of 145 fellowships awarded in a wide range of disciplines in maternal and child health, pediatrics, nursing, and nutrition; and with many of the fellows, upon returning from their studies, being placed or returning to work in positions of direct relevance to UNICEF's concerns.⁴² But in those early months, in the words of Dr. Su, "Beginning is difficult".

With regard to the \$3 million block allocation for Asia (other than China), the Executive Director, having no UNICEF staff in position in any of the countries, advised the relevant Governments about the Board allocations in a letter through the appropriate Permanent Delegations to the United Nations. He also suggested in a separate communication that the Governments nominate persons who could begin working on developing plans.⁴³ This was because

none of the UNICEF funds could be implemented until individual project plans of operations had been prepared and sent to the Programme Committee and Executive Board for approval.

Indeed, in the very early years, when health programmes predominated, health plans of operations — including detailed supply lists — had to receive the technical approval of WHO; and the Programme Committee and the Board required, for their review also, rather full documentation. This practice was gradually modified until consultations by UNICEF field staff with the appropriate field personnel (WHO for health, UNESCO for education, etc.), rather than formal clearances at the HQ level, became the prevailing practice. But, in the beginning, there were no WHO or UNICEF field staff in position in Asia, thus compounding the clearance problem.

:Administrative organization for Asia

China did not have a resident UNICEF Chief of Mission until early 1948. Asia did not have any UNICEF staff until the end of 1948, when Dr. Michael Watt, formerly Director of Health of New Zealand, was appointed as Asia's first Regional Director. After a brief exploration in a few Asian cities, he established the UNICEF Regional Office in Bangkok in the spring of 1949 at the invitation of the Government of Thailand.

Gradually, other staff were posted in Asia. Watt (who served from November 1948 to November 1949) recalls these first appointments:

"In Pakistan the Chief of Mission was Victor Fenn, an Anglo-Burmese doctor who came to UNICEF from Central Burma where he had been trapped by the civil war then at its height. In India the Chief of Mission was T. Glan Davies, an Englishman who knew India well. He had previously worked for a Quaker unit on famine relief in Bengal and was on excellent terms with the Government of India. The UNICEF representative in Indonesia was Carl Bergithon, a Canadian who for a while had worked for UNRRA.... In the Philippines UNICEF was represented by James McCall, a very competent American who had been Superintendent of Education in one of the Provinces of the Philippines and more lately in charge of the agency for the administration of U.S. war relief in the Philippines. I mention their names because a great deal of the success of our undertaking was due to these men with their patience, persistence and wise understanding of the temperaments of the people with whom they had to deal".⁴⁴

Thus, by the fall of 1949, as the UNICEF programme in China was closing out, the other countries in Asia were approaching centre stage, with UNICEF's administrative structure beginning to take shape.

:Plans of operations

Approved plans of operations were also multiplying, covering feeding operations in India, the Philippines, Indonesia, Hong Kong, and Japan; malaria control demonstrations in Pakistan, India, and Thailand; and programmes for child care training abroad or locally on behalf of Pakistan, India, Thailand, Indonesia, the Philippines, and certain United Kingdom territories in Southeast Asia.

Virtually all of these were approved after the Board decided in March 1949 to delegate authority to approve plans of operations to the Chairman of the Executive Board, Chairman of the Programme Committee, and the Executive Director.⁴⁵ Eventually, such authority was delegated to the Executive Director and, through him, to the UNICEF Representatives in the field offices.

In the early years, however, the Executive Director was meticulous in submitting regular reports to the Board, summarizing all plans of operations approved under this delegation of authority. Such reports, continued for a number of years, contained much useful information on the social situation in the various countries, along with detailed plans for the utilization of UNICEF assistance.⁴⁶

:Non-discrimination: Indonesia; Indo-China

In the fall of 1949, because Indonesia had not yet gained its independence, the Executive Director reported that two feeding projects had been developed, one in the "Island of Lombok, under the Government of Indonesia; and the other in Jogjakarta in the Republic of Indonesia". The Dutch authorities had given every assurance to the Farran/Lakshmanan mission that the non-discrimination requirements of UNICEF would be fully met, including the endorsement and forwarding of the Republican request, and unimpeded entry of UNICEF supplies into Republican territory.⁴⁷

However, by the time the Executive Director prepared his next report to the Programme Committee in January 1950, he was able to say that, "In view of the recent establishment of a single government and administration for the whole of Indonesia, this division of the allocation to Indonesia has now been consolidated and will be administered as a single allocation to Indonesia as a whole".⁴⁸

In the case of Indo-China, however, the situation was much more difficult. Watt, in his memoirs, remarked that "During the whole period of my stay in the Far East, Indo-China was the scene of bitter fighting. It was not possible to obtain the permission of the French for a visit to Indo-China and consequently no attempt was made to forward UNICEF supplies to this war-wracked country where need was so great".⁴⁹

Spurgeon M. Keeny, who succeeded Watt as Regional Director for Asia early in 1950, also tried in June of that year, visiting Saigon together with Dr. John Grant, who by then had left the Peking Union Medical College and was now senior medical adviser to the U.S. Economic Cooperation Administration. Keeny was able to make his way north to Haiphong as well.

Upon his return to Bangkok, Keeny recommended "immediate emergency help, with some safeguards to make sure that our money would not be wasted. But the situation was so tangled politically as well as militarily that the negotiations dragged on without decision. Before UNICEF had done anything in the North, the soldiers had come down out of the blockhouses and gone away; and North Vietnam was behind the Curtain".⁵⁰

:Japan

In the case of Japan and Korea, where exceptional political circumstances also prevailed, the Executive Board in March 1949 had reserved an amount of \$1.5 million, to be "apportioned by the Board after a survey and recommendation by the Administration".⁵¹

Accordingly, in the case of Japan, a representative of UNICEF made a survey early in 1949 and provided a wealth of data which enabled SCAP, the Supreme Commander for the Allied Powers, to place a request before the Programme Committee in May. But several more months of discussions were needed before a suitable plan could be produced and approved by the Chairmen of the Executive Board and the Programme Committee. A demonstration feeding programme in schools received an allocation of \$238,000. Raw cotton (\$262,000) was also approved and shipped, which was manufactured into children's clothing by the Japanese Government and distributed to 400,000 children of indigent families.

With regard to the feeding programme, meticulous records were kept of the height, weight, and chest size of over 50,000 school children receiving UNICEF skim milk during 1950. These records, stated a 1952 report, "show a significant improvement in the rate of growth of these children which set them well above the national average".⁵²

:Korea

As for Korea, Dr. Marcel Junod, Chief of the UNICEF Mission for China, visited South Korea for a week beginning 19 August 1948, only four days after Korea had proclaimed its independence. The Government in Seoul was too new, the visit too early; a formal application for UNICEF aid was tabled later. Nor did Dr. Junod go to North Korea, lacking an invitation. The Executive Director in August 1948 reported to the Programme Committee that the "...Government of Northern Korea has been approached about the possibility of a survey of Northern Korea, but no word has been received on this matter as yet".⁵³

Nevertheless, true to UNICEF's principle of non-discrimination, the Executive Director in mid-1949 submitted a recommendation for Korea for \$750,000: \$550,000 to South Korea for BCG vaccination and feeding, and \$200,000 to be held in reserve "pending a possible application for aid from the authorities of North Korea".⁵⁴

The Democratic People's Republic of Korea finally did apply -- some 37 years later, enabling the Executive Board at its April 1986 session to approve a \$1 million programme for the period 1986-1988.⁵⁵

UNICEF aid continues for the Republic of Korea, which is presently focussed inter alia on the development of a low-cost health care system based on community maternal and child health (MCH) services in urban as well as in rural areas.

:Criteria for allocating more aid to Asia

When, early in 1949, UNICEF's financial resources turned out to be greater than anticipated, the Executive Director recommended that UNICEF's global planning budget for 1949 be increased from \$78 million to \$98.5 million, of which, inter alia, \$20.5 million would be for Asia; \$2.5 million for Latin America (its first regional block allocation), and \$42 million for Europe.

This touched off a lengthy and heated debate in the Programme Committee and the Executive Board as to how UNICEF's resources should be distributed between Europe and other areas. Several basic issues arose: when does an emergency end? How are needs measured? What should be the criteria for distributing UNICEF aid?⁵⁶

The United Kingdom delegate was outspoken in his view that European recovery was well on its way, and that an emergency no longer existed in those European countries in which the UNICEF Secretariat had recommended the continuation of feeding programmes for children. Referring to the criteria for aid which the Board had adopted in mid-1947, he said that Board members should ask themselves "whether there were more undernourished children in India or Czechoslovakia.... Could the deprivation of children due to war in China, Burma and Malaya be compared with that due to the war in Europe?.... By all the criteria, therefore, the claims of Asia were at least as strong as those of Central and Eastern Europe". The U.K. delegate recommended that the European figure be reduced by \$5.5 million, which he later modified to \$3.5 million.

The majority of the Board members, however, felt that although European recovery was indeed taking place, the feeding programmes already begun with UNICEF help should continue. Dr. Rajchman, Chairman of the Executive Board, noted that, whereas FAO had forecasted improved agricultural conditions for Europe for 1950/51, this optimistic forecast "did not refer to the milk situation". As for Poland, the country he represented, while it was true that general food conditions had improved and she had contributed sugar to UNICEF, "this did not imply a lack of need for milk".

The Danish delegate remarked that, clearly, the feeding programmes would have to be terminated some time; "the only question was when and at what speed". In other words, when does an emergency cease to be one? Although the cuts in the U.K. proposal were "perhaps too drastic" (they would have reduced the allocations for many of the European countries by 50%), he nevertheless supported the proposal on general grounds. As to the "when": it might be when the milk processing equipment could be delivered by UNICEF to a number of Eastern European countries. Pate thought "spring or early summer 1950".

And that, in the end, constituted the basis for the continuation of feeding assistance to Europe through the summer of 1950. The Programme Committee filed a report which dutifully reported on the "Minority View" of the United Kingdom representative, and the Executive Board, after rejecting each one of the numerous U.K. proposals for cutting individual European country allocations, adopted a compromise resolution which did provide for a reduction in the European total from \$42 million to \$37.9 million.⁵⁷

:Reconstitution of the UNICEF Executive Board

The vigorous efforts of the United Kingdom delegate to secure a greater share of UNICEF resources for Asia, although supported by several others, did not succeed in 1949. The "Far East" was indeed just that -- too far away, psychologically as well as physically. This is reflected in the expenditure figures: by the end of 1950, UNICEF had spent more than \$114 million, of which only 11% was for Asia.⁵⁸

By the very composition of the UNICEF Executive Board in its early years, Asia's own voice was weak because it consisted of only one country -- that of China. It was not until the UN General Assembly on 1 December 1950 reconstituted the Executive Board as of 1 January 1951, and included a consideration of geographical distribution with regard to Board membership, that the representation of Asia began to improve on the UNICEF Board and on its various Committees.

Thus, when the UN Economic and Social Council (ECOSOC) elected eight members to the Executive Board following the General Assembly's decision, three of the 8 countries were from Asia (Ceylon, Indonesia, and Thailand) which, added to India and China by virtue of their membership in the Social Commission, made a total of five from Asia out of 26 seats on the Executive Board.

* * *

Summary

In summary, the early period 1947-1950 for Asia, including China, was one of high expectations but relatively low allocations and even lower expenditures. Nevertheless, there were some important developments besides the feeding and health training projects in China and the approval of block allocations for other countries in Asia.

Supplementary feeding programmes in a number of countries consumed some 30 million lbs. of skim milk powder; a five-year, \$930,000 commitment was made to the All-India Institute of Hygiene and Public Health in Calcutta to provide training for doctors and public health nurses; and BCG vaccination projects were launched in several countries, along with the beginning of yaws control measures in Indonesia and Thailand. Other large allocations in this period included \$850,000 for an antibiotic plant in Bombay, India.⁵⁹

The vast needs of children and mothers in Asia, compared with the limited UNICEF resources available to the region, made it necessary to scrutinize very carefully every dollar allocated, and this early period was characterized by an almost painful fidelity to meticulous reviews of draft plans of operations (for all regions, not just Asia) at the level of the Programme Committee and the Executive Board -- something quite inconceivable today.

There were, however, a number of policy considerations which have stood the test of time, including in particular the principle of non-discrimination in UNICEF aid for all sides in civil conflicts, applied from the very beginning to several situations in Asia.

But, in general, Asia took a backseat to Europe in this early period.

All this was to change, however, with the decade of the 1950s.

*

*

*

THE MASS CAMPAIGN ERA: 1950-1960

- 24 -

Blank Back

Introduction

UNICEF, as an organization, almost didn't make it beyond 1950. As the emergency in Europe began to recede, the specific purpose for establishing a temporary emergency fund for children under UN auspices appeared to be fulfilled. Some of UNICEF's main financial backers proposed that the United Nations work for children should be distributed among the technical assistance agencies of the United Nations system.

A number of countries, however, mostly developing, wanted UNICEF to continue, working outside Europe. The issue was studied and debated, formally and informally, in various UN bodies -- including, of course, UNICEF itself -- from mid-1949 on. It was dramatized in a critical debate in the UN General Assembly's Third Committee in October 1950, highlighted by an extemporaneous, eloquent speech of Professor Ahmed Bokhari, the representative of Pakistan. Judith M. Spiegelman, in her pictorial history of UNICEF, has described what took place:

"Bokhari was vice-chairman of the (Social, Cultural, and Humanitarian) committee, so he opened the meeting at Lake Success that morning. Then he gave the floor to Mrs. Roosevelt. She read a speech prepared for her by the U.S. State Department. True, she said, UNICEF had done marvelous work feeding the children in Europe, but the postwar emergency was over. UNICEF was supposed to be a temporary agency. Its main supporter, the U.S. government, was signaling, 'Cut out massive food aid.' When she had finished, Bokhari said he would like to step down from presiding over the committee and speak extemporaneously as the delegate from Pakistan.

'I have the greatest respect for my distinguished colleague, Mrs. Roosevelt,' he began, 'but in listening to her, I felt as though I was at the funeral of the International Children's Emergency Fund.' In an intense, husky voice, he continued: 'Pakistan as well as other countries in Asia have been shocked to see UNICEF photographs of emaciated European children, victims of the war. They have been even more shocked, however, to realize that those European children still appear to be in no worse state than millions of children living so-called 'normal lives' in underdeveloped countries. You were willing to help postwar needy children in Europe,' Bokhari concluded, 'but now you're not willing to come through for equally needy children of the developing world?'"⁶⁰

The tide turned in favour of continuing UNICEF. The UN General Assembly on 1 December 1950 unanimously decided to extend the life of UNICEF for another three years with emphasis on programmes outside Europe. As it had from the start, the United States continued to provide the lion's share -- about two-thirds -- of UNICEF's funding, and although its percentage of the overall funding dropped, the United States remained one of the strongest supporters of UNICEF after the General Assembly, in 1953, extended the life of UNICEF "indefinitely".

*

*

*

UNICEF allocations: from Europe to Asia

Combined with the recovery of post-war Europe and a growing awareness of Asia's needs was Asia's enhanced presence on the Executive Board, now not just a solo voice but a small chorus of five; plus strong support by some developed countries on the Board with special interests in Asia. To this was added the prominent role of a peripatetic Regional Director, Sam Keeny, as UNICEF's spokesman for Asia. This brought about an improvement in the situation of UNICEF in Asia, almost immediately after the Executive Board was re-constituted as of January 1951.

At the May 1951 session, the Board adopted a global target for mid-1951 to mid-1952 of \$30 million, of which \$7.5 million was earmarked for Asia. At its April 1952 session, the Board approved long-term programme aid (i.e., excluding emergencies, freight, etc.) totalling \$5,765,000, of which \$2,203,000, or 38%, was for Asia. And, at the October 1952 session, the percentage for Asia rose to 50% (\$1,564,000 out of \$3,119,000).

By the time the Executive Board in March 1953 prepared a special report on its work (in view of the General Assembly's decision to discuss the future of UNICEF in 1953), the figures on distribution of UNICEF's allocations for long-term aid showed a definite shift away from Europe to other regions, particularly Asia:

Table III⁶¹

UNICEF allocations: from Europe to Asia

	<u>1947 to 31 Dec. 1950</u>	<u>1951 through March 1953</u>
Asia	10.4%	41.0%
Eastern Mediterranean	10.1%	27.3%
Europe	76.0%	11.6%
Latin America	3.2%	15.4%
Africa	0.3%	4.7%
	<u>100.0%</u>	<u>100.0%</u>

* * *

An exhilarating decade for UNICEF in Asia

The decade of the 1950s was an exhilarating period for UNICEF in Asia. Massive campaigns were launched against tuberculosis (with BCG vaccination as the preventive measure) and yaws (using penicillin to treat this crippling tropical disease), achieving quantitative results which were beyond all expectations. The network of maternal and child health (MCH) centres was gradually extended to more and more villages. The small anti-malaria demonstration projects, financed by UNICEF out of the regional block

allocation of \$300,000, proved to be successful, providing the basis for bilateral United States participation in the largest programmes in Asia. And leading the good fight for UNICEF in Asia was Spurgeon ("Sam") Keeny, formerly head of UNRRA in Italy, and Regional Director for Asia from 1950 until his retirement from UNICEF in 1963.

:The role of Sam Keeny

Keeny, as Spiegelman has aptly written, was most certainly the "right man in the right place at the right time.... Some say Sam Keeny 'made a greater contribution to UNICEF's practical work than any other single person in its history'".⁶² This was due to the happy juxtaposition of two things: Asia at that moment in history needed someone capable of pulling together national and international resources to launch large mass campaigns against some major public health diseases, largely affecting children, in the region; and it just so happened that Keeny was the head of UNICEF in Asia who -- in the words of Maggie Black, author of the UNICEF history -- had that "particular style of leadership and inspiration" that was "specially suited to the era of the mass disease campaign".⁶³

Keeny had another talent: the ability to write, and speak, simply and compellingly. His easy, readable style and story-telling skills were a hallmark of his stewardship of UNICEF in Asia, for he wrote a monthly report which was widely circulated and read, and which remains unsurpassed for its graphic descriptions of life in the Asian village, and of UNICEF's efforts on behalf of needy children and mothers.

:And the Asian village

The Executive Board by now had regularized its sessions to twice a year, compared to the early period when they met as often as funds became available for allocation. Keeny therefore had two occasions each year to brief the Board on what was happening in Asia, and he never allowed the Board members to forget that UNICEF aid was meant for the needy children and mothers in the villages. Here, for example, was how he opened his statement to the Board at its September 1953 session:

"I have returned only forty-eight hours ago from Bangkok, with stop-overs in Burma, East Pakistan, India, and West Pakistan. Against this background, it is hard for one who has been thinking particularly about helping the Asian village to comment to an audience in this setting. For the first day or two, one never pushes an electric switch without remembering that UNICEF is trying to bring help to a world that goes to bed at dark because there is no light, and is astir at dawn. He doesn't turn a water tap without feeling: (1) surprise that water comes out of the tap at all; (2) amazement if it is hot; and (3) a warning not to drink it. He thinks that, if he could take back to the village the facilities from the men's room, half the health problems of Asia would be solved, and if he could take the free soap as well, yaws might eventually disappear, too. The one thing that makes him feel at home here in the Conference Room from the beginning is the foreign languages he hears before he turns the button to the right number. One of these buttons would be handy for us in the village, where language is always a problem".⁶⁴

Keeny added that "We in the field are often impatient; but that action does take place within a few months from the time this body decides what to do is a marvel unique to our time. It seems even more amazing when I reflect that the diseases we are helping to attack could not have been fought at all when I was at the age of the children we are trying to help, and that two out of the three mass programmes (malaria and yaws) could not have been undertaken even ten years ago because the key discoveries had not been made". Keeny was referring to DDT for malaria, and penicillin for yaws. The third one, for which the vaccine bearing their initials had been discovered by Calmette and Guérin in the early part of the twentieth century, was BCG vaccination against tuberculosis.⁶⁵

* * *

BCG vaccination against tuberculosis

When the Parran/Lakshmanan survey team visited Asia in 1948, practically all of the countries, recognizing tuberculosis as a serious public health problem, requested UNICEF help in launching BCG vaccination campaigns as a preventive measure. The Parran/Lakshmanan report recorded the efforts going on at that time in the field of tuberculosis in Asia:

"Only in Indo-China has BCG vaccine heretofore been done and there through the use of the dried vaccine administered orally. However, in the Philippines, a small scale trial of dried vaccine from the Pasteur Institute in Paris is being made. In India plans have been completed for the manufacture of BCG vaccine. In this country, a WHO team is functioning. In Malaya and Singapore the authorities hope to secure a supply of BCG vaccine from Australia and tentatively propose training of field personnel through fellowships. In Indo-China modern drying equipment is requested and, if approved, the government is anxious to supply BCG without cost to neighbouring countries".⁶⁶

The Executive Board in March 1949 took an earlier block allocation of \$2 million for BCG programmes and transferred the amount to specific countries, including \$1 million to India, Pakistan, and Ceylon, thus launching BCG vaccination in Asia under UNICEF's auspices.⁶⁷

:Operational problems

In those early days -- including the large and successful BCG campaigns in Europe -- BCG vaccination was carried out with liquid vaccine, which was very fragile and required protection against the intense heat and light so characteristic of tropical and sub-tropical countries. Also, two visits were required for every child covered: once to do the tuberculin testing, and, two or three days later, a return visit to measure the induration level and to vaccinate the negative reactors. Thus, from the outset, there were tremendous logistical and operational difficulties in providing an adequate cold chain system for the BCG vaccine, and in developing and executing a management plan by which as many children as possible be seen twice.

The Parran/Lakshmanan mission in 1948 had thought that the controversy over the use of freeze-dried vaccine would be solved "within a short time", but this was not to come to pass until 1962,⁶⁸ when Keeny was nearing retirement from UNICEF. And direct vaccination without prior testing, with its tremendous logistical advantage of not having to see the same child twice, as well as a substantial reduction in operational costs and simplification of training, did not receive WHO's formal approval until 1965.⁶⁹ Nevertheless, the BCG campaigns in those early years persevered.

There was another problem, this one fortunately solved very early. E.J.R. Heyward (who was now the Deputy Executive Director for Operations) visited Asia in the early part of 1951, and reported that "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".⁷⁰

Heyward discussed this problem with Dr. Johannes Holm of the International Tuberculosis Campaign, who had just spent two months in India, Pakistan, and Ceylon, and it was recommended that vaccination be carried out by teams of lay vaccinators under medical supervision -- a significant breakthrough in methodology and approach. These lay vaccinators would be sanitary inspectors, smallpox vaccinators, compounders, etc. Heyward reported that in India, where this recommendation had been most widely adopted, there were now 100 local teams in the field, and the Indian authorities were targetting 200 more teams in 1952, and 200 more in 1953. UNICEF's main contribution would be in the form of transport because India was now manufacturing BCG vaccine locally, with WHO/UNICEF help.

:BCG accomplishments in Asia

BCG statistics soon led the way in UNICEF's reporting of beneficiaries. In his statement to the September 1954 session of the Board, Keeny said that a fresh cable from the UNICEF New Delhi office reported a July accomplishment alone of 1.7 million tests, "equivalent to 40 tests a minute around the clock throughout the month". But, in reporting these and other impressive achievements, he was careful to place UNICEF's contribution in a modest perspective, and to give credit where credit was due:

"UNICEF is proud of these achievements, and if we repeat the figures often enough we might convince ourselves that UNICEF has done most of the work. In fact, the main credit goes to the governments and especially to the local workers. It is little short of amazing that in the face of all the local difficulties that have to be met, annual targets for these major mass programmes can be forecast within 5 to 10 per cent. This means not only that many of the governments are taking extraordinary steps to find the necessary money, but also that the workers are generating and maintaining the enthusiasm that it takes to get these jobs done. Many of the teams are in the field for weeks on end, living in isolated places of the country, separated from their families, thankful if they have a dry suit after a day's work in the rain, and all too often with their pay or their allowances in arrears".⁷¹

Keeny also praised UNICEF's technical partners in health, the WHO staff working in the field. These 100 workers, noted Keeny, had shared the hardship of the mass campaign teams. "Until one has been out with these teams in the jungle for a few days, it is hard to realize just what this means. It means going to bed at dusk, or reading a little by candlelight under the mosquito net, with proper precautions lest you set the net on fire and spend the rest of the night with the mosquitoes. It means drinking your water warm... it means, in short, life in the rough".

Beginning with the Board session in March 1955, the various regions presented separate progress reports as part of the Executive Director's General Progress Report. Keeny was able to report that, for BCG, the 1955 target for Asia of 37.5 million tests would be close to the peak for this programme. The 275 teams now in the field in 11 countries of Asia would probably not expand beyond 300. Keeny added that, while the workers would have the benefit of growing experience, they would also have to "fight against the waning of enthusiasm that often takes place in extended mass campaigns".⁷²

Six months later, in the fall of 1955, Keeny noted that, "By the time this report is read, the cumulative total of tests in this Region will have passed the 100 million mark against a target in all current plans of operations of 182 million". The time had come, he said, to make definite plans for consolidation.⁷³

By the time the Board met in March 1960, the BCG programme in Asia had reached an astounding cumulative total of 236,000,000 tests and 85,100,000 vaccinations.

:With miles to go

But, lest UNICEF be carried away by these huge figures, the Executive Director noted that UNICEF's Asia region contained 800 million people, about two-thirds of them children and mothers; and that at least 30 million new babies were being born each year. Therefore, the BCG programme had reached "only" 236 million children; "at the present rate, the campaigns are barely keeping up with the yearly births...."⁷⁴

There were miles to go, and many more millions of children to vaccinate.

* * *

Anti-yaws campaign

If the BCG accomplishments were impressive, those for yaws — a debilitating tropical disease, exacerbated by bad sanitation — were equally if not more so. For, unlike BCG vaccination, where the preventive effects are not visually and readily apparent, one injection of penicillin into a yaws patient produced rapid, discernible results in the dramatic disappearance of the painful sores, which often covered the entire body and head. This was a vast improvement over the earlier, expensive and unreliable treatment with

arsenicals, and the UNICEF-assisted yaws programmes quickly caught on. As Keeny remarked to the Board in April 1952, "the difficulty was not so much to persuade populations to be treated but rather to curb their impatience".⁷⁵

Initially the cost of penicillin alone for treating a yaws case was very high: 75 cents, according to Heyward's April 1951 statement to the Board, prompting him to comment that the limited size of the health budgets would make it very difficult for the Governments to finance extensive campaigns on this basis.⁷⁶ However, Heyward also expressed the hope that, as a result of the mass campaigns which had already been initiated with UNICEF aid (including Indonesia and Thailand in Asia), the number of cases remaining for control would be so greatly reduced that it would be financially possible for the Governments to maintain control measures.

:Early and quick accomplishments in Asia

And that, indeed, was what was beginning to happen, helped enormously by falling prices for penicillin: only 43 cents per vial of 10cc in 1952, compared to \$1.50 in mid-1949 and \$3.00 in January 1949.⁷⁷ The number of yaws cases treated in Asia increased from 440,000 in 1952 to 727,000 in 1953 -- over two-thirds in Indonesia alone, according to Keeny's statement to the Board in March 1954. The achievement was more significant than it seemed because, in the most difficult programme of all -- Indonesia -- treatments doubled in 1953, and this despite the fact that, because of financial constraints, the public health budget had been cut within the last three years by more than one-third.

Keeny added that the Board's fears "that requests for more and more elaborate equipment will be made will be allayed by our experience in East Java, where some of the best work against yaws is being done. To fit their budget, they have asked for fewer jeeps and more motorcycles and bicycles".⁷⁸

By the fall of 1954, the Executive Director informed the Board that the three largest yaws programmes in Asia -- Indonesia, Thailand, and the Philippines, having 85% of the total population involved -- were really beginning to take off. Examinations during the first half of 1954 "leaped from 3.6 to 6.03 million -- an increase of 60 per cent. The cases treated rose from 330,000 to 676,000 -- an increase of 105 per cent. The target of 12.4 million (examinations) and 1.23 million cases treated in 1954 should be met in full".⁷⁹

All of the increase in volume of examinations took place in Indonesia, where a "simplified" strategy of fielding para-medical teams under the supervision of doctors was paying rich dividends in terms of achievements. Things were also going well in Thailand: when Danny Kaye came in 1954 to do a film with a sequence on yaws, the leaders of the yaws project were "proud that it was very hard to find infectious cases, so thoroughly had the teams done their work".⁸⁰

But it was not all smooth sailing. In the fall of 1955, Keeny reported that the big question in yaws was treating contacts in addition to active cases. WHO in April of that year had issued a special paper recommending this, on the grounds that treating active cases alone was not an effective way of controlling yaws in mass campaigns.

This, however, would require many things: getting higher initial coverage (WHO had urged 95 per cent compared with 85 per cent); changing government regulations to permit case finders also to do injections; retraining staffs in new routines; and, also, persuading people without any signs of the disease to accept injections — not an easy task (in Thailand, "about one third in a trial area have refused"⁸¹).

:Indonesia: a success story

In Indonesia, the method of work was based on repeated re-surveys and treatment of yaws cases by augmented polyclinic staff, with only limited treatment of direct contacts, as compared to the general WHO recommendation of "total mass treatment" (all the population) in areas of 10 per cent incidence or higher.

A potential crisis was avoided when Indonesia's programme was reviewed in the early part of 1956 by a world-renowned WHO expert in the field of treponemal diseases, Dr. C. J. Hackett, who found the methodology "completely satisfactory", and the careful planning and execution "a guide for yaws control campaigns elsewhere". These favourable findings were happily reported to the Board in the fall of 1956,⁸² and repeated in a further supporting statement by the Executive Director at the next session in April 1957. It was important to note, said Pate, that "from its origin the (Indonesian) campaign is connected with the permanent district health services, and in the consolidation stage, becomes integrated in them and serves to strengthen them".⁸³

Indonesia's success story is best summarized by Keeny himself, one of the key participants:

"In Indonesia, where there were more than ten million cases of the disease, Dr. Kodijat, one of the really great Indonesians, worked out a ... method which reached the people in their own villages. On the appointed day, case-finders (young men with high-school educations and three months of training in finding open yaws cases) came to the village. The headman then beat on his hollow log for the villagers to assemble. Everyone with yaws received a card. A few days later, the injector arrived, and the headman called in the card-holders by a special signal on the hollow log. Brown buttocks were bared, the needles flashed, and the job was done. One case-finder could examine more than one hundred persons a day this way, and an injector could treat many more than that.

By 1960, more than ten million persons had been cured. We did it in ten years. And there was no problem for the future because the clinics in those neighbourhoods, including the 'mantris' (male nurses) who were looking after the health of the neighbourhoods, had stores of penicillin. People knew what to do if a case came up in their village. They simply went to the 'mantri' and asked for a dose of penicillin that cured it. They literally wiped out the disease. It's almost nonexistent in Asia now, even in Indonesia."⁸⁴

As the decade of the 1950s drew to a close, the record for yaws in Asia was as follows:

Table IV⁸⁵

Yaws in Asia: achievements

	<u>1950</u>	<u>Cumulative end-1959</u>
Examinations	500,000	179,000,000
Cases treated	60,000	10,000,000

In addition to Indonesia which had the largest statistics, these figures also included beneficiaries from five small yaws campaigns in the South Pacific Islands. "All were remarkably successful, and on UNICEF's records are resolutions from councils of chieftains conveying the populations' appreciation..."⁸⁶

:Multiplier effect - success in yaws as an entry point

The significance of the successful prosecution of the anti-yaws programmes in the Asia region goes beyond the treatment of 10 million cases, important though that must have been for the vast numbers of individuals concerned, who were now able to lead normal lives. Having personally benefited from this combination of external (UNICEF-provided penicillin and other inputs) and internal (Government-provided personnel and local facilities) assistance, the people were more than willing to support other health measures. The success of the anti-yaws campaigns, in effect, resulted in the social preparation of the communities for the introduction of other measures, thus generating a multiplier effect.

In his statement to the September 1954 session of the Executive Board, Keeny had been noting all the things that had to be done to make the villages a healthy place in which to live -- fighting malaria, yaws, and tuberculosis, and tackling such difficult subjects as environmental sanitation. Just enumerating them, he said, was a discouraging job, but "we must remember that the tasks can be tackled one at a time. The first victory builds courage and confidence for the second fight". Keeny provided the following illustration:

"In June (of 1954), I visited a village in Indonesia to see the family of a little boy, Soestrino, whom I had first seen when he was shown to me as one of the worst cases of yaws the Indonesian teams had seen. He had been cured - and his father and sister. The headman in the village told me they had had 200 cases. At the moment they had none.... The headman was naturally proud of what his village had achieved. When I asked him what he could do about trachoma, his answer was, 'You show us how, and we'll do the job - just as we did with yaws'".⁸⁷

Keeny pointed out to the Board that there were a quarter of a billion children in Asia, which meant that UNICEF was providing only 2 cents per child per year; but "we can do much with little. Thirty cents from UNICEF will cure a case of yaws. A nickel's worth of DDT will protect a person for a year if we provide all - and usually we provide only half. The cost to UNICEF in India

for testing a child against tuberculosis costs UNICEF less than one cent and the government less than 3 cents. This is good value for the money of any contributing government, however thrifty".⁸⁸

* * *

Anti-malaria programmes

The Parran/Lakshmanan report had included a general recommendation for UNICEF support to regional malaria control demonstration projects, and Dr. Parran had the opportunity of amplifying on this to the Programme Committee in July 1948.

Dr. Parran suggested a block allocation of \$300,000 for malaria control demonstrations in Asia. He noted that malaria was an important cause of death among young children in all the developing countries. Since the war, it had been possible to develop new methods of malaria control, specifically through spraying with DDT, which made possible campaigns on a mass scale.

No one, at that time, could have foreseen that the malarious mosquito would prove to be such a difficult opponent; that it would develop resistance to DDT and diieldren; and that, to be successful in the long run, malaria eradication campaigns would demand a degree of organization and perfection reaching so close to 100% as to be beyond human accomplishment.

:Should UNICEF support programmes benefiting adults as well as children?

Prior to its approving \$300,000 for malaria demonstration projects, the Programme Committee had an exchange of views about the extent to which UNICEF should be committed to a campaign in which part of the supplies donated would be used for the adult population as well.⁸⁹ The Board in July 1948 had approved the recommended amount of \$300,000, but Heyward, after visiting Asia in the early part of 1951, and recalling the earlier discussion, addressed this point directly in his statement before the Programme Committee:

"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.... (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".⁹⁰

Heyward noted in this connection that, largely as a result of spraying operations, the infant mortality rate in Ceylon had fallen from 140 in 1946 to 87 in 1949. He added that 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 programme, UNICEF's contribution to the cost of malaria control would be one quarter. And, on that basis, the programmes went forward.

:Malaria demonstration projects in Asia

In Asia, out of the regional block allocation of \$300,000, five malaria demonstration projects were initiated in 1949 with WHO/UNICEF assistance, one in Thailand and four in different parts of India. These were evaluated by the WHO Regional Office for South-East Asia in 1952, following an interim report on initial operations in 1950.⁹¹

The 1952 review by WHO found that the project at Chiangmai, Thailand was "extremely successful. Not only malaria transmission has been interrupted, but a sort of elimination of vector species, A. minimus, almost amounting to eradication, has been accomplished by the exclusive use of DDT indoor spraying". The Terai project in Uttar Pradesh, India "has also been very successful.... In areas where the operations started in 1949, malaria transmission has been definitely stopped. In East Terai, where the operations started one year later (1950), a remarkable reduction has been achieved".

In the other pilot demonstrations in India (Jeypore Hill tracts of Orissa, Malnad area of Mysore, and Ernad in Madras), results were good. However, in another area, it was found that two years was not long enough for a successful completion of the demonstration, and absence or inadequacy of national understudy personnel was a problem in another.

:Large bilateral support for malaria in Asia

Nevertheless, on the whole, these demonstration projects had clearly proved the efficacy of DDT spraying for the control of malaria. In his Progress Report to Board at its March 1953 session, the Executive Director reported that the biggest event for malaria was the signing of the India-United States agreement to protect a population of 200 million over a 3-year period. UNICEF would help start this programme by releasing 400 tons of DDT until supplies from U.S. bilateral aid arrived. Meantime, India was pressing ahead with the construction of a DDT production plant, for which UNICEF had already shipped most of the equipment.⁹²

Moreover, U.S. bilateral aid was also taking over in Pakistan and Thailand, and Pate was able to state that "UNICEF is thus in the happy position of going out of the anti-malaria business in Asia, but with the important knowledge that UNICEF played an important role in starting mass campaigns".⁹³

UNICEF's contribution to the malaria cause in Asia did not, of course, cease abruptly. Equipment was provided for DDT production in Pakistan as well as in India. Support for the Burma malaria programme continued for a number of years, despite political difficulties; some insurgent-held areas even allowed the spraying teams to enter. Thus, at one point, Keeny told the Executive Board that "one insurgent group in Burma recently agreed to keep the peace while their area was being sprayed for malaria - and maybe longer, they promised, if the results were really good. It is just another form of matching".⁹⁴

UNICEF also provided assistance to several smaller programmes, including the one in Afghanistan. But by far the heaviest load for anti-malaria operations in Asia was carried by U.S. bilateral assistance. Enormous gains were achieved -- in India, for example, "eight years of the campaign reduced 100 million malaria cases a year to 80,000"⁹⁵ -- despite the later abandonment of malaria eradication as a global target, and a turning away from DDT because of its disastrous effects on the environment.

* * *

Fight against malnutrition

The Parran/Lakshmanan mission had identified malnutrition among children and mothers as one of the leading problems in post-war Asia, and the decade of the 1950s was characterized by large feeding programmes, based mainly on the availability of low-cost or free skim milk powder from the enormous surpluses of this commodity in the United States. In effect, it was a mass campaign against malnutrition, using one weapon only.

:Supplementary skim milk feeding

As the decade of the 1950s opened, supplementary skim milk feeding programmes were reaching around one million children and mothers in 15 countries and territories of Asia, rising sharply and temporarily in 1954 to cover emergencies in Korea (2 million beneficiaries) and Japan (1.6 million),⁹⁶ and remaining at a level of about 2.6 million beneficiaries as the decade closed.⁹⁷

Some of the programmes were for long-range MCH feeding; many, however, were for emergencies which afflicted the Asia region year after year. UNICEF's invariably quick responses reinforced its reputation as an organization which could be counted on under difficult circumstances -- a reputation which was to be tested to its limits, later on, in the agonies of Biafra and Indo-China.

The feeding programmes in Asia received their share of reviews and evaluations during the 1950s. All of them arrived at essentially the same conclusion: that, whereas skim milk feeding, whether emergency or long-range, undoubtedly helped children and mothers to fight malnutrition and hunger, it was based on a single, imported, manufactured product, and efforts should be made to find local, indigenous solutions to the problem of hunger and malnutrition which would be economical and acceptable.⁹⁸

:Search for indigenous solutions to malnutrition problem

The Board at its April 1957 session asked for ideas for new types of aid for child nutrition, agreeing with the Executive Director that "the majority of the malnourished children of the world cannot be fed on factory products and that a more fundamental solution lies in teaching the rural family, particularly the mother, to make the best use of available and possible local food resources".⁹⁹

Accordingly, extensive consultations were carried out in the summer of 1957 among the secretariats of FAO, WHO and UNICEF, resulting in the preparation of a number of recommendations which were placed before the Board in the fall of that year. These recommendations were designed to encourage governments to develop long-range, broad-scale programmes at the village level, and included the following five related measures:

- a) Nutrition surveys, to establish the facts on which practical programmes must be based;
- b) Training of local staff at various levels to carry out nutrition programmes;
- c) Broadened support to nutrition education at the village level, meaning simple, practical measures to be pursued through a variety of channels, including mothers' classes, schools, agricultural extension, adult education, etc.;
- d) practical nutritional activities in the villages, to provide some help to people to put into practice what they are learning about nutrition. Such activities would include vegetable gardens in schools, home, community development centres, etc.; fish culture where appropriate; small animal or poultry raising; home food storage and preservation demonstrations; and
- e) Limited vitamin supplementation, directed against deficiency diseases seriously affecting children and mothers.

All of these recommendations were endorsed by the Executive Board at its September 1957 session.¹⁰⁰ They were not new and had been supported by FAO and WHO; UNICEF involvement would help countries to apply them in rural areas.

A number of countries in Asia took advantage of this broadening of Board policy on nutrition, and as the decade drew to a close, the Executive Director was able to report many "firsts" to the March 1959 Board session, including the following:

- a) The first distribution to mothers and children of free milk from a UNICEF-assisted production plant began, and by year-end (1958) was exceeding its targets in Anand, India;¹⁰¹
- b) The first milk-substitute food (soya) from a UNICEF/FAO-assisted plant ("Saridele") was put into regular production, made available for free distribution through MCH centres, and was put on sale to the public in Indonesia, at a price one-quarter the price of imported dried whole milk;
- c) The first Asian seminar on school and pre-school feeding was held in Tokyo, sponsored by FAO and supported in part by UNICEF. This seminar emphasized inter alia that base-line data to guide nutritional programmes must be gathered, and that education would play a most important role. "Ignorance plays as great a part as poverty in bringing about the almost catastrophically low nutritional level of the region".¹⁰²

- d) First requests were developed for four new projects in the nutrition field under the new nutrition policies. These were:
- i) A proposal from India to extend poultry and fish culture and the cultivation of garden produce in the large Community Development programme;
 - ii) A proposal from Thailand to encapsulate shark liver oil, which is produced locally and is rich in vitamin A, for distribution to children and mothers;
 - iii) A proposal from Indonesia to train nutrition workers who will work directly with mothers and children in the villages;
 - iv) A proposal from the Philippines for UNICEF assistance to a major nutritional survey, which was approved in 1958, followed by a similar request from Indonesia.

Still, there was such a long road ahead. As the decade of the 1950s came to an end, the Executive Director commented, with regard to Asia, that "the problem of child malnutrition, increasingly recognized as probably the most important of all, has barely been touched; indeed, its true magnitude is not even known". Clearly, concluded the Executive Director, the "work of the last ten years has been only the beginning".¹⁰³

The search for answers or solutions to the problem of child hunger and malnutrition in Asia continues to this day. Many feel that the ultimate answer lies not so much in the nutrition field as in the political sphere, seeing a firm link between malnutrition and poverty. Others link malnutrition with economic development, contending that the coming of the latter will take care of the former.

While there may be a great deal of truth in both propositions, there is also general agreement that the world cannot just stand by and let children die of malnutrition while waiting for economic development to take place, or poverty to go away; and that, in this situation, UNICEF has an important role to play.

* * *

Maternal and child health

The building of a maternal and child health (MCH) service, as with the feeding programme, is not a single-purpose mass campaign against a particular disease such as yaws or tuberculosis. But, like the feeding programme, MCH may also be considered as an attack -- against ill-health, ignorance, and indifference, as well as against malnutrition.

:Linear expansion of MCH centres

Following World War II, with much of the health infrastructure devastated, many countries in Asia had to begin the laborious task of rebuilding and expanding their MCH services. When Keeny, in March 1950, wrote the first of his well-known and widely circulated Asia Regional Office (ARO) monthly reports, there were UNICEF allocations to equip 200 MCH centres. By the time the decade of the 1950s drew to a close, the allocation total had grown to 18,600, almost all for the rural areas, of which 12,200 centres had actually received UNICEF equipment by the end of 1959.¹⁰⁴

But, even by the mid-1950s when the total allocated had reached only 5,000, Keeny was already cautioning that, in the compiling of such statistics, their meaning was often lost. Again and again, in his verbal statements to the Board and through the pages of the Asia Addenda to the Executive Director's General Progress Reports, he reminded Board members about the various conditions under which the MCH centres were utilizing the UNICEF supplies and equipment. — whether they be situated "in the midst of rice fields, in jungle clearings, among the salt mines, under factory chimneys, in thatched villages, in mountain passes, in refugee camps".¹⁰⁵

:Training of MCH personnel

The Parran/Lakshmanan mission had given high priority to the training of health personnel, for which Asia's first mail poll had approved an amount of \$214,000 for overseas fellowships.

After this early allocation by UNICEF, other sources of fellowships became available from WHO and bilateral sources, and UNICEF virtually withdrew from offering fellowships for study abroad, except for fellowships at the All-India Institute of Hygiene and Public Health at Calcutta. UNICEF began to focus mainly on strengthening training activities within each country for their own nationals, for it was becoming increasingly clear that the lack of trained staff constituted one of the major obstacles to a more rapid expansion of the MCH network.

The heavy weight of tradition, in turn, constituted a major problem in recruiting girls and women for training as midwives or nurses. In Afghanistan, two daughters of the Prime Minister enrolled for midwifery training — one of whom had just delivered a baby at the time of one of Keeny's visits — "'all by herself'. When one considers the low esteem in which the occupation of midwife is held in this part of the world, it is hard to overestimate what the Prime Minister and his daughters have done by this example".¹⁰⁶

In 1951, a rough calculation of the pupil-months of training in UNICEF-assisted training schools showed only 3,400 in midwifery, 4,500 in nursing, and 550 in health visiting or public health nursing. By 1954, the numbers of pupil-months had jumped to 73,000 in midwifery, 31,700 in nursing, and 2,630 in lady health visiting, with an even more spectacular increase for 1955: 110,000, 33,700, and 4,870 respectively.¹⁰⁷

:All-India Institute of Hygiene and Public Health, Calcutta

The Board in 1950 had approved an allocation of \$930,000 to assist the All-India Institute of Hygiene and Public Health to upgrade and strengthen its Maternal and Child Health Department (the Calcutta Training Centre) on a fifty-fifty basis, with the Government bearing the construction costs and operating expenses, including fellowships; and with UNICEF providing supplies and equipment, plus some fellowships, reimbursement to WHO for technical personnel, and reimbursement to Government for some of the operating costs.

The intention was to develop the Training Centre as a regional and inter-regional centre, serving students from countries in Asia in addition to India as well as fellows from other regions. The graduates from the Calcutta Centre would not constitute a huge addition to the work force; rather, their contribution would be to enhance the quality of MCH services through their roles as administrators, teachers and supervisors.

The Certificate in Public Health Nursing (CPHN), a one-year course first offered in 1953, was very popular from the beginning, attracting the maximum number of Indian and non-Indian students (40) almost every year. However, the Diploma in Maternal and Child Welfare (DMCW), also a one-year course, was not so well attended, partly because the degree was not considered high enough to make holders of it eligible for leading positions in the health services of the Indian and other Governments. Other short-term orientation, refresher and seminar courses for various categories of health personnel, including epidemiologists, public health administrators, and health educators, for which UNICEF provided stipends, were highly appreciated.

Progress reports were submitted regularly to the Board, with a final report presented in June 1962, when UNICEF aid came to an end.¹⁰⁸

:Pediatric training at medical colleges

In April 1957, the Board endorsed a proposal by the Executive Director to extend its training policy in MCH by providing support to selected schools of medicine or public health, for periods of up to five years, to help them begin or strengthen the teaching of pediatrics (with special reference to social pediatrics), as well as preventive medicine.¹⁰⁹

India was to benefit the most from this policy. By the early 1960s UNICEF had provided assistance to 37 medical colleges to include pediatrics as part of their curriculum, and WHO assistance covered about 420 expert-months of service from visiting professors of pediatrics and pediatric nurse-educators during the period 1958-1962. UNICEF also provided aid in this field to Pakistan and Vietnam.¹¹⁰

:Training of indigenous midwives

At the other end of the hierarchy, i.e., the traditional midwife or birth attendant, known by various names in the region (hilot in the Philippines, mohtamyae in Thailand, dukun in Indonesia, and dai in India and Pakistan), UNICEF support to provide them with simple training in safe deliveries was a useful way of increasing the scope of the health centres.

By the end of 1957, the Executive Director took pleasure in reporting that, at least in one category — that of midwives — three of the countries (the Philippines, Burma, and Thailand) were within sight of having sources of supply great enough to keep pace with the development of services.¹¹¹ By the end of 1959, UNICEF had allocated more than 40,000 simple midwifery kits for this category of health workers, with over 30,000 issued.

The unit cost of these kits may have been relatively low for UNICEF, but to the midwives themselves, this item was precious and sought after. Keeny recalled visiting a rural clinic in East Bengal (now Bangladesh) by rowboat during the flood season, and asking the two traditional birth attendants there if they had attended the midwifery training courses.

"'Yes', they said. 'Did you like the courses?' I asked. 'What do you think? We were doing it on our own time and at our own expense — if we didn't like it, we wouldn't have gone,' they snapped back. They had already gained their midwifery kits and were very proud of them. I had approved the issue of tens of thousands of these kits, but only then did I see fully what it meant to get them into use".¹¹²

Keeny in his oral statement to the Board in March 1955 noted that the new simplified kits devised by UNICEF ("cheap and practical") had been generally well received. The whole question of instructing local midwives, however, had raised a great deal of discussion about the usefulness or even desirability of helping this type of worker. "In theory she should not exist, but in practice she delivers at least three-quarters of all the babies born in Asia".

"In my judgment," continued Keeny, "UNICEF has done a real service in encouraging a re-examination of her place in the health services of Asia. More and more it is being agreed that she should be encouraged, however informally, to establish working relationships with a health centre, and we all agree that she should be given instruction on how to prevent infections".¹¹³ Today, traditional midwives everywhere in Asia continue to perform essential services in the rural areas.

:MCH: from linear expansion to network of health services

By the mid-1950s, as the mass disease campaigns hit their peak, there was a gradual shifting of emphasis to MCH programmes, which were now taking about one-third of the allocations for Asia (in 1956, MCH was \$12,409,000 out of \$37 million¹¹⁴).

In his General Progress Report to the April 1957 session of the Executive Board, the Executive Director analyzed the development of MCH as occurring in three stages, the starting point being the opening of separate MCH centres, often with voluntary agencies and other local initiatives. In the second, and present (1957) stage, efforts were being made in many countries of the region to organize these MCH centres into a network of rural health services. The third, and coming, stage would be "to join them with community development so that the improvement of food production and nutritional practices, housing and education of the mothers and other social activities make a convergent attack on the main factors retarding the development of the child".¹¹⁵

India was the first country in Asia to reach this third stage. For the March 1958 Board session, the Executive Director reported that UNICEF would be assisting India's health efforts by equipping 1,160 primary health centres, each with 2 or 3 sub-centres; 138 hospitals, and 101 laboratories. This network, built into the country's extensive Community Development programme, was expected to bring essential health services to areas inhabited by a population of about 75 million people, or 22 per cent of the population of India at that time. "For the first time, the developments in basic MCW services have out-paced the campaigns against communicable diseases".¹¹⁶

The Executive Director also noted that MCH supervision was improving. "Three years ago there was practically no supervision of nurses or midwives in the field, only what could be done as a side-line through field inspection visits. In 1957, at a rough estimate, 20 to 25 per cent of the UNICEF-assisted centres were under direct supervision, and in 1958 this will probably increase by another 10 per cent. The countries having made the biggest advances in this direction are India, Indonesia, Thailand, and China (in Taiwan)".¹¹⁷

* * *

Emergencies

The decade of the 1950s saw UNICEF gradually changing from an agency with a major preoccupation with emergency aid to one devoted to the long-range needs of children, but that did not mean that UNICEF would no longer respond to emergency requests; quite the contrary.

Thus, the decade opened with emergency assistance being provided to children and mothers in Korea, resulting from the outbreak of hostilities in June 1950. The Board had previously allocated \$550,000 for MCH and immunization programmes, but in view of the warfare in Korea, these long-range projects had to be suspended, and the funds were spent instead on relief supplies.

UNICEF's reputation for speedy action was enhanced when 180,000 blankets out of a requirement of 300,000 were purchased and booked for shipment to Korea from the United Kingdom, Belgium, France, Switzerland, and South Africa within eight days of the receipt of the request on 2 October 1950. Also, 150 tons of skim milk powder were actually "aboard vessel and enroute to destination" within seven days of the receipt of the request.¹¹⁸ And, still in October, 100,000 lbs. of soap were shipped by UNICEF from Australia to Korea.

Other emergencies included the unprecedented floods which took place in India and Pakistan during the latter half of 1955. UNICEF supplies of skim milk for both countries (plus rice and drugs for India) were among the first to reach the stricken areas, thus demonstrating once again "the importance of holding emergency stocks in the country".¹¹⁹

The decade closed with allocations amounting to nearly \$250,000 for emergency assistance to the victims of typhoons in Japan, Korea, and China (Taiwan), in contrast to the preceding two years when UNICEF had not been called on to do any emergency aid to Asia.¹²⁰

* * *

Summary

In the 1950s there was a major preoccupation in Asia with (a) implementation of the huge mass campaigns against tuberculosis, yaws, and malaria, as well as with feeding programmes, many of them for emergencies; and (b) quantitative expansion of the MCH network so that, when the mass health campaigns eventually reached their conclusion, the regular health services would be able to take over.

The first objective -- the planning and execution of mass campaigns in health -- was successfully achieved, due to a combination of circumstances:

- a) In yaws, the mass campaigns would not have been possible without the significant drops in the price of penicillin. Also, treatment with penicillin yielded results dramatically, immediately -- and visibly;
- b) Control measures against malaria were also yielding good to excellent results;
- c) The local governments were willing to cover the salaries of local staff and other expenditures needed for the mass campaigns, a very important factor in view of the constant budgetary constraints;
- d) The local staff, despite heavy schedules which often took them away from home for long periods at a time, heartily cooperated;
- e) On the UNICEF side, the inspirational leadership of Sam Keeny drew the best from his field staff.

In other words, it was truly a team effort of considerable magnitude.

However, the second objective for the decade, that of expanding the regular health services so that they could take over when the mass campaigns were completed, proved to be more difficult. Among the many problems facing the countries in Asia were two basic dilemmas: should they appoint additional personnel to improve the quality of existing services, or start new services where the people were not getting any help at all? Also, should they give short-term training in order to produce MCH personnel as quickly as possible, or lengthen and strengthen the training to produce fewer but better-qualified personnel?

Keeny, reflecting on these and other problems at the March 1953 session of the Board, felt that truly long-term planning would be essential. "We shall all look forward to the happy day when the village, to which our thoughts constantly return, will, as a matter of course, be protected from disease by prevention wherever possible, but by cure when necessary; when they will be free from malaria, from yaws and from trachoma and tuberculosis; and when their water and food will be protected from contamination. For some diseases, such as with malaria and yaws, this step will be a matter of a few years; at other times it will involve a plan that is nearer 50 years than 5 -- but the plan will have to be made and we shall have to stick to the job".¹²¹

Keeny's 1955 forecast of the need for a 50-year perspective has turned out to be more true than perhaps even he could have imagined, as UNICEF today works towards various targets which now touch the year 2000.

But, during the 1950s, the UNICEF staff in Asia were not thinking about the year 2000. They were largely engaged in tasks which, to many, were mundane and ordinary: planning, programming, and delivering supplies, equipment, and transport. No matter; to the UNICEF field personnel in Asia at the time, in no way could there be any sense of detachment about this supply function.

UNICEF supplies constituted the lifeline of support for needy children and mothers: skim milk powder for feeding; penicillin for yaws; DDT, sprayers, and vehicles for malaria; BCG vaccine, needles and syringes for BCG vaccination. Almost everything the UNICEF staff touched, touched a needy child or mother, visibly and directly. Ordering BCG vaccine or penicillin was not just a paper exercise; it was part of an important process of actually helping someone in need at the village level. And, because regular field visits to the villages was a standing order of Keeny's, one which quickly became a staff obsession, actually touching and helping a child, many children, became the means by which the UNICEF staff in Asia, already highly motivated, could articulate their idealism of service to an organization dedicated to helping children everywhere.

It is in that sense that the decade of the 1950s, the Keeny decade, was such an exhilarating one for the UNICEF staff in Asia.

* * *

THE TRANSITION YEARS: 1960-1970

- 46 -

BLANK BACK

Introduction

There were many highlights for UNICEF during the decade of the 1960s, and being awarded the Nobel Peace Prize late in 1965 was arguably the most significant of all. The only sad note was the passing of Maurice Pate early in 1965, for there was no doubt in the minds of many that the award was really intended to be a personal honour for the first Executive Director of UNICEF, who had served the organization so wisely and so well. Spiegelman records that, several times, "admirers wanted to nominate Pate for the Nobel Peace Prize. He would reply: 'No, not for myself alone. It's UNICEF -- our whole dedicated team, whom I'd like to see get the award'".¹²² And that, indeed, was what happened.

Henry R. Labouisse, Pate's successor, received the Nobel Peace Prize on behalf of UNICEF in December 1965.

* * *

From supply to planning: the beginnings

For Asia, as for the other UNICEF regions, the decade of the 1960s was a period of transition and challenge.

The mass disease campaigns continued to fight their gallant fight against tuberculosis, trachoma, malaria, and yaws; the feeding programmes continued to reach millions of needy children and mothers; and the MCH network continued its linear expansion, slower here, faster there. But, out of all this experience, a new perception of the child was beginning to emerge: that his needs could not continue to be compartmentalized into neat mass campaign or MCH boxes, but were interrelated and interdependent; that his needs must therefore be tackled on a comprehensive basis; and that the child must not be seen in isolation, but as an integral part of the family/community/nation.

The Executive Board had said as much in 1959, as the decade of the 1960s was approaching, when it called attention to the interrelationship of the needs of children arising from hunger, disease and ignorance, and also to its corollary, "namely that concentration of effort on one of those evils to the exclusion of the others had proved less successful than efforts to attack those interrelated ills together".¹²³

Such a concerted attack, however, would require careful planning. It would also mean mobilizing more resources; and, for that, the national planners would have to be convinced that investing in the non-productive young child had a real economic pay-off in the long run. The problem was that, in the short run (which was all the time), other more pressing problems tended to push the social sectors into a perpetual state of lower priority.

The decade of the 1960s, therefore, was characterized by the beginnings of UNICEF's efforts, which continue to this day, to have the needs of children accorded their rightful place in national planning, not out of a sense of compassion, but in explicit recognition of the economic and child development benefits of investing in this young human resource called children.

If UNICEF's efforts were to succeed, there would need to be a basic change in everyone's perception of the place of children in development and, hence, of UNICEF: by the governments, recipient and donor; by UNICEF's sister UN agencies, which worked in close collaboration with UNICEF in a wide variety of programmes; by the public at large, whose support was vital for maintaining UNICEF's solid reputation; and, last but not least, by the UNICEF staff itself.

Several major events in the UN system during the 1960s provided the basis and stimulus for UNICEF's gradual evolvement from a predominately emergency aid and supply agency to today's position as a full-fledged partner in the international development system, maintaining an emphasis on children.

:UN Declaration of the Rights of the Child

The UN General Assembly in November 1959 adopted the Declaration of the Rights of the Child (resolution 1386 (XIV)) which re-affirmed, in its oft-quoted preamble, that "mankind owes to the child the best it has to give". The General Assembly at the same session also recognized that UNICEF constituted a practical channel for countries to carry out the aims proclaimed in that Declaration, and urged all governments to contribute to UNICEF as generously as possible, considering the magnitude of the many needs as yet unfulfilled (resolution 1391 (XIV)). It was therefore natural that the UNICEF Executive Board, at its session in March 1960, should be seized of the matter.

:Survey of children's needs: prelude to country approach

Ten years had elapsed since UNICEF shifted its major emphasis from emergency relief to aid for programmes of long-range benefit to children in developing countries. Would it not be useful now, with the Declaration of the Rights of the Child as an important back-drop, to undertake a systematic survey of children's needs, on a global basis, to help determine the future orientation and scope of UNICEF aid?

Charles A. Egger, Deputy Executive Director (Programmes) from 1967 until his retirement at the end of 1981, has credited two senior UNICEF staff members, Dr. Georges Sicault (who served as Deputy Executive Director for Planning and later as Director for Europe), and E.J.R. Heyward, Deputy Executive Director for Operations, for proposing this "bold initiative in launching a world-wide survey of the needs of children with the close collaboration of the developing countries and the technical agencies of the UN."¹²⁴

The far-reaching results, he added, were not foreseen by many: the intensive Board debate generated by UNICEF's offer to assist in such surveys, as recommended by the Executive Director and endorsed by the Executive Board at its June 1961 session, resulted in producing the concept of the "whole child", whose needs were interrelated and could no longer be considered as being separate or apart from the family and community.

It also led to the development of the concept of the country programming approach, involving analysis of the main problems of children in a country and the possibilities of action. Both of these concepts constituted key elements in the evolution of UNICEF's thinking about the place of children in national planning and in its own cooperation with countries.

:UN's First Development Decade

The UN General Assembly in December 1961 declared the 1960s as the "United Nations Development Decade", thus providing the UNICEF Board at its June 1962 session with an opportunity to continue and intensify the consideration of UNICEF's role in that decade, including the question of planning for children in national development.

After extended debate, the Board adopted a "Declaration on a Long-term Policy for Children in Relation to the Development Decade",¹²⁵ — another step in the direction of UNICEF's involvement in planning for the needs of children.

The Board at its 1962 session also authorized the Executive Director to enter into a dialogue with the UN regional economic commissions, and in the course of those discussions, the idea of holding regional seminars on the needs of children was mooted. The Executive Director reported to the June 1963 Board that he was exploring the idea of holding a round-table meeting in advance of these regional seminars in order to develop broad lines of further work.¹²⁶ Thus was born the Bellagio Conference, an outstanding landmark in the evolution of UNICEF policy, which took place in April 1964.

:Bellagio Conference on Children and Youth in Development Planning (1964)

The Round-Table Conference on Children and Youth in Development Planning, sponsored by UNICEF in cooperation with the UN Department of Economic and Social Affairs and the specialized agencies, was held at Bellagio, Italy, in April 1964. Egger has described Bellagio's rationale and the high calibre of the participants as follows:

"UNICEF wanted to be considered a serious partner in overall development, but the economists and planners were not yet prepared to accept this. UNICEF took the initiative to advocate these ideas in special gatherings, starting with the ground-breaking meeting in Bellagio, Italy, in the spring of 1964, where for the first time eminent child specialists and paediatricians, like Professor Robert Debré of France, and welfare administrators such as Ludovici Montini of Italy came together with economists, planners and researchers such as V.K.R.V. Rao of India, Jan Tinbergen of the Netherlands and Ahmed Ben Salah of Tunisia, to analyse and discuss this new dimension of a better preparation and protection of children in planning, teaching and research".¹²⁷

The Bellagio Conference, along with the national seminars which followed, contributed greatly to awakening the conscience and interest of senior decision-makers, planners and others to the importance of this hitherto

neglected resource. A key person in UNICEF's follow-up and extension of activities for what was called "planning for children in national development" was Edward Iwaskiewicz, Deputy Executive Director for Planning. He was later succeeded in this work by Tarlok Singh.

The Conclusions of the Bellagio Conference were considered by the Board which met in June 1964. These Conclusions, in retrospect, may appear to state the obvious, but at the time they were quite revolutionary, and indeed are very much applicable today. Thus, the Conclusions:

- a) Affirmed "the necessity of ensuring that the needs of children and youth are given adequate consideration in the national planning of developing countries;
- b) Recommended that each country, "whether or not fully equipped with data and planning machinery, should develop a national policy for its children and youth";
- c) Urged — whatever the degree of development of the country — "periodic and systematic assessments of the situation of children and youth... in order to determine the most important problems, to evaluate the results of previous actions, and to select logical points on which to concentrate";
- d) Recommended that "Planning for the interests of children and youth would be aided by the expression and stimulation of public awareness through a national group composed of governmental as well as non-governmental leaders";
- e) Recommended that "The organization of planning for the needs of children and youth should be co-ordinated at an inter-ministerial level and in the planning commission"; and
- f) Urged positive thinking by stating that "Insufficient quantitative data need not preclude a programme of action".¹²⁸

After Bellagio, there was no turning back: UNICEF was firmly embarked, in its own right, on the long and difficult, but rewarding, road to help countries in national planning for the needs of their children and youth, and to become the main advocate for this in the international community.

Bellagio by itself, of course, was only the first step. It, in turn, generated a number of regional conferences, the first of which was held in Santiago, Chile for Latin America in November/December 1965. The next one was the Asian Conference on Children and Youth in National Development, held at Bangkok from 8-15 March 1966.

Just as the Bellagio Conference constitutes a landmark in the evolution of UNICEF's global policy, so does the Bangkok Conference represent a watershed for Asia in changing attitudes and refocussing thinking about the place of children in national development planning.

:Bangkok Conference on Children and Youth in National Development

The Asian Conference on Children and Youth in National Planning and Development, jointly sponsored by UNICEF, the Economic Commission for Asia and the Far East (ECAFE), and the Asian Institute for Economic Development and Planning, and with the cooperation of the UN Department of Economic and Social Affairs, ILO, FAO, UNESCO, WHO, and the World Bank, was held in Bangkok from 8-15 March 1966. A preliminary report was made available to the May 1966 session of the Executive Board.¹²⁹

Seventeen Asian countries submitted case studies or national reports, and 14 universities and other national institutes contributed in one way or another in the deliberations. There were altogether 112 participants, not counting representatives from the UN agencies.

The extensive documentation produced proved to be useful to government officials, universities, and the professional community. The Report of the Asian Conference was made available in English, French, and Spanish, and several sociological and economic development journals requested permission to publish specific papers.¹³⁰

The theme of the unity of children's needs was emphasized by Heyward at the Asian Planning Conference, when he observed that the social services which the participants had been looking at were "complementary and mutually reinforcing. For example, education services need the help of the health services and of the midday meal. Health services are in turn helped by education, especially the education of women".

Heyward also observed that, in looking at the cycle of growth of the child, "There seems to be a very general phenomenon that much more is done at the stage of childbirth and infancy, and much more is done at the school age; but much less is done at the pre-school age, and much less is done at the age of school-leaving. The reasons for this are simple enough - it is harder to reach the pre-school child, it is harder to reach the school-leaver or the child who is not in school".¹³¹

As for economic measures affecting children and youth, Heyward noted that new job opportunities being created in development plans were in urban areas rather than in rural areas; and that, in the rural areas where most of the populations of Asia still lived, traditional agriculture was being transformed, requiring knowledge of modern techniques and inputs -- and hence more education and training.

What UNICEF was attempting to do at this Asian Planning Conference was to stimulate thinking on the essential place of children and youth in national development planning, and the measures which would be required to implement policies directed at improving their situation. The Asian Conference itself did not yield many on-the-spot answers, nor was that the intention.

:National conferences on children and youth

One important result, however, was the decision by many of the Conference participants to hold national-level seminars on planning for the needs of children and youth in their respective countries, and indeed a number of national conferences were held later on, each one of which represented a significant step in the evolution of thinking about planning for the needs of children, and about UNICEF's role in that process. As the Executive Director was to remark later to the May 1973 Board, "Perhaps the most significant feature of these (national-level) conferences was that they brought together, often for the first time, people professionally concerned with development planning and those concerned with programmes more specifically for children".¹³²

However, in the beginning, UNICEF was still tied to sectoral ministries of health, education, and social welfare, through specific projects in those fields, not to economic development or planning ministries. The national conferences on children and youth, therefore, represented pioneering efforts in the 1960s to promote UNICEF's added role as advocate for children's needs.

Pakistan held the first such national conference in August 1969, followed by Indonesia in October 1969. These were truly national in nature; UNICEF staff attended only as observers.¹³³ Five more national conferences were held in the following year (China (Taiwan), Malaysia, the Philippines, Korea, and Thailand), making seven in all for the East Asia and Pakistan region.¹³⁴ They differed in coverage, choice of subject matter, and attendance, but each one helped in its own way to advance the cause of national planning for children.

In some countries, national surveys of the needs of children and youth were carried out in lieu of, or pending a decision on, holding a national conference. Thus, in Laos, a consultant from the French Société des Etudes pour le Développement Economique et Social (SEDES), financed by UNICEF, prepared a study on "Children and Youth in the National Development of the Kingdom of Laos" which was accepted with "great satisfaction" by the Commissioner of Planning.¹³⁵

To enhance awareness among national planners and other officials of the role of children and youth in national development, UNICEF in association with ECAFE and the Asian Institute for Economic Development and Planning sponsored a Seminar for Planners in Bangkok in July 1967. Twenty government officials concerned with the planning of programmes benefiting children and youth in 15 Asian countries attended.¹³⁶

Also, as a follow-up to the Asian Conference's call for better statistics on children and youth for planning purposes, UNICEF and the Statistical Section of ECAFE initiated a joint project in 1967, one objective of which was to prepare a supplement on children and youth to the ECAFE Statistical Yearbook.¹³⁷

:The example of India

The proof of the pudding, as they say, is in the eating; and the success of these national conferences and other efforts, regardless of how stimulating they may have been for the participants, must reside in the allocation of more resources for child development. The Executive Director was able to report on one such favourable development in 1967; this was in India, which had participated actively in the Asian Planning Conference:

"This evidence lies in the fact that the funds budgeted by India in its fourth Five-Year Plan beginning in 1967 are double what was budgeted for social welfare in the preceding plan. A substantial part of the India social welfare budget is earmarked for the extension of family and child welfare services, with special provision for the young child in rural areas. In parts of India there is also a growing interest in pre-school education of young children. This is a dramatic development in a country facing so many urgent problems as in India".¹³⁸

In most of the other countries of Asia, however, the health and social welfare sectors had to struggle to maintain a minimum level of services, for they were quite often the first to be cut in times of financial crises.

:National development plans

Almost every country in the region had a national development plan by the mid-1960s. Although these varied widely in content and focus, ECAFE noted that almost all of them had one common characteristic: "the enlargement of welfare and the promotion of social justice for the population at large.... Rapid economic growth is looked upon as a major means to these ends, rather than as an end in itself. Thus, social betterment is conceived as the central justification for all development planning."¹³⁹

However, there was also the feeling, as noted by the Executive Director in his progress report to the June 1968 session of the UNICEF Board, that such statements were often "lip-service" only, and that economic development still received the major attention of the planners, with social policy content remaining pretty sparse.¹⁴⁰ Nevertheless, the struggle for greater recognition of young human resources as an economic factor in development -- the only language that the planners recognized -- continued through the 1960s. It still goes on today, in varying degrees, in many countries.

:The example of Indonesia

UNICEF in the 1960s was beginning to augment its sectoral ties by opening up dialogues with government planning commissions or departments, and these in the long run proved to be of enduring value. They also represented an exciting enlargement of UNICEF's scope to include national planning for children as well as project planning for action at the village level. But, in the beginning, it was not easy.

In Asia, for example, Martin Sandberg, an experienced staff member who has held a number of senior posts in the organization, recalled his first contact in the 1960s, as the UNICEF Representative for Indonesia, with a member of

Government's National Development Planning Board known as BAPPENAS. It was "perhaps typical of what can happen when, in those days, a UNICEF worker and an economist met: they seemed poles apart. The smiling Javanese professor looked at me, first with some puzzlement, and then it dawned: 'Oh yes, UNICEF, that lovely organization that gives milk to children'".¹⁴¹

It did not take long, however, for Sandberg to develop and maintain a close and cordial working relationship with BAPPENAS which was wholly in accordance with UNICEF's broadened mandate in the field of planning as endorsed at Bellagio. Sandberg also found kindred spirits in the representatives of the World Bank and UNDP in Indonesia; together, they worked in harmony for the good of the children in the country, eschewing any bureaucratic worries about jurisdiction. His Indonesia posting, recalls Sandberg, was "the most fascinating, constructive and satisfying one I had in UNICEF.... One had a real sense of achievement".¹⁴²

* * *

Organizational changes

Considering the large numbers of countries and huge populations now being covered in Asia, the workload involved in continuing UNICEF support to the "regular" programmes of mass campaigns, feeding programmes, and MCH services, plus these new dimensions of planning, was proving to be too heavy for one regional office in Asia to carry. It was decided to create another UNICEF region for Asia.

:Two regional offices for Asia

The Asia Regional Office (ARO) in Bangkok, heretofore covering everything from Afghanistan to Korea, was to "lose" India, its biggest country (along with, at that time, Afghanistan and Ceylon) to an upgraded New Delhi office, to be re-designated as the South Central Asia Regional Office (SCARO). ARO would become the East Asia and Pakistan Regional Office, or EAPRO.

This change was approved by the Executive Board at its January 1961 session,¹⁴³ with the actual split taking place a little later. Beginning in 1964, the Board received two programme progress reports on Asia — one from the regional office in New Delhi, and another from the regional office in Bangkok. UNICEF's Asia would never be quite the same again.

:South Central Asia Regional Office (SCARO) in New Delhi

Glan Davies headed up the India office when it was a country mission and then an area office — from 1950 to 1961. Charles Egger was the South Central Asia Regional Office's first Regional Director (1961-67), followed by Gordon Carter (1967-74) and John Grun (1974-76). Glan Davies returned to India as Regional Director in 1976. David P. Haxton succeeded him in 1980.

SCARO's outreach from an original three countries (India, Afghanistan, and Ceylon, or Sri Lanka) now also includes Bhutan, Maldives, Mongolia, and Nepal. Its name has also been changed; it is now the Regional Office for South Central Asia (ROSCA).

:East Asia and Pakistan Regional Office (EAPRO) in Bangkok

As for the East Asia and Pakistan Region (EAPRO), Sam Keeny retired as Regional Director towards the end of 1963 and joined the Population Council; he was succeeded by his deputy, Brian Jones. He in turn was followed by Yehia Darwish (1969 to 1974); Roberto Esquerra-Barry (1974 to 1980); and Titi Tanumidjaja Memet (1981 to 1983). Ahmed Mostefaoui took over from Mrs. Memet in 1983.

The East Asia and Pakistan Regional Office is responsible for Bangladesh, Brunei Darussalam, Burma, the Democratic People's Republic of Korea as well as the Republic of Korea, the Territory of Hong Kong, Indonesia, Kampuchea, the Lao People's Democratic Republic, Malaysia, Pakistan, Papua New Guinea, the Philippines, Singapore, Thailand, Viet Nam, and the countries of the Pacific.

:Country offices

A third tier in the UNICEF administrative structure is the country office. The traditional organizational chart places Headquarters at the top of the pyramid, the regional offices in the middle, and the country offices at the bottom. Increasingly over the years there has been a recognition in UNICEF's programming concepts that the real emphasis lies the other way. The country offices are in closest touch with what is happening to children and mothers at the village level, and it is here that the essence of UNICEF's work is carried out by the country offices, supported by the other two tiers.

In Asia, the small handful of country offices in 1949 (Pakistan, India, Indonesia, and the Philippines) has gradually evolved into a substantial network which, today, stretches from Afghanistan to Korea. Each office has a mixture of international and local (professional and general service) staff, the latter serving to provide among other things the indigenous knowledge of local customs and procedures, peoples and politics, so essential to the proper functioning of the UNICEF-assisted projects and programmes.

:And sub-offices

As for sub-offices or outposting of staff within a country, China in the early years of 1948-49 led the way by stationing international and local staff in each of the six cities where the feeding programme was being implemented; albeit briefly. Today, state, district, and other sub-offices or outpostings may be found in a number of field offices in Asia, enabling UNICEF to operate ever closer to the local governmental entities and beneficiaries they were established to serve. The case of India is illustrative.

As far back as 1967, the Executive Director informed the Board that proposals were being formulated to have the UNICEF India office decentralize some staff to the field level. "This would imply working in close liaison with the States as much as with the Central Government...."¹⁴⁴

Eventually, a number of Zone Offices were established in India, including Bombay for the western part, Calcutta for the east, Madras for the south, and several others, including one in New Delhi (physically separated from the Regional Office) for middle and north India (MNIO). Sub-offices were later attached to some of the Zone Offices. Thus, for the MNIO office, sub-offices were opened in Jaipur for Rajasthan; Bhopal for Madhya Pradesh; and Chandigarh for the Punjab, Haryana, and Himachal Pradesh.

This decentralized set-up in India enabled the field staff to function much more closely with the programmes themselves, serving as an effective channel for relaying needs, formulating solid project and programme proposals, and conducting observations and discussions at State, District, and local levels.

UNICEF, of course, was careful to keep the Central Government in the picture, although time lags were sometimes inevitable in an operation as large as the UNICEF one in India.

For example, the District Collector for Dewas in Madhya Pradesh, an energetic, dynamic young woman by the name of Mrs. Alka Sirohi, had with strong UNICEF support proceeded with an immunization campaign against polio, DPT, and tuberculosis, despite some queries from the State Government as to how she could be negotiating directly with UNICEF (in her case, with the Middle and North India Zone Office).

By the time the query had made its way through channels to the UNICEF Regional Office in New Delhi, the campaign (through an innovative decision by Mrs. Sirohi to hold a fourth or "mop-up" round) had achieved an excellent 76 per cent coverage of three completed shots in polio, as well as good accomplishments in DPT and BCG vaccinations; and the State Health authorities themselves were soon talking about a State-wide immunization campaign.¹⁴⁵

The Dewas experience in immunization in a rural area stimulated a similar pilot project (also assisted by UNICEF) in two urban slums of New Delhi in 1983. By applying the same approach of social mobilization, drawing on local resources and personnel, coupled with computer tracking of drop-outs, the urban project was able to achieve a record of over 90 per cent of completed vaccinations (three shots) in DPT and polio, plus BCG -- an outstanding achievement. Both of these experiences helped to set the stage for the launching of the current nation-wide immunization programme.

* * *

Executive Board session in Bangkok, January 1964

Another outstanding UNICEF highlight in Asia in the 1960s was the holding of an Executive Board session in the region.

The Board session in Bangkok, Thailand, which took place in January 1964, was notable for several reasons, not the least of which was that it was the first time the Board had met in a developing country. And, because it was to be

held in Asia, it was only natural that the Board should place on its agenda the question of the needs of children in Asia. This decision had many spin-offs.

:Focus on Asia

First, the Governments of India, Indonesia, Iran, Pakistan, the Philippines, and Thailand each invited a small group of delegates to the Board (in the case of India, two groups) to observe at first hand the problems concerning children and youth in their respective countries, and the efforts and programmes they were making to solve those problems. These visits took place a week before the opening of the session in Bangkok, and each group later reported on its observations to the full Board. This experience with pre-Board field trips was so successful that it was adopted for subsequent Board sessions held in developing countries, including the ones in Addis Ababa in 1966, in Santiago in 1969, in Manila in 1977, and in Mexico city in 1979.

Secondly, the Bangkok Board session generated an enormous amount of documentation on the situation of children and youth in Asia, beginning with the projects which the Board members had visited before the session began. Briefing reports were prepared by the host countries on different subjects: India, applied nutrition; Indonesia, rural MCH and yaws; Iran, malaria; Philippines, family and child welfare services; and Thailand, education.

At the macro level, the Economic Commission for Asia and the Far East (ECAFE) prepared a paper dealing with the growth of national income, food supply, and the demographic situation in the ECAFE region. ILO, FAO, UNESCO, and WHO also prepared reports, and from all of these documents, the following profile of Asia in the early 1960s emerged:

- a) More than half of the world's population lived in this region, about 40 per cent of whom are children under fifteen years of age. The children in Asia, which numbered about 650 million in 1960, would reach nearly 1.5 billion by the end of the century. Also, the age structure was such that it produced a high dependency ratio: 84 dependents to 100 productive persons in most countries of Asia. The Executive Board in its report on this session noted that the Asian Population Conference had considered this demographic situation at its New Delhi meeting in December 1963, and had recommended to the Governments of the region that "each should decide what kinds of action should be taken to moderate population growth...."¹⁴⁶
- b) While the population in Asia constituted over half the world's population, they lived on only about a quarter of the world's total food supplies. With few exceptions, the countries of Asia had not improved their nutrition levels in the past two decades, and were barely holding their own. Children, particularly the very young, were the most vulnerable, and among them there was widespread under-nutrition and malnutrition.
- c) In health, most of the countries in the region lacked the kind of basic health infrastructure that was needed to provide a minimum level of preventive health services to the peoples of the rural areas, and in many instances to those in the urban areas as well.

- d) Primary school enrolment in Asia in 1960/61 as a whole was below one-half the target set in the Karachi Plan. "But the actual situation is worse than this, because many students attend school only briefly, and the quality of education in primary schools is often poor. Teachers may be ill-trained and overworked, the curricula obsolete, the classes crowded, the buildings inadequate and the textbooks scarce. Poverty, malnutrition, ill-health and the indifference of parents towards education are common factors retarding the education of children".¹⁴⁷

:The unity of children's needs in Asia

The Executive Director, Maurice Pate, drew from all of the reports one major, unifying conclusion. He emphasized the interrelatedness of the needs and problems which had been presented, and the consequent necessity to devise policies and programmes which would cover the whole complex of needs of children and young people.

Specifically, looking at the "growing child of Asia who will become the adult citizen of tomorrow, we find how futile it is to try to deal separately with his physical, intellectual, emotional and social needs. To look at the child and the school, what use is it to send a sickly, malnourished child to an ill-equipped school with an untrained teacher? The child's health and nutritional needs must be taken care of at the same time as the school system is improved".

Pate went on to ask: "how can child labour be controlled if there are not enough schools, if the school does not really help prepare the child for life, or if the family does not care? This reminds us that the approach to the child, while a special approach with a particular focus, is through the family -- and through the community".

This interrelationship of child and community, continued the Executive Director, "is again dramatically evident in considering his health: the child, the mother, the father, the teacher are all exposed to the same diseases and drink the same contaminated water. Wherever we touch the child, therefore, we are led to his social, cultural and physical environment; and we must keep this environment in mind when planning for children".¹⁴⁸

These comments were typical of the kinds of questions being raised by UNICEF itself about where the organization should be going. Indeed, during the entire period of the 1960s, beginning with the 1961 and 1962 Board discussions on the future direction of UNICEF, and continuing through the series of regional and national conferences on planning for children and youth in national development, there was a great ferment of ideas, some of which (especially those couched in economic and planning jargon) were rather bewildering to the seasoned UNICEF field staff who had, by this time, become quite expert and efficient in what UNICEF's world-wide reputation was built on: delivering the right supplies at the right time to the right places to reach the right beneficiaries.

For, throughout the decade's debate and discussions on planning, the "regular" programmes carried on, and many of the field staff felt that all this talk about planning was simply a fancy wrapping to what they had been doing all

along. After all, careful planning had to precede any supply action in the form of objective setting, identification of needs, calculation of beneficiaries, establishing time-tables, and so on.

In a sense, they were right; but, in a larger perspective, UNICEF had to persuade its own staff that this different type of wrapping surrounding their same activities had a very serious dimension: delivering the package to the door of the economic planners; opening that door; and having that package accepted by the planners as an integral part of their economic development plans.

But, meantime, the on-going UNICEF-assisted programmes had to be looked after.

* * *

Maternal and child health (MCH) services

In the South Central Asia region, with India as their biggest country and producer of the largest statistics, the MCH network continued to grow in an integrated manner in the Community Development (CD) programme, with the ultimate target of establishing a primary health centre (PHC) with sub-centres in all 5,223 CD blocks.

By mid-decade, over 4,700 such PHCs had been established, and of these, 1,723 main centres and 4,306 sub-centres had qualified for, and received, UNICEF assistance. This meant that a third of the existing centres had fulfilled the requirements as to personnel, buildings, basic equipment, and sanitation conditions. Also, by the end of 1965, the applied nutrition programme was active in 291 blocks, having 10,000 villages with a population of about 10 million.¹⁴⁹

In the East Asia and Pakistan region, there were also a number of interesting developments on the MCH front.

As reported by Executive Director Henry Labouisse to the June 1968 session of the Board, West Pakistan had downgraded the construction of expensive rural health units, and was giving priority to much larger numbers of small health centres. Indonesia was working on the principle of team-work training for all health personnel as a substitute for individual guidance from medical officers, "which is presently impossible". The Philippines was dividing its health units into categories according to the number and needs of the population to be served, and was adding personnel as needed. And Korea was establishing 1,300 new sub-centres within two years by a massive auxiliary nurse training programme, "as a measure to bring about a much-needed increase in direct contacts with the people".¹⁵⁰

In Cambodia, much of the progress in developing health facilities was attributed to the continuing willingness of the rural population to engage in self-help activities, such as building health centres, dispensaries, and infirmaries, the staff and equipment for which were provided by the Government.¹⁵¹

Progress was also recorded even under conditions of civil strife. The Executive Director reported to the Board in June 1967 that, for South Vietnam, 1966 was "the second year of a greatly accelerated war". In view of the large volume of emergency aid available from other sources, UNICEF at Government's request continued to support long-range programmes in the fields of health and education. Following completion of a training programme by WHO, the national MCH team operated entirely on its own for the first time, travelling throughout the year and visiting 27 of the 47 provinces. "Travelling in Vietnam is no mean feat; this itself speaks highly of the devotion to duty of the staff. This team spirit and devotion to duty radiates to many rural midwives in training or at work, some in lonely and dangerous outposts".¹⁵²

The Executive Director also noted that, in South Korea, the public demand for better health services had expressed itself through the National Assembly, which increased the health budget for 1967 over the sum approved by the Economic Planning Board.¹⁵³

:MCH assessment

But, overall, the MCH picture was still rather discouraging. The Board at its June 1967 session, after reviewing a WHO global assessment of MCH, concurred with its major finding that "far too few mothers and children were being reached by MCH programmes and the services they received were often of poor quality".¹⁵⁴ And, at the present (mid-1960s) pace of linear expansion, "it might be generations before coverage was accomplished in most countries".

Innovative approaches and flexible methods were needed, particularly with regard to the training of para-medical staff. And — as one of the earliest expressions of community participation in primary health care — the Board commended "enlisting the participation of leading members of rural communities who, if trained and motivated, could play an active role in promoting the health of the community".¹⁵⁵ UNICEF in Asia was to pick up on this important issue in the 1970s.

* * *

MCH and family planning

Meantime, help to expand MCH services came from an unexpected quarter -- family planning.

There was much debate in the beginning as to whether family planning was a part of MCH; and whether family planning was, or should be, a separate entity with its own objectives, organization, and staff. In reality, the MCH network, being weak, resulted in some countries (such as Pakistan) in the creation of a separate family planning entity; in others, integration took place from the outset. Whatever the pattern, in the end MCH benefited.

Maggie Black in her history of UNICEF has provided a full background on this sensitive and controversial issue, including the leading role played by Nils Thedin, the delegate of Sweden to the UNICEF Board, in persuading fellow Board members to take up the question of family planning.

"By 1965, pressure was coming not only from Sweden, but also from the United States and elsewhere to raise the issue and debate it fully. UNICEF could hardly be serious about its new emphasis on planning for the needs of children and youth at the national level if the twin issues of population growth and uncontrolled fertility were not to be directly tackled. The two post-Bellagio regional meetings on planning and children, which took place in Santiago and Bangkok in November 1965 and March 1966 respectively, raised them openly and addressed them seriously. Under the pressure of what was now being widely described as a population and development crisis, opinion was rapidly changing".¹⁵⁶

:UNICEF Board -- and family planning policy

Family planning was placed on the agenda of the UNICEF Executive Board session in Addis Ababa in May 1966 -- producing the most bitter and most explosive confrontation in UNICEF's history thus far, with the Board split in half over the issue of UNICEF aid to family planning.

As a result of this impasse at the 1966 Board session, the recommendations prepared by India and Pakistan for family planning assistance were not considered by the Programme Committee or the Executive Board (WHO also would not give its technical approval "until the UNICEF Board had accepted the principle of aid to family planning"¹⁵⁷). The two proposals were revised and approved by mail poll in the latter part of 1966 as being a part of basic health services.¹⁵⁸ This mail poll action was most timely. In the case of Pakistan, for example, UNICEF had ordered some 100 vehicles for family planning and, in anticipation of a favourable nod from the Board on the principle of UNICEF aid to family planning, had already initiated shipping arrangements.

Later, after extensive discussion, the Executive Board at its June 1967 session approved in principle UNICEF's participation in family planning programmes, in response to Government requests, as part of a country's maternal and child health services and not as a separate category of assistance.¹⁵⁹ This enabled the Executive Director to report, with respect to Pakistan health, that "The bright spot of 1968 was the President's directive to the Ministry of Health to expand greatly the MCH work done by family planning personnel. Two of the immediate effects of this directive were the provision of UNICEF MCH equipment to 600 new rural family planning clinics, and the lengthening of the family planning health visitors' training course by one month to include MCH, health, and nutrition education".¹⁶⁰

The senior officer in the Pakistan family planning programme at this critical time in the 1960s was Dr. Nafis Sadik -- today the Executive Director of the UN Fund For Population Activities (UNFPA). And the Minister of Health for India, who participated in the Addis Ababa Board session, was one of the UNICEF fellows in the early days of the fellowship programme.

For many years now, UNICEF has served as the executing agency for UNFPA in the procurement of supplies and equipment, while at the same time saving UNICEF's resources for other inputs in the field of maternal and child health.

As the decade drew to a close, the Executive Director, in his progress report to the March 1970 Board, stressed again the intimate relationship between MCH and family planning, citing a UN evaluation of the India family planning programme:

"In Asia, at least ten countries have family planning programmes, including Ceylon, China, India, Korea, Indonesia, Malaysia, Pakistan, the Philippines, Singapore and Thailand. UNICEF has for many years been helping these countries to extend their maternal and child health services. Paradoxically, family planning requires the survival in good health of the children who are born. This was the unanimous conclusion of the United Nations team which examined India's family planning programme in the early months of 1969. The team found that, wherever they went, parents did not wish to have a large number of children. But without the assurance that the children who had been born would have a reasonable prospect of surviving, the parents were not ready to accept the notion of limiting the number of births. Accordingly, an adequate maternal and child health service is a prerequisite for successful family planning. Not only MCH services, however, but other means of reaching the family must be brought in, including organized women's groups, the school system and the mass media".¹⁶¹

* * *

Water and environmental sanitation

During the 1960s, UNICEF aid for clean water supplies and environmental sanitation was just beginning. The huge water supply programmes in India and Pakistan (and, later, Bangladesh) were still in the future. In April 1967, for example, the Executive Director reported that pilot schemes in five States in India had been completed in 1966.¹⁶²

In what was then West Pakistan, assistance for rural water supply projects was being implemented with a new type of polyethylene piping (in addition to the usual cast iron and galvanized iron piping). Progress was slow, and enormous quantities of piping and fittings began to pile up as UNICEF deliveries out-paced the rate of installation. It was a trying time for the UNICEF staff in Pakistan.

A WHO global assessment of environmental sanitation and rural water supply programmes felt that, in the case of the West Pakistan programme, the basic reason for the disappointing results was the "lack of experience in the newly organized Public Health Engineering Department, and insufficient technical support from WHO".¹⁶³ However, UNICEF was also at fault for over-ordering, due to optimistic forecasts on the rate of implementation. A young UNICEF volunteer, Richard Phillips, was sent to the PHED warehouse near Karachi to sort out an enormous quantity of piping and fittings, occupying an area as big as a football field. The PHED staff were bemused by the young man's solo

efforts to sort out the huge jumble of piping and fittings -- until, as the days went by, they saw that he was really serious about it. The PHED staff thereupon pitched in with great energy, and a full and detailed inventory was produced.

:Excreta disposal

In environmental sanitation, the global policy originally was to undertake water supply and excreta disposal simultaneously in the community in order to obtain the maximum effect from the environmental improvements.¹⁶⁴ In the case of Asia, Keeny back in the early 1950s had done a little "amateur inquiry" into the possibility of improving wells and latrines simultaneously. "If we mean that both elements should be stressed and if we are willing to do the wells now and the latrines gradually, there is no difference of opinion; but if we expect that an entire community will build and use latrines as quickly as they will use clean water from a properly protected well, there is a vast amount of experience in Asia to the contrary".¹⁶⁵ Keeny then recounted to the Board a visit he had made to a health centre which had been started with Rockefeller Foundation help some 20 years ago.

"It seems that, after all these years, about 10 per cent of the sixty thousand people now have and use sanitary latrines. We asked about the merits of education versus law enforcement -- if there were laws covering this situation.

Education is the only way, was the answer. 'We got a law passed and arrested about a hundred of the villagers for violating it. But, when the day for the trial came, the Judge was indignant about violating the tradition of centuries, and making these poor people lose a day's work and pay. He freed the lot! If we're to rely on the law, we'll have to begin with health education for the judges. Besides, if you did win your cases, you'd have all the village against you, and would get nowhere with any of your schemes!'"

As it turned out, this policy linkage of clean water supply to safe excreta disposal was observed mainly in the breach, and most of the water supply projects approved later on made little effort to insist on this other component of excreta disposal.

In March 1969, the WHO/UNICEF Joint Committee on Health Policy recommended that, while as far as possible the two projects should be programmed and implemented together, "this should not be insisted upon". The Board agreed, saying that "Every endeavour should be made to carry out improvements to water supply and excreta disposal concurrently. This should not be a rigid condition of assistance if either of the improvements is likely to be delayed in consequence".¹⁶⁶ With this flexibility in policy, rural water supply programmes in Asia developed rapidly, especially in India and Bangladesh.

* * *

Disease control

Throughout the 1960s, mass campaigns against tuberculosis, yaws, trachoma, leprosy, and other diseases continued to be implemented.

:BCG vaccination

During the 1960s the BCG vaccination campaigns continued to make good to excellent progress. It was, of course, the cheapest method of preventing tuberculosis. As the Health Minister of Indonesia remarked, "We cannot put an X-ray in every regency, but we can put BCG everywhere".¹⁶⁷

However, even at the beginning of the decade, many of the BCG programmes were suffering from field fatigue due to many years of hard and monotonous work, with little if any extra financial benefit to compensate for the rigours of continuous work in the field. India, with the largest BCG programme in the world, was suffering most from this condition. The Executive Director reported to the June 1961 Board that India's field staff was about 15 to 20 per cent below strength through 1960. Thus, the fact that the India staff came within 5% of achieving its target for the year (19,018,000 tests performed against a target of 20 million) was a credit to the programme.¹⁶⁸

Fortunately, freeze-dried BCG vaccine became available for mass campaign work in 1962, followed by direct vaccination without prior testing in 1965.¹⁶⁹ The Executive Director was able to report that much progress had been made in India in instituting direct vaccination without prior testing, as evidenced by the 1966 results: vaccinations outnumbered tests done (6.9 million tuberculin tests and 9.3 million BCG vaccinations).¹⁷⁰

In the case of Pakistan, consisting at that time of two provinces a thousand miles apart and a population of at least 110 million, BCG vaccination in West Pakistan had reached a plateau of around 800,000 vaccinations annually, "but should increase markedly now that the Government has agreed to vaccinate without prior tuberculin testing". In East Pakistan, with direct vaccination already taking place, vaccinations increased from 1.6 million in 1965 to 2.3 million in 1966.¹⁷¹

Small campaigns also benefited from direct vaccination. In Mongolia, direct BCG vaccination was extended to 170,000 children in 1968, including all school children and many pre-schoolers in the capital city of Ulan Bator, as well as new-borns in all maternity homes in the country.¹⁷²

In Ceylon, direct BCG vaccination without prior testing was introduced in 1967 with UNICEF freeze-dried vaccine, and the annual estimate of children vaccinated was 1.3 million. Also, 95 health units had referred sputum collected from symptomatic cases to two chest clinics and a base hospital for diagnosis.¹⁷³

:TB detection by sputum microscopy

Sputum collection is relatively cheap when compared to X-rays, and fairly easy to carry out. It had been approved by WHO in 1966 as part of a number of reformulated policies designed to encourage developing countries to initiate nation-wide tuberculosis control programmes within basic health services.

WHO had also recommended ambulatory treatment of infectious cases with the inexpensive drug combination of isoniazid and thiacetazone. The major problem here was that persons diagnosed as having tuberculosis must have the patience and willingness to swallow the pills, daily, for long periods of time, even after the symptoms had disappeared. Asia had a number of TB control projects in addition to the one in Ceylon, but the success rates varied, partly if not mainly because of the problem of prolonged treatment.

:Leprosy control

Leprosy, a disease going back to pre-biblical times, affected a number of countries in Asia. The first project to receive UNICEF aid was the Philippines, followed by Thailand and a number of other countries, including Burma, India, and Pakistan. By the end of 1959, the number of leprosy cases under treatment in Asia had reached 100,000.¹⁷⁴

World-wide, however, some of the leprosy projects were not going well. The UNICEF Board at its 1966 session reviewed a general assessment carried out by the WHO Expert Committee on Leprosy, and decided to continue UNICEF support under certain conditions, including "regular treatment of at least 75 per cent of the estimated contagious cases in each operational area (as) the campaign target, this target to be reached as soon as possible, and in any case within a period of not more than five years".¹⁷⁵

While programmes not yet achieving this level could still qualify for UNICEF aid if they could show a steady rate of progress compatible with the achievement of this 75% target within five years, not many projects were able to do so, and UNICEF aid began to be phased out. But the leprosy problem remains to a certain extent in a number of countries in Asia to this day.

:Burma leprosy: another success story

One programme which went well in Asia was the Burma leprosy project. When the Government began its anti-leprosy programme in 1952, the incidence of the disease was around 7.5 per 1,000, one of the highest rates in the world, with children below the age of 15 making up about 20 per cent of the cases -- of which about one-third were of the lepromatous or most infectious type. In 1958, an intensive control scheme in three pilot areas was established, covering case finding, contact tracing, and regular examination of the cases under treatment with sulphones, an inexpensive drug which, like the TB drugs, had to be taken daily and over a long period of time.

This intensive control method in the pilot areas proved to be effective, and it was extended to other districts. By mid-1968 the Executive Director reported that, "out of an estimated 200,000 cases, around 175,000 are under

treatment, and most are receiving regular treatment. By the end of 1969, the entire country will be covered". Most encouraging was the news that the number of new patients under 15 years had steadily decreased until, "at the present time, a lepromatous case in this age group is relatively rare".¹⁷⁶

And, as the decade of the 1960s came to an end, the Executive Director was able to say that the Burma leprosy project, "operated for the last twelve years as a mass campaign, is among the most successful in the world. There is increasing evidence of regression of the disease. Trials for integration of the campaign into the regular health services have begun."¹⁷⁷

Today, although there are still pockets of leprosy in the country, the dedicated leprosy staff continue to work vigorously, providing effective treatment for all cases, including multi-dose therapy (MDT) with rifampicin, clofazimine, and dapsone for lepromatous cases.

:Trachoma control — and success in China (Taiwan)

Keeny, in Spiegelman's book, has introduced the story of trachoma control in Asia in his usual inimitable style:

"We had another opportunity to protect children. This time it was their eyes. Millions of children in the region had trachoma, an eye disease that has been around for centuries. It thrives in hot, dusty places where hygiene is under par. Dirty handkerchiefs, towels, and flies spread it. Like yaws, it doesn't kill. But it blinds. In the past, trachoma was the world's leading cause of blindness. In the fifties, suddenly we had a cure: newly discovered antibiotic ointments -- aureomycin and terramycin -- and luckily, the price was one UNICEF could afford.... In Taiwan, in 1953, two million were afflicted. That seemed a good place to begin...."¹⁷⁸

First, however, an epidemiological survey had to be carried out to establish the prevalence, distribution, and gravity of the disease throughout the island; this took time (1959-1961). A six-year plan was then formulated for the complete control of trachoma in Taiwan -- the largest UNICEF-assisted trachoma control project in Asia. The strategy was to carry out case-finding and treatment of all active cases where the prevalence was low or moderate, and mass treatment without preliminary case-finding where the prevalence was high.

The campaign was very successful among school children, eliciting tremendous cooperation from pupils and teachers alike. It had started with a pilot project with the help of a WHO trachoma expert. Doctors taught teachers the routine, and the pupils were their aides. Keeny continued with his recollections:

"I dropped in... to see how these kids were doing. It was astonishing. A classroom eye-care drill was in progress. Children moved with clockwork precision. When the teacher gave the signal to begin, fifty children each put on a numbered armband. One read out the names of those to be treated, while another got a basin of soap and water, so that

everyone could wash his hands. A third gave out tubes of ointment, each numbered to avoid cross-infection. They lined up. The teacher pulled down the lower lids of every infected youngster, squeezing ointment into the corners. The last step was to press small squares of tissue paper over the lids to help spread the ointment inside the eye. Tubes were collected. Children returned to their seats. Only five minutes had gone by."¹⁷⁹

Altogether, some two million school children were covered in this programme. Achievements in the communities, while not as spectacular, were quite respectable: a WHO assessment carried out in 1970 found that, out of 362 districts, trachoma remained a problem in only sixteen.¹⁸⁰ In those remaining pockets of prevalence, where sanitation was generally poor, a maintenance programme was carried out.

:Other diseases

The spectacular success of the Indonesia yaws programme, already described, was followed by the Philippines yaws project, which was officially terminated as a separate programme in June 1962. Yaws work in the Philippines, reported the Executive Director to the Board in January 1964, had now been integrated into the regular health services.¹⁸¹

Also at the Board session in Bangkok in 1964, it was announced that UNICEF aid to the successful anti-typhus campaign in Pakistan came to an end with the 1961/62 dusting season.¹⁸²

Throughout the 1960s, the largest engagement of UNICEF for malaria eradication continued to be in Latin America and the Eastern Mediterranean regions. However, eradication as a global target was reluctantly giving way to control, as the mosquito proved to be a most formidable adversary, developing resistance to DDT, dieldrin, and almost everything else man could throw into the war against malaria. Thus, the Executive Director had to report to the June 1968 Board that "Ceylon, which was one of the first countries to achieve eradication, last year (1967) experienced an epidemic which required emergency measures".¹⁸³

* * *

Nutrition

Malnutrition -- identified in 1948 by the Parran/Lakshmanan mission as one of the most serious problems affecting children in Asia -- proved to be as elusive as malaria in terms of coming up with effective means to attack it during the 1960s.

UNICEF had, during the emergency and post-emergency years, relied on skim milk powder in its feeding programmes, followed by support to various countries wishing to make better use of their local supplies of milk through milk conservation programmes. These efforts were later supplemented by applied

nutrition programmes in rural areas, as well as by the development of a number of high-protein food mixtures which could be manufactured and marketed in selected developing countries for supplementary feeding to young children in needy urban areas.

:Difficult beginnings

But, on the whole, there was little interest at the time on the part of Governments to deal with child malnutrition as a priority problem, and this was reflected in the figures for UNICEF allocations for nutrition. In 1968, for example, they amounted globally to \$4.4 million, or 13.6 per cent of programme allocations. While this figure did not take into account nutrition elements in other projects such as health and education, the Board still considered the amount to be too low, and did not hesitate in laying part of the blame on Governments themselves when it said that, "In part, the lack of increase in nutrition aid reflected a slow recognition by Governments that child malnutrition could be a serious deterrent to national development".¹⁸⁴

:Applied nutrition projects

The Board also took note of another reason, however, and that was that there were no quick and easy ways to tackle this child malnutrition problem with its formidable sociological dimensions. People were usually conservative about what they ate and how they fed their children, so that the problem was often as much a matter of changing attitudes as it was a problem of access to nutritious foods. For that reason, the Board placed great emphasis on applied nutrition projects, which were much closer to the villages and people, and which advocated such ordinary but vital activities as school, community and family gardens, village fish ponds, small animal-raising schemes, home economics and food preservation.

One of the earliest applied nutrition (ANP) projects in Asia was in India, where, despite many administrative and other problems, it was proving to be among the most worthwhile types of programmes that UNICEF could assist in the nutrition field. The pilot projects in applied nutrition, initiated in the four States of Orissa, Andhra Pradesh, Uttar Pradesh, and Madras, had been evaluated by the Government in 1963, and had been found "to be necessary and sufficiently successful to justify application to the entire country".¹⁸⁵ A global evaluation of applied nutrition projects also found that such programmes constituted "the most effective means so far found for UNICEF, working together with FAO and WHO, to help meet the nutritional problems of rural children at the village and family level".¹⁸⁶

:Child malnutrition report

For Asia as a whole, however, progress was slow; the child malnutrition problem appeared to be deteriorating, not improving. The Executive Director in 1969 prepared a special report on child malnutrition which reviewed the activities taking place in both urban and rural areas, and which concluded that:

"To achieve the best results in approaching the problem of malnutrition, Governments need to establish a national food and nutrition policy and to evolve a co-ordinated plan of action in which the several interested Ministries (for example, Agriculture, Health and Education) should participate. Each country needs to identify its particular nutrition deficiencies. There is no one solution applicable to all countries; each country has to work out its own policy and programme in a flexible and realistic way"¹⁸⁷

The Executive Director added that UNICEF and other international organizations, in working with Governments on this problem, would also need to be flexible and responsive, and concluded by saying that, "Since many countries are not yet able to mount a comprehensive national food and nutrition programme, which represents the ideal approach, UNICEF should be ready to assist in more limited measures to combat child malnutrition, beginning where the countries are ready to act". The Board agreed.¹⁸⁸

:Some progress in Asia

And, indeed for Asia, the nutrition picture for the 1960s was not all bleak, for there were a number of countries willing at least to take some measures to alleviate malnutrition among children and mothers, even though they were of limited scope and not yet national in coverage.

In Indonesia, success was reported with a small pilot project to combat xerophthalmia in young children which often resulted in blindness because of vitamin A deficiency. It was found that the daily administration of two spoonsful of red palm oil (produced in the country) to every pre-school child in two pilot villages over a six-month period had resulted in the rapid disappearance of symptoms of xerophthalmia. The significant feature of this project was that it was completely managed by the village people themselves through their village social organization.¹⁸⁹

The UNICEF-equipped shark-liver oil plant in Thailand was producing sufficient quantities of vitamin A capsules so that imported supplies by UNICEF were no longer required. The monthly production of about one million capsules was being distributed free through rural health centres, midwifery centres and other institutions.¹⁹⁰

Skim milk distribution continued to reach about 1.3 million beneficiaries in 15 UNICEF-assisted countries in the East Asia and Pakistan region.

A significant step was taken by India in 1968 when, for the first time, the Planning Commission convened an interministerial committee on nutrition to work on guidelines for action in nutrition for the country's Fourth Five-Year Plan. International, bilateral, and voluntary agencies had already been associated with the committee's work, with UNICEF, United States bilateral aid, and later FAO playing the most active roles.¹⁹¹

:Goitre control

The Executive Director noted that the UNICEF-assisted salt iodization programmes in Burma, China (Taiwan), India, and Thailand continued to have beneficial effects on the population in areas which formerly had a high incidence of goitre. In Thailand, three more plants were brought into operation in 1969. On the other hand, the goitre programme in India, though basically successful, was experiencing some difficulties in the distribution of iodated salt to the endemic areas.¹⁹²

Such was not the case in China (Taiwan): there, island-wide distribution of iodated salt commenced in October 1966 after trials with locally made equipment. Success was guaranteed because salt was produced and distributed under Government monopoly and was iodated at source — and it was the only salt on sale in the Island.¹⁹³

:Weaning food project: Saridele

In Indonesia, the Government decided to manufacture a weaning food based on soya bean. With the assistance of UNICEF and WHO, the "Saridele" plant began operations towards the end of the 1960s. This project generated a great deal of expectation because, if successful, it would have served as a prototype for other countries where soya was plentiful, or could be grown without great difficulty.

However, as Maggie Black has noted in her history of UNICEF, the project did not go entirely according to plan. "Originally the intention had been for the government to buy the whole output, and distribute it to hospitals, health centres, and in the school-feeding programme. Instead, half the output was sold as a flavoured drink, imitating the milk conservation pattern UNICEF promoted in the dairy industry: high-priced products subsidizing the welfare component".¹⁹⁴

Title to the UNICEF equipment installed in the plant was formally transferred to the Government in September 1967, thus completing UNICEF's assistance to this project.

:Milk conservation programmes

Milk conservation projects dominated the nutrition field in Asia during the 1960s in terms of the size of allocations and the large Government matching commitments for buildings and distribution of free or subsidized milk to the value (or more) of the UNICEF contribution.

By 1969, increasing amounts of milk were being processed each year in most of the UNICEF-assisted plants in Asia. Ceylon recorded a tenfold-plus increase in milk purchased, processed and sold by the National Milk Board between the years 1956-1967. In Pakistan, the Karachi scheme was rehabilitated under new management and World Food Programme (WFP) assistance came into the picture, thus brightening prospects for success.¹⁹⁵

The World Food Programme was also contributing greatly to the success of the milk conservation programme in India by providing feed grains, as well as skim milk powder for "toning" of the local milk (i.e., mixing reconstituted skim milk powder with the high-fat milk locally available, to produce a less expensive low-fat milk).¹⁹⁶

In Lahore, the UNICEF-assisted milk plant began operations in October 1967. Distribution of milk in inexpensive polyethylene pouches (first introduced successfully by UNICEF in East Africa) was well received from the beginning. A big advantage of this type of packaging, of course, was that there were no bottles to be collected and returned for washing, etc. The pouched milk was in such great demand that two more hand-operated machines had to be ordered for filling and sealing the milk into pouches.¹⁹⁷

* * *

Education

UNICEF's very first involvement in education got off to a shaky start in the fall of 1958. The Pakistan delegate had proposed that the Executive Director study the possibilities of UNICEF aid for primary education and present a report to the Board at its March 1959 session. A number of representatives expressed support, but there were others who, although not opposing the study, expressed varying degrees of misgiving, taking the view that the problems confronting UNICEF were already sufficient to absorb all its resources, and that much remained to be done in concentrating on the priorities already established by the Board. Also, several delegates wondered whether aid for certain aspects of primary education might not bring UNICEF into a controversial area involving ideological considerations.¹⁹⁸

In view of this background, the Executive Director's report to the Board in 1959, prepared in consultation with UNESCO, was cautiously phrased. It recommended limited support for teacher training in subjects related to fields in which UNICEF was already giving assistance, such as health and nutrition education, with special attention to the education of girls as well as to projects in rural areas.

Nevertheless, the Board went through an extensive debate on the subject, the major difference of opinion apparently turning on whether aid to primary education would be appropriate for UNICEF at that time; there were still large tasks ahead in the fields of child health and nutrition, and it was feared that the addition of education may have an unfortunate dispersal effect.

In the end a working group of Board members had to be formed to reconcile the various views expressed. The Board cautiously agreed to some trial projects in the training of primary school teachers in connection with UNICEF's traditional fields of interest such as health, nutrition, hygiene, and home economics, with such trial projects to be carried out, as far as possible, within the framework of already existing programmes such as those aided by UNESCO, FAO, WHO, or UNICEF itself.¹⁹⁹

:Towards a flexible policy on education

Within two years, the pendulum was to swing to quite the opposite direction of greater flexibility. In the words of H.M. Phillips, author of the UNICEF History Project's monograph on Education, "From extreme caution in 1959, the Board... moved in 1961 to what a number of its members considered to be too wide a scope for its educational assistance".²⁰⁰ The majority of Board members, however, felt that UNICEF should go fully into education, at that time the only major field excluded from UNICEF aid.

Accordingly, the Board in 1961 decided to put an end to the requirement that it must first approve in principle a field of assistance before considering a project in that field, and agreed that it was ready to consider requests in whatever field there were priority problems of children in the country concerned.

One of the most immediately visible effects, noted a report of the Executive Director which was later printed for wide circulation, was to allow assistance to education and vocational training, thus initiating UNICEF's relationships with UNESCO and ILO, which proved to be "particularly appreciated by the African countries".²⁰¹

And by the countries in Asia too. As the Executive Director informed the Board at its June 1965 session, a striking feature of the period under review was the enthusiastic response of Governments to the offer of UNICEF aid to education projects. By the end of 1964, aid had been allocated for education projects in eight countries in Asia.²⁰²

These projects varied in size and emphasis, but almost all of them focussed on teacher training, revision of curricula, and upgrading of facilities at primary and secondary schools as well as at teacher-training institutes.

:Pakistan

In Pakistan, for example, UNICEF's commitment of \$5 million over a five-year period assisted the Government in improving 12,000 primary schools in East Pakistan through the provision of simple sets of equipment, as well as the upgrading of 47 primary teacher-training schools. UNICEF stipends and teaching materials were also provided to help tackle the huge problem of giving some training to 33,000 unqualified teachers. In West Pakistan, after a successful experiment in the re-training of science teachers during summer vacation, the Government was encouraged to proceed with the revision of the science syllabus at the secondary level. A total of 3,500 Class IX science teachers were re-trained in the summer of 1968, and 4,000 more in the summer of 1969.

:South Pacific

News travels fast — and far. In the South Pacific island territories, UNICEF aid had been primarily in health, due in part to the presence of WHO advisers in the region. Following the assignment of a UNESCO adviser to the South Pacific, UNICEF aid in education began to increase, beginning with an allocation in 1966 to help refresher training of primary school teachers and to improve the curriculum in science teaching in Papua New Guinea.²⁰³

:South Central Asia Region -- and India

As for the South Central Asia region, UNICEF in this early period supported education projects in Afghanistan (teacher training, with UNESCO assistance, at the Kabul Academy for Teacher Trainers and at six regional teacher training colleges) and in Ceylon (development of new science and mathematics curricula for secondary schools, and printing equipment to produce the new textbooks, with teacher training supported by the British Council and other aid).

The biggest project was in India, and Phillips singled out the science education programme in that country for special mention because of its unusual size and importance. The plan was worked out between the Government and UNESCO in 1964 by ten UNESCO experts with 15 local counterpart staff. In 1967 UNICEF allocated \$2.5 million for two years, to which the Government made a matching contribution of \$3.6 million. The total Government expenditure was planned at around \$23 million, including contributions from the States.²⁰⁴

The operating agency for India was the National Council for Educational Research and Training (NCERT). Beginning in 1964, with the assistance of the team of 10 UNESCO experts, the Council began producing textbooks, teachers guides, curricula, and other instructional materials in both English and Hindi. NCERT also designed 150 items of simple science equipment for self-contained physics and chemistry kits, with much of the materials for these kits obtainable from the local bazaar. A large training plan was launched to train 25,000 teachers in short refresher and in-service training courses.

Phillips noted that, although the project had been carefully planned, UNICEF's aid "never came to full fruition on the scale originally envisaged... partly because of delays in the formulation and support for the project and because UNICEF in 1972 eliminated its policy of aiding science teaching in middle and secondary schools and decided to concentrate on basic education at the first level".²⁰⁵

:In perspective

One reason for this intense interest in education in Asia, as contrasted to nutrition, may have been that this was the one element of UNICEF aid which was most easily understood as supporting human resource development. As the Executive Director reported to the Board in June 1968, 37 per cent of total programme aid in 1967 had been for this category of assistance. Indeed, the most spectacular increase in requests from Governments had been in education, with UNICEF allocations increasing from \$2.3 million in 1962 to \$9 million in 1967.

Viewed in relation to the total amount which the developing countries themselves were investing in education and training, UNICEF's contribution in 1967 was minimal. Nevertheless, the Executive Director pointed out in 1968 that, aside from UNESCO, UNICEF was providing more direct aid than any other international agency to primary education.²⁰⁶ Equally noteworthy was the fact that, by end-1967, UNICEF had provided stipends to help Governments train, in courses of various durations, some 325,000 persons in nutrition, health, education, family and child welfare, and other child-related fields.²⁰⁷

As the decade drew to a close, guidelines for UNICEF aid in education, established by the Board in 1968 on the basis of a global assessment, were beginning to have an effect, and projects were increasingly moving in the direction of helping to improve the quality of education through the training of teachers and supervisors, curriculum reform and a new concept of the school, especially in the rural communities.

* * *

Social welfare

The Executive Board first considered aid to social welfare at its March 1959 session, when it considered a report by a special consultant on the possibilities of UNICEF aid for social services for children with particular reference to institutions, day-care centres, and other methods of caring for children outside their homes. WHO had also submitted a report on the health aspects of such services.

The Board approved in principle the extension of UNICEF aid in this field, with priority for training for all levels of workers, and for services which would reach the more vulnerable age groups, namely infants and young children. Technical approval for such projects would come from the UN Bureau of Social Affairs.²⁰⁸

A number of relatively small projects were initiated in Asia during the 1960s, providing basic training for child-care workers who had no professional training, as well as in-service training for officers posted to various social welfare projects. Some assistance was also provided to schools of social work, as well as to selected institutions such as orphanages, day-care centres, and homes for abandoned babies.

The Board at its 1966 session reviewed a global assessment of UNICEF-assisted family and child welfare projects, but asked for a fuller evaluation to be carried out later because there had not been sufficient time for the projects to gain enough experience and results.²⁰⁹

One of the more successful projects in Asia was in China (Taiwan), partly because it helped to serve an economic need. Started in 1963 with less than 100 day-care centres, by 1968 there were 545, plus 1,700 operating seasonally for children of farmers.²¹⁰

In general, however, the social welfare projects in this early period were structured largely along Western lines, and required considerably more funding than Governments in Asia could afford, as well as an infrastructure (such as referral services) which hardly existed. As the corner was turned into the 1970s, some of the countries in the region were beginning to search internally for methods and solutions which would be more in tune with local culture and needs.

* * *

Programme recommendations, the country approach, and area concentration

As UNICEF's income during the 1960s improved, the global target for fund-raising also rose: from \$50 million at mid-decade to \$100 million as the decade ended.

Compared to a total income in 1986 of \$463 million and a projection of \$512 million by 1990,²¹¹ \$100 million does not seem very large; but, in the middle of the 1960s, even the target of \$50 million, to be reached by the end of the UN's first Development Decade, seemed ambitious.

:The birth of "noted" projects

Total income in 1966 amounted to \$45.2 million, in 1967 to \$38.5 million, and was estimated to reach \$42 million in 1968. However, \$1.7 million of that 1968 estimate represented a one-time transfer of accumulated profits from the Greeting Card Fund. UNICEF found itself about \$10 million short of the income target of \$50 million by the end of 1969 as endorsed by the General Assembly.²¹²

The Executive Director in 1968 therefore proposed, in an effort to bring about a substantial increase in UNICEF's income, a new procedure of "Noting", by which the Board would authorize the Executive Director to accept additional contributions for projects "noted" by the Board for which funds from general resources were not available. Such projects would not be isolated schemes, but would be related to the country programme and conform to Board-approved principles.

After approval in principle by the Board in 1968, the first series of "noted" projects were presented to the Board in May 1969.²¹³ This method of fund raising, developed to a fine art by the first Director of the Programme Funding Office, Victor A.M. Beermann, proved to be so popular with donor Governments that, in 1986, supplementary funding by Governments alone amounted to \$99 million for regular programmes, plus \$22 million for emergencies.²¹⁴ This did not include contributions for "notings" from non-governmental sources. The "Sales Book" for 1987 listed projects for supplementary funding for 21 countries and 7 regional and other projects in the amount of \$219 million. Many of the projects in Asia have benefited from this "noting" procedure, and continue to do so, thanks to the generosity of a number of donor Governments.

Indeed, the very popularity of the "noting" procedure has caused some Board members to express concern that it may lead to an imbalance in the proportion of programmes and countries being assisted out of UNICEF's general resources as against those being assisted by supplementary funds. Following an intensive debate at its 1987 session, the Board asked for a report on the criteria, procedures and proportion (as compared to general resources) of supplementary funding.²¹⁵

Accordingly, the UNICEF Secretariat prepared for the 1988 session of the Board an "Update of UNICEF Policy on Supplementary Funds" which recommended, inter alia, that existing policies and procedures be maintained, and that "noted" projects "should henceforward be referred to as projects for supplementary funding and, when funded, as supplementary-funded projects. The use of the term 'noted' should be discontinued".²¹⁶

:Programme recommendations and country approach

The other side of the coin to increased funding, of course, is increased allocations and expenditures. The volume of programme recommendations, for all regions, kept multiplying; by the time the Board met at Addis Ababa in May 1966, it was swamped with 228 separate recommendations from 84 countries and territories.

In self-defence, the Board requested the Secretariat to focus UNICEF aid on fewer and larger projects in each country, bearing in mind that the size of the project needed to be related to the size of the assisted country, and recognizing that pilot projects of an innovative or demonstrative character were valuable — and that these would normally be small.²¹⁷

This decision had two major consequences. First, project recommendations up until 1969 had been reviewed by fields of aid categories. Beginning with the May 1969 Board, the Executive Director announced an innovation: the Programme Committee would consider proposed UNICEF assistance in projects grouped by countries rather than by programme categories. While this did not mean, automatically, the implementation of the country approach, the putting together of all project proposals for one country in one paper greatly facilitated a country review by the Programme Committee and the Board.

The 1966 decision by the Board to have fewer programme recommendations had another important consequence: it opened the way for the development of an integrated approach and area concentration. In fact, the Board at that session had noted with approval three proposals (not in Asia) which had provided comprehensive integrated services for children and mothers in a defined area.²¹⁸

:Integrated approach and area concentration in Asia

In Asia, it was the Regional Office for South Central Asia which took the lead in advocating — and implementing — an integrated area development approach, beginning with India. This was perhaps almost inevitable, considering the size of the country on the one hand, with its concomitant enormity of children's needs, and the relatively modest UNICEF resources to tackle those needs, on the other. "The inter-relationships of inadequate health, deficient nutrition, and incomplete education", in the view of Charles Egger, Regional Director for South Central Asia (speaking through the Executive Director's progress report to the June 1965 Board), "calls for a more integrated effort and would justify the merging of major programmes in the same area with the purpose of obtaining more concentrated effect".²¹⁹

This was followed up at the Board session in June 1967, when it was proposed that UNICEF aid for the South Central Asia region be re-structured, based on "selectivity against comprehensiveness"; and, with selectivity, a greater concentration of UNICEF's resources, either geographically or sectorally.²²⁰ And, at the next Board session in June 1968, the SCARO regional report noted that an approach to development favoured in Nepal was that of comprehensive area development schemes, of which a number were under way, assisted by United Nations agencies, Israel, Switzerland, and others.²²¹

:India - precursor to integrated approach and area concentration

However, it was in India that the integrated area approach saw its most comprehensive expression through several large programmes which are described in the next section, including the "Integrated Child Development Services" (ICDS) programme, which took off in the 1970s. Its roots, however, may be traced to this period of the 1960s.

Thus, an integrated family and child welfare project was approved for India in 1967, with the aim of bringing about a combined impact of various programmes in selected blocks and villages. Health services and family planning, applied nutrition, community water supply, and child welfare would be integrated in 50 projects planned for 1967/68; 25 were inaugurated in November 1967.²²²

By end-1969, despite a slow start, 175 of an original 289 welfare projects had been converted to this new "integrated" programme, coordinating local pre-school care, applied nutrition, health and education services at block and village levels. The Executive Director also reported that UNICEF was thinking of local procurement for most of the project supplies for this programme, as local items would be more familiar to the villagers than imported items.²²³

:Local procurement

Actually, local procurement in India — which eventually developed into a multi-million dollar affair — had already begun in the mid-1960s. As the Executive Director reported to the Board in June 1967, a significant trend in India during the past year had been the replacement of imports by indigenous products:

"UNICEF has encouraged the procurement of supplies within India for local programmes as well as for export to UNICEF-assisted programmes in other parts of the world. Ophthalmic ointment, for example, was procured in large quantities for use locally as well as for export with satisfactory results. Bicycles and sewing machines too, were procured for export, although some complaints have been received as regards the quality and packing of the sewing machines exported. The experience gained during the period has underlined the need to persuade manufacturers to lay more emphasis on maintaining uniform quality standards".²²⁴

Indeed, by the time the famous Mark II handpump was developed with the help of UNICEF — and now manufactured widely in India — quality control was an integral feature of supplies and equipment submitted for local procurement.

This practice of local procurement, followed in many countries besides India, forms a significant part of the expenditure pattern of UNICEF today. This is good for internal trades and businesses in the country; good for the receiving communities and villages; and good for UNICEF's credibility as an organization which does take into account local acceptability of the goods it delivers.

:Non-supply assistance

The same justification applies equally, if not more so, to non-supply assistance, covering such items as training grants, project personnel, and other cash assistance.

The Executive Board had never set any special limitation on the percentage of total project allocations which could be used for non-supply assistance, but it was understood from the beginning that such expenditures were to be kept to an absolute minimum. By mid-1965 the Board, perhaps feeling somewhat uneasy on this matter, asked for a review, and a report was accordingly prepared for the June 1965 session.

The report showed that, during the three-year period 1962-1964, 13 per cent of programme allocations had been used for non-supply assistance, the largest part of which was for stipends for within-country training programmes.²²⁵

This percentage for training grants, project personnel, and other local costs gradually rose to 19 per cent (1970), settling down to around 21-25 per cent by the mid-1970s.²²⁶

Interestingly, while non-supply assistance in 1980 (training grants, project support, and other cash assistance) amounted to 26 per cent, it jumped to 45, 42, and 43 per cent in 1984, 1985, and 1986 respectively, due mainly to increases in the item for project personnel.²²⁷

Local costs as such (i.e., excluding project personnel) represented a flexible and useful programming tool. It helped all projects which have large training components, and was particularly relevant for integrated schemes and area development programmes where the focus was on flexibility and responsiveness to local expressions and determinations of needs. UNICEF, by being able to react quickly and commit some local costs during on-the-spot discussions, established and consolidated its position as an organization which practiced what it preached about flexibility and the need to cut red tape. This worked to great advantage in many of the projects in Asia, almost all of which included some funding to cover such local costs as training grants, pilot surveys, social mobilization efforts, workshops, evaluations, printing costs of materials in the local language, and a host of other local needs.

*

*

*

Emergencies

In the 1960s, as in previous years, emergencies continued to generate requests to UNICEF. This was only natural, considering that UNICEF's solid reputation in the international field had been built on its ability to respond quickly and effectively.

In this decade perhaps the worst natural disaster was the terrible drought, and ensuing famine, which occurred in India in 1967.

Monsoon failures in the north-central belt of India in 1965 and 1966 culminated in extreme drought conditions, the worst in a century, affecting some 100 million people, mostly in Bihar and the adjacent States of Uttar Pradesh and Madhya Pradesh. In Bihar alone, 35 million people lived in officially declared famine areas, and as many more were indirectly afflicted.

The response from the international community was to mount one of the biggest mass relief programmes the world had known in twenty years, thereby averting a major catastrophe by a narrow margin. Assistance from various sources by mid-1968 included emergency feeding programmes by CARE for some eight million children and mothers in 30,000 centres; free airlift of eleven UNICEF drilling rigs from Great Britain by Air India and the Royal Canadian Air Force; and substantial donations of foodstuffs by Australia, the Grain Growers' Association of France, the Federal Republic of Germany, New Zealand, the Polish UNICEF Committee, and U.S. bilateral aid.²²⁸

The quick and decisive action by State Governments in establishing thousands of relief work sites provided employment and minimum purchasing power to 3.4 million persons. Timely public health measures by the State authorities averted large-scale outbreaks of epidemics. UNICEF contributed protein food supplements, medical supplies, well-drilling equipment and vehicles, and delivered 10,000 tons of skim milk powder and corn-soya milk flour which had been generously donated by the United States Government. A survey conducted in Bihar by the All India Institute of Medical Sciences confirmed that the feeding programmes had appreciably reduced the severity of malnutrition among the vulnerable groups.

As for man-made catastrophes in Asia, surely the one which befelled Viet Nam and Kampuchea have seared themselves in the memory of the world, but that will be for the next decade to record.

*

*

*

Summary

If programming in the decade of the 1950s was exciting, the decade of the 1960s was perplexing to some and challenging to all. It was an era of change and transition, with new ideas and concepts being thrust onto the horizon, blurring the outlines of achievements and experiences.

In the decade of the 1960s the Secretariat and the Executive Board wrestled with new perceptions of the needy child and the whole child, as well as with the interrelatedness of the child's various needs, indivisible in their effects. UNICEF was impelled by these perceptions to develop the country approach so that these interrelated needs could be effectively tackled within the framework of national planning and development. This was the substantive element.

There was also a procedural aspect. At the Administration's suggestion, the Board adopted a change in UNICEF's methods of looking at project proposals, from review by categories of programmes to a country-by-country review. If this seems obvious now, it was innovative then. Such procedural devices helped to propel UNICEF towards a country approach.

And the Board, in this decade, opened the door wide to project requests for children and mothers as determined by the requesting countries themselves -- including, in particular, the field of education.

But, as with all rights, there were corresponding duties. While the requesting countries had the right to submit proposals according to their own priorities, they also had a duty to temper this right with reasonableness and respect for UNICEF's mandate -- and her limited resources.

This, in turn, led to another innovation in this decade -- the invention of "Notings", which has turned out to be a sustained inspiration for enhanced fund-raising for some countries and some types of programmes, as well as for emergency aid.

The decade of the 1960s was also a challenging one for UNICEF staff in the field. In addition to what they had been doing all along -- supplying and delivering the right ingredients to solve children's needs at the village level -- the field staff now had to contend with this new concept called Planning. Some of them felt that that was what they had been doing all along; for, how else could skim milk powder and penicillin and BCG vaccines and all the other items be programmed and delivered, on time, to the right places, without planning?

Well, this was a different type of planning, with a capital "P". This was Planning for intersectoral collaboration in integration, and the aim was to persuade economic planners and political decision-makers at the senior-most levels of Government to give high priority to the needs of children. This was new to UNICEF. And new, of course, to receiving as well as donor Governments alike.

The decade of the 1960s, finally, was also a challenging one for the beneficiaries themselves. Up until now, the family and the community had been more or less the passive recipients of skim milk, or penicillin, or BCG vaccine, or whatever. Now, UNICEF was beginning to talk about the child as a part of the family and community; the child as requiring more than just external aid; the child for whom the people themselves, as members of the community, had primary responsibility to take individual and collective action to correct interlocking needs.

However, the people in many parts of the Asia region were ahead of UNICEF in this respect. UNICEF did not discover community involvement and participation; the people already had ample experience of this in various places. But that is for the decade of the 1970s to reveal.

*

*

*

- 82 -

BLANK PAGE

THE MATURING YEARS: 1970-1980

- 84 -

BLANK PAGE

Introduction

The decade of the 1970s was a turbulent era, with more than its share of man-made and natural disasters for UNICEF in Asia: the oil crisis in the early 1970s, with its serious effects on the developing countries, especially with regard to their social sector programmes; the anguish of creating Bangladesh out of East Pakistan; the agonies of Viet Nam, and the horrible genocide in Kampuchea — plus the recurring floods and tidal waves, droughts and earthquakes — all combined to put UNICEF through its severest test in Asia. UNICEF matured in the process.

In 1971 UNICEF turned 25: twenty-five years of good, solid experience in a wide variety of fields, beginning with supplementary feeding and health, but gradually widening the scope of these fields and extending into other areas of concern to the whole child. By the time the decade ended and UNICEF turned 35, planning for children in national development was no longer something strange or perplexing, but had been absorbed and accepted as an integral part of UNICEF's activities.

* * *

Country programming

Indeed, beginning with the 1970s, UNICEF's programme planning process became highly structured, based not on types of projects or programmes, but rather on a deliberate exercise of first evaluating the situation of children in a country framework, then setting objectives (general and specific), identifying and prioritizing the target groups, spelling out the methods of implementation, and building into the country plan from the very beginning a methodology for periodic monitoring and evaluation.

This programme planning process was implemented with enthusiasm in Asia as in other regions, for it systematized a very important part of the whole cycle of planning/implementation/evaluation: i.e., the first step of planning. Good plans do not by themselves guarantee good implementation, but bad plans impede good implementation, often killing it. Similarly, evaluation is helped enormously if, in the very first stage of planning, adequate thought had been given to setting clear goals, identifying an appropriate set of indicators, and spelling out the UNICEF inputs so that they can be monitored as to their relevance and effectiveness. With the advent of microcomputers, many UNICEF field offices are now able to raise programme management to a very efficient level.

Ideally, the programme planning process begins some two years before a country needs to present a fresh programme recommendation for review and approval by the UNICEF Executive Board, and during the 1970s, this was implemented with a fair degree of success in Asia.

Typically, a bench-mark study would be undertaken on the Situation of Children in a country. An inter-ministerial group would be formed, consisting of representatives from the various government departments dealing with, or having a concern in, children, as well as representation from the private sector, which often makes an invaluable contribution. Chairing the group would be someone from an overall body such as the planning commission, to provide objectivity and balance. Properly done, the Situation Study could consume a year. Great care has to be taken with selecting good representatives from each department; a dentist from the health department, for example, may wish to put dental caries as the nation's first priority, even though malnutrition may be a more pressing issue. And so on.

Based on that Situation Study with its identification of children's problems, including some indication of priority or ranking by subject as well as by underserved regions or areas in a country, the next task would be prepare a programme recommendation to the UNICEF Executive Board. Again there should be representation from the private as well as government sectors, and it is at this stage that discussions can become quite heated, for the subject is not generalities about children's needs; rather, it is about the size of the UNICEF pie, and how to cut it up, in how many slices, and how thick or thin should they be. The end result could be three major outputs:

- a) a programme framework which would identify the major child problems, set down broad strategies and objectives, and outline general principles for monitoring and evaluation;
- b) project plans of action which would cover specific projects (five, six, ten, or whatever number would be needed), each one of which would set down firm time tables and spell out service coverage and output objectives (i.e., what is to be done, when, by whom, where, and how?);
- c) a statistical profile which would pull together available data, and would serve as the basis for future improvement.

This painstaking, deliberate, careful approach to programme planning paid off in terms of much better programme presentations to the Board. It also resulted in enhancing the status of UNICEF as a development agency, for it was no longer possible to present an ad hoc scheme and expect approval. Requests now had to be fitted into a country's identified priorities, examined by inter-ministerial bodies, and approved at the highest levels. In this way, UNICEF became better known in the governmental system as a whole.

In addition, of course, UNICEF's image also began to change vis-a-vis her UN sister agencies. They, too, were involved in this careful planning process, and while it was often as observers rather than active participants, it soon became clear, as one country after another followed this process, that UNICEF was indeed serious about programme planning, implementation, and evaluation.

But there was another aspect to UNICEF's relations with technical and other agencies which occurred in the 1970s, although it certainly began to develop in the 1960s.

*

*

*

Relations with technical and other agencies

UNICEF had always acted, and continues to act, in consultation with the relevant technical agency in the UN system: WHO for health, UNESCO for education, FAO for nutrition, the UN Bureau of Social Affairs for social welfare, ILO for vocational and pre-vocational training; and in the case of Asia, the Asia and Pacific Development Institute (UNAPDI) in Bangkok for the training of planners and the promotion of primary health care (for which it received the Maurice Pate Award). Multi-agency discussions were also becoming more frequent with the increasing awareness of the interrelatedness of the child's needs.

By the 1970s, however, there was a difference. UNICEF continued to consult, listen, discuss, and review -- and then, taking into account the technical advice and suggestions offered, made up its own mind, very often in consonance with the recommendations offered, but not always. There was no longer a veto by the UN partners as had existed in the early years, or a condition that approval depended on the use of the agencies' technical advisers in the project, for many years financed by UNICEF.

This process was gradual but unmistakable. UNICEF, maturing with knowledge and experience, came to be acknowledged as an equal partner, although the degree of acceptance varied. Nevertheless, the battle was substantially won. As Adelaide Sinclair, UNICEF Deputy Executive Director (who retired in 1967), so aptly put it, a relationship developed with the UN agencies "which has been described as something resembling a marriage that was not always very affectionate but was very fruitful".

Relationships were also increasing with other agencies not previously within UNICEF's orbit, such as the World Bank, and regional groupings of various types. In addition, Governments financing "multi-bilateral" programmes through UNICEF's "noting" procedure began raising substantial amounts of supplementary funds for worthwhile projects from bilateral aid sources. And greater use was being made of national institutes, often with financing from UNICEF, to strengthen national capabilities.

* * *

Commitments and allocations for Asia

For Asia, the volume of commitments and allocations was steadily increasing. At the opening of the decade, in 1970, programme commitments for the two regions of Asia (East Asia and Pakistan, and South Central Asia) totalled \$13,545,000 out of a global commitment of \$51,336,000, or 26 per cent. By mid-decade, Asia's share had risen to \$40 million, or 54 per cent of the global figure of \$74 million. And, as the decade closed, programme commitments for Asia had risen to \$120 million out of \$226 million, or 53 per cent.

Globally, total revenues in 1978 had reached a record \$211 million, compared to a target of \$200 million that had earlier been set, with some trepidation, to be reached by the end of the second UN Development Decade in 1979. This reflected the excellent support given to UNICEF by Governments, National Committees, NGOs, and private groups and individuals.

* * *

Basic Services concept: the beginnings

Rising income levels, of course, were accompanied by rising expectations. Even as the decade began, the Executive Director and the Board were stressing the need for innovative measures to "reach the unreached", those millions of needy children still living in unserved or underserved areas.

Thus, the Board at its April 1972 session, after decrying the limited outreach of the existing health services, called for innovative methods of delivering simple preventive health care, including more extensive use of auxiliary personnel, and "with greater community-level participation, especially in rural areas and urban slums and shanty towns".²²⁹

This theme of community involvement at the local level was picked up and elaborated on by the Executive Director, Henry Labouisse, in his progress report to the May 1973 Board.

"I believe," said Labouisse, "that one of the most important elements in the success of any development efforts concerned with the quality of life is the extent to which the people themselves, at the local level, can become committed and involved. I also feel that, in the past, much too little consideration has been given to this aspect of development progress. Active involvement of people at the level of the small community or district is essential.... This is not a new thought: 'community development' has been a popular concept for many years, and there have been many discussions among planners as to the relative merits (of) emphasizing development 'from the top down' or 'from the bottom up'. In my view, this theoretical debate is unrealistic. Development needs all the help it can get, at all levels of the society concerned".²³⁰

Labouisse acknowledged, however, that "we are only at the beginning of a genuine community participation in development programmes. No one, as far as I know, has yet found the ways to do enough on a national scale to identify local leadership and give it adequate support. At this point, we in UNICEF can only confirm our determination to help countries stimulate and make technically possible a popular effort toward self-help and national development, particularly as far as programmes benefiting children are concerned".

The Board agreed. It "recognized that much of the work for children had to be done at the grass-roots, at the level of the family and the community, against the background of local and regional development needs and possibilities".

A major objective in UNICEF's cooperation with countries, therefore, should be to "help strengthen their inherent capacities to sustain and expand the effort for change and development and to harness the resources of local communities".²³¹ Thus, the ground-work for the formulation of UNICEF's Basic Services policy was laid at the 1973 Board session.

* * *

Basic Services: the missing link in development

It was at the May 1975 Board session that the concept of Basic Services, with its essential component of community involvement and participation, was formally adopted. It was to shape in an important way the policies and practices of UNICEF for the remainder of the 1970s.

The international political scene was dominated by events in Viet Nam when the Executive Director presented his progress report to the May 1975 session of the UNICEF Board. Labouisse, in expressing concern for the children in Indochina (on which a separate note was being presented to the Board, along with recommendations for further UNICEF action), also noted that hundreds of millions of children elsewhere were being affected by the "quiet emergency" -- to which "UNICEF has been calling attention for many years and which, unfortunately, never stops". He also expressed the fear that the international community would become so hardened to "instantly televised suffering", and so discouraged by the accumulation of one disaster after another, that they may conclude that there is no use in continuing international aid efforts.

Nevertheless, Labouisse felt that there were grounds for at least qualified optimism; that, if the poor and affluent countries really worked together, they could meet the basic needs of children "in a not too distant future". He then introduced his concept of basic services:

"In my opinion, what is most needed at this stage is to help countries establish a 'package' of basic services in the interrelated fields of food and nutrition, clean water, health measures, family planning, basic education and supporting services for women. This 'package' should be put together in different ways to suit the needs and the administrative structure of each particular country".²³²

Labouisse stressed that, while crucial components of such services would be the necessary supplies and equipment, there was "also, and most importantly, local leadership, with adequate support from higher levels of Government, short training courses frequently renewed, and full or part-time work by the village or urban people". With regard to costs, he felt that, although they would vary from place to place and would depend on the size of the "package" in each case, the costs should fall in the range of "only dollars per child per year". Later, for the following session of the Board, Labouisse provided some estimates of the global costs which might be involved.

Labouisse felt very strongly that the basic services he had outlined "represent, in fact, the missing link in the development process as practised in the past". While it would be preferable that such services form part of a rural or urban development scheme, he was of the view that this need not necessarily be the only approach; that basic services can, in many situations, be a kind of forward echelon for development, around which more complex and comprehensive improvements could be built.²³³

:Community participation: a vital component

Two major elements in the concept of Basic Services deserve special emphasis. First, it rested on a bed-rock of community involvement and participation. The people must be involved in the entire process, beginning with project planning, through project implementation, to project evaluation, modification, and back to a new cycle of revised project planning and implementation on the basis of experience, good and bad.

:And the multiplier effect in the "package" concept

Secondly, Basic Services was to consist of a package of services, including clean water supply, MCH services, food and nutrition, basic education, and the development of women and girls. The implications of this package concept were never completely articulated, but it was clearly intended to mean that UNICEF's inputs had to be coordinated to reach the same child in the same community, at least to the greatest extent possible. No longer would UNICEF vaccinate in village 1, carry out water supply in village 2, and support nutrition activities in village 3, just because those three villages happened to "belong" to three separate Ministries in the Government, requesting aid from UNICEF in three separate voices.

Also, by implication, such packaging, integration, and deliberate overlapping of different UNICEF inputs to reach the same needy child would also be followed by the Government; or, rather, Government itself would first need to be persuaded, since there are no UNICEF projects as such -- only Government programmes, supported by UNICEF.

Of course, reality being what it is, it is impossible to have complete overlapping for all of UNICEF's and Government's inputs; nor would this be desirable, since some programmes have a broader outreach than others, and limiting UNICEF aid to the smallest denominator of "overlapped" villages would be self-defeating. The pragmatic way to proceed is quite simple, almost simplistic, but it works: whenever new plans of action are prepared, the siting of the new activities should as much as possible be located in areas with existing activities supported by UNICEF (assuming that they have been carefully sited in the first place in accordance with such criteria as high infant mortality rate, high malnutrition rates, and very low literacy rates for girls and women).

Gradually, as this happens more and more, there would be more and more overlapping -- deliberately -- of UNICEF and Government aid, thus evoking a multiplier effect of $1 \times 1 = 3$, or $2 \times 2 = 5$ or 6. Where community involvement and participation is involved, and it invariably should under the Basic Services concept, the multiplier effect would be greatly enhanced.

This multiplier effect of combining several inputs to produce results greater than the sums of the individual components is not just a theoretical equation; it has actually happened under field conditions, as will be seen below in a discussion of a programme in the Philippines called Project Compassion.

In any event, the Board at its May 1975 session adopted the Basic Services approach, stressing that such a package of services need not require new or cumbersome institutions. In most countries, the institutional infrastructure already existed to some degree; what needed to be added "were the antennae - the local individuals in each village or urban slum who could be trained as motivators and front-line workers. That required the active involvement of local leadership, community participation and adequate support from higher levels of government".²³⁴

This marked the first extended, formal expression by the Board of support for community participation at the grass-roots level. Indeed, at this same session, the Board had also discussed a report prepared by the Secretariats of WHO and UNICEF on alternative approaches to meeting basic health needs; reviewed the shortcomings of conventional health systems; examined a few successful or promising experiences, and identified some aspects which appeared to contribute to success. "Possibly the most important among them", concluded the Board, "was the consideration of primary health care as one of the measures to be undertaken by the community as part of its own over-all development. For that reason, the community's involvement was considered essential in planning, supporting, staffing and managing its own health service. In that perspective, primary (health) care would truly belong to the people...."²³⁵ The UNICEF Executive Board had anticipated the 1978 Alma Alta principles on primary health care by three full years.

The Board in 1975 also endorsed WHO's expanded programme on childhood immunization and the strengthening of UNICEF support for immunization, as well as (in the field of nutrition) greater efforts to arrest the decline of breast-feeding -- thus laying the foundations for two of the pillars in the concept of a Child Survival and Development Revolution, which was to dominate the decade of the 1980s.

The UNICEF Board forwarded its advocacy of Basic Services in the form of an annex to its appeal to the General Assembly to consider the plight of children, since the Assembly was scheduled to hold its seventh special session in the fall of 1975 to discuss the economic crisis.

:Basic Services: reprise at 1976 Board session

Accordingly, the UN General Assembly at its seventh special session was seized of the UNICEF appeal advocating this Basic Services approach. In a resolution adopted in November 1975 (Resolution 3408 (XXX)), the Assembly endorsed this strategy. It also took the further and unusual step of inviting the Executive Board to consider this matter in depth at its next (1976) session, and to submit a report through the ECOSOC to the General Assembly at its thirty-first session.

The Executive Director therefore presented a study for consideration by the Board at its 1976 session, elaborating on the concept of Basic Services, and providing some estimates of the range of costs involved. A working group was established, and a report on Basic Services was prepared and approved by the Board for transmittal to the General Assembly.

Salient features of the Basic Services approach, on which its success depends, and which were emphasized throughout the discussion, included these four basic elements:

- a) The active involvement and support of the community itself, from the initial planning stage;
- b) The use of locally selected persons as village agents for delivery of simple routine services;
- c) The engagement in the public services of substantially increased numbers of auxiliary personnel who, given increased responsibilities, would free professionals to devote more time to training, supervision, referral and supporting services;
- d) The firm commitment of the Government to the Basic Services approach as an integral part of its national development strategies.²³⁶

The Board was careful to emphasize that Basic Services did not mean an inferior level of attention; rather, what was proposed was a chance to begin services in unserved or underserved areas, which could be improved as personnel and other necessary resources grew. Thus, flexibility was important if Basic Services were to be progressively upgraded as the level of general development rose.

And, as if the primary importance of community involvement needed any further underlining, the Board agreed to consider at its following (1977) session a UNICEF/WHO study on "Community Involvement in Primary Health Care: a Study of the Process of Community Motivation and Continued Participation"²³⁷.

:General Assembly's second endorsement of Basic Services approach

The General Assembly at its session in the fall of 1976 considered UNICEF's Basic Services approach once again. Upon the recommendation of its Second (Economic) Committee, the following resolution was passed, addressed to both developed and developing countries:

"The General Assembly,

...

Recognizing that the provision of basic services constitutes an important link in the development process,

...

Convinced that the basic services concept and strategy, while providing guidelines for future action by the United Nations Children's Fund, are equally appropriate for adoption by agencies and authorities concerned with the promotion of programmes for human development in developing countries,

...

1. Urges the developing countries to incorporate the basic services concept and approach in their national development plans and strategies;
2. Urges the developed countries and others in a position to do so to provide through bilateral and multilateral channels, including the United Nations Children's Fund, external assistance to supplement the efforts of developing countries in launching or expanding basic services benefiting children;
3. Urges the international community to recognize its responsibility for increased co-operative action to promote social and economic development through its support of basic services at the international and the country programming level."²³⁸

The Basic Services approach of UNICEF, therefore, had received the strongest possible endorsement from the largest body of the UN system.

* * *

Special Meeting on the Situation of Children in Asia with Emphasis on Basic Services: Manila, May 1977

If, indeed, good things happen in threes, the Special Meeting on the Situation of Children in Asia with Emphasis on Basic Services, which took place in Manila in May 1977, was the third for Basic Services, the first being the 1975 Board session, when the Basic Services concept was born; and the second being the 1976 Board session, when the Basic Services approach was further developed and re-emphasized at the behest of the General Assembly, which had adopted a second and supportive resolution on the matter.

This Special Meeting on the Situation of Children in Asia with Emphasis on Basic Services took place in Manila from 17-19 May 1977, just prior to the regular session of the UNICEF Executive Board which was held from 23 May to 3 June 1977.

As planned, this Special Meeting, attended by Asian Governments not members of the Board as well as by Board members themselves; Asia regional offices of the UN system; NGOs, journalists, and others, did indeed focus on Basic Services, and how that concept was already being implemented, with varying degrees of success, in a number of countries in the Asia region. Nine projects in Asia with a wide range of settings and innovative approaches were selected for presentation to the Special Meeting, three urban, three rural, and three in area development:

Urban:

- (a) "Development of Education and Welfare Programmes for Children in the Klong Toey Slum" by Ms. Prateep Ungsongtham (Thailand);

- (b) "Face to Face with Poverty: The Mobile Creches" by Ms. Meera Mahadevan (India);
- (c) "A Review of the Slum Improvement Programme in Calcutta with Special Reference to Services for Women and Children" by Mr. K.C. Sivaramakrishnan (India);

Rural:

- (a) "Integrated Health Services Project, Miraj, India" by Dr. Eric R. Ram (India);
- (b) "Sarvodaya Shramadana Movement for Social Development in Sri Lanka" by Dr. A.T. Ariyaratne (Sri Lanka);
- (c) "Basic Services Delivery in Underdeveloping Countries: A view from Gonoshasthaya Kendra" by Dr. Zafrullah Chowdhury (Bangladesh);

Area:

- (a) "Development in West Sumatra, Indonesia" by Governor Harun Zain (Indonesia);
- (b) "The Need for an Integrated Approach to Social Development in Underdeveloped Countries -- A Look at Project Compassion" by Mr. Ramon P. Binamira (Philippines);
- (c) "Case Study by the Comité Central de Protection de la Mère et de l'Enfant" (Socialist Republic of Viet Nam).

The authors of six of the papers were able to introduce them personally; summaries of the remaining three papers were presented by resource persons. The ensuing discussions, as recorded in the Report of the Special Meeting, brought out the difficulties and shortcomings as well as underlining the achievements.²³⁹ In almost all cases, the important ingredient of community commitment, involvement, and participation was present.

Thus, in the Klong Toey urban slum project of Bangkok, Ms. Prateep Ungsongtham (who later was awarded the prestigious Magsaysay Award for her work) emphasized the need for ensuring the active participation of the slum dwellers and low-cost methods of operation. The mobile creches of New Delhi, founded by Ms. Meera Mahadevan, also involved the local workers and parents in decision-making and activities for the young children.

The Sarvodaya Movement in Sri Lanka was a non-governmental, non-profit, people's movement, and represented one of the oldest programmes in community involvement to come before the Special Meeting -- having been founded in 1958. This movement, under the leadership of Dr. Ariyaratne, also won a Magsaysay Award.

Dr. Zafrullah Chowdhury of Bangladesh, in presenting his rural project, noted that the active involvement of people -- "especially women" -- was the only effective approach to delivery of services.

And so it went: in the area development project of West Sumatra, the Government actively involved people at different levels, including villagers, officials, religious leaders, students, and the chiefs of clans. The Philippines project, called "Project Compassion", was based on an innovative scheme by which groups of 20 families were organized, under a unit leader, to conduct a "doorstep" delivery system in nutrition, food production, family planning, and environmental management.

:Some Asian perspectives on community participation

The discussions at the Special Meeting on the Situation of Children in Asia with Emphasis on Basic Services brought out the following points:

1. It was wrong to assume that the people in the community invariably welcomed the programmes; in fact, they were "sometimes suspicious of or even opposed to them". In this context, programmes were most effective when they used indigenous materials and locally trained staff who were recruited from the community itself, or from one with a similar social background.
2. While this indigenous support was important, equally vital to any long-range sustaining of the programme, if it were to become permanent, was the recognition and financial support from the Government. "The more comprehensive a programme became, the more that was true".
3. Another myth about community participation was that slum communities had some built-in cohesion which automatically led to successful mobilization and results. Low-income groups, as with any other groups, had their diversity of views, differences over objectives, and sometimes confusion between means and ends. And they, too, were stratified into the haves, the have-nots, and the have-mores.
4. Low-cost projects often yielded the best results. For example, in the Miraj project in India, 186 village birth attendants (dais) were given simple training in hygienic delivery and provided with a small "kit" consisting mainly of a razor blade costing a few cents each, for hygienic cutting of the umbilical cord. Infant mortality in three years fell sharply. The State Government of Maharashtra decided to extend this type of project in ten districts of the State.
5. In the view of one of the resource persons, the situation of children cannot be considered in isolation, but rather as an important facet of the over-all poverty problem; until UNICEF aid became part of a comprehensive strategy for the eradication of poverty, its activities would have no significant impact. Also, if the poor were to make proper use of the services provided, their ability to take advantage of them must be improved. It was therefore necessary to organize the poor.

These and other observations, linking Basic Services (with its central core of community participation) to the political issue of poverty, were challenging and provocative. They could not be otherwise, because the very essence of Basic Services was the social mobilization of the community -- for the good of needy children and mothers, of course; but who knows what the community would do when they taste success through self-help? How does one draw the line between social mobilization and politicization?

Perhaps something along these lines was what the Chairperson of the Special Meeting, Dr. Estefania Aldaba Lim, Minister of Social Services and Development of the Philippines (and later Special Representative of the Secretary-General for the International Year of the Child) had in mind when she commented, in her closing remarks, that "the meeting had achieved its objective. While some views put forward had seemed heretical, the heresy of today was the truth of tomorrow. History would judge the work done at the Special Meeting by the programmes and policy changes put into effect as a result of its work".²⁴⁰

:The Philippines: Project Compassion

"Project Compassion" deserves a special look because it represents a rather unusual example of the multiplier theory actually working in field conditions.

When the leaders of Project Compassion first approached the UNICEF/Manila Office in the fall of 1975, the Board had just recently enunciated its advocacy of a "package" of basic services. An appealing feature of Project Compassion, therefore, was that it, too, had only recently "packaged" itself by combining four separate schemes, namely food production (Green Revolution), nutrition, family planning, and environmental management, into one delivery system.

The project director, Ramon Binamira, and concurrently head of the Green Revolution programme, explained that the purpose of the combined scheme was to help the needy child by improving his nutrition, his environment, and his family and community through a combination of measures offered by the four programmes. The families would be motivated, or socially prepared, by a small group of highly trained and experienced community development workers who were graduates of a series of the well-known "PACD" training courses, begun in the 1950s under President Magsaysay's Presidential Assistance for Community Development programme (of which Binamira was the head).²⁴¹

This group of workers had recently returned to the Philippines in the summer of 1975 after serving in a non-combatant capacity as community development workers in Vietnam. They would be assigned by Project Compassion to live and work in the villages. This would be a field project, not a paper exercise.

The method of reaching and motivating the families, evolved over time, seemed simple -- but required an enormous amount of detailed organization and preparation. Two of the trained staff would go to a village and gather data -- number of families, number of children, number of babies and young children who died recently; amount of money spent on beer and cigarettes, what vegetables were bought in the market, etc.

This profile of the village would be presented to the community at an evening meeting. The approach was frankly emotional, for the people were emotional, and warm. When confronted with the fact of child malnutrition in their midst, whole communities would respond. They would be motivated to organize themselves into 20-family units, with three units forming a chapter which elected its own president, vice-president, secretary and treasurer.

In a moving candle-light ceremony, the officers and the people in the community would pledge to work together for the improvement of the situation of children -- thus giving Project Compassion a new name, "Ilaw ng Buhay", or Light of Life Movement. These Ilaw ng Buhay villages, as they came to be known, over a short period of time would show very visible signs of improvement.

The whole village would be cleaned up; backyard vegetable gardens would flourish; malunggay trees would be planted and grow quickly, which was good for nutrition, but also for environmental management (their roots grew into the ground as long as the height of the tree, thus helping in soil conservation); malnourished children would be rehabilitated. Above all, or because of all this, a strong feeling of community would develop.

At the beginning of the project, however, Project Compassion was desperate for some assistance for the supervisors and field workers. The grant which the project received from the Population Centre Foundation to initiate operations had specifically precluded the purchase of equipment. The field staff were determined to proceed by foot from village to village if they had to, and they would talk until their voices gave out in mobilizing the communities; but some small vehicles would help them meet their targets in a more efficient and effective manner, and some public address systems would save some lost voices. Would UNICEF help?

The UNICEF/Manila office would. By bending (some said breaking) the local procurement rules, about two dozen small vehicles with Volkswagen engines and plain, locally-made bodies, plus some public address systems and other supplies and equipment, were provided to Project Compassion within a few weeks. Things began to move.

When the UNICEF-sponsored Special Meeting on the Situation of Children in Asia with Emphasis on Basic Services took place in May 1977, Project Compassion had been in operation in the field for just a little over a year. Nevertheless, in his paper to the Special Meeting, Binamira noted the tremendous enthusiasm which had already been generated by the innovative approach of the "doorstep delivery" system which directly helped families and communities in the ten provinces and two cities where Project Compassion was operating. Neighbouring provinces and cities were clamouring to join. Some local governments were willing to contribute cash -- the hardest test of all.

:The multiplier theory in practice

But it was the project results which were startling, even to a seasoned community development worker like Binamira. The following statistical highlights of accomplishments, based on data collected by the field workers from 1,025 villages, were presented to the Special Meeting:

Table V ²⁴²

Project Compassion: accomplishments

	<u>Base line*</u> (mid-1975)	<u>Additional since</u> <u>project coverage</u> (by October 1976)	<u>Percentage</u> <u>increase</u>
<u>Nutrition</u>			
No. children fed at centres	4,177	41,624	996
No. feeding centres	52	154	296
No. nutripak plants	1	3	300
Malwards (for malnutrition)	1	9	900
No. participants attending mother's classes	6,570	5,847	89
<u>Green Revolution</u>			
No. of home gardens	73,724	19,864	27
<u>Environment</u>			
Households with sanitary garbage disposal methods	53,881	26,075	48
Families with sanitary toilets	94,726	14,752	16
Households with potable water sources	71,038	4,527	6
<u>Population</u>			

("Before" and "after" data on population were not available in the report).

* The baseline accomplishments were those achieved when the four projects of Green Revolution, nutrition, family planning, and environmental management were operating separate from each other.

"It is worth noting", commented Binamira in his report, "that the Green Revolution programme carried out in other parts of the country could not produce results as extensive as those under Compassion coverage - the shining example is the province of Misamis Occidental, where vegetable gardens can be seen throughout the whole length of the province".

Similarly, the nutrition, population, and environmental sanitation programmes could not exhibit as much progress within the same time frame. "This is no accident. It is not that the workers of these functions in other areas expended less effort. They did not have the machinery to link their efforts with those of the people themselves".

Binamira concluded: "The most telling proof of the beneficial effects of co-operation is that Project Compassion during its short existence has produced more results for each of the sectoral programmes that were integrated in its area of coverage than in other areas where the same programmes were carried out in isolation".²⁴³

Here was proof positive that four x one = six or seven. When time came to prepare a new UNICEF commitment for the Philippines, Project Compassion was accepted by the Government as the link between communities and the government set-up in the provinces and localities for social mobilization efforts -- a credit to the hard-working and dedicated staff of Project Compassion. The Board at its 1980 session approved a long-term commitment with this innovative feature of social mobilization.²⁴⁴

At a subsequent Board session in 1983, support was extended to establish two resource and training centres for the training of local government officials and leaders of community Ilaw ng Buhay groups in the Project Compassion programme.²⁴⁵

* * *

UNICEF Board session, Manila, May/June 1977

Immediately following the Special Meeting on the Situation of Children in Asia, the UNICEF Board held its regular session in Manila, 23 May to 3 June 1977. It naturally carried over the theme of community involvement and participation, as well as the vital point of packaging, or deliberate overlapping of services, into its regular discussions. Thus, when the Board reviewed a report on formal and non-formal education, prepared by the Secretariat with the assistance of H.M. Phillips, UNESCO and bilateral aid agencies, support was expressed for more "innovative forms of education as part of a basic services approach involving maximum community participation".²⁴⁶

At this session, the Board also reviewed a joint UNICEF/WHO study on community involvement in primary health care (PHC), which reinforced its views as to the necessity of active community involvement in determining needs, and in preparing and implementing activities to meet those needs. The Board recognized, however, that there were serious obstacles to the activation of communities which needed further and careful study; not every country had the kind of dedicated staff as in Project Compassion, with its deep commitment to working at the grass-roots level.

The important relationship between Government and community was explored in the Board discussion. Obviously, conditions for community involvement and participation were optimal where the Government had a dynamic approach to achieving goals for social and economic development, and itself encouraged and facilitated social mobilization, including appropriate structural changes.

:UNICEF as a connecting bridge for Government and community

But what if the national authorities did not support community involvement, or preferred to impose their preconceived ideas and programmes on communities? The Board could only argue that "The real desires, needs, attitudes, and practices of the communities must be understood and respected.. Very often a community was a shrewd judge of its priority needs and in many respects had a better notion of how to tackle its problems than any outsider could have. It was essential therefore to achieve an open dialogue and true communication between government officials and the communities". And in that process, continued the Board, "the attitudes and the understanding of government health staff and other personnel could be greatly affected. A two-way learning process might be instituted".²⁴⁷

Here was a most suitable role for UNICEF -- to serve as a bridge for Government and community to facilitate this two-way learning process. But what patience, and how much time, is needed! In the case of the Davao Institute for Primary Health Care, for example, located in the southern part of the Philippines, this private agency -- although wanting very much to have UNICEF aid for training village-level health workers -- balked at first at the UNICEF/Manila office's condition that Government rural health personnel must be involved, since they were also part of the communities they worked in. Reluctantly, Davao agreed.

It took well over a year for everyone, government and non-government alike, including the leaders of the Davao PHC Institute, Dr. and Mrs. (Dr.) Jesse de la Paz, to realize that involving the whole community really had tremendous advantages. In the beginning, of course, it was difficult: one overly-enthusiastic municipal health officer, for example, whose cooperation was being solicited, said, "No problem. I'll select the candidates myself, and everything will be fine!" -- thus potentially vitiating the vital element of community involvement and participation from the start (selections from his municipality were finally made by the communities concerned). Such attitudes, common in the beginning, gradually gave way to a better understanding of what true community participation was all about.

In this case, as in many others in other country situations, UNICEF staff members (accompanied on occasion by national government officials) served as a bridge between private efforts and local government health officials, allowing views to emerge -- and often clash -- but, eventually, to facilitate their coming together for the good of the community. Perhaps this was what the Board at its 1977 session had in mind when it urged UNICEF to reinforce its advocacy of community involvement in PHC and in basic services generally, beginning with the UNICEF staff, but including major partners in the United Nations system, major financing institutions and important bilateral aid organizations.²⁴⁸

Thus, community participation would not just be internal UNICEF policy, but something to be advocated with other UN agencies, institutions, and governments in the developing countries -- but beginning, of course, with the UNICEF staff.

This gave rise to some interesting experiences. Those staff members in the field who were political activists were very enthusiastic, and even needed to be restrained at times, since they were not aware of (or, more likely, did not care about) crossing the thin line between social mobilization and politicization. On the other hand, those who felt that social mobilization was inimical to the interests of the Government tended to be more conservative in their programming and implementation of UNICEF aid in this sector, and needed encouragement to be more responsive and flexible.

* * *

Alma Ata Conference on Primary Health Care (1978)

The Alma Ata Conference on Primary Health Care, held in the USSR in September 1978 under the sponsorship of WHO and UNICEF, was a landmark in the evolution of global health policy. It was held not only because there was "a growing recognition that the promotion of health was essentially a development issue which was the responsibility of Governments as a whole, and not only a technical matter for Ministries of Health", but because "The primary health care approach placed high priority on the improvement of health through effective measures to meet main health needs carried out with appropriate technologies at moderate costs, and which actively involved the community in identifying its health needs and in carrying out measures to meet them".²⁴⁹

* * *

From sectoral programmes to Basic Services

By the end of the 1970s, the community-based approach for providing essential services was becoming a recognized alternative to the more traditional methods of linear expansion of services. The Executive Director, in his progress report to the May 1979 Board session (which was held in Mexico City), provided a number of examples of community involvement from Asia:²⁵⁰

- a) In Burma, primary health care was introduced through the Government's "People's Health Plan", initiated in 1978. A first batch of 670 community health workers, chosen by their communities and trained by the Government, had begun work early in 1978 in their townships, against a national target of 5,300. These community health workers would be supplemented by auxiliary midwives, also chosen by the communities, and trained and equipped with UNICEF assistance.
- b) In Malaysia, the strategy to develop the primary health care approach emphasized early involvement of villagers in the planning process through village-level consultations;
- c) In Nepal, the National Planning Commission for the Sixth Plan had established clear principles to foster grass-roots involvement in planning and implementation;

- d) In the Philippines, with echoes of the very early advice of Dr. Su in China, the International Institute for Rural Reconstruction (a well-known international voluntary agency) was concluding that the delivery of primary health care should not rest on one multi-purpose village worker, but a combination of workers providing services, such as the hilot or rural midwife for delivery of babies, and the herbolario for the treatment of ailments. The IIRR was promoting ways in which these and other village-level workers could function as a team;
- e) In Thailand, a special effort was being made in the rural water supply programme to involve women in all relevant decisions, including the important question of site selection as well as planning for water pump installation and maintenance.

Two other fine examples of community involvement in the implementation of primary health care and basic services, described by Maggie Black in her history of UNICEF, are the work of Drs. Mabelle and Rajanikant Arole at Jamkhed in Maharashtra State, India, and the Kasa project, also in Maharashtra, of Dr. P.M. Shah.²⁵¹

India seems to produce more than its share of dedicated people who devote their entire lives in the service of the needy in poverty-stricken areas. Aruna and Bunker Roy, for example, of the well-known Tilonia Centre for Social Work and Research in Rajasthan State, became involved as a result of the terrible drought which affected many parts of India in 1966/67. Nevertheless, it took them literally years of patient living and working in the area before they, with all the commitment implicit in their giving up promising careers to work in the poverty belt of central India, could overcome the traditional suspicion of the villagers to "outsiders" who come into their midst. Their experience makes gentle though unintended mockery of the neat timetables which UNICEF sometimes set for implementing projects in this field of community participation and social mobilization.

* * *

From Basic Services to area development and convergence of services:
the India experience

India is one of the leading exponents and practitioners of "packaging" basic services so that UNICEF's resources can converge on the needy child to produce a multiplier effect, much like what happened in Project Compassion in the Philippines. Only, in India, no less than four major programmes are being carried out by the Government under the heading of convergent services.²⁵²

:India - Integrated Child Development Services

The Integrated Child Development Services (ICDS) programme, which had its roots in the 1960s as described in the previous section, is focussed on the young child 0-6 years, and its area approach is expressed in its goal of helping needy mothers and children in rural/tribal areas and urban slums.

The ICDS programme as such got off to a cautious and somewhat shaky start, as a pilot scheme, in 33 of India's more than 5,000 administrative blocks at the beginning of the country's Fifth Five-Year Plan (1975-1980). With increasing confidence as some of the early problems were solved, the programme gradually expanded to 300 blocks/projects by March 1982, and to 1,356 by March 1985, covering roughly 20 per cent of the population. Under the current Five-Year Plan 1985-1990, the plan is to expand the programme to cover a total of 2,200 blocks/projects, or over 40 per cent of the total number of blocks in the country. The ICDS programme is now rated as one of the most successful of India's attempts to improve the quality of life for the vulnerable groups.

UNICEF support for the programme is being reinforced by convergence from two external food-giving agencies: the World Food Programme and CARE, which have agreed with the Government to channel food aid through ICDS. Also, within the Government itself, a number of Ministries (in addition to the two major sponsors of the Social Welfare and Health Ministries) have agreed to coordinate their inputs with ICDS, including Rural Development (water), Urban Development (sanitation), Information & Broadcasting (radio programme), Energy (smokeless stoves), Education (non-formal means of education), and Food & Civil Supplies (ready-to-eat foods).

At the project level, convergence is reflected in the expansion of services to include such elements affecting the needy child as safe drinking water, sanitation, identification of childhood disability, distribution of Vitamin A, and diarrhoea management through oral rehydration therapy. Other activities such as immunization and supplementary feeding are already being carried out at the anganwadis or village centres, which form the backbone of the ICDS programme.

These are all encouraging developments. If maintained, and if the administrative and other difficulties already identified in the Plan of Operations can be overcome, chances would be very good for achieving India's national goal of reducing the infant mortality rate from 110 to 87 by 1990, and to below 60 by the year 2000.

:India - Social Inputs in Area Development

The Social Inputs in Area Development (SIAD) programme is also area-specific, focussing on particular parts of the country which are lagging badly behind in terms of social and economic development.

Begun by the Ministry of Social Welfare in 1978, results so far in 26 projects in as many districts, spread over 16 States, have been mixed, but the experience gained is proving to be invaluable in determining future implementation.

Each project begins with an assessment, without any preconceived parameters, in order to allow the greatest possible flexibility in determining needs and solutions. This is SIAD's strongest attribute; it is also the most difficult to handle in terms of implementation. The range of activities carried out so far, as listed in the Plan of Operations for India, indicate the diversity of schemes being assisted, including: vector and parasite control in Kerala; social forestry in Ladakh (Jammu & Kashmir); bio-gas plants in Andhra Pradesh;

house-to-house transfer of diarrhoea management skills in tribal Bihar; tapping of solar energy in Gujarat, and safety measures against occupational hazards of child labour in Tamil Nadu.²⁵³

Achievements have been substantial in the field of child health and related areas. In Ratnagiri (Maharashtra State), 83 per cent of the 40,000 eligible children have been immunized, compared with a coverage of less than 25 per cent at the start of the project. The corresponding figure for East Godavari (Andhra Pradesh) is around 66 per cent, starting from a very low percentage. Hundreds of protected water systems have been installed and similar numbers of health workers trained. And, contrary to the general situation in many parts of the country, thousands of latrines have been built in fishermen's villages in coastal Kerala.²⁵⁴

The plan in the current Five-Year Plan is to phase out UNICEF support in eight of the 26 existing projects, and to add 32 new ones. This is an exciting programme, due partly to its unpredictability.

:India - Urban Basic Services

One mistaken assumption often made is that, because of population density, services reach the urban child more than they do the rural child. Recognizing that this is not true for the great majority of children living in urban slums, UNICEF has been cooperating with the Government since 1976 to strengthen the basic services component of a number of slum improvement programmes in the country. By 1983, over 40 urban projects in different States had been assisted by UNICEF, reaching an estimated 1.4 million people. Current plans are to expand to 250 by 1989, with new areas to be selected where, inter alia, convergence with other UNICEF-assisted schemes such as ICDS and SIAD can be effected — thus implementing the multiplier factor.

In fact, to ensure that there will be convergence, the three main urban programmes supported by UNICEF in India — Urban Community Development, Small and Medium Town Development, and Low-Cost Sanitation — have been brought together in a single programme called Urban Basic Services, with a common focus of helping needy children and women of low-income families in selected least-developed urban areas.

:India - Development of Women and Children in Rural Areas

As a counter-point to the urban programmes, and recognizing that women in the rural areas need special assistance, the Government in 1982 launched a programme of Development of Women and Children in Rural Areas (DWCRA) as a sub-scheme of the Integrated Rural Development Programme. The main thrust of this programme is income-generating activities for women, on the basic assumption that, among poor families, enhancing women's income would have a positive impact on the nutritional status and learning opportunities of the children, as well as on the status of the women themselves. Implementation is proceeding well in a number of States, including Rajasthan, where female literacy is substantially lower than the average for India; and in the Kaira district of Gujarat, where a well-developed infrastructure is already available in the form of dairy cooperatives, thus enhancing the chances for success.

*

*

*

Urban Development

Almost all of UNICEF's work in the early years had been in the rural areas, where the majority of the populations of the developing countries live. The needs of children in urban slums and low-income areas began to command the attention of the Board in 1971, when it adopted guidelines for extending UNICEF aid to children in urban slums and shanty towns.²⁵⁵ Initial progress was slow; it was difficult to come up with solutions that would be economically realistic, attainable within a reasonable time frame, and at the same time also politically feasible.

However, as the 1970s progressed, the momentum for urban basic services began to pick up, and the Executive Director was able to report on some global developments in his progress report to the Board in May 1979, supplemented by additional information presented to the May 1980 session.

For Asia, the following achievements were recorded:

- a) In Bangladesh, UNICEF at the request of the Department of Social Welfare had assisted the Centre for Urban Studies at Dacca University with a survey of living conditions for the urban poor in the four largest urban areas of the country -- Dacca, Chittagong, Khulna, and Rajshahi. The information collected did, in fact, provide the basis for preparing an urban component of the Bangladesh country programme recommendation which went before the 1980 Board, and which covered such activities as skills training and income-generating activities for women, family planning, provision of water and sanitary latrines, and basic health care.
- b) In India, in addition to continuing support for the large Hyderabad urban project, UNICEF extended assistance to six more cities, and consideration was also being given to UNICEF support for medium and small-sized towns. In the ICDS programme, some of the projects were located in urban slums.
- c) In Indonesia, low-income urban areas in four cities as identified by the Government were being assisted by UNICEF in the fields of non-formal education, community development, health, nutrition, and water.
- d) In Malaysia, a seminar supported by UNICEF in May 1979 found that the health status, mortality rates and environmental health and sanitation in squatter communities were unsatisfactory, and were posing a hazard to the inhabitants themselves as well as to other communities. Quick action followed: by October 1979, three multi-purpose preschool child community centres called the Sang Kancil Project had been opened in squatter areas, and activities had already commenced, including MCH, family planning, and nutrition programmes.
- e) In Pakistan, the University of Karachi and the local chapter of the Jaycees were cooperating in a small project in Karachi to construct pit latrines and to provide the necessary accompanying health education to slum dwellers. In Lahore, following a November 1979 workshop, a plan of action was developed to improve conditions in ten katchi abadis (low-income urban areas) over a three-year period.

- f) In the Philippines, as part of a Government/World Bank-financed urban improvement programme, UNICEF supported training workshops and seminars that brought together community residents, agency field workers and Slum Improvement and Resettlement Project (SIR) management staff in the three regional cities of Davao, Cebu, and Cagayan de Oro. The workshops resulted in a variety of community-initiated social development services for children, including day-care services, health and nutrition education for parents/teachers; community leadership training for formal and informal leaders, and construction of sanitation facilities.
- g) In Sri Lanka, UNICEF assisted in the upgrading of community water supply and sanitation facilities in 68 slum and shanty communities in Colombo. Also with UNICEF aid, the Colombo Municipal Council recruited 85 health wardens and put them through an intensive training course in order to prepare them for organizing the communities to maintain their sanitary facilities. In addition, UNICEF provided a short-term consultant to the Women's Bureau to initiate income-generating activities among women in four low-income urban communities. The activities were those that would not require much training and capital, and some of the women were already engaged in manufacturing paper bags, labelling cigarettes, and making balls of string with unwound gunny-thread.
- h) In Thailand, the Government had launched a pilot project on urban improvement in five areas of Bangkok with World Bank assistance. Meantime, UNICEF through the women's project was supporting Government plans in two urban slums of Bangkok to strengthen the capacity of the community to plan and carry out development activities.²⁵⁶

UNICEF assistance in World Bank-financed projects is interesting from the point of view of the ability of the respective agencies to respond quickly to local needs. The World Bank's requests to UNICEF have been in the area of social mobilization, which often required relatively small but quick inputs -- something in which UNICEF has a good record.

* * *

Water and environmental sanitation

Water programmes, on the other hand, call for sizeable inputs, and UNICEF in the 1970s was able to respond accordingly in a number of cases, the largest of which was in India.

The 1966/67 drought in India, described briefly in the previous section, had, if one could say so in the case of such a terrible disaster, one bright side: the drilling rigs purchased by UNICEF from the United Kingdom were high-powered models which represented a technical breakthrough in drilling technology, and these were instrumental in launching in India, in 1970, the largest UNICEF-supported rural water supply programme in the world.

:Hard-rock drilling for water in India

From time immemorial in India, as Martin Beyer, in his monograph on "Water and Sanitation in UNICEF 1946-1986" has explained it,²⁵⁷ the people had tediously dug open wells ("some of them very large, which could be likened to inverted pyramids") for their drinking water supply. Until fairly recently, 40 or 50 years ago, the water table was quite high; there was much more vegetation and soil to protect the water from evaporating; and the land had not been de-forested to the extent it is now, nor was there over-pumping with modern power pumps by farmers with large holdings and small industries.

But these recent factors of de-forestation and installation of deep wells with power pumps, combined with the tremendous population increase, had contributed to a dramatic lowering of the water table for the open wells. This meant that deeper wells were required, but until about 1960, the only way to do this was the very slow drilling method called cable-tool drilling, with one well to an average depth of 50 metres taking three or four months to drill.

A technical breakthrough occurred just about the time of the Bihar drought. Compressed-air hammer drill rigs, hitherto used for drilling blast holes for mining and construction, plus new advances in metallurgy to produce very hard metal-tipped drill bits, could now be used for water well drilling. They had just become available, and the eleven drilling rigs which UNICEF had purchased for the Bihar drought were of this new type. Depending on the terrain, they could drill a 50-metre well within a matter of a few days!

Within two months, records Maggie Black, these new drilling rigs had pounded "swiftly through soil and rock, bringing water to 222 villages in Bihar and Uttar Pradesh whose thirsty inhabitants had been faced with imminent evacuation to relief camps".²⁵⁸

This instant success led the Government of India to request UNICEF to provide 70 or 80 more of these drilling rigs to begin a new nation-wide village water scheme. Beyer has recounted how he came to be involved in the preparation of a very large programme recommendation for this project, which the Board in April 1970 approved in the amount of \$5,893,000 for a four-year programme.²⁵⁹

No one, however, had ever been confronted with a situation "that already for the first two or three years of the programme foresaw the drilling of over 8,000 wells in the State of Andhra Pradesh alone, not to speak of some vague plans for 25,000 more wells in Orissa". Nobody then, continued Beyer,

"could foresee that something like 100,000 wells for handpump installation would be drilled annually in India. The risk that UNICEF took by supporting this first really major part of the programme, was considerable. But, as Gordon Carter, then UNICEF's Regional Director recalls, 'The first lot of rigs were literally nursed onto the job by our people, and even as numbers grew, programme and project staff kept a pretty close eye on them.' The drilling programme as it rapidly expanded was an outstanding success".²⁶⁰

:India's Mark II handpump

Drilling holes rapidly was one thing; installing handpumps by the tens of thousands was quite another. "Most of the handpumps available in India and manufactured there in those days, were cast iron pumps of the traditional type as developed in Europe and North America for single-farm households. They were fine for families of a few persons and a total use of a few minutes per day. No provision to speak of had been made for any organized maintenance and repair of such pumps. Everyone just went optimistically into this whole programme".²⁶¹

At first, the handpumps being installed were going out of order at an alarming rate. The head of one international nongovernmental organization who visited the project in 1973 found that over 80 per cent of the pumps he saw were out of order. Reacting to this serious situation, a very sturdy handpump eventually emerged, based on excellent work by various NGOs in India, and improved and perfected by two UNICEF water experts, who named the pump the Mark II.

The rest, as they say, is history. By the end of 1975, India had installed with UNICEF assistance nearly 18,000 handpumps, bringing the benefits of clean drinking water to an estimated 9 million people.²⁶² Beyer records that, from 1976 onwards, the India Mark II handpump went into production on a large scale, reaching a level by 1986 of some 150,000 pumps per year. Quality control over the 40 or so officially recognized manufacturers is carefully maintained through strict testing by firms outside India.

:Handpump maintenance

As for handpump maintenance, a three-tier system was developed in Tamil Nadu which was applied nation-wide. The first tier would be the village volunteer caretaker, who would be responsible for maintenance and very simple repairs. The second tier would consist of roving mechanics at the block level who would be able to help in more complicated situations. The third tier, at the district level, would consist of a repair team with a truck and a tripod for pulling out the rather heavy rising main of the handpump, something which the village caretaker would not be able to do. UNICEF assisted in the training and provision of equipment and transport for this three-tier system.

In the State of Rajasthan, however, the experience of Bunker Roy of the Tilonia Centre (which was one of many places involved in the UNICEF-assisted training scheme) convinced the State authorities that a two-tier system would be practical and more economical. A crisis developed when the water section of the UNICEF Regional Office declined to support this modification -- a good example of the kind of dilemma which often arises when UNICEF and the Government disagree over a practical approach to a field problem.

Nation-wide, Beyer cites a recent evaluation showing that the average number of pumps functioning at any given time in four sample areas of India amounted to about 85 per cent. "Most of the maintenance carried out seems one way or the other to be spontaneous. This is a sign that the local populations give a high priority to the pumps and try to keep them up, as they would do with their trucks or bicycles".²⁶³

:Environmental sanitation

The total UNICEF investment in clean water and environmental sanitation in India, starting almost from scratch in 1970, has grown to roughly \$15 million. On the Government's side, their annual budget has increased to \$650 million, with some 3,000 water well drilling rigs of the rapidly-operating type and thousands of engineers, water well drillers, and other personnel. Relatively little of this, however, is spent on environmental sanitation. As Maggie Black has put it, "While water was a deeply 'felt need', a latrine decidedly was not. While communities willingly organized themselves to dig a hole in the earth for a pipeline, they evinced little or no enthusiasm to do the same for a latrine.... Until the human race is able to abandon its inhibitions about the subject, as it has done for sex and reproduction, excreta disposal is likely to remain the joker in the health-care pack".²⁶⁴

Nevertheless, the New Delhi Office cannot be faulted for lack of trying. At the request of UNICEF, a WHO sanitary engineer, Alberto Besa, was seconded to the UNICEF/India Office for some five years, during which time he worked tirelessly to promote the cause of proper excreta disposal. And, currently, there are two project officers who have, in their quiet but persistent manner, managed to initiate a number of excreta disposal projects in various parts of India. But old habits die very hard in the country-side.

One environmental sanitation/excreta disposal project (not UNICEF-assisted) which is working - and yielding a profit! - is the amazing story of Dr. Bindeshwar Pathak and his Sulabh Shauchalaya project in Patna. Pathak had the ingenious idea of constructing toilets-cum-showers, strategically located in market towns and other places where he knew there would be a heavy transit population. For a few paisa, a traveller could go into a private cubicle, relieve himself or herself (separate facilities were provided for men and women), and have a shower with soap provided by a paid attendant whose duty it was to keep the place clean. The success of this enterprise was such that Pathak now travels internationally as well as to other parts of India to propagate this innovative approach.

It is not easy to duplicate, however. The crucial factor seems to be location. Where traffic is heavy, as in a market town, chances for success are good. But, in the vast majority of the rural areas, with scattered population, such an approach would not be feasible. This may be the one area where economic development may have to precede social development before improvements on a wide scale can take place.

:Other water supply projects in Asia

UNICEF is assisting in many other water supply projects in Asia, and Beyer has provided colourful descriptions of them in his "WET" history of water and sanitation in UNICEF, from Pakistan (which included a technical curiosity of the first use in UNICEF's history of a horizontal water well drilled into the mountain-side); to Afghanistan (where UNICEF almost got involved in tapping an underground river which would have meant cooperating with the International Atomic Energy Agency for the purpose of isotope tracing of the water); to Nepal (where helicopters had to be used to deliver piping to inaccessible villages buried in the mountains, a very dangerous operation); to much more,

including a rainwater cistern project in an area of Indonesia where infiltration of salt sea water made the groundwater undrinkable -- and which proved to be so successful that the World Bank later stepped in with loans to enlarge the coverage, which is exactly what UNICEF's catalytic role is all about.²⁶⁵

The project in Bangladesh, however, had a very unusual financial twist.

:Bangladesh rural water supply - and a revolving fund

In Bangladesh, soft silt exists in contrast to the hard rock of India. UNICEF had been assisting in a modest way in a rural water supply project in what was then East Pakistan. Ironically, it was only because of an unprecedented disaster in the latter part of 1970 that UNICEF's water involvement in Bangladesh began to accelerate in earnest.

In November 1970, a terrifying combination of tropical cyclone and tidal wave struck East Pakistan and in one night killed some 300,000 people, destroying 87 per cent of the homes and ruining the ripening rice about to be harvested.

UNICEF responded with alacrity. Perry Hanson, then serving in Dacca, noted in his July 1971 report that, "By February... public health engineers, technicians and crews had brought clean water to the survivors through an acceleration of the UNICEF-aided rural water supply project: over 1,100 deep wells and 15,000 shallow wells, all fitted with handpumps, had been sunk, re-sunk or repaired".²⁶⁶

Crucial to the success of any rural water supply scheme was the development of a strong, sturdy handpump, and, as in India, one was also developed for Bangladesh after much experimentation, although work on design improvements continue to this day in both cases. When the activities grew, UNICEF was delivering annually thousands of tons of pig iron, coke and limestone to the foundries in Bangladesh, and the Public Health Engineering Department soon had a workload of installing some 90,000 suction pumps per year.

With the spread of both private and village handpumps, a number of farmers with very small holdings were in need of assistance to increase their harvests. Rain-fed irrigation yielded only one crop a year, but if more of the low-cost handpumps (about US\$45 each) could be made available, year-round irrigation could result in one or two more rice crops, thus enhancing the family income -- and improving the situation of children.

It was Karim, one of the UNICEF engineers, who in the mid-1970s developed an unusual solution to this problem. Beyer has the story:

"Karim took the opportunity to have UNICEF support a pilot project for the spread of such handpumps with the financing on a loan basis, through the local Grameen Bank, a rural credit institute. The back-breaking task of actuating a handpump for hours on end, in many cases was made easier by the farmers themselves through attaching treadles to operate them by foot. The increase in harvest through this so-called 'MOSTI' (manually operated shallow tube-well irrigation) programme did a great deal, not only towards increasing their income but to even cause a kind of agricultural revolution in the country....

"For this project, UNICEF provided the seed money for a total of 30,000 handpumps. That money then was to be retrieved through the credit institution. It would be returned to UNICEF, in order to be plowed back into other UNICEF-assisted programmes in Bangladesh, such as health and education particularly. In New York, Martin Beyer had a faint echo of this when one day the UNICEF Comptroller, Mr. Giovanni Cavaglia, came up to his office, visibly agitated, and said, 'What is this? We are all of a sudden getting one million dollars back from Bangladesh from the water programme!'. Through some accounting channel, the funds being returned to UNICEF in Bangladesh had come back to our Comptroller's office. He had not been informed of the whole operation and of course found the whole matter quite irregular, especially when UNICEF was supposed to provide funds to Bangladesh and not to extricate them from the country".²⁶⁷

This commendable idea of a revolving fund was not new; it had been raised very early in Asia, during Keeny's time, with regard to vehicles.

The misuse of vehicles provided by UNICEF was a constant problem in the early days. Jeeps could be used for such activities as BCG vaccination, yaws follow-up -- and duck shooting, or to go to a relative's wedding. To solve this problem, why not sell the vehicle to the BCG team leader or malaria supervisor, so that he could operate it in an official capacity as well as for personal use, a practice which would be strictly in accord with, and be regulated by, government regulations for reimbursement for mileage done on personal time? UNICEF could recover the cost of the vehicle through monthly instalments; put the money in a revolving fund, and finance other aspects of programmes with the proceeds. Regrettably, the proposal was turned down.

In community development schemes, where income-generating activities are often crucial to their success, small loans, or part-grant/part-loan, would be a very good way to proceed. People in urban slums and poor rural areas have pride and self-dignity, just like everyone else. An outright grant has the stigma of an old-fashioned welfare hand-out. A loan, or part-grant/part-loan, properly handled, can convey confidence that the receiving person will do his or her best to succeed; and this, in so many cases, can be self-fulfilling, as evidenced by the extraordinarily high rate (98 per cent) of loan re-payment to the Grameen Bank in Bangladesh by very poor people, who had no collateral to offer except their own faith in themselves to succeed. Latest reports also indicate that excellent progress has been made in integrating social development components into the Grameen Bank's credit extension services.²⁶⁸

The successful Grameen experience has stimulated replications. One of the Indonesian participants at a 1984 workshop in Comilla, which visited the Grameen scheme, was the head of a skills training programme in the Education Department's Directorate of Community Education; upon returning to Indonesia, he started -- with UNICEF support -- a similar scheme for 500 landless farmers. The aim is to support large-scale income-generating efforts that would have a significant impact in reaching large numbers of families and their children. A second UNICEF-assisted credit scheme in Karawang, West Java, is reaching 100 groups of farmers, each group consisting of five members. The interesting feature of this project is that, to ensure the full participation of women, every group of 5 must include at least three women.²⁶⁹

Also, in Nepal, where women spend 60 per cent of their earnings on their children or on the family's food, more than 210 women's credit groups have started up in the past five years. "The women have bought livestock or seeds to grow vegetables for market, or have started small businesses. And the credit groups have become the starting-point for literacy classes, improved child care, and the promotion of immunization and oral rehydration therapy".²⁷⁰

* * *

Women in Development

Virginia Hazzard, in her monograph on "UNICEF and Women" for the UNICEF History Project,²⁷¹ has presented a comprehensive review of the changing perceptions of women by UNICEF from its inception to the present day.

In the early days of UNICEF the main beneficiaries were, of course, children -- and "pregnant and nursing" mothers. This soon gave way to a more reasonable definition of needy mothers in general.

Almost from the very beginning, too, UNICEF had provided training for indigenous midwives, who were mostly female (here and there, there were a few men). Training courses at the Calcutta Centre (referred to in a previous section) offered opportunities for professional staff, but these were relatively few; the vast majority of women touched by UNICEF were the traditional midwives, numbering into the tens of thousands for Asia. Later, when volunteers or part-time workers were needed for nutrition and day-care centres and other activities, UNICEF touched many more women.

UNICEF field staff in Asia recall ordering and delivering sewing and knitting machines for mothercraft and homecraft projects in the early days. These items were much maligned, but in conservative, traditional societies, they were the means by which many women, for the first time in their lives, were able to come out of their homes and meet and talk with other women in a setting other than the village well.

When the rural water supply programme began to expand, women were among the primary beneficiaries in terms of lightening their burden as water carriers. But, in general, women in Asia -- apart from the urban professionals and other educated and trained women -- were pretty much treated as beasts of burden, put on earth to serve man and home. The weight of traditionalism and conservatism still rest very heavily on women in many parts of Asia today.

The International Women's Year in 1975 was a major water-shed in terms of helping bring about changes in efforts to improve the status of women.

First, the UN family had to improve its own act. In Asia it began with the sponsorship by ESCAP, the Economic and Social Commission for Asia and the Pacific, of a regional conference on the integration of women in development, held in Bangkok in May 1974, resulting in the preparation of a regional work programme by ESCAP.

As for UNICEF, the decade of the 1970s opened with an assessment of projects for the education and training of women and girls, which was reviewed by the Board in 1970, and which prompted it to mandate a new orientation of UNICEF's activities in this field.²⁷² Later, as part of initiatives accelerated by the International Women's Year, the UNICEF Board in 1975 approved assistance to three regional projects for the enhancement of the role of women in development, with special reference to the child and the family.

* * *

Regional women's project in Asia

The regional women's project in Asia was originally intended to be carried out in Burma, Pakistan, and the Philippines, but in Burma there were no developments beyond some preparatory activities, and Thailand took her place.

:Pakistan

In Pakistan, five village sites were identified, one in each of the four provinces plus one near the federal capital. Using the method of community self-survey, women from the villages were selected and trained in data gathering on such things as the work schedule of women, existing skills, family structure, child-rearing practices, and food patterns. With this training they were encouraged to identify and discuss issues that affect their daily life, and their possible participation in solving those problems. The process helped them to think through and express their needs.

:Thailand

In Thailand, leadership training for women was undertaken, and some community-level women's councils were established to promote their participation in village development. Skills training for income-generating activities were offered, and local projects involving food preservation, dressmaking, mat weaving, silkworm breeding, fish farming and vegetable growing were undertaken.

:Philippines

In the Philippines, the project was carried out in both a rural (Kibawe, Bukidnon) and urban (Cebu city) setting, with UNICEF touching base with the appropriate government officials in the Ministry of Social Services and Development and the National Economic Development Authority.

In the rural area of Kibawe, located in the central part of Mindanao, UNICEF worked through a women's organization, covering 12 barrios or villages. The organization was new, and it was touching to see rural women, who had never had the opportunity of presenting their views in public, speaking up for the first time to voice their concerns.

The initial UNICEF input was in the form of medicines, requested by the women, which became a factor in motivating them to plan for a training programme in simple health care. Because the barrios were widely scattered, the seemingly simple chore of calling a meeting entailed much walking. But the women were determined, and the programme took place with the help of trainers from a Rural Missionaries group working in the area. UNICEF support included the financing of a training manual in the local language.

The urban component consisted of three low-income areas in Cebu city -- Barrios Luz, Camputhaw and Alaska. There was great diversity in terms of social mobilization: one had undergone years of struggle with the city authorities who had tried unsuccessfully to evict them; another had not been organized before at all. The dynamics of social change in each barrio differed one from the other, calling for different responses from UNICEF.

Fortunately, the project adviser was Prof. Mary Racelis of Ateneo de Manila University (who later joined UNICEF and eventually became the Regional Director for East Africa), and she, together with Teresita Polacios as project director and Carmen Santiago as project adviser, were able to guide UNICEF through some difficult but exciting moments in project planning and implementation.²⁷³

Income-generating activities were supported by UNICEF in all three barrios such as a poultry broiler production scheme and a garment industry, but the main thrust of the programme was to develop self-awareness among the women and to strengthen their own motivation for advancement, which could only redound to the benefit of the family. As the programme came to an end towards the latter part of the 1970s, an innovative self-evaluation technique was developed by an experienced community development consultant in an attempt to measure changes in attitudes.

:Other women's projects in Asia

The regional women's project, of course, was not the only channel through which women were being reached in Asia. Many UNICEF-assisted country programmes contained components which were specifically directed at meeting the needs of women. In Indonesia, for example, UNICEF support included leadership training, training in income-generating activities, and various activities in primary health care, mother and child health, nutrition education, family life education and community development. In Bangladesh, 27 workshops on leadership training for 2,300 village women were held during 1979. In India, as noted earlier, a project on the "Development of Women and Children in Rural Areas" is progressing well, particularly in Rajasthan and Gujarat. In other countries of Asia, UNICEF supported many day-care programmes for pre-school children, which were primarily run by women, and which were aimed at meeting the needs of working mothers.²⁷⁴

But, as Virginia Hazzard's monograph makes clear, it is indeed a "Long Voyage" for women in Asia in attempting to overcome centuries of tradition. Margaret Gaan, long-serving UNICEF staff member in Asia who retired as Deputy Regional Director in Bangkok in 1974, felt that the first step in many cases was to persuade parents to let their daughters go to school to overcome illiteracy.²⁷⁵ This, in the long run, is the key to women in development.

Education

Education is also, of course, the key for illiterate boys and men to enter into the world of development. The harsh reality in many, if not most, parts of rural Asia is that boys and girls either do not go to school at all; or, if they do, they drop out after only one or two grades. Young boys have to tend cattle in the fields. Young girls have to do household chores and look after their siblings.

Thus, in one of the rural areas of India where a successful immunization project was being carried out (Dewas district in Madhya Pradesh), it was noted that, despite the tears and pleading by the young children who did not relish the needle (especially after they had experienced the first shot!), the parents and the older siblings who had brought them to the vaccination centres were quietly determined that the immunization should proceed.

:Female illiteracy

However, as noted in the course of a field trip to the area, it was "also very disheartening to observe, in village after village, that hardly any of the older girls had gone to, or were attending, school; yet, these are the future mothers of the community. It is one thing to read in cold print about the low literacy rate for females in Madhya Pradesh (15.5%); it is quite another to actually talk to bright, attractive girls who are living proof of that statistic. Thus, out of this immunization programme, there has also developed a determination to move forward in the area of female education and literacy, focusing on practical measures to enhance the situation of girls and women in the villages".²⁷⁶

In some countries of Asia, such as China, Singapore, and the Republic of Korea, high rates of literacy have been achieved, although they too have pockets of illiteracy. In the majority of the developing countries in Asia, however, these pockets or islands of illiteracy are so large as to constitute continents of ignorance which inhibit national development.

:Link between infant mortality rate and level of female illiteracy

For UNICEF, helping to conquer illiteracy is more than just a good thing in and of itself. Particularly among girls and women, the reduction of illiteracy means that the infant mortality rate can also be reduced -- one of the prime aims of UNICEF. Over 24 separate studies in 15 different countries, according to the 1984 State of the World's Children Report, have established that the level of the mother's education -- even within the same economic class -- is a key determinant of her children's health.

In Pakistan and Indonesia, for example, the infant mortality rate among children whose mothers have had four years of schooling was found to be 50% lower than among the children of women who were illiterate. In eleven countries studied by the Latin American Demographic Centre, the influence of the mother's education on the child's chances of survival was found to be stronger even than the level of household income. And one particular study in

Kenya had even gone so far as to say that 86 per cent of the decline in infant mortality in that country over the last twenty years could be explained by the rise in female education.²⁷⁷

In the case of India, similar findings were reported in a study prepared by the UNICEF Regional Office in New Delhi for the 1982 Board session:

Table VI²⁷⁸

Infant Mortality Rate and Female Education Level

Level of education of women	Infant mortality rate	
	rural	urban
- Illiterate	132	81
- Literate below primary class	105	59
- Primary and above	64	49

:Female literacy: two steps forward, one step back

What happens when girls and women gain some measure of literacy, besides a commendable drop in the infant mortality rate? Obviously they have more self-confidence; they begin to look for economic activities which were closed to them before, so that they could enhance the family income; they, in short, become assets to the community. But, sometimes, for every two steps forward, there may be one step back; sometimes three.

Take the case, for example, of two hundred or more women in a rural area of Rajasthan who engaged in an unheard-of strike, because they felt they were being cheated by their overseers in being paid for road work performed under a drought relief programme. Only a few of the women were literate enough to know that the length of road work completed at the end of each day by unceasing pounding of rocks was not being measured correctly in the case of women who could not read and did not know what figures meant. There were other ways of cheating the women out of their daily wages. But they had been sensitized to social issues by the Social Work and Research Centre at Tilonia (established near Jaipur, Rajasthan, by Aruna and Bunker Roy, two dedicated rural community development workers), and the women rebelled at this injustice.

The case went to the Supreme Court because the pay for drought relief was lower than the national minimum wage, and Bunker Roy served as the channel for this legal remedy. It was also shown that the women were being systematically cheated by the overseers and others involved in kick-backs, and there were dismissals of government officials. Although that was a victory for the women, it exacted a heavy price: for a very long time, they were not hired again for any more Government work programmes. But that did not discourage all of the women. They knew there would be set-backs, but they were also acutely aware that, to survive and develop, they would need a great deal of perseverance and strong resolve.

:Functional literacy: what is relevant content?

And what does one teach the shepherd boys who do come to the night schools, tired at the end of each long day, but grimly determined to learn? That honesty pays? That corruption should be resisted and fought, even though it will cost you whatever fragile income you are able to squeeze out of the system? Or do you tell them the cold facts of life as they exist in their own communities, and how to survive in that harsh reality? What is meant by relevant curriculum content, after all, to these boys and girls who hunger for release from ignorance? Aruna Roy, who was instrumental (among many other things) in helping to start up night schools for the shepherd boys, took a year's sabbatical to reflect on these and related issues, so troubled was she by the lack of clear answers.

There are certainly no quick answers. There are many attempts at solutions, some of which are supported by UNICEF, in countries determined to attack a root problem affecting women and children.

:Some gains in education

Some gains were recorded in the 1970s. In most countries of Asia, UNICEF continued to support the in-service training of primary school teachers; production or distribution of various types of basic supplies or teaching aids for primary schools; and, in some cases such as Bangladesh, Pakistan and Viet Nam, paper for the production of primary school textbooks. The strengthening of primary school supervision was supported through training schemes in Thailand, and through the provision of transport in Pakistan.

In India, six States (Assam, Gujarat, Karnataka, Kerala, Maharashtra and Tamil Nadu) improvised cheaper and simpler science kits than the prototype provided by UNICEF. The National Council of Educational Research and Training, however, was beginning to emphasize the teaching of science through the environment rather than through a kit. There was also an encouraging development of local crash training programmes for primary teachers; more than 250,000 primary teachers were trained during 1977.²⁷⁹ Also, as a further step in integration, a project combining nutrition education, health and environmental sanitation was successfully piloted by the Sri Avinashilingham Home Science College for Women in Coimbatore, for which UNICEF had assisted in the preparation of teachers' handbooks, charts and posters by five regional centres, and in the training of some 4,200 primary school teachers.

In Afghanistan, where primary school enrolment was only 28.8 per cent of school-age children and drop-outs (20 to 30 per cent) was causing a serious waste of human and financial resources, UNICEF aid was directed at the three interrelated elements of curriculum development, pre-service training for teachers, and in-service training for primary school teachers, as well as at the development of women and girls' activities through pre-school education and functional literacy programmes.

In the Maldives, UNICEF and UNESCO were assisting in a teacher-training programme, and a revision of the primary school curriculum was under way.

In Bhutan, a new National Education Policy announced in 1976 was aimed at reforms in the curriculum and the integration of a pre-school component in primary education. UNICEF assisted the Paro Teacher-Training and Demonstration School with its programme of curriculum adjustment and in-service training of Dzongkha (vernacular) teachers.

As for Nepal, the equal access for women to education programme in Pokhara, Dhankuta and Nepalgunj was making good progress. During 1977, 210 girls including 134 new recruits were enrolled, and eighty girls graduated from this programme in the summer. And, under the National Development Service scheme in which all university students were required to serve in the rural areas for one year before being granted a degree, some 536 students of the 1977/78 group were working in 54 of Nepal's 75 districts. The students spent half of their time teaching and the other part in a wide range of other village development activities such as nutrition, health, water supply, reforestation and promotion of family planning.

In Sri Lanka, the age of admission to schools, which had been raised in 1974 from 5 to 6 years, was lowered to accommodate five year olds in "lower grade one" beginning in January 1978. This involved an extra 325,000 new pupils coming into the school system in addition to the regular intake of first graders. UNICEF support included the upgrading of 2,500 small rural primary schools with basic science kits and basic school supplies; assistance in primary school training through the provision of audio-visual supplies and equipment for ten primary school teacher-training colleges; assistance in primary school textbook production through the provision of printing paper, printing equipment and supplies, and special assistance to 250 remote rural schools and 250 estate schools through the provision of basic furniture and school supplies.

In the Philippines, an innovative pilot project was initiated to reach the unserved tribal areas of Mindanao by providing accelerated teacher training for motivated men and women, selected by the communities themselves, to open schools in their villages. This project has since been expanded, and the teachers have been given full accreditation by the Dept. of Education and Culture.

In Burma, a project to provide safe drinking water for primary schools was begun, thus starting the process of overlapping of services to produce a multiplier effect.

Also in Burma, as part of the Government's policy of "basic education for all", the number of primary schools had increased during the period 1961-1974 from nearly 13,000 to over 18,000; the number of students doubled, from 1.7 million to 3.4 million. UNICEF aid was extended to the production of textbooks and teaching aids, and for a science equipment workshop.

:Burma and the conquer of mass illiteracy

In addition to this quantitative increase in formal schooling, the Government under the leadership of Dr. Nyi Nyi (who later joined UNICEF Headquarters as Director of the Programme Division) had conducted a mass campaign to eradicate illiteracy. No sophisticated techniques were used; the teacher could be any

person capable of teaching, although the "best mix" for promoting high motivation among the village people were university students with village teachers and other literates, so that they could take over as the students left after their summer vacations. The campaign was also low-cost, the major expense being the production of learning materials. All authors waived any remuneration for their contribution, and the cost of materials was met by a fund established for the purpose. The university student volunteers who lived and worked in the villages were looked after by the villagers in accordance with traditional Burmese hospitality.

Between 1965 and 1974, with 200,000 volunteer teachers participating, over one million people became literate.²⁸⁰

:Government and UNICEF inputs for education

As indicated in the progress report by the UNICEF Regional Office for East Asia and Pakistan to the May 1977 Board session, education accounted for the largest share of social expenditures by Governments:

Table VII²⁸¹

Expenditure on education, health and welfare,
as percentage of total social expenditures

	<u>Year</u>	<u>Education</u>	<u>Health</u>	<u>Welfare</u>
		-per cent-		
Hong Kong	1974	50.9	23.0	26.1
Malaysia	1975	69.9	22.0	8.1
Pakistan	1974	59.1	15.6	25.0
Philippines	1973	76.3	17.6	6.1
Korea	1974	68.1	2.8	29.1
Singapore	1974	62.3	24.7	13.0
Thailand	1974	73.0	11.5	15.5

As for UNICEF's own inputs for education, an evaluation carried out by H.M. Phillips for the May 1977 Board session had shown that, next to the World Bank (\$30 million), UNICEF was the largest with \$29 million -- out of a total of \$70 million in multilateral aid for primary and non-formal education in 1975. The remaining \$11 million came from the regular budget of UNESCO (\$3 million), UNDP/UNESCO (\$3 million), and others (\$5 million). Thus, UNICEF aid for education amounted to 40 per cent of general multilateral aid in that field, and 20 per cent of multilateral plus bilateral aid.²⁸²

:Non-formal education

As the 1970s unfolded, more and more of UNICEF's aid in education was turning to non-formal education, an emphasis which had been adopted by the Board in 1973 and 1974 on the basis of reports prepared at UNICEF's request by the International Council for Educational Development.²⁸³ An assessment carried out by the Executive Director for review by the Board in May 1980, and endorsed by it, noted "the need for one main new emphasis, namely to encourage and support the convergence of schooling in the education sector and of

non-formal education in the various fields in which UNICEF co-operated (e.g., women's activities, water supply and sanitation, food and nutrition, health)".²⁸⁴ Here was another recognition and endorsement of the importance of convergence, and, implicitly, support for the multiplier theory.

Very soon thereafter, the Board reported that UNICEF commitments for non-formal education had increased from \$6.1 million in 1980 to \$29.9 million in 1981, reflecting a strong desire on the part of developing countries to reach larger numbers of out-of-school children through non-formal means, and to meet the learning needs of children through dissemination of relevant information to parents, families and communities as part of the educational component of basic services.²⁸⁵

The future for education, formal and non-formal, looked bright as the 1980s began. Indeed, latest reports indicated good advances in a number of countries, including Thailand, where UNICEF support for non-formal education covered the production of reading materials for use in village reading centres; and in Bangladesh, where assistance was extended to a mosque-based project aimed at pre- and primary-school age children.²⁸⁶

* * *

Nutrition

Unfortunately, this was not the case for nutrition; it remained the area in which the needs were greatest and progress achieved the least. The malnutrition problem is not a matter of black and white, but comes in various shades of grey. The Executive Director expressed it frankly and succinctly to the Board at its April 1973 session when he stated that, "While many countries express deep concern and interest, developments lag behind. The programmes touch only the periphery of the problem in small segments of the population.... The key to making a real impact on child malnutrition in this region has not yet been found, and we continue our efforts".²⁸⁷

Although assessment results indicated little change in eating habits or measurable improvements in the vulnerable groups as a result of applied nutrition and other programmes, efforts to make progress in nutrition continued throughout the 1970s.

In the India applied nutrition programme (ANP), the Government and UNICEF early in 1970 had commissioned the Indian Institute of Management at Ahmedabad to carry out an evaluation study of ANP. This was completed in October 1971, following extensive field visits in 150 villages in 150 ANP blocks scattered throughout eleven States. The overriding observation of the evaluation team was that, at the household level, there was statistically little significant difference in dietary practices between beneficiary villages and those outside the programme. The report had little analysis of the reasons for this, nor how they could be remedied.²⁸⁸

Still, encouraged by other developments which represent the lighter shades of grey, the programme continued to expand, and the figures for 1,056 blocks, or one-fifth of the number in India, were impressive: training had been given to 25,000 people (in 1971), bringing the cumulative total to 124,000. In this programme there were now 1.9 million gardens, 27,000 poultry units, 6,900 inland fisheries units and 43,000 women's and youth clubs.

As for Indonesia's applied nutrition programme, an evaluation carried out in 1975 found that it had exerted a positive influence in creating nutrition awareness and generating income in the model villages, although measurable nutritional improvement of the vulnerable groups had not been up to expectations.²⁸⁹ The main findings included the observation that efforts to increase protein consumption of poorer families through poultry and fish production were likely to be unsuccessful, partly because of their high costs.

In processed foods, the weaning food plant at Anand, Gujerat, had increased its production of an enriched instant baby food from 1,000 to 3,000 tons. "The relevance of this to the urgent needs of the lowest income groups remains in doubt".²⁹⁰ However, the plant produced at cost price 5,000 tons of a special weaning food for the special child relief project, "which justifies the investment made in this plant".

In Sri Lanka, results of a sample survey on nutrition in 1976 by the Ministry of Health showed that there was a higher incidence of under-nutrition in the estates sector (tea, coconut and other cash crop estates) than in the rural areas. UNICEF was directing its efforts to the Food and Nutrition Policy Planning Unit in the Ministry of Planning and Economic Affairs to enhance inter-ministerial coordination and the upgrading of services.

The Philippines initiated a pilot project on nutrition surveillance in five municipalities of Albay Province, as well as launching a new type of extension worker, the barangay nutrition scholar (BNS), as an outgrowth of the nation-wide weighing campaign called "Operation Timbang" to identify degrees of malnutrition in young children. The term "scholar" was an ingenious idea to provide a nice touch to the volunteer worker, who wore the T-shirt with the identification "barangay nutrition scholar" with much pride. The BNS scheme expanded and became an integral part of Project Compassion, with UNICEF help, in the 1970s.

In Nepal, UNICEF provided 20,000 tapes to be used for arm circumference measurements, another method of determining the degree of malnutrition in children.

Thus, slowly, the countries in Asia take some steps forward in the fight against malnutrition during the 1970s.

:Breast-feeding

Part of the forward movement in nutrition was due to developments in the important field of breast-feeding. WHO, in cooperation with the International Children's Centre in Paris and the Swedish International Development Authority, had started work in several countries with UNICEF assistance to identify the main factors influencing the decline of breast-feeding, and to

develop means of countering those factors. The WHO Division of Family Health, in a report to the UNICEF Board in May 1978, described a methodology for an action programme to promote breast-feeding, based on an epidemiological study of infant feeding patterns, to be followed by activities focused on identified needs.

:Changing hospital practices in breast-feeding: the Philippines experience

Meantime, however, a remarkable pioneering experience in breast-feeding in a hospital setting had already taken place from 1973 to 1977 in the Philippines, at a hospital in Baguio in the northern part of the country. This hospital experience was important because rural practices often tended to follow the examples set in the urban centres, and if breast-feeding was the practice in city hospitals, that was what would also be adopted in the rural areas.

A first-hand account of Dr. Natividad Clavano's pioneering work may be found in Judy Spiegelman's book.²⁹¹ Here is a slightly different perspective as told to the 1981 Annual Meeting of the National UNICEF Committee for Canada by a Canadian, a former UNICEF Representative to the Philippines, who first met Dr. Clavano in 1978 when she had just returned from testifying before a U.S. Congressional sub-committee on breast-milk substitutes:

"In the northern part of the Philippines there is a city called Baguio, and in that city there is a plucky little pediatrician named Dr. Natividad Clavano. She went to London in 1974 to study under Dr. David Morley, a fiery crusader for the needy young child, developer of the 'Under-Five' Clinic concept, author of a definitive book on child growth charts, and one of the strongest advocates of breast-feeding. It was of course inevitable that Dr. Clavano would switch from her intended specialization of child allergies to establish her own Under-Six Clinic at Baguio.

At the Baguio General Hospital, where she is Chief of Pediatrics, Dr. Clavano began gradually to phase out bottle-feeding and phase in breast-feeding along with the rooming-in strategy. This was no easy task: she had first to convince her hospital administrator, who was fortunately supportive; she then had to convince her own doctors and nurses who were bottle-feeding their own babies; and she had to convince the mothers themselves. But she persevered.

Don't forget: this was a doctor who by her own admission had accepted, like every other hospital, generous samples from the various milk companies; allowed their representatives to come in and out of the nursery; put up their colourful posters and calendars; in short, had allowed them in her own words 'to touch the lives of our babies, not because we did not care but because we did not realize the consequences of granting them the privileges'.

Anyway, Dr. Clavano closed the door of the nursery to the milk companies; stopped giving the babies the starter dose of powdered milk; took down the posters and calendars; and personally rejected samples and donations from the milk companies. The interval between delivery and giving the newborn to the mother was gradually reduced (over a period of many

months) from eight hours to six, to four, then to two, and finally to 30 minutes. Snuggled now beside their mothers, the babies felt warm and secure. Nowhere else have I come across such a pervasive feeling of contentment and well-being than in the Baguio maternity ward. The nursery is now full of empty cribs, something which Dr. Clavano has retained to demonstrate its archaic nature.

Nearly 10,000 babies were delivered at the hospital in the four years 1973 to early 1977, divided roughly into two periods. In the first period January 1973 to March 1975, there were 4,720 babies born in the hospital; less than half, or 40%, were breast-fed. In the second ('after Dr. David Morley') period April 1975 to April 1977, there were 5,166 babies delivered, and most of them -- 87% -- were breast-fed. The number of roomed-in babies also increased from 49% to 93%. The infant profile for the two periods was quite similar.

Now for the startling (or, upon reflection, not so startling) results:

1. There was a dramatic reduction in clinical infections between the two periods. In the four-year period there were 98 cases of clinically septic babies: 88 in the first period, only 10 in the second period. Of that total of 98, 88 (nearly 90%) were on bottle-feeding, 7 were on mixed feeding, and only 3 were breast-fed. 'The linkage between the mode of feeding and the occurrence of infection in the new-born', says Dr. Clavano, 'supports the contention that the use of formula/bottle-feeding directly increases the risk of infection among the neonates'.
2. There was an equally dramatic decline in infant mortality: out of the 98 babies with clinical signs of infection, 67 died; 64 in the first period when bottle-feeding was the predominant form of feeding; only three died during the second period. Out of those 67 who died, 64 were on bottle-feeding; 2 were on breast-feeding; 1 was on mixed feeding.

Thus, Dr. Clavano's work showed that there is a clear and direct correlation between the high morbidity and mortality rates, found over a four-year period, and bottle-feeding. This, conversely, supports the protective role of breast-feeding. Breast milk, from Dr. Clavano's work, is crucial to the survival of infants in developing countries".²⁹²

But, when asked if these results and findings had been published in order that they may be shared widely, Dr. Clavano replied that she did not have the time or resources to go through very carefully nearly 10,000 baby records to ensure that the write-up would be completely accurate, for she knew that the milk companies would be scrutinizing her report with a fine tooth-comb. The UNICEF Manila office offered her some assistance in computer analysis and research support. After months of patient (and, later, not so patient!) prodding, Dr. Clavano's article finally appeared in UNICEF's Assignment Children.²⁹³ Her important findings have had a wide impact, both in the Philippines as well as for other countries, in promoting breast-feeding.

UNICEF also provided training grants to enable all 1,600 health personnel in Health Region I in the northern part of the country to be trained in simple, low-cost, no-cost methods of child care, including the supreme advantages of breast-feeding. The Minister of Health was personally persuaded to visit Dr. Clavano's project, after which he issued a directive to all government hospitals to implement the rooming-in principle and breast-feeding.

Dr. Clavano concluded in her own write-up that there was more good news: "Breast-feeding is finally being taught today as part of the curriculum in Philippine medical and nursing schools, and health workers (nationally) are now being trained to promote it as well. One day soon we hope breast-feeding will be taught in all our primary and secondary schools, too".

When that happens, that will be another giant step forward for nutrition.

* * *

UNICEF and the disabled child

For many years, UNICEF's main contribution to the problem of childhood disability was in the area of prevention through general health and nutrition programmes, as well as specific immunization and health measures which prevented crippling (yaws, leprosy, tuberculosis, trachoma, measles, endemic goitre, xerophthalmia).

In its work in post-war Europe through the early 1950s, UNICEF provided orthopaedic supplies for remedial surgery and therapy for disabled children, equipment for the production of prosthetic appliances, and other forms of assistance, including Braille typewriters and testing devices for hearing.

As UNICEF began concentrating its work in developing countries, questions about the character and extent of aid for rehabilitation were raised in the Board on several occasions. The general view of the Board was that rehabilitation projects should have a low priority because they reached only a small number of the children in need of them, and had a relatively high per capita cost. In line with this position, aid by UNICEF was provided on only a modest scale for never more than a handful of countries at any one time, mostly in Asia.

Thus, UNICEF provided 20 iron lungs when a severe outbreak of poliomyelitis occurred in India in the summer of 1949. UNICEF also assisted Japan by providing some equipment in 1953 to the National Children's Centre in Tokyo as well as for hospitals for crippled children at the prefectural level. Other programmes included support for a prosthetics workshop in Thailand, and aid for blind children in Malaysia.

But all this was in the field of treatment, not prevention. Not until the report of Rehabilitation International to the 1980 Board session,²⁹⁴ and its strong enunciation of the principle of prevention and early treatment of impairments before they deteriorate into disabilities (and disabilities into

handicaps), was UNICEF seized of a low-cost approach which could be applied widely, and which fitted in naturally with UNICEF's emphasis on maternal and child health.

Susan Hammerman, then Assistant Secretary General of Rehabilitation International (and now head of RI), had visited eleven countries in 1979, including the Philippines, as part of the preparation of the report to the Board. In an address before the National Commission Concerning Disabled Persons in Manila in May 1979, she stated that "It has been said of rehabilitation that we have pioneered many miracles for a few. The challenge that we face is to accomplish just a few miracles for the many".

The Philippine Foundation for the Rehabilitation of the Disabled (PFRD), the national affiliate of Rehabilitation International, readily and eagerly accepted the challenge, and, together with UNICEF and the Mental Feeding Programme (devoted to early stimulation of the young child) of the Nutrition Centre of the Philippines, launched in 1979 a project named "Reaching the Unreached".

:"Reaching the Unreached" through low-cost intervention measures

Two villages in the province of Nueva Ecija were selected for a pilot project to identify impairments among the very young child, and to promote community involvement for their early detection and treatment. Two young researchers were assigned to live in the villages. They carried out a house-to-house survey, helped present the results to the community, and assisted in the training of the mothers and community volunteers to administer simple preventive and treatment measures. Professor Charlotte Floro of the PFRD and Dr. Aurora Tiu of the Mental Feeding Programme provided overall guidance and support.

The survey found that, among the 568 children in the age group 0-6 years, 449, or 79 per cent, had no disabling impairment. The balance of 119, or 21 per cent (one out of five) had one or more disabling impairments, i.e., an impairment which may deteriorate into a disability if not treated early.

An important finding was the crucial importance of malnutrition in the whole field of impairments, malnutrition itself being an impairment. None of the children found with only one impairment were malnourished, but the more malnourished the child, the higher the average number of multiple impairments.²⁹⁵ Fortunately, it was also found that many impairments in the young child were reversible, if detected in time and early intervention measures applied. Thus, through nutrition education of the parents, promotion of breast-feeding and supplementary feeding, 80 per cent of the malnourished children were rehabilitated to normal or near normal weights. Distribution and administration of vitamin A capsules by village workers and trained parents resulted in the virtual elimination of xerophthalmia, to the vast relief of concerned parents.

In addition to treating these and other physical impairments, simple measures of sensory stimulation developed by the Mental Feeding Programme of the Nutrition Centre were also applied to the impaired children, and results

showed that such measures helped them to catch up with children who had no impairments. Overall, 80 per cent of the children in the project showed complete recovery or a modification of their impairment.

This pilot project stimulated the development of an expansion scheme in the Philippines, with strong support from the voluntary sector such as the Philippines Pediatric Society and the Philippine Medical Women's Association. Early detection and treatment of disabling impairments is now part of maternal and child health activities in the country.

:Emphasis on locally available resources

The emphasis on early detection and treatment of impairments, and on low-cost appliances based on locally available materials, so strongly recommended by Rehabilitation International and supported by UNICEF, was translated into practical projects by Don Caston, a rehabilitation expert from the United Kingdom. In a down-to-earth, "hands-on" approach, he showed parents, friends, and volunteers how to use bamboo, wood, or whatever is locally available to produce simple play equipment, exercise bars, crutches, and other practical appliances for young disabled children to enable them to be mobile and to exercise. Don Caston's approach was adopted, for example, by an integrated kindergarten in New Delhi, run by Mrs. Uma Tuli of the Amar Jyoti Charitable Trust, a voluntary society for disabled persons, which has shown that this simple approach really works for the good of the impaired and disabled children — as well as for the "normal" children attending the centre.

* * *

Mass disease campaigns

During the 1970s, efforts continued to integrate the campaigns against malaria, tuberculosis, and yaws into the regular health services, so that the enormous beneficiary figures which were the hallmark of reporting during the mass campaign years began to disappear.

Reporting by the regional offices also changed as the decade progressed, reflecting UNICEF's preoccupation with the broader aspects of economic and social development, and with UNICEF's new role as advocate for children's needs in national planning. The frequency of reporting also changed.

After the early emergency years, the UNICEF Board had settled down to two sessions a year, usually March and September, and the regions submitted two progress reports a year. The Asia progress report for 1955 was 33 pages long. By March 1957 it had grown to 114 pages. To reduce the general volume of Board documentation, it was decided in 1958 to have the regions report just once a year (for the March session only). But even this was too much.

Another decision was made in the early 1970s not to consider all regions (eight at the time) each year, but four in a given year, so that a region would be reviewed in alternate years. This decision affected the years 1972 through 1975. All regions resumed their annual progress reporting in 1976 because it was felt that biennial reporting covered too long a period for the Board's review.

The annual progress reports by the East Asia and Pakistan Regional Office (EAPRO) became more selective; for the May 1973 Board session, for example, three countries were selected for special review. Included, however, were some figures on the mass campaigns. Thus, Burma's BCG campaign was vaccinating about one million children a year, or roughly 80 per cent of annual births, with five BCG mass campaign teams still operating in the more remote areas, and another ten consolidated teams training health staff. And Burma's leprosy programme was being integrated into the basic health services, with 240,000 of an estimated 300,000 cases registered, of which 228,000 were under treatment.

In Indonesia, the BCG programme, after several years of poor performance, made remarkable advances in 1971 and 1972 because smallpox vaccinators were being re-trained in BCG techniques. As for the yaws programme in Indonesia, the disease had been virtually eradicated on Java and the more populous islands where, however, control continued to be maintained by yaws workers attached to the health centres, formerly single-purpose but now being re-trained for other jobs, such as detection of leprosy cases.

By the second half of the 1970s, however, such detailed reporting, even on a selective basis, was gradually being replaced by broad macro-analyses, including reporting on such aspects as national social expenditures and UNICEF's advocacy role. Data on country progress and plans were now to be found in the individual country programme recommendations to the Board.

The Regional Office for South Central Asia in New Delhi, on the other hand, continued its country-by-country summaries in addition to broad analytical reviews.

In the latter part of the 1970s, it was beginning to be difficult to trace the progress of the mass campaigns as they gradually became incorporated into the regular health structure, and as reporting became less quantitative and more qualitative. The attention of UNICEF, also, was turning to Basic Services with its community involvement component, as well as to the area-specific approach with its concomitant integration of UNICEF's inputs.

* * *

Emergencies

However, during the 1970s, there was one category of assistance which could not be relegated to second priority status in reporting: emergencies.

:India, Pakistan, and Bangladesh

As the decade of the 1970s began, a civil conflict of enormous dimensions began in East Pakistan, leading to a mass exodus of refugees to India which eventually reached the staggering total of 10 million persons. The international community responded to the need, with the High Commissioner for Refugees (UNHCR) coordinating relief efforts for the UN system. Maggie Black captures the hectic pace, and UNICEF's contribution, in the following paragraph:

"UNICEF, with its experience in supply procurement and shipment, became UNHCR's quartermaster-general for shelter materials, high-protein foods, vehicles, sanitation supplies, drilling rigs and cooking utensils, spending altogether \$33.7 million. Planes were lent by the United States and Canadian Governments and, at the height of the rescue effort, at least one was in the skies with forty-two tons of UNICEF cargo between the Western hemisphere and Dum Dum Airport in Calcutta in every twenty-four hours".²⁹⁶

In December 1971 India intervened militarily, leading to the creation of the new state of Bangladesh and another mass exodus, this time back to the new nation. For the next two years, the new Government of Bangladesh grappled with the immense problems of reconstruction with the help of the United Nations Relief Office for Bangladesh, headed by Sir Robert Jackson, whose operations reached a total of \$1.3 billion before terminating at the end of 1973.

UNICEF's contribution of \$30.2 million to the joint UN programme included over \$10 million to install or repair 160,000 shallow tube-wells for clean drinking water, and drill 1,200 deeper wells in coastal areas where ground water near the surface was too saline to drink.

:The agony of Indo-China

The early unsuccessful attempts by UNICEF in the 1950s to uphold its principle of non-discrimination and help children in North Viet-Nam were initially matched by equally frustrating efforts throughout the early part of the 1960s, so that UNICEF's assistance was confined to South Viet Nam. When the war escalated sharply and it was evident that children on both sides were suffering, there was increasing pressure in the Board that UNICEF aid should not be confined to the south.

Through a prolonged process of discreet diplomacy,²⁹⁷ UNICEF was able to raise the Curtain to North Viet Nam which Watt and Keeny were not able to do in the 1950s. From 1973 to 1975, the Board allocated increasing amounts for its Indo-China programme, with most of the \$44 million coming from special contributions through the "noting" procedure.

In his report to the Board in 1974 on emergency relief and rehabilitation, the Executive Director was able to announce an improved UNICEF field organization for Indo-China: an office had been established in Vientiane in September of 1973 to serve all parts of Laos; another field office was set up in Phnom Penh, in the beginning of November; and the UNICEF office in Saigon had also been considerably strengthened. The liaison group set up at UNICEF Headquarters in 1973 to coordinate operations in the Indo-China Peninsula had established and maintained contact with authorities in the Democratic Republic of Viet Nam and with representatives of the Provisional Revolutionary Government of the Republic of South Viet Nam.²⁹⁸

When Viet Nam became one again in April 1975, the UNICEF office in Saigon was closed; aid to all of Viet Nam was henceforth to be channelled through Hanoi. In Laos, UNICEF had been able to maintain working relationships with both the Royal Lao Government and the Pathet Lao, with some aid going to both sides; when the country was reunified towards the end of 1975, UNICEF was able to assist in the development of long-term plans in health and education for the Lao People's Democratic Republic.

But, for Cambodia, conquered by the Khmer Rouge and renamed the Democratic Republic of Kampuchea, another chapter of agony began. The full extent of the horror inside Kampuchea, beginning in April 1975 and ending in January 1979 with the entry of the Vietnamese Army into Phnom Penh, is mind-numbing. Maggie Black has described in vivid detail the events and political problems posed by the non-recognition of the People's Republic of Kampuchea by the United Nations; the designation by the UN Secretary-General of UNICEF as the lead agency in the UN system for the delivery of relief to Kampuchea; and UNICEF's attempts during 1979 to maintain its basic principle of non-discrimination in the midst of an extremely complicated international political situation, while at the same time coordinating a massive relief effort.²⁹⁹

Henry Labouisse retired as Executive Director at the end of 1979. Maggie Black notes that "His fifteen years at the head of UNICEF had culminated with the triumph of the International Year of the Child, and, simultaneously, with the Kampuchean crisis and its extraordinarily taxing demands. Almost his last act as Executive Director was to write to President Heng Samrin asking him to place the highest priority on improving the distribution of relief food".³⁰⁰

:And natural disasters

While all of these momentous events were taking place, calling for the utmost in response from the international community, including UNICEF, there was no let-up in natural disasters. In newly-created Bangladesh, extensive floods in the summer of 1974 rendered several million families temporarily homeless and exposed to hunger and sickness; UNICEF took a number of emergency actions, including the airfreighting of cholera vaccines and the mounting of a crash programme to provide safe water on higher ground. India also suffered in 1974 from drought -- and floods. Sri Lanka, seriously affected by drought, lost one-third of its normal rice harvest in 1974. UNICEF upheld its reputation for swift emergency action in all cases.

In 1976, earthquakes struck Indonesia, and floods occurred, again, in Pakistan (Punjab and Sind) and India (Bihar). And, in 1977, Bangladesh was struck by a cyclone early in the year; India by cyclone and tidal wave later in the year. UNICEF helped with emergency measures in all cases.

* * *

International Year of the Child (IYC)

The decade of the 1970s closed with the celebration of the International Year of the Child (IYC) in 1979.

The idea for such a year, first mooted seven years before by Canon Joseph Moerman, had met with a "distinctly mixed reception", as borne out by the Board debates on this subject. Some Board members were concerned with the financial costs of such an undertaking; they were also worried that it would take an inordinate amount of time away from the UNICEF staff, who were already totally preoccupied with both the quiet as well as the loud emergencies.

These reservations were mutually shared by Labouisse, but once the strong desire to have a Year became clear, he did his best to make it a success, with UNICEF as the international "lead" agency. It was decided that, rather than a world conference on children, the emphasis should be on national actions. And that, in the end, was what happened.

The Special Representative for IYC, Dr. Estefania Aldaba-Lim from the Philippines, was ably assisted by two senior UNICEF veterans who served as the directors of the IYC Secretariat's two branches: John Grun (former Regional Director for South Central Asia), in New York, and James McDougall (former Regional Director for the Middle East and North Africa), in Geneva.

Dr. Estefania Aldaba-Lim had served for many years as Minister of Social Services and Development in the Philippines. As IYC's Special Representative, she took on an exacting role, including a gruelling travel marathon to over sixty-five countries during the course of the next two-and-a-half years. She succeeded in enlisting the support of Heads of State, First Ladies, and senior government officials, and her visits and the publicity surrounding them, particularly in developing countries, succeeded in nudging many national IYC commissions into existence and action, for her own enthusiasm for the Year was infectious. Dr. Lim's contribution made a vital difference to the way in which the International Year of the Child subsequently evolved.³⁰¹

The General Assembly in December 1976 had passed a resolution proclaiming the International Year of the Child, to be celebrated in 1979, the twentieth anniversary of the Declaration of the Rights of the Child. By mid-1977, 85 international NGOs had formed a special committee of their own for IYC, headed by Canon Moerman, and their network mushroomed into the thousands by the end of 1979. The IYC emphasis on a national focus resulted in the forming of national IYC commissions to prepare plans and implement activities; by the end of 1979, there were 148 in existence.

The range of activities undertaken was as wide as imagination would reach. While some national commissions made only symbolic gestures, such as issuing a stamp or putting up some posters in the capital city, others took IYC much more seriously, as a lever for fundraising, for calls on government to do more for children, and as an umbrella for many different causes. Several undertook a national diagnosis of their children's situation, some for the first time ever; others studied their nutritional condition, set out to eradicate polio, or immunize newborns. Some looked at more specific problem areas, such as the children of migrant labourers, "latchkey" children, or street children; yet others tried to do more for the orphaned, the nomadic, the victims of war, and refugee children. By any reckoning, commented Maggie Black, the list of efforts and achievements was "extraordinarily wide-ranging".³⁰²

The General Assembly in October 1979 designated UNICEF as the lead agency of the UN system for coordinating the development aspects of the follow-up of IYC, and this was followed by a flurry of suggestions and recommendations, some of which began to be implemented, such as in the field of information exchanges and referral services. "But however hard its enthusiasts might plead that every year should be a year of the child, that kind of exuberant fellow-feeling linking groups with disparate interests and different energies could not be cultivated on a year-in, year-out basis. A Year is a year.... IYC was an event. It changed hearts and minds; it dented policies and programmes; it left a vital residue of goodwill both for children and for UNICEF. But once it was over, it was over, and attention moved elsewhere".³⁰³

However, as time went on, the concerns kindled in the Year, and the expectations of world opinion placed upon UNICEF, led to a broader scope of UNICEF advocacy and involvement with issues affecting children.

* * *

Summary

In summary, the decade of the 1970s was most certainly a period of momentous events, affecting children and mothers in the countless millions. The decade opened and closed with gigantic emergencies, challenging UNICEF to out-do its very best. UNICEF did, at all times maintaining its principle of non-discrimination in helping all sides in civil conflicts.

In between these "loud" emergencies, life went on: support for on-going programmes was critically assessed, and new policy guidelines emerged, revolving around the concept of Basic Services with its innovative base of community involvement and participation. With the advent — and absorption — of national planning for children in development, UNICEF in Asia, as in the other regions, approached its programme planning with new methodologies, focussing on preparing first a national survey or summary of the situation of children before embarking on helping to prepare a country programme.

Better planning and programming was accompanied by better assessment. The Board had, almost from the very beginning of its "permanent" mandate, decided on a policy review of one or two programmes every year, and throughout the 1960s and now the 1970s, the Board had carried out reviews of all of its major involvements, from water to MCH, from leprosy to malaria. Internal assessments of individual country programmes in Asia also improved, and multiplied. All of these efforts had the combined effect of sharpening implementation in the region.

New fields were added, opening up additional vistas for UNICEF. Women in Asia began to be viewed as agents of change and as integral, if not yet equal, partners in development. The needy child in the urban setting, hitherto largely by-passed, moved to the foreground of UNICEF planning along with the rural child in need.

As for the Board itself, it took a further step in the direction of equity and fairness in 1975 when it decided that "The Chairman of the Board and the Chairman of the Committees should be from different regions", and that "A system of rotation should be set up to ensure that each geographical region... should be represented in the Chair in an equitable manner".³⁰⁴ In 1982, when the Executive Board was enlarged from 30 to 41 members, there was an explicit spelling out of the regional quotas. Thus, "The formulation for the enlargement increased the representation of the African and Asian seats from six seats each to nine each; of Latin American States from four seats to six; and of the Western European and other States from 10 seats to 12. The forty-first seat will rotate among those regional groups and the Eastern European States, which have a representation of four seats...."³⁰⁵

This represents quite a change from the early years, when Asia, it will be recalled, had only one seat out of 26.

The decade of the 1970s closed with the retirement of Henry Labouisse. His passing in March 1987 was a universal loss. The Executive Board paid tribute to his memory in the following terms:

"Mr. Labouisse served as UNICEF Executive Director from 1965, when he accepted the Nobel Peace Prize on behalf of the Fund, to 1979. He was remembered for his great moral stature, his sense of justice, his acute analytic capacity and his sound judgement. Under his leadership, UNICEF grew from a humanitarian junior partner in the United Nations system into a full-fledged member of the international development community, stressing the importance of investment in children as a prerequisite for economic and social development. It was during his tenure that UNICEF became more involved in long-term development efforts for children, introducing the basic services strategy and joining with the World Health Organization (WHO) to develop the primary health care (PHC) strategy".³⁰⁶

Labouisse's successor, James P. Grant, took over in January 1980, thus opening up a new decade — and a new chapter — in the life of UNICEF.

THE CHILD SURVIVAL AND DEVELOPMENT ERA: 1980 --

- 134 -

BLANK BACK

Introduction

In the year 2000, a UNICEF staff member, charged with writing a history of UNICEF and looking back on the decade of the 1980s, might wish to characterize this as the child survival and development era, for it is being dominated by an accelerated campaign against the "silent" emergency which had long been quietly killing millions of children every year. He might also see the decade close with some notable achievements in the provision of basic services and primary health care to the vulnerable groups in the developing countries, including the immunization of at least 80 per cent of the world's children by the UN target date of 1990.

But the decade of the 1980s is not yet over, and with changes and new developments still occurring at a rapid pace, it would be highly presumptuous to describe this section as anything other than incomplete.

Within that limited perspective, some events stand out.

* * *

Kampuchea: a "loud" emergency

James P. Grant took over the leadership of UNICEF in January 1980, and one of his first acts was to convene a special session of the UNICEF Executive Board in February 1980 on the Kampuchean relief operations, for he had inherited one of the largest emergency situations ever to confront UNICEF.

In September 1979, the UN Secretary-General had designated UNICEF to act as the lead agency to coordinate humanitarian relief operations in Kampuchea. By the time UNICEF relinquished this role at the end of 1981, the joint United Nations and International Committee of the Red Cross programme had provided some \$634 million in assistance, with UNICEF shouldering most of the administrative burden inside Kampuchea and much of it outside as well.

Altogether, 300,000 tons of food aid had been distributed, as well as thousands of tons of rice seed, fertilizers, pesticides, agricultural equipment, vehicles, handling equipment, fuel, and medical supplies. More than 6,000 schools and 1,000 clinics and hospitals had been re-opened.

It was not perhaps quite the largest relief and rehabilitation programme ever undertaken, but it was the most complex, and the most all-encompassing for a single country. As Maggie Black has commented in her history of UNICEF, "Operationally, diplomatically and financially, the Kampuchean crisis was one of the stormiest and most difficult passages of UNICEF's history. It was also one of which it could be justifiably proud".³⁰⁷

However, while the "loud" emergency is over, Kampuchea -- indeed, the whole of Indo-China -- continues to suffer from the negative effects caused by the lack of peace, and remains an area of deep concern for the Asia region. As stated

in a 1986 United Nations report, the Kampuchean problem "has not gone away. Although new emergencies have arisen and pushed the plight of this small South-East Asian nation off the front pages of our newspapers, the children of the 'killing fields' still wait for peace to return...."³⁰⁸

* * *

For the "silent" emergency: a child survival and development revolution

In the first half of this century, many "loud" emergencies -- because of the lack of instant communication, or international lethargy -- went largely unnoticed. In the 1940s, for example, an estimated 3 million men, women and children starved to death in Calcutta and Bengal, "while the world knew little and did less".³⁰⁹ In the second half of this century, "loud" emergencies continued to occur -- along with the "quiet" emergency which, because of a vicious circle of disease, malnutrition, and insanitation, was taking away the lives of 280,000 children every week.

Grant decided to launch, against this "quiet carnage",³¹⁰ a campaign to be known as the child survival and development revolution (CSDR). It would be realized within the context of basic services and primary health care for children. Appeals would be made to heads of states, WHO and other sister UN partners, bilateral agencies, non-governmental organizations, and a host of other support groups, to join hands with UNICEF in this massive undertaking. The specific goal: to reduce at least by half the number of infant and child deaths by the time of UNICEF's fiftieth anniversary in 1996.

:Low-cost, high-impact measures

To achieve this ambitious target, a number of measures were advocated as being low in cost but high in effectiveness. These included: (a) growth monitoring of the child through the use of growth charts; (b) diarrhoea management with oral rehydration therapy (ORT); (c) better nutrition for the baby through breast-feeding and good weaning practices, and (d) immunization against tuberculosis (BCG), diphtheria, pertussis (whooping cough) and tetanus (DPT), as well as measles, for children; along with protection of pregnant women against tetanus (TT), since tetanus of the newborn accounts for the vast majority of tetanus deaths in developing countries.

Many of these measures had long been part of UNICEF-assisted programmes; they had already been successfully applied, for example, as a package of interventions in the case of Indonesia. The aim would be to encourage a greater acceleration of progress in child survival and development by applying these and related measures in concert with a renewed political commitment, and by employing the latest advances in communications technology.

The UNICEF Board at its 1983 session endorsed the proposal for a special emphasis on child survival and development. Grant then launched a personal "top-to-top" approach, visiting some thirty-nine heads of states or national government in all the regions by the end of 1985, along with meetings with WHO, UNDP, and other UN partners; bilateral agencies, and international NGOs.

:The Asia response

The response, world-wide, was highly encouraging. In the case of Asia, Prime Minister Rajiv Gandhi of India early in 1985 committed his nation to immunizing all its infants by 1990. "The hundreds of thousands of children a year whose lives would be saved by this achievement are to be a 'living memorial' to his mother, Indira Gandhi".³¹¹ And, soon thereafter, the President of the People's Republic of China announced an "85/85" expanded programme of immunization (EPI) target of reaching 85% coverage in each province by 1988 and 85% coverage in each county by 1989, with procedures to be instituted to ensure the sustainability of regular immunization beyond 1990, the target date set by the World Health Organization for Universal Child Immunization. The two most populous countries in the world had joined the crusade.

Other countries in Asia soon followed suit. President Corazon Aquino of the Philippines not only issued proclamations on the attainment of universal child immunization (UCI) by 1990 and the necessity for appropriate child development, but also announced the Year of the Filipino Child. In Indonesia, President Soeharto proclaimed the Decade of the Indonesian Child and underlined the importance of reducing the infant mortality rate as an indication of positive social development in his address to the Parliament on Children's Day. The five-point programme of the Prime Minister of Pakistan included health, safe drinking water and literacy, all elements that have a definite impact on the quality of life of children.³¹²

:South Asian Association for Regional Co-operation (SAARC)

This mobilization of political will and commitment at the highest levels of government found further expression with the formation of the South Asian Association for Regional Co-operation (SAARC).

At an historic summit meeting of SAARC in November 1986, the Heads of State or Government of Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka called for greater public consciousness and political consensus on the rights of the child and, in this context, supported an early conclusion and adoption of the Convention on the Rights of the Child. They declared that meeting the needs of all children was the principal means of human resources development, and that children should therefore be given the highest priority in national development planning.

The seven governments of SAARC also subscribed to the goals of universal child immunization by 1990, universal primary education, maternal and child nutrition, provision of safe drinking water and adequate shelter before the year 2000. And they expressed the belief that by the end of the century it should be possible to ensure that no child need die or be denied development for reasons of material poverty in the family. Finally, they directed SAARC's Standing Committee (comprised of the seven Secretaries of External Affairs) to undertake annual reviews of the situation of children in the SAARC countries, monitoring of programmes and exchange of experience.³¹³

The first of these annual reviews took place in Kathmandu in November 1987.³¹⁴ A measure of political will in the region will be the continuation of these annual SAARC reviews, and the degree to which they can identify problems and recommend solutions which will be implemented in an effective manner.

:Association of South-East Asian Nations (ASEAN)

There have been other regional developments. The Association of South-East Asian Nations (ASEAN), consisting of Brunei, Indonesia, Malaysia, the Philippines, Singapore, and Thailand, held a symposium for their parliamentarians on child survival, population and development in Jakarta in June 1987. An "Agenda for Action for ASEAN's Children" was adopted to stimulate greater national and local involvement of parliamentarians in children's issues and programmes.

Four ministers of national Governments and the Executive Director of UNICEF were among those who addressed the symposium. Observers from China, India and Sri Lanka were present. UNICEF Goodwill Ambassador Liv Ullmann also spoke to the gathering on her first visit to Asia. By the end of the year, follow-up included a national-level workshop for parliamentarians in Thailand and an invitation by the House of Representatives in the Philippines for UNICEF to make a presentation of its policies and programmes.³¹⁵

:Political will -- plus concrete achievements

Forming associations, issuing statements, and holding annual reviews is one thing; actually carrying out projects at the grass-roots level, and with measurable results, is quite another. Happily, in the 1980s in Asia, the two have come together and are intertwined. Detailed reporting is on the increase, partly because the two low-cost measures being emphasized -- immunization, and oral rehydration therapy -- are susceptible of quantification.

In immunization, for example, the 1988 progress report for East Asia and Pakistan showed that a number of countries in Asia were achieving high levels of achievement for BCG, DPT, and polio vaccination, in a few cases exceeding 90 per cent.³¹⁶ On the other hand, a number of other countries would require special attention and effort to improve their performance.

Of course, in Asia, several countries -- notably China³¹⁷ and Sri Lanka³¹⁸ -- had begun their own child survival and development revolutions several decades ago. Thus, the varied experience in Asia with child survival and development has produced a rich mixture.

:Social mobilization in Asia

A notable ingredient in that rich mixture has certainly been the immense mobilization of volunteers and community participation in many countries of Asia, enhanced by today's technology of mass communication through print, radio, television, and other avenues, and supplemented by the more traditional forms of plays, folk music, and dance. By the tens and hundreds of thousands, volunteers from all sectors of society in a number of countries in Asia have made a vital difference in the attainment of the goals of the child survival and development revolution.

In Indonesia, for example, close to one million trained village volunteers, or kaders, have played a vital role in a number of health, welfare and nutrition programmes.³¹⁹ Thailand's nearly half a million village health communicators and village health volunteers have helped to bring health services to the rural areas.³²⁰ Sri Lanka's Sarvodaya Movement has already been noted in the section above on the 1970s, but in addition, many of Sri Lanka's 19,000 Buddhist priests have helped in the promotion of child well-being.³²¹ Burma's volunteer literacy corps has also been noted above in the education section of the chapter on the period 1970-1980.³²² And China's barefoot doctors, mostly part-time volunteers, have played a significant role in promoting primary health care at the village level.

In sum, these tremendous numbers of volunteers, together with committed governments and other supportive bodies and personnel, formed the basis for what Grant in his 1988 State of the World's Children Report called a "Grand Alliance for Children". And this alliance was achieving quantifiable results: by focussing mainly on two measures -- immunization and oral rehydration therapy -- the lives of approximately 2 million children each year were being saved.³²³

Immunization, in particular, received tremendous international support in response to the global challenge of Universal Child Immunization (UCI), from governments, bilateral sources, and National Committees of UNICEF, as well as many other non-governmental organizations -- including, in particular, Rotary International, which in 1985 launched an extraordinary initiative called the 'Polio Plus' programme, pledging to provide all the polio vaccine necessary for up to five consecutive years for any participating city, state or country. By the end of 1987, Rotary International had almost reached its target of raising \$120 million for polio and "polio-plus" vaccination programmes world-wide.³²⁴

:Over-emphasis on immunization and oral rehydration therapy?

The high priority being given to immunization and oral rehydration therapy prompted some UNICEF Board members to ask whether the operationalization of other components of the child survival and development revolution might not be adversely affected. In particular, concern was expressed that allocations for certain traditional areas of UNICEF activity may be reduced as a result of the increased expenditure for immunization.³²⁵

Grant, however, had the view that, "when the world has at its disposal two of the least expensive and most effective public health techniques of all time, techniques which are capable of defeating both of the greatest threats to the lives and the normal growth of the world's children, then it surely makes sense to give them the highest priority until that job is done".³²⁶ At the same time, he emphasized that experience with the two measures had shown that they could be a "thin end of the wedge" for primary health care itself.³²⁷ Thus, the focus on immunization and oral rehydration therapy would help to open the door for other developments as well.

:In practice - a balanced approach

In point of fact, actual programme expenditures by the mid-1980s indicated that, in the developing countries themselves, a balanced approach was being followed. In immunization, for example, no country spent more than 18 per cent of its UNICEF commitment for this programme in 1985. Projections for immunization for 1986-1988 showed a rising level with the increasing priority being given to this activity, but much of this was coming from special contributions, not out of UNICEF's general resources.³²⁸

Equally striking were the expenditure figures for water and sanitation. They revealed that countries in Asia continued to devote a very high percentage of their UNICEF resources to these components (or, more accurately, to water supply): as much as two-thirds in the case of Pakistan, and more than a third in the case of Burma and Bangladesh.³²⁹

In short, while the two low-cost measures of immunization and oral rehydration therapy were receiving the great majority of media attention, other components of primary health care and basic services, including water and education, continued to command high priority in many developing countries.

This was reflected in the progress reports submitted to the Executive Board by the UNICEF Regional Directors: David P. Haxton, for South Central Asia, reported on continuing efforts in basic education, water supply and sanitation, and women in development, plus other programme areas, in addition to immunization and diarrhoea management.³³⁰ Ahmed Mostefaoui, for East Asia and Pakistan, gave equal attention to other primary health care activities such as strengthening the basic infrastructure and the important field of training; water supply and environmental sanitation; urban basic services; education; women's activities; children in especially difficult circumstances; and early childhood development, an often overlooked but significant aspect of the child survival and development revolution.³³¹

This comprehensive approach being followed by virtually all of the UNICEF-assisted countries in Asia was in line with the holistic view of the child, and of the interrelatedness of the factors impinging on the health and welfare of the child, his family, and the community, as advocated by Grant's predecessor, Henry Labouisse, in the 1960s; and was wholly in accord with the Board's urging at its 1987 session that UNICEF "maintain the broad-based, cross-sectoral approach exemplified by the basic services strategy".³³²

When the full story of UNICEF in Asia in the 1980s and 1990s is written, it will hopefully show a continuing fidelity to this comprehensive approach to child development.

*

*

*

Global priorities and focus for the 1990s

This broad-based approach had, indeed, been emphasized in a report to the 1987 session of the Board on "Priorities and Focus in UNICEF Programmes of Co-operation".³³³ The report predicted that, although child survival and development (CSD) would probably remain the major initiatives for a few more years, CSD expenditures would probably begin to come down in the early 1990s, when immunization is expected to achieve good coverage world-wide and enters the maintenance phase.

Looking ahead, education would probably receive special emphasis in the coming decade in view of renewed interest and various reform measures being implemented in a number of countries, especially in the field of education for girls. Water supply and sanitation would also remain a major sector, given the vast unmet needs in this area. Urban basic services would probably increase and expand steadily in view of the rapid urbanization taking place all over the developing world. As for nutrition, this would probably maintain its slow but steady growth, reflecting the difficult dimensions of the problem. And, in the next decade, there would most likely be increasing support for women's programmes.³³⁴

The Board at its 1987 session welcomed this balanced and comprehensive approach in terms of future global directions and priorities. At the same time, the Board also stressed that UNICEF should put particular emphasis on the reduction of maternal, infant and child mortality and the improvement of maternal and child health (MCH); the protection and improvement of the well-being of children and their environment, emphasizing the particular needs of the female child; the improvement of the well-being, situation and environment of women and their role in development; and, finally, appropriate child spacing to protect the health of the mother and child as part of overall development.³³⁵

These, then, would constitute the main guidelines to be followed by all the regions, including Asia, as UNICEF approaches the end of the 1980s and turns the corner into the 1990s, the UN's fourth development decade. At the same time, the guidelines would also serve as useful indicators by which progress and achievements can be measured.

:Priorities and focus for the 1990s: Asia

As noted in the "Medium-term Plan for the Period 1987-1991",³³⁶ presented to the 1988 session of the Board, a number of countries -- notably China, India, Pakistan, the Republic of Korea, Thailand and Sri Lanka -- have been able to record moderate to rapid economic growth despite the prolonged global economic crisis. Other countries in Asia, however, have been severely affected, with cut-backs in social sector budgets reported in Bangladesh, Burma, Indonesia, Malaysia, Nepal, Papua New Guinea, the Philippines and Sri Lanka.

The application of a regional strategy for Asia would therefore vary from country to country, depending on such factors as economic realities, political and social circumstances, and cultural traditions. Such a strategy would also need to take into account some new challenges, as well as old challenges in new forms, requiring fresh initiatives and innovative answers and solutions.

New challenges would include drugs, alcohol, and AIDS, affecting children in developing as well as developed countries alike. Also, children in especially difficult circumstances -- abused, neglected, orphaned, abandoned, delinquent, and exploited children, as well as children of female migrant workers -- were gaining recognition as constituting groups requiring priority attention. In particular, the problem of street children, a growing phenomenon in many urban areas,³³⁷ was beginning to be tackled on a systematic basis in the Philippines and other countries in Asia, thereby directing attention to the whole issue of the quality of life after survival beyond the age of five years.

Other important questions requiring imaginative and innovative actions would include the politically sensitive matter of children in situations of armed conflict. The principle of non-discrimination by UNICEF to help children on all sides of a civil conflict had been applied on numerous occasions in Asia, going as far back as 1948 in the case of China. In the latter part of the 1980s, it was being invoked by UNICEF field staff in a number of countries throughout the world, including, in Asia, Afghanistan, the Philippines, and Sri Lanka.

In the field of education, although a number of countries in Asia could boast of a very high enrolment rate for primary school, 70 per cent of the world's total illiterate population, of which 60 per cent were women, may be found in Asia. A major challenge, therefore, would be to increase both enrolment in, and completion of, the primary grades by students, especially girls, through such measures as developing more relevant curricula to meet everyday needs, including health and nutrition. Incorporation of these subjects into the primary curriculum had already been accomplished in several countries in Asia; such efforts would need to be encouraged and extended.

At the same time, innovative measures would be required to provide basic education or some form of functional literacy to women in low-income families if they are to do well in income-generating activities. Some excellent results had been achieved with low-interest loans to organized groups of women in a number of countries, including Bangladesh and Indonesia; this practical approach should be replicated in other countries, wherever possible.

While significant progress had been made towards the 1990 goal of universal child immunization in some of the countries in Asia, the level of achievement in others would require more intensive and sustained efforts.

As for diarrhoeal diseases control, excellent progress had been made in Asia in producing oral rehydration salts, and in spreading knowledge about their efficacy. The big problem here for the 1990s would be to encourage more and more mothers to actually use ORS, or a locally-devised solution, when their children had moderate to severe attacks of diarrhoea.

Maternal malnutrition, morbidity and mortality remain high in most of Asia, even where infant mortality has been declining. The health and nutrition of women and girls would need to command increasing priority.

Family food production was receiving increased attention as a household security strategy in countries such as Indonesia, the Philippines, Fiji and Viet Nam. One promising approach was the use of bio-intensive gardening (for which the Philippines had devised the acronym BIG) to provide easily accessible, independent sources of essential foods for children and women.

Underlying all of these various projects and efforts is the basic element of social mobilization. In Asia, where this is particularly strong, special efforts would need to be sustained to nurture and extend social mobilization at the grass-roots level, for it is not a self-perpetuating mechanism; it is a fragile, human factor, so critical for the change of attitudes and values which underpin the child survival and development revolution. .

:And the importance of country programming

This wide range of fields of concern to UNICEF, both globally and for Asia, underlines the imperative of the country programming process. In Asia, the current decade has been characterized by the steady application, first initiated in the 1970s, of the country programming approach.

This systematic approach begins with a careful analysis of the situation of children in the country, and then proceeds to the setting of objectives, both general and specific; the identification and prioritizing of target groups; the spelling out of methods of implementation, as well as its phasing; and the building into the country plan from the very beginning a methodology for periodic monitoring and evaluation. The important components of social mobilization, and communications, are now well recognized in Asia, and these also form an integral part of every country programme.

In a number of cases, including the Philippines, Bangladesh and Sri Lanka, this meticulous country programming process is in its third cycle or generation, establishing a strong sense of orderly approach as well as a comprehensive framework for fitting in components for child survival and development within basic services and primary health care. It has also promoted a growing interest on the part of other UN partners, bilateral agencies, and non-governmental organizations to take on questions relating to child development.

Thus, the solid experience with country programming in Asia in the 1980s augurs well for programme planning, implementation and evaluation in the 1990s.

* * *

Poverty -- and a new regional focus

The number of people below the poverty line has increased over the period 1980-1985 from 820 million to 880 million, with substantial increases in Africa and Latin America, more than offsetting decreases in Asia. Assuming the same growth rates for the period 1991-1995 as for the period 1989-1991 and an unchanged pattern of income inequality, the number of poor in the year 1995 will be some 900 million -- with Africa contributing all of the increase.³³⁸

The Executive Director has advocated three major lines of action for the future if the worst aspects of mass poverty are to be overcome. First, the growing "Grand Alliance for Children", encompassing support ranging from the child survival and development and "Adjustment with a Human Face" to the Convention on the Rights of the Child, would need to be further mobilized and broadened to place children on the political agenda of all countries and appropriate organizations.

Secondly, goals for the 1990s, the UN's fourth development decade, would need to be defined and focused, building up from country and subregional levels to a meaningful strategy for action which would attract widespread public interest and national and international support.

And, thirdly, a special initiative for Africa and the least developed countries would need to be defined and developed in order to mobilize sustained economic support from international and domestic resources.³³⁹

:From Asia to Africa

Thus, for the remainder of the 1980s and into the 1990s, there will probably be a major shift from Asia to Africa in terms of global commitments and allocations of UNICEF's resources.

This trend is already taking place with respect to programme expenditures. Asia's programme expenditures increased from \$106.7 million in 1984 to \$155.2 million in 1987; Africa's increased at a faster rate, from \$78.5 million in 1984 to \$135.0 million in 1987.³⁴⁰ By the end of the 1980s or early 1990s, Africa's programme expenditures will probably exceed those of Asia.

It is entirely appropriate that UNICEF should concentrate greater attention and resources on Africa, which has the world's highest maternal death rate, and which is the one region in the world where the absolute number of infant and child deaths continues to rise. At the same time, support for the countries in Asia would continue; after all, half the world's children may be found there, although population alone, of course, is not the only factor in the allocation of UNICEF resources.

* * *

Criteria for allocating UNICEF resources

UNICEF, almost from its inception, had been seized of the question of developing acceptable criteria for allocating its programme resources, but it was not until the 1970s that two simple yardsticks were adopted: population, and per capita GNP.

Countries were divided into three categories, low, middle, and higher income; the lower the GNP per capita, the higher the claim to UNICEF resources. This, however, was interpreted in a flexible manner, taking into account any special

circumstances or needs, such as countries in especially severe economic and other difficulties. For countries "in transition", characterized by a rise in the GNP per capita and strong economic development, as in the case of the Republic of Korea, the forms of UNICEF support would be gradually modified to suit changing circumstances.

As for the population yardstick, it too was applied in a flexible way so that large countries would not swallow up too big a share of UNICEF's total resources, nor would small countries end up with infinitesimal amounts of aid.

:Infant mortality rate (IMR)

With the advent of the child survival and development revolution, the Board at its 1983 session approved a third criterion as a guide for determining the levels of support as well as the content of UNICEF programmes. This was the infant mortality rate, or IMR, calculated on the number of infant deaths under the age of one year per thousand live births.

Countries with extremely high (150 or more), or very high (105 to 145) infant mortality rates would receive a larger share of UNICEF's resources -- and vice versa. The number of infant deaths occurring in the developing world had always been a major concern of the UNICEF Executive Board; its formal adoption in 1983 as an indicator for allocating UNICEF programme assistance simply confirmed its importance.

This IMR indicator, as with the other two of GNP per capita and population, was also being applied in a flexible manner, recognizing that there would be margins of error in compiling many of the IMR estimates.

:A new index - the under-five mortality rate (U5MR)

The child survival and development revolution has gone a step further in improving on the IMR indicator, for it is concerned not only with survival beyond the perilous period of the first year of life, but through the early years as well, if the child is to have any chance to develop in later life. UNICEF has therefore prepared, in collaboration with the United Nations Population Division, a new index of infant and child mortality, known as the under-five mortality rate (U5MR), which is now an integral part of the annual State of the World's Children Reports.

The rationale for including, in the new index, children up to the age of five is that, of the 14.5 million infants and children in the world currently dying each year, nearly 5 million are above the age of one year -- a higher proportion than was previously estimated.³⁴¹ Also, it is possible for a country or large area of a country to have a relatively low infant mortality rate but an unacceptably high mortality rate for children 1-5 years of age.

:The U5MR -- and its challenge for Asia

Beginning with his State of the World's Children Report for 1987, Grant presented statistical tables which ranked countries in descending order of their estimated 1986 under-five mortality rate (U5MR).

Ten of the 64 countries listed as having very high U5MR (over 170) or high U5MR (95-170) were in the Asia region,³⁴² suggesting strongly to the UNICEF field staff as well as to the governments concerned that equal emphasis would need to be placed on measures to reduce child mortality in the age group 1-5 years in addition to reducing infant mortality in the age group 0-1 years.

Thus, another measure of progress in the Asia region for the 1990s will be the extent to which these ten countries have been able to improve their infant and child mortality rates.

:The U5MR - and its link to female illiteracy

An important key to the improvement of the infant and child mortality rate resides in a successful attack against female illiteracy. If indeed there is a strong link between the infant mortality rate on the one hand and female illiteracy on the other -- and study after study, as noted above in the section on education in the 1970s,³⁴³ have shown this to be so -- then it would make great good sense to accord the female illiteracy problem much higher priority in terms of UNICEF planning and programming. National literacy rates for women need also to be disaggregated by region, or province, and by a rural/urban dichotomy, in order to pinpoint the neediest areas. Thus, another key indicator to measure progress in Asia in the 1990s would be a reduction in the female illiteracy rate.

Tackling the crucial problem of female illiteracy, or lack of basic education for girls, has a more fundamental justification than simply lowering the infant mortality rate, important though that may be. Girls who have never gone to school, or who have dropped out after only a year or two of schooling, will remain trapped in illiteracy, condemning a large segment of society to perpetual darkness. If they have no access to basic education, how will they be able to take that giant step towards self-awareness and self-confidence, which is the key to opening up young minds to new ideas? How will they be able to want, and demand, change, which is the key to development?

* * *

Some concluding thoughts

The paths to improving the situation of children and women are many. The challenge is to find the right ones which will converge at the major cross-roads of child survival and development.

For UNICEF, they include such diverse activities as helping to bring safe water supply and sanitation to the majority of poor communities, rural and urban; spreading the good word about diarrhoeal control through oral rehydration therapy; expanding an awareness of good nutritional practices, including breast-feeding at birth, proper weaning, and careful growth monitoring; immunizing the great majority of children against preventable diseases; providing basic education for children, especially girls; raising the literacy levels, particularly for women; and, last but most definitely not least, promoting community awareness, commitment and participation, which are necessary pre-conditions for success in the various fields.

The net result of all of these activities, especially if they are focused in the same geographical areas to produce a multiplier effect, would be an improvement in the child survival rate.

Such an achievement would also mean that UNICEF has succeeded in helping to attack, in a very direct way, the basic issue of poverty. Children and women and their family members who live in insanitary conditions, with no access to safe water and health facilities, with little or no basic education or literacy, and very few opportunities to enhance their family incomes, will continue to live in absolute poverty. A rise in the infant and child survival rate will be a positive indicator that these issues are being addressed seriously, and successfully.

But mere survival, of course, is not enough; and, indeed, the child survival and development revolution has been so named precisely because child development is of equal importance to the basic issue of surviving beyond the first few crucial years of life.

The Executive Director, in his progress report to the 1988 session of the UNICEF Executive Board, referred not just to child survival, but also to child development, at the conclusion of this summary statement:

"...UNICEF has helped to demonstrate, through its ongoing work of past decades, and especially through participation in the CSD initiatives of this decade, that the world today possesses a greatly increased capacity to prevent - at low societal and financial cost - a majority of the deaths and disablement of so many millions of children annually in the silent emergency of avoidable malnutrition and infection. Does this not now require that UNICEF accelerate its efforts to encourage Governments and society to bring our sense of morality to par with our increasing capacity, and to take the readily available actions which are not only necessary but also now realistically possible to put the mass deaths of children on the shelf reserved for slavery, racism and apartheid - which are no longer conscionable to humankind? Have we now an opportunity to help the world establish the right of children to survive, to grow in health and to be protected and nurtured in their growth to full potential?"³⁴⁴

The answer, surely, must be a resounding "yes". This means giving high priority to the question of the quality of life after survival beyond the age of five, so that children may grow up to lead happy, productive lives. If early childhood development -- meaning the mental, social and physical growth and development of children -- is crucial for the under-five age group, the same applies, with equal force, to the next five growing years, if not the next ten.

For, what good is it to be born to Sweet Delight and "survive" -- only to be condemned to Endless Night?

- 148 -

BLACK BACK

NOTES

- 150 -

BLANK BACK

NOTES

1. Maggie Black, The Children and the Nations. The Story of UNICEF. UNICEF edition, 1986, p. 3. Hereinafter referred to as Black. A somewhat shorter trade edition of this book was issued in 1987 under the title, "The Children and the Nations: Growing up Together in the Postwar World".
2. George Woodbridge has described the wide range of activities carried out by UNRRA in China in UNRRA, the History of the United Nations Relief and Rehabilitation Administration (New York, Columbia University Press, 1950), Vol. II, pp. 376-451.
3. United Nations document A/230, 9 Dec. 1946. China is mentioned in paras. 4 and 9.
4. Perry O. Hanson, Jr., UNICEF in China: 1947-1951 (paper prepared for the UNICEF History Project (unpublished), 20 August 1984), p. 1. Hereinafter referred to as Hanson. Hanson served with UNRRA in China from 1945 to 1948 and was a member of the UNICEF North China Field Team from June 1948 and Senior UNICEF Representative in China from September 1949 to May 1951. He later served in Asia and Africa, as well as at New York Headquarters, retiring in 1976.
5. This debate covered two meetings on 17 and 18 June 1947 (UNICEF documents E/ICEF/C.1/SRs.7 and 8 dated 18 July 1947 and 18 August 1947 respectively). Executive Board approval of 700,000 beneficiaries for China is recorded in the Board's first Report to the Fifth Session of the UN Economic and Social Council (ECOSOC), United Nations document E/459, 10 July 1947, para. 39. For ease of reference, United Nations and UNICEF documents will hereinafter be referred to by their document symbols.
6. Programme Committee debate and approval of \$3.5 million for China covered two meetings held on 30 Sept. 1947 (E/ICEF/SRs. 21 and 22 of 30 Sept. 1947). Executive Board approval is recorded in its Report to the Sixth Session of ECOSOC, E/590, 11 Oct. 1947, para. 19.
7. E/590, supra note 6, para. 34. These criteria may also be found in "Compilation of Major UNICEF Policies", E/ICEF/107, 8 March 1949, pp. 3-4.
8. Thus, in the case of Romania, the desperate post-war nature of the situation in that country, highlighted by a very high infant mortality rate, prompted Prof. Robert Debrè, the French delegate, to announce that France would defer part of her allotment so that Romania's share could be increased. Programme Committee, Summary Record of 14th Meeting on 20 Aug. 1947, E/ICEF/C.1/SR.14, 19 Sept. 1947, p. 3.
9. Programme Committee discussion of the plan of operations (planops) for China took place at its 44th meeting on 15 April 1948 (E/ICEF/C.1/SR.44, 20 April 1948). The planops itself, plus supporting data, were attached as Annexes I and II respectively to the Report of the Programme Committee, E/ICEF/58, 16 April 1948.

10. E/ICEF/58, supra note 9, Annex II, para. 5, on p. 8.
11. Report of the Executive Director on the Programme in China, E/ICEF/91 of 12 Jan. 1949, and Add. 1 of 28 Jan. 1949. The beneficiary figures for the feeding programme were given in E/ICEF/91 and updated in Add.1, Annex I. In this report the Executive Director also paid tribute to the UNICEF staff in China, who "displayed great courage in remaining on duty".
12. Hanson, supra note 4, p. 56.
13. The debate on adding cities to the feeding programme for China began in the Programme Committee's 44th meeting on 15 April 1948, when it was considering the plan of operations for that programme (E/ICEF/C.1/SR.44, 20 April 1948), and was carried over to the Executive Board at three meetings on 20 and 28 April 1948 (E/ICEF/SR.26 of 27 April 1948 and SRs. 27 and 28, both dated 7 May 1948). Heyward's original draft resolution and his amended, approved version may be found in SRs. 27 and 28 respectively.
14. Newton R. Bowles, "Progress Report on UNICEF Programme for China", 23 August 1948, cited in Hanson, supra note 4, p. 26.
15. Leo Eloesser, Medical Service to the Chinese People. Its Beginning and its Development (unpublished paper, reproduced by UNICEF History Project), pp. 44-45. Hereinafter referred to as Eloesser.
16. The UNICEF/WHO Joint Committee on Health Policy reviewed the draft plan of operations as document JC.2/UNICEF/WHO/W.7. The Programme Committee approved the draft on 19 Nov. 1948 (E/ICEF/C.1/SR.70 of 2 Dec. 1948, p. 3); the Executive Board cleared it on the same day (E/ICEF/86 of 27 Nov. 1948, para. 49). The Chinese Government's approval is recorded in the Executive Director's Report on the Programme in China, E/ICEF/91 of 12 Jan. 1949, para. 5.
17. Letter from Su Chin Kwan to Leo Eloesser dated 22 Jan. 1949, given in full in Eloesser, supra note 15, pp. 51-54. Italics added.
18. See Chapter Seven entitled "Barefoot Doctors and Midwives" in Mary Brown Bullock's An American Transplant: the Rockefeller Foundation and Peking Union Medical College (Berkeley, University of California Press, 1980).
19. J.E.B. McPhail, "Summary of CLARA-UNICEF Medical Program in North China" (mimeographed, 6 Feb. 1950), p. 6. Hereinafter referred to as McPhail. Dr. McPhail, a Canadian pediatrician, was on the teaching staff for the second course.
20. This manual, widely used in the early years, has now been superseded by later manuals in the UNIPAC (Copenhagen) catalogue. In a booklet on "UNICEF in China", produced by the UNICEF/Beijing Office in June 1987, there is a picture on p. 3 with the caption "girls in a liberated area community learn to be midwives in a programme assisted by UNICEF". From the classroom facilities shown in the photograph, the locale would appear to be T'ung Chow, where the second course was held.

21. Executive Board, Summary Record of 59th Meeting on 4 Nov. 1949, E/ICEF/SR.59, 2 Dec. 1949, pp. 8-13.
22. "Statement of Dr. Leo Eloesser to Executive Board of UNICEF on the Fund's Progress in China", 2 Nov. 1949, cited in Hanson, supra note 4, p. 59.
23. Eloesser, supra note 15, p. 59.
24. The votes were 10-6 with 5 abstentions, and 9-3 with 6 abstentions. Executive Board, Summary Record of 63rd Meeting on 6 March 1950, E/ICEF/SR.63 of 13 March 1950, p. 3; and Summary Record of 66th Meeting on 19 June 1952, E/ICEF/SR.66 of 27 June 1950, p. 4.
25. The Executive Director referred to this exchange of confidential communications in his General Progress Report of 26 Oct. 1950, E/ICEF/155, para. 90.
26. Executive Board, Summary Record of 70th Meeting on 27 Nov. 1950, E/ICEF/SR.70 of 30 Nov. 1950, p. 9.
27. Executive Board, Summary Record of 71st Meeting on 27 Nov. 1950, E/ICEF/SR/71 of 27 Nov. 1950, p. 6.
28. Hanson, supra note 4, p. 55.
29. There was a shipment of cotton to Japan not too long after, but Barney Fraser, long-retired UNICEF staff member who was involved in this matter at the time, recalls that this cotton shipment for China was eventually sent to Europe.
30. McPhail, supra note 19, pp. 12-13.
31. In an Information Note dated October 1951 to the Programme Committee, the Executive Director had reported that allocations to China had totalled \$8,947,000. Expenditures amounted to \$1,716,000, mostly for food and maternal and child health (MCH) supplies, leaving a balance of \$7,231,000 (E/ICEF/R.253, 15 October 1951). The Board at its Nov. 1951 session returned \$469,000 of this amount which had been earmarked for BCG vaccination but not used, leaving a net balance of \$6,762,000.

This amount of \$6,762,000 was returned to the general resources of UNICEF in two actions: \$5,227,000 in April 1952 because the Board at that session had approved allocations greatly in excess of then-existing resources, due in part to the inclusion of Africa (E/ICEF/198, p. 4); and the balance of \$1,535,000 in June 1961, when the Board decided that any allocations more than five years old which were not spent should revert to general resources (E/ICEF/431, para. 143).
32. The original Basic Agreement with China was signed on 21 May 1948. A new one was signed in Taiwan on 19 July 1950 which was virtually identical to the earlier one, except that all references to "China" were amended to read "Republic of China".

33. Executive Director, General Progress Report, "Programme Developments in East Asia and Pakistan", E/ICEF/L.1418, 10 April 1980, para. 41.
34. During 1979 and 1980, Ralph Eckert was the senior staff member at Headquarters responsible for UNICEF's relationships with China. While almost all of the story, involving sensitive discussions, has not been recorded, the outcome was clearly favourable; China today ranks near the top in terms of magnitude of programme commitments approved by the Board.
35. Executive Board, Report on its 26th-28th Meetings of April 1948, E/ICEF/59, 30 April 1948, para. 4 (a). Subsequent references to Reports of the Executive Board on its various sessions will be shortened to Executive Board Report, followed by date and document number.
36. "Report of the Survey Mission to the Far East (other than China)", E/ICEF/72, 1 July 1948, p. 1. Hereinafter referred to as the Parran/Lakshmanan Report.
37. Programme Committee, Summary Record of 49th Meeting on 4 July 1948, E/ICEF/C.1/SR.49, 12 July 1948. Signs of the times: Jack Charnow, long-serving Secretary of the Executive Board and, subsequent to retirement, manager of the UNICEF History Project, recalls that the staff worked through Saturday night of July 3 and into Sunday morning of July 4, cutting stencils, mimeographing, and collating the survey report in time for the meeting at 10:30 a.m.
38. Parran/Lakshmanan Report, supra note 36, para. 18.
39. Programme Committee, Summary Record of 50th Meeting on 4 July 1948, E/ICEF/C.1/SR.50, 12 July 1948, p. 3.
40. Executive Board Report, 30 July 1948, E/901, Table 7 on p. 18;
41. Executive Director, Report to Programme Committee, E/ICEF/79, 20 Aug. 1948, para. 55.
42. As part of a global paper on UNICEF's aid for training in maternal and child health programmes, presented to the April 1957 session of the Executive Board, the Executive Director summarized the results of a study made by the Asia Regional Office on the 145 fellowships financed by UNICEF during the period 1948-1953 (E/ICEF/336/Add.1, 16 March 1957, para. 65).
43. E/ICEF/79, supra note 41, para. 26.
44. Michael Watt, "UNICEF Comes to Asia", mimeographed by UNICEF New York, March 1964, pp. 26-27. Hereinafter referred to as Watt.
45. Executive Board Report, 14 March 1949, E/1144/Add.2, para. 29.
46. One of the earliest of these summaries may be found in E/ICEF/114 of 17 May 1949 which, besides covering 12 countries in Europe, also included summaries of the plans of operations for the first two feeding projects in Asia (Hong Kong and the Philippines).

47. Parran/Lakshmanan Report, supra note 36, Annex B/7, Report on Netherlands East Indies, p. 1.
48. Executive Director, Report to Programme Committee, E/ICEF/L.3, 27 Jan. 1950, para. 28.
49. Watt, supra note 44, p. 43.
50. S.M. Keeny, Half the World's Children (New York, Association Press, 1957). Hereinafter referred to as Keeny. This was a compilation of selected excerpts from Keeny's monthly reports which he wrote when serving as UNICEF's Regional Director for the Asia Region.
51. Executive Board Report, 14 March 1949, E/1144/Add.2, para. 13.
52. "Experience with UNICEF-assisted Feeding Programmes in Asia", E/ICEF/191, 3 April 1952, para. 23. Visual evidence of this difference was captured in a remarkable photograph, taken in Tokyo in 1950, and reproduced in Judith M. Spiegelman's We Are The Children (Boston/New York, The Atlantic Monthly Press, 1986), pp. 54-55. Hereinafter referred to as Spiegelman.
53. Executive Director, Report to Programme Committee, E/ICEF/79, 20 Aug. 1948, para. 34.
54. Recommendation of the Executive Director for an Allocation and Programme for Korea, E/ICEF/W.67, 24 June 1949, para. 4.
55. "Country Programme Recommendation for Democratic People's Republic of Korea", E/ICEF/1986/P/L.16, 7 Feb. 1986.
56. Programme Committee debate covered 3 meetings on 21 and 22 Feb. 1949 (E/ICEF/C.1/SRs. 78, 79, and 80, all dated 5 March 1949). Executive Board discussion extended over 4 meetings on two days, 9 and 10 March 1949, and is recorded in E/ICEF/SRs. 48 to 51 inclusive, dated 24, 29, and 30 March, and 1 April 1949, respectively. The Executive Director's budget proposals were presented in E/ICEF/100 of 11 Feb. 1949.
57. The Programme Committee report is contained in E/ICEF/106 of 28 Feb. 1949. The Executive Board decision is recorded in Executive Board Report, 14 March 1949, E/1144/Add.2, Table I on page 13. The total for Europe of \$37.9 million included \$1 million for Germany as well as a reserve for Europe of \$2 million..
58. "An Overview of UNICEF Policies, Organization and Working Methods", E/ICEF/670/Rev.3, 22 Aug. 1984, para. 4.
59. Final Report of the First Executive Board Session, 11 Dec. 1946-31 Dec. 1950, E/ICEF/160, 22 Jan. 1951, paras. 69-100, summarizes the work of UNICEF in Asia.
60. Spiegelman, supra note 52, pp. 66-69.
61. "A Special Report of the Executive Board, 25 March 1953", E/ICEF/226, 21 April 1953, paras. 5 & 10.

62. Spiegelman, supra note 52, p. 72.
63. Black, supra note 1, pp. 89-90.
64. Keeny, Statement to the Sept. 1953 Executive Board session, E/ICEF/238, 10 Sept. 1953, p. 1.
65. The story of BCG vaccine, its discovery, trials and tribulations in the early years, and its later vindication, first by the Scandinavian countries in the late 1930s and then by a mass vaccination campaign in post-war Europe with UNICEF assistance in an International Tuberculosis Campaign (ITC), may be found, in rich detail, in Black, supra note 1, pp. 49-55; and Spiegelman, supra note 52, pp. 48-51.
66. Parran/Lakshmanan Report, supra note 36, para. 14.
67. Executive Board, Report to Eighth Session of ECOSOC, E/1144/Add.2, 14 March 1949, para. 15.
68. The change-over from liquid to freeze-dried BCG vaccine (which "must be preceded by training of the vaccinators in the special techniques required for the reconstitution of dried vaccine") was endorsed by the UNICEF/WHO Joint Committee on Health Policy (JCHP) in its Report of Thirteenth Session, 31 Jan.-1 Feb. 1962, JC13/UNICEF-WHO/8, 7 Feb. 1962, para. 6.6. The Executive Board approved this and other recommendations of the JCHP at its June 1962 session, E/ICEF/454/Rev.1, 4-12 June 1962, paras. 121-126.
69. The omission of the tuberculin test in the young age-groups as a necessary screening prior to BCG vaccination was recommended by the WHO Expert Committee on Tuberculosis in its Eighth Report of 1964; endorsed by the JCHP in JC14/UNICEF-WHO/7.65, 8-10 Feb. 1965, p. 7; and approved by the Executive Board at its June 1965 session, E/ICEF/528/Rev.1, 14-23 June 1965, pp. 39-40.
70. Heyward, Statement to Programme Committee, E/ICEF/176, 30 April 1951, p. 6.
71. Keeny, Statement to the Sept. 1954 Board session, E/ICEF/270, 9 Sept. 1954, para. 10.
72. Executive Director, General Progress Report, Addendum on "Programme Developments in Asia", E/ICEF/281/Add.3, 1 Feb. 1955, para. 30.
73. Executive Director, General Progress Report, Addendum on "Programme Developments in Asia", E/ICEF/300/Add.3, 8 July 1955, para. 44.
74. Executive Director, General Progress Report, Addendum on "Programme Developments in Asia", E/ICEF/397/Add.3, 25 Jan. 1960, para. 7 (d).
75. Executive Board, Summary Record of 92nd Meeting on 23 April 1952, E/ICEF/SR.92, 12 May 1952, p. 8.

-
76. Heyward, Statement to Programme Committee, E/ICEF/176, 30 April 1951, p. 9.
 77. Executive Director, General Progress Report, E/ICEF/221, 15 March 1953, para. 51. The price fell even lower -- to 18-1/3 cents -- by 1955.
Executive Director, General Progress Report, E/ICEF/309, 15 Feb. 1956, para. 44.
 78. Keeny, Statement to March 1954 Board session, E/ICEF/251, 3 March 1954, para. 3(c).
 79. Executive Director, General Progress Report, E/ICEF/267, 15 July 1954, para. 10.
 80. Keeny, supra note 50, p. 133.
 81. Executive Director, General Progress Report, Addendum on "Programme Developments in Asia", E/ICEF/300/Add.3, 8 July 1955, para. 80(b).
 82. Executive Director, General Progress Report, Addendum on "Programme Developments in Asia", E/ICEF/322/Add.3, 4 Sept. 1956, para. 72(a).
 83. Executive Director, General Progress Report, "Appraisal" chapter, E/ICEF/336/Add.1, 16 March 1957, para. 30.
 84. Spiegelman, supra note 52, p. 74.
 85. Executive Director, General Progress Report, Addendum on "Programme Developments in Asia", E/ICEF/397/Add.3, 25 Jan. 1960, para. 7(d).
 86. Ibid., para. 85.
 87. Keeny, Statement to Sept. 1954 Board session, E/ICEF/270, 9 Sept. 1954, para. 31.
 88. Ibid., para. 33.
 89. Programme Committee, Summary Record of Fifty-Fifth Meeting on 19 July 1948, E/ICEF/C.1/SR.55, 15 Sept. 1948, p. 3.
 90. Heyward, Statement to Programme Committee on 30 April 1951, E/ICEF/176, 30 April 1951, pp. 4-5.
 91. "A Review of the Achievements of the WHO/UNICEF Malaria Control Demonstration Projects Undertaken in Southeast Asia During 1949-1950", E/ICEF/204, 2 Oct. 1952.
 92. Executive Director, General Progress Report, E/ICEF/221, 15 March 1953, para. 114.
 93. Ibid., para. 119.

94. Keeny, Statement to Sept. 1953 session of Executive Board, E/ICEF/238, 10 Sept. 1953, p. 2. The Burma malaria programme was the subject of Wah Wong's doctoral dissertation at New York University, with research based mainly on files in the Asia Regional Office in Bangkok, where he served as one of Keeny's programme officers.
95. Black, supra note 1, p. 135. Maggie Black devotes chapter 5 of her book to "The Perfidious Mosquito".
96. Executive Director, General Progress Report, Addendum on "Programme Developments in Asia", E/ICEF/281/Add.3, 1 Feb. 1955, paras. 127 and 130. UNICEF was able to turn over the large Korea feeding programme to CARE by mid-1957, the first step of many by UNICEF to disengage itself from skim milk distribution for mass feeding.
97. Executive Director, General Progress Report, Part IV, "Programme Developments in Asia", E/ICEF/376/Add.3, 6 Feb. 1959, para. 4. The total for 1958, as reported in this document, was 2,666,000 beneficiaries.
98. The first review, which included summaries of controlled experiments in a number of Asian countries, including Japan, was presented to the Board at its April 1952 session ("Experience with UNICEF-assisted feeding programmes in Asia", E/ICEF/191, 3 April 1952). This was followed by a Board review in April 1954 of a report on the distribution of skim milk for emergencies ("Progress Report on Use of Low-Cost Milk", E/ICEF/L.555, 17 Feb. 1954). And, for the Sept. 1959 Board session, a special report on UNICEF-assisted programmes of skim milk distribution was prepared by FAO, WHO and UNICEF ("Report on UNICEF-Assisted Programmes of Dry Skim Milk Distribution"), E/ICEF/385, 14 May 1959.
99. Executive Director, General Progress Report, E/ICEF/336, 16 March 1957, para. 43.
100. Executive Board Report, 3-12 Sept. 1957, E/ICEF/353/Rev.1, para. 73.
101. A full account of this remarkable project in Anand, India, which was based on a very strong co-operative union, and which eventually expanded to over 40,000 village societies and produced a variety of milk products, including buffalo cheese, may be found in Black, supra note 1, pp. 147-153.
102. Executive Director, General Progress Report, Part IV on "Programme Developments in Asia", E/ICEF/376/Add.3, 6 Feb. 1959, para. 68.
103. Executive Director, General Progress Report, Part IV, "Programme Developments in Asia", E/ICEF/397/Add.3, 25 Jan. 1960, para. 7(d).
104. Executive Director, General Progress Report, Part IV, "Programme Developments in Asia", E/ICEF/397/Add.3, 25 Jan. 1960, paras. 7(b) to (d).
105. Executive Director, General Progress Report, Addendum on "Programme Developments in Asia", E/ICEF/281/Add.3, 1 Feb. 1955, paras. 90-100.

106. Keeny, supra note 50, p. 69.
107. Executive Director, General Progress Report, Addendum on "Programme Developments in Asia", E/ICEF/281/Add.3, 1 Feb. 1955, para. 109.
108. Executive Director, General Progress Report, Annex on "Programme Developments in Asia", E/ICEF/447/Add.3, 19 April 1962, Annex entitled "Final Report on Calcutta Training Centre". See also the Interim Report attached to the General Progress Report of the Executive Director, Part IV, "Programme Developments in Asia", E/ICEF/409/Add.3, 24 March 1961, Annex.
109. Executive Board Report, 3-16 April 1957, E/ICEF/344/Rev.1, para. 31.
110. Executive Director, General Progress Report, Part IV, "Programme Developments in Asia", E/ICEF/409/Add.3, 24 March 1961, para. 27.
111. Executive Director, General Progress Report, Addendum on "Programme Developments in Asia", E/ICEF/356/Add.2, 22 Jan. 1958, para. 32.
112. Spiegelman, supra note 52, p. 80.
113. Keeny, Statement to Executive Board, E/ICEF/288, 9 March 1955, pp. 4-5.
114. Executive Director, General Progress Report, Addendum on "Programme Developments in Asia", E/ICEF/322/Add.3, 4 Sept. 1956, para. 11.
115. Executive Director, General Progress Report, Addendum on "Programme Developments in Asia", E/ICEF/336/Add.4, 12 March 1957, para. 176.
116. Executive Director, General Progress Report, Addendum on "Programme Developments in Asia", E/ICEF/356/Add.2, 22 Jan. 1958, para. 6.
117. Ibid., para. 29.
118. Executive Director, General Progress Report, E/ICEF/155, 26 Oct. 1950, paras. 40-41.
119. Executive Director, General Progress Report, "Programme Developments in Asia", E/ICEF/309/Add.3, 24 Jan. 1956, para. 1.
120. Executive Director, General Progress Report, "Programme Developments in Asia", E/ICEF/397/Add.3, 25 Jan. 1960, para. 9.
121. Keeny, Statement to March 1955 Board session, E/ICEF/288, 9 March 1955, p. 9.
122. Spiegelman, supra note 52, p. 65.
123. Executive Board Report, E/ICEF/380, 2-12 March 1959, para. 27.
124. Charles A. Egger, "Main Trends in UNICEF's Policy: 1947-1980". A review prepared for the UNICEF History Project. HIST 45/Rev.1, January 1986, p. 5. Hereinafter referred to as Egger.

-
125. Executive Board Report, 4-12 June 1962, E/ICEF/454/Rev.1, para. 12.
 126. Executive Board Report, 20-21 June 1963, E/ICEF/469/Rev.1, para. 17.
 127. Egger, supra note 124, p. 6.
 128. "Children and Youth in Development Planning. Conclusions of a round-table conference held at Bellagio, Italy, 1-7 April 1964", E/ICEF/498, 2 June 1964, paras. 1-8.
 129. "Report of the Asian Conference on Children and Youth in National Planning and Development", E/ICEF/CRP/66-8, 1 April 1966. The final printed version contained Annexes which were not ready when the preliminary report was issued, and these included addresses by the Prime Minister of Thailand, the Executive Secretary of ECAFE, and the Conference Chairman, as well as a statement by Heyward at the beginning of the second part of the Conference (Annex V of printed version). Subsequent references will be made to the printed version, hereinafter referred to as the Asian Planning Conference Report.
 130. Executive Director, General Progress Report, E/ICEF/558, 1 May 1967, para. 172 (b).
 131. Asian Planning Conference Report, supra note 129, Annex V, p. 64.
 132. Executive Director, General Progress Report, E/ICEF/626 (Part I), 29 March 1973, para. 16.
 133. Executive Director, General Progress Report, "Programme Developments in the East Asia and Pakistan Region", E/ICEF/602/Add.6, 25 Feb. 1970, para. 10.
 134. Executive Director, General Progress Report, "Programme Progress and Trends in East Asia and Pakistan", E/ICEF/626/Add.1, 11 Jan. 1973, para. 9.
 135. Executive Director, General Progress Report, "Programme Progress in the East Asia and Pakistan Region", E/ICEF/CRP/70-7, 27 Feb. 1970, para. 26.
 136. Executive Director, General Progress Report, "Major Trends in the East Asia and Pakistan Region", E/ICEF/573/Add.6/Part I, 11 April 1968, para. 40.
 137. Ibid, para. 42.
 138. Executive Director, General Progress Report, "Programme Developments in the South Central Asia Region", E/ICEF/558/Add.6, 24 April 1967, para. 33.
 139. Executive Director, General Progress Report, "Programme Developments in East Asia and Pakistan", E/ICEF/558/Add.7, 14 April 1967, para. 7.

140. Executive Director, General Progress Report, "Major Trends in the East Asia and Pakistan Region", E/ICEF/573/Add.6/Part I, 11 April 1968, para. 17.
141. "Interview with Martin Sandberg conducted by Herman Stein in Spain on 8 September 1983", UNICEF History Project, p. 16.
142. Ibid., p. 22.
143. Executive Board Report, 12-13 January 1961, E/ICEF/407, para. 75.
144. Executive Director, General Progress Report, "Programme Developments in the South Central Asia Region", E/ICEF/558/Add.6, 24 April 1967, para. 50.
145. Wah Wong, "An Immunization Programme in Dewas District, India: Successes and Failures", Assignment Children, No. 61/62, 1983, pp. 281-291.
146. Executive Board Report, 13-24 Jan. 1964, E/ICEF/492, para. 17.
147. Executive Director, Note on "The Problems and Needs of Children in Asia", E/ICEF/479, 24 Dec. 1963, para. 12.
148. Ibid., paras. 22-24.
149. Executive Director, General Progress Report, "Programme Developments in South Central Asia Region", E/ICEF/542/Add.7, 21 March 1966, para. 76.
150. Executive Director, General Progress Report, "Programme Developments in East Asia and Pakistan", E/ICEF/573/Add.6/Part I, 11 April 1968, para. 21.
151. Executive Director, General Progress Report, "Country Project Progress" for the East Asia and Pakistan Region, E/ICEF/573/Add.6/Part II, 15 April 1968, paras. 17-18.
152. Executive Director, General Progress Report, "Programme Developments in East Asia and Pakistan", E/ICEF/558/Add.7, 14 April 1967, para. 116.
153. Ibid., para. 107.
154. Executive Board Report, 12-20 June 1967, E/ICEF/563, para. 35.
155. Ibid., para. 37.
156. Black, supra note 1, pp. 247-248.
157. Executive Board Report, 19-27 May 1966, E/ICEF/548/Rev.1, para. 185.
158. Executive Board Report, 12-20 June 1967, E/ICEF/563, para. 45.
159. See ibid., paras. 44-58, for a summary of the Board's debate on UNICEF and family planning.

160. Executive Director, General Progress Report, "Country Project Progress" for the East Asia and Pakistan Region, E/ICEF/Add.7/Part II, 25 Feb. 1969, para. 67.
161. Executive Director, General Progress Report, E/ICEF/602, 19 March 1970, para. 68.
162. Executive Director, General Progress Report, "Programme Developments in the South Central Asia Region", E/ICEF/558/Add.6, 24 April 1967, para. 103.
163. "Assessment of Environmental Sanitation and Rural Water Supply Programmes Assisted by UNICEF and WHO, 1959-1968", JC16/UNICEF-WHO/69.2, p. 4.
164. The UNICEF secretariat was presented with a request from Greece in the 1950s for a village water supply project — without provision for excreta disposal. The request was turned down and explained in a note to the Board (Executive Director, "Note on environmental sanitation: interpretation of policy", E/ICEF/R.521, 2 March 1954). See also Executive Board Report, 1-9 March 1954, E/ICEF/260/Rev.1, paras. 167-168.

The Board in 1958, which had several new members, felt that they were simply "rubber-stamping" proposals already screened by the Administration, and asked for a list of proposals which had been turned down, and the reasons for doing so. The Administration complied, and this was done for a number of Board sessions, but the Administration was always careful to keep anonymous the names of the countries involved.
165. Keeny, Statement to the Executive Board, E/ICEF/288, 9 March 1955, p. 7.
166. JC16/UNICEF-WHO/69.2, p. 28; and Executive Board Report, 21-30 May 1969, E/ICEF/590, para. 122, point 7 on p. 35.
167. Executive Director, General Progress Report, "Programme Developments in Asia", E/ICEF/447/Add.3, 19 April 1962, para. 4.
168. Executive Director, General Progress Report, "Programme Developments in Asia", E/ICEF/409/Add.3, 24 March 1961, para. 45.
169. See the section above on BCG vaccination in the chapter on the 1950s, pp. 26-27, and supra notes 68 and 69.
170. Executive Director, General Progress Report, "Programme Developments in the South Central Asia Region", E/ICEF/558/Add.6, 24 April 1967, para. 110.
171. Executive Director, General Progress Report, "Programme Developments in the East Asia and Pakistan Region", E/ICEF/558/Add.7, 14 April 1967, para. 94 (g).
172. Executive Director, General Progress Report, "Programme Developments in the South Central Asia Region", E/ICEF/586/Add.8, 12 March 1969, para. 88.

173. Executive Director, General Progress Report, "Programme Developments in the South Central Asia Region", E/ICEF/573/Add.7/Rev.1, 10 June 1968, para. 34.
174. Executive Director, "Programme Developments in Asia", E/ICEF/397/Add.3, 25 Jan. 1960, para. 7 (d).
175. Executive Board Report, 19-27 May 1966, E/ICEF/548/Rev.1, para. 164 (d).
176. Executive Director, General Progress Report, E/ICEF/573, 18 April 1968, p. 19.
177. Executive Director, General Progress Report, "Programme Developments in the East Asia and Pakistan Region", E/ICEF/CRP/70-7, 27 Feb. 1970, para. 2.
178. Spiegelman, supra note 52, p. 78.
179. Ibid.
180. Executive Director, General Progress Report, "Programme Developments in East Asia and Pakistan Region", Part II, Programme Progress, E/ICEF/608/Add.5 (Part II), 9 Feb. 1971, para. 7.
181. Executive Director, General Progress Report, "Programme Developments in Asia", E/ICEF/480/Add.4, 24 Oct. 1963, para. 83.
182. Ibid., para. 84.
183. Executive Director, General Progress Report, E/ICEF/573, 18 April 1968, para. 109.
184. Executive Board Report, 6-19 June 1968, E/ICEF/576, para. 58.
185. Executive Director, General Progress Report, "Programme Developments in South Central Asia", E/ICEF/480/Add.5, 18 Nov. 1963, para. 9.
186. Executive Board Report, 12-20 June 1967, E/ICEF/563, para. 105.
187. Executive Director, General Progress Report, "Child Malnutrition in the Developing Countries", E/ICEF/586/Add.9, 17 March 1969, para. 62. Hereinafter referred to as Child Malnutrition Report.
188. Executive Board Report, 21-30 May 1969, para. 77.
189. Executive Director, General Progress Report, "Programme Developments in the East Asia and Pakistan Region", E/ICEF/480/Add.4, 24 Oct. 1963, para. 56.
190. Executive Director, General Progress Report, "Programme Developments in East Asia and Pakistan", E/ICEF/480/Add.4, 24 Oct. 1963, para. 83.

191. Executive Director, General Progress Report, "Programme Developments in the South Central Asia Region", E/ICEF/586/Add.8, 12 March 1969, paras. 64-65.
192. Child Malnutrition Report, supra note 187, para. 52.
193. Executive Director, General Progress Report, "Programme Developments in the East Asia and Pakistan Region", E/ICEF/558/Add.7, 14 April 1967, para. 61.
194. Black, supra note 1, p. 161.
195. Child Malnutrition Report, supra note 187, paras. 32, 37, and 38.
196. Executive Director, General Progress Report, E/ICEF/573, 18 April 1968, para. 98.
197. Executive Director, General Progress Report, "Programme Developments in East Asia and Pakistan", Part II, Country Project Progress, E/ICEF/573/Add.6/Part II, 15 April 1968, para. 98.
198. Executive Board Report, 2-11 Sept. 1958, E/ICEF/374, para. 76.
199. Executive Board Report, 2-12 March 1959, E/ICEF/380, para. 104.
200. H.M. Phillips, "UNICEF in Education: A Historical Perspective", UNICEF History Series, Monograph IX, Oct. 1987, p. 6. Hereinafter referred to as Phillips. This is a review of UNICEF's education policy and practices from its inception to the present day.
201. Strategy for Children, A Study of UNICEF Assistance Policies, UNICEF, E/ICEF/559/Rev.1, UN Pub. 67.IV.29, p. 31.
202. Executive Director, General Progress Report, "Programme Developments in the East Asia and Pakistan Region", E/ICEF/511/Add.4, 10 April 1965, para. 9.
203. Executive Director, General Progress Report, "Programme Developments in the East Asia and Pakistan Region", E/ICEF/558/Add.7, 14 April 1967, para. 134.
204. Phillips, supra note 200, p. 28.
205. Ibid.
206. Executive Director, General Progress Report, E/ICEF/573, 18 April 1968, para. 56.
207. Ibid., para. 61, Table 3 on p. 35.
208. Executive Board Report, 2-12 March 1959, E/ICEF/380, paras. 105-114.
209. Executive Board Report, 19-27 May 1966, E/ICEF/548/Rev.1, para. 129.

210. Executive Director, General Progress Report, "Programme Developments in the East Asia and Pakistan Region", Part II, Country Project Progress, E/ICEF/586/Add.7/Part II, 25 Feb. 1969, para. 33.
211. Executive Director, "Medium-Term Plan for the Period 1986-1990", E/ICEF/1987/3, 5 March 1987, Table 8 on p. 43.
212. Executive Director, General Progress Report, E/ICEF/573, 18 April 1968, para. 13.
213. The Board at its 1968 session accepted the principle of special contributions on a one-year trial basis, on the understanding that such funds would not be actually receivable by UNICEF until the Board had given its agreement for its acceptance, either by mail poll or at the next regular Board session. However, in the case of emergencies, the Executive Director was authorized to receive special contributions from both governments and private sources without additional Board approval. Executive Board Report, 6-19 June 1968, E/ICEF/576, paras. 100-110.

At its next session in 1969, the Board re-affirmed the principle of specific purpose contributions, subject to the understanding that experience with such contributions would be reviewed by the Board after three years. The Board also "noted" 26 project proposals. Executive Board Report, 21-30 May 1969, E/ICEF/590, paras. 185-193.
214. E/ICEF/1987/3, supra note 211, Table 6 on p. 39.
215. Executive Board Report, 20 April-1 May 1987, E/ICEF/1987/11, para. 38.
216. "Update of UNICEF Policy on Supplementary Funds", E/ICEF/1988/L.2, 10 Dec. 1987, para. 47.
217. Executive Board Report, 19-27 May 1966, E/ICEF/548/Rev.1, para. 102.
218. Executive Board Report, 19-27 May 1966, E/ICEF/548/Rev.1, para. 104.
219. Executive Director, General Progress Report, "Programme Developments in the South Central Asia Region", E/ICEF/511/Add.5, 30 April 1965, para. 38.
220. See Executive Director, General Progress Report, "Programme Developments in the South Central Asia Region", E/ICEF/558/Add.6, 24 April 1967, paras. 55-60, on suggestions for restructuring UNICEF assistance in the SCARO Region.
221. Executive Director, General Progress Report, "Programme Developments in the South Central Asia Region", E/ICEF/573/Add.7/Rev.1, 10 June 1968, para. 133.
222. Ibid., para. 119.
223. Executive Director, General Progress Report, "Programme Developments in the South Central Asia Region", E/ICEF/602/Add.7, 16 Feb. 1970, para. 109.

-
224. Executive Director, General Progress Report, "Programme Developments in the South Central Asia Region", E/ICEF/558/Add.6, 24 April 1967, para. 54.
225. Executive Board Report, 14-23 June 1965, E/ICEF/528/Rev.1, para. 99.
226. Executive Director, "Criteria for Developing an Appropriate Balance of Inputs into Country Programmes", E/ICEF/P/L.1612, 7 April 1975, para. 11, table on p. 4.
227. Report of the Executive Director, Addendum on Programme Statistics, E/ICEF/1987/2/Add.1, 30 March 1987, Table 2 on p. 7.
228. Executive Director, General Progress Report, "Programme Developments in the South Central Asia Region", E/ICEF/573/Add.7/Rev.1, 10 June 1968, paras. 68-72.
229. Executive Board Report, E/ICEF/624, 24 April-5 May 1972, para. 41.
230. Executive Director, General Progress Report, Introduction, E/ICEF/626/(Part I), 29 March 1973, paras. 20-21.
231. Executive Board Report, E/ICEF/629, 30 April-11 May 1973, para. 29.
232. Executive Director, General Progress Report, Chapter I: Introduction, E/ICEF/637 (Part I), 29 April 1975, para. 6.
233. Ibid., para. 11.
234. Executive Board Report, 14-30 May 1975, E/ICEF/639, para. 12.
235. Ibid., para. 25.
236. Executive Board Report, E/ICEF/644, 17-28 May 1976, para. 17.
237. This report was prepared by the UNICEF and WHO secretariats and was considered at the 1977 Board session. See "Community Involvement in Primary Health Care: A Study of the Process of Community Motivation and Continued Participation", E/ICEF/L.1355, 12 Jan. 1977.
238. General Assembly Resolution 31/167 of 21 Dec. 1976. Laura Lising of the UNICEF History Project recalls how, as a member of the Philippine Delegation to the UN, she helped to draft this resolution, and fought to have it adopted by the Second (Economic) Committee.
239. "Report of the Special Meeting on the Situation of Children in Asia with Emphasis on Basic Services, Manila, 17-19 May 1977", E/ICEF/650/Rev.1, 4 Aug. 1977.
240. Ibid., para. 69.

241. Perry Hanson -- after his North China experience -- was the UNICEF Representative to the Philippines at the time, and recalls that the training of these eager young community development workers included field studies of UNICEF-aided projects at the village level, where they experienced first-hand the relationships among the various projects and the local communities. Sometimes, of course, the CD workers were too enthusiastic: in December 1955, a farmer in Cagayan re-thatched his latrine and next morning found a 'Self-help Toilet-construction Project' sign nailed up over the seat!" Personal letter from Perry Hanson to the author dated 13 October 1987, p. 7.
242. Ramon P. Binamira, "The need for an integrated approach to social development in under-developed countries - a look at Project Compassion, Philippines", E/ICEF/ASIA.2, 6 April 1977, para. 97.
243. Ibid., para. 104. Italics in the original.
244. "Country Programme Profile, Philippines", E/ICEF/P/L.1924(REC), 9 May 1980, pp. 6, 13-14; and "Statement of Mr. Wah Wong, UNICEF Representative to the Philippines to the Programme Committee, 21 May 1980", E/ICEF/CRP/80-32, 27 May 1980, pp. 2, 5-6.
245. "Philippines, Country Programme Profile", E/ICEF/1983/CRP.31, 6 April 1983, para. 45.
246. Executive Board Report, E/ICEF/651, 23 May-3 June 1977, para. 29.
247. Ibid., para. 49.
248. Ibid., para. 51.
249. Executive Board Report, 15-26 May 1978, E/ICEF/655, para. 133. For a full treatment of events leading up to the Alma Ata Conference on Primary Health Care, and a brief summary of the salient points arising out of that Conference, see Black, supra note 1, Chapter 14, "Health for Some or Health for All?".
250. Executive Director, General Progress Report, "Programme Progress and Trends", E/ICEF/658 (Part II), 4 April 1979, paras. 120-127.
251. Black, supra note 1, pp. 338-348.
252. Information on the four major programmes in India which fall in the category of convergent services has been taken from the "Country Programme of Cooperation - Government of India and UNICEF: Plan of Operations 1985-89", signed on 3 March 1986. This covered the Board's approved commitment of \$175 million (plus \$52.3 million in supplementary funding) for the 5-year period 1985-1989. Hereinafter referred to as India Plan of Operations.
253. India Plan of Operations, supra note 252, Chapter 4, "Social Inputs in Area Development", para. 1.6 on p. 85.
254. Ibid., para. 1.8 on p. 86.

-
255. Executive Board Report, 13-29 April 1971, E/ICEF/612, paras. 126-129.
256. Executive Director, General Progress Report, "Programme Progress and Trends", E/ICEF/658 (Part II), 4 April 1979, paras. 87-94; and "List of Countries Receiving Support from UNICEF in Area Development", E/ICEF/CRP/80-9, 28 April 1980, pp. 11-17.
257. Martin Beyer, "Water and Sanitation in UNICEF 1946-1986" (UNICEF History Series, Monograph VIII, Oct. 1987; edited by John Balcomb), pp. 11-15. Hereinafter referred to as Beyer.
- An earlier edition by Martin Beyer, entitled "Water and Sanitation in UNICEF 1946-1986: The Wet History", was issued for limited circulation, and will be referred to by its full title.
258. Black, supra note 1, p. 285.
259. Beyer, supra note 257, pp. 13-14. The India rural water supply recommendation is contained in E/ICEF/P/L.1358 of 3 April 1970, with a summary of the consultants' conclusions attached as Annex I.
260. Beyer, supra note 257, p. 14.
261. Ibid.
262. Executive Director, General Progress Report, "Programme Developments in the South Central Asia Region", E/ICEF/L.1351, 6 Feb. 1976, para. 93.
263. Beyer, supra note 257, p. 15.
264. Black, supra note 1, p. 302.
265. See the earlier edition of Beyer, "Water and Sanitation in UNICEF 1946-1986: The WET History" (UNICEF, 1986), pp. 68-82, for full summaries of various water and sanitation projects in Asia, in addition to the one in India (pp. 57-66).
266. Personal letter from Perry Hanson to the author dated 13 October 1987, p. 10.
267. See the earlier edition of Beyer, "The WET History", supra note 265, pp. 70-71.
268. Latest reports indicate that, by 1988, the Grameen Bank will be operating in 10,000 villages, extending credit to 600,000 loanees, of whom 84 per cent are women. See Bangladesh, Country Programme Recommendation, E/ICEF/1988/P/L.18, 3 Feb. 1988, para. 26.
269. "UNICEF INTERCOM", Issue 44, CF/DIPA/IC/1987-01, Jan./March 1987, p. 17.
270. James P. Grant, The State of the World's Children 1987 (New York, Oxford University Press), p. 76. These annual reports will hereinafter be referred to as Grant, State of the World's Children Report, identified by year.

-
271. Virginia Hazzard, "UNICEF and Women: The Long Voyage", UNICEF History Series, Monograph VII, 1987. Hereinafter referred to as Hazzard.
 272. Hazzard, supra note 271, pp. 27-31, carries a full summary of the main findings and conclusions of the 1970 assessment.
 273. Mary Racelis, in an article on "People Power: Community Participation in the Planning of Human Settlements", Assignment Children, No. 40, 1977, pp. 11-47, has provided an interesting analysis of six types of community participation which are possible, ranging from (1) "solid citizens" endorsing outside-planned programmes; (2) local leaders being appointed to positions in the government bureaucracy; (3) community's choice of a final plan from among predetermined options; (4) consultation between people and planners from the beginning of plan formulation; (5) people's representation on decision-making boards, and (6) community control over expenditure of funds - "the triumph of people's participation in that the grass-roots elements dominate the membership of the decision-making board".
 274. Executive Director, General Progress Report, "Programme Developments in East Asia and Pakistan", E/ICEF/L.1418, 10 April 1980, paras. 25-27. A progress report on women in development, including an analysis of field experiences with particular emphasis on Ethiopia, India, Kenya, and Togo, may be found in "Progress Report on Achievements Made in the Implementation of UNICEF Policy on Women in Development", E/ICEF/1988/L.1, 9 Feb. 1988.
 275. Hazzard, supra note 271, p. 39.
 276. Wah Wong, "An Immunization Programme in Dewas District, India: Successes and Failures", Assignment Children, No. 61/62, 1983, p. 287.
 277. Grant, State of the World's Children Report, 1984, p. 59.
 278. "Assistance to Programmes for the Urban Poor in India 1977-1981", a case study for the 1982 Executive Board Meeting, UNICEF, New Delhi, Oct. 1981, Part I: Overall Analysis, p. 5.
 279. Executive Director, General Progress Report, "Programme Developments in the South Central Asia Region", E/ICEF/L.1380, 8 Feb. 1979, para. 71.
 280. Nyi Nyi, "Planning, Implementation and Monitoring of Literacy Programmes, the Burmese Experience", Assignment Children, No. 63/64, 1983; and Executive Director, General Progress Report, Chapter II, Programme Progress and Trends, E/ICEF/637 (Part II), 9 April 1975, para. 266.
 281. Executive Director, General Progress Report, "Programme Developments in East Asia and Pakistan", E/ICEF/L.1364, 20 Jan. 1977, para. 8.
 282. The main points of the Phillips report were summarized in Executive Board Report, 23 May-3 June 1977, E/ICEF/651, para. 26.

-
283. See Phillips, supra note 200, pp. 47-50, for a summary of UNICEF assistance to non-formal education.
 284. Executive Board Report, 19-30 May 1980, E/ICEF/673, para. 99.
 285. Executive Board Report, 10-21 May 1982, E/ICEF/695, para. 70.
 286. Executive Director, General Progress Report, "Programme Development in the East Asia and Pakistan Region", E/ICEF/1987/8, 22 Jan. 1987, para. 61.
 287. Executive Director, General Progress Report, "Programme Progress and Trends in East Asia and Pakistan", E/ICEF/626/Add.1, 11 Jan. 1973, paras. 16-17.
 288. Executive Director, General Progress Report, "Programme Developments in the South Central Asia Region", E/ICEF/616/Add.5, 15 Feb. 1972, para. 80.
 289. Executive Director, General Progress Report, "Programme Developments in East Asia and Pakistan", E/ICEF/L.1350, 27 Jan. 1976, para. 68.
 290. Executive Director, General Progress Report, "Programme Developments in South Central Asia", E/ICEF/L.1351, 6 Feb. 1976, para. 86.
 291. See Spiegelman, supra note 52, pp. 185-189. Dr. Clavano is pictured on p. 190, holding a new-born baby.
 292. Wah Wong, "UNICEF and the North-South Issues: A Grass-Roots Perspective", address before the Annual Meeting of the UNICEF National Committee for Canada, Toronto, 18-19 Sept. 1981, pp. 12-14.
 293. Natividad Relucio-Clavano, "The Results of a Change in Hospital Practices", Assignment Children, No. 55/56, 1981, pp. 139-165.
 294. The Report of Rehabilitation International to the UNICEF Board is contained in E/ICEF/L.1410 of 26 March 1980. See the Board discussion and decision on childhood disability, its prevention and rehabilitation in Executive Board Report, 19-30 May 1980, E/ICEF/673, paras. 150-172. The Executive Director also presented a paper which included a review of the development of UNICEF policy on childhood disability (E/ICEF/L.1411, 16 April 1980).
 295. Aurora Tiu and Wah Wong, "A Community Programme in the Philippines: 'Reaching the Unreached'", Assignment Children, No. 53/54, Spring 1981, Tables 1 and 2 on pp. 170-172.
 296. Black, supra note 1, p. 287.
 297. See Black, supra note 1, pp. 383-385, for details of the persons involved, including key Executive Board members such as Robert Mande of France and Boguslaw Kozusnik of Poland; and Henry Labouisse, Martin Sandberg, and Jacques Beaumont on the UNICEF secretariat side.

-
298. Executive Director, General Progress Report, "Emergency Relief and Rehabilitation", E/ICEF/632/Add.1, 20 March 1974, para. 53.
299. See Black, supra note 1, Chapter 16, "The Crisis in Kampuchea".
300. Ibid., pp. 399-400.
301. Ibid., p. 357.
302. Ibid., pp. 358-359.
303. Ibid., pp. 365-366.
304. Executive Board Report, 14-30 May 1975, E/ICEF/639, para. 163.
305. Executive Board Report, 10-21 May 1982, E/ICEF/695, para. 117.
306. Executive Board Report, 20 April-1 May 1987, E/ICEF/1987/11, para. 7.
307. Black, supra note 1, p. 406.
308. Kampuchean Humanitarian Assistance Programmes: the International Community's Response. New York: United Nations, 1986, p. 11. See also William Shawcross, The Quality of Mercy. Cambodia, Holocaust and Modern Conscience. New York: Simon and Schuster, 1984, for a moving account of this incredible era, including a detailed story of UNICEF's involvement.
309. Grant, State of the World's Children Report, 1987, p. 1.
310. Grant, State of the World's Children Report, 1988, p. 1.
311. Grant, State of the World's Children Report, 1987, p. 54.
312. "Programme Development in the East Asia and Pakistan Region", E/ICEF/1987/8, 22 Jan. 1987, para. 2.
313. "Programme Development in South Central Asia", E/ICEF/1987/9, 13 Jan. 1987, para. 9.
314. "Programme Development in the South Central Asia Region", E/ICEF/1988.9, 13 Jan. 1988, para. 13.
315. "Programme Development in the East Asia and Pakistan Region", E/ICEF/1988/8, 2 Feb. 1988, para. 86.
316. Ibid., para. 16.

-
317. China is an outstanding example of a country which has been able to reduce greatly her infant mortality rate without waiting for an advanced level of economic development. "With an estimated GNP of only \$300 per person per year, China is still among the world's poorest nations. Yet its infant mortality rate is among the very lowest in the developing world. More than technology or money, that achievement has depended on political commitment and social organization". Grant, State of the World's Children Report, 1984, p. 46.
318. "Sri Lanka ranks alongside China in showing that a country need not be rich to increase its children's chances of survival. Despite an average capita income of little more than \$300 a year, Sri Lanka has brought its infant mortality below 40 deaths per 1,000 live births; 86% of the population is literate, and on average, 65% of one-year-olds are fully immunized". Grant, State of the World's Children Report, 1986, p. 56.
319. Ibid., p. 40.
320. Ibid., p. 66.
321. Ibid., p. 50. Sri Lanka's Sarvodaya Movement has been described above on p. 89.
322. See above, pp. 113-114, for a brief description of Burma's volunteer literacy corps.
323. Grant, State of the World's Children Report, 1988, p. 5. Of the estimated 2 million lives saved each year, 1.5 million would be due to immunization efforts and 500,000 to successful oral rehydration therapy. See Report of the Executive Director to the 1988 session of the UNICEF Board, "Children in a global context", E/ICEF/1988/2 (Part I), 18 Feb. 1988, p. 3. Hereinafter referred to as Report of the Executive Director to the 1988 Board session.
324. Report of the Executive Director to the 1988 Board session, supra note 323, Part I, p. 3.
325. Executive Board Report, 20 April-1 May 1987, E/ICEF/1987/11, para. 18.
326. Grant, State of the World's Children Report, 1988, p. 13.
327. Ibid., p. 21.
328. "Priorities and Focus in UNICEF Programmes of Co-operation", E/ICEF/1987/L.3, 10 Feb. 1987, Table 4 on p. 15.
329. Ibid., Tables 6 and 7 on p. 16.
330. "Programme Development in South Central Asia", E/ICEF/1987/9, 13 Jan. 1987, pp. 7-10; and Haxton's progress report to the 1988 session of the Board, "Programme Development in the South-Central Asia Region", E/ICEF/1988/9, 13 Jan. 1988, pp. 8-10, 12-14.

-
331. "Programme Development in the East Asia and Pakistan Region", E/ICEF/1987/8, 22 Jan. 1987, pp. 9-15; and Mostefaoui's progress report to the 1988 session of the Board, "Programme Development in the East Asia and Pakistan Region", E/ICEF/1988/8, 2 Feb. 1988, paras. 15-66.
332. Executive Board Report, 20 April-1 May 1987, E/ICEF/1987/11, para. 13.
333. "Priorities and Focus in UNICEF Programmes of Co-operation", E/ICEF/1987/L.3, 10 Feb. 1987.
334. Ibid., para. 45 (d) to (h).
335. Executive Board Report, 20 April-1 May 1987, E/ICEF/1987/11, decision 1987/17, para. (b) on pp. 31-32.
336. "Medium-term Plan for the Period 1987-1991", E/ICEF/1988/3, 18 March 1988.
337. See Executive Board Report, 14-25 April 1986, E/ICEF/1986/12, decision 1986/12, and paras. 107-123. Removing street children from the streets is not the solution. A number of Governments, with UNICEF and NGO support, are implementing projects in which children remain in their own environment, where they are accepted and given responsibilities vis-a-vis other children, younger or weaker than they, which give meaning to their lives while allowing them to retain self-respect.
338. Report of the Executive Director to the 1988 Board session, supra note 323, Part I, para. 7 (c).
329. Ibid., Part I, para. 18 (c).
340. Report of the Executive Director to the 1988 Board session, E/ICEF/1988/2(Part II)/Add.1, 15 March 1988, Tables 1 and 3 on pp. 4 and 6 respectively.
341. Grant, State of the World's Children Report, 1987, p. 88.
342. Grant, State of the World's Children Report, 1988, Table I on p. 64. The ten countries in Asia with high to very high under-five mortality rates are: Afghanistan, Bangladesh, Bhutan, India, Indonesia, Kampuchea, Lao People's Democratic Republic, Nepal, Pakistan, and Viet Nam.
343. The strong linkage between the infant mortality rate and the rate of female illiteracy is described above on pp. 110-111.
344. Report of the Executive Director to the 1988 Board session, supra note 323, Part I, para. 21.

- 174 -

BLANK BACK

STATISTICAL TABLES

- 176 -

BLANK BACK

I. UNICEF expenditures for Asia and Pacific Islands
from inception through 1985
by main categories of programme activities

	<u>1947- 1959</u>	<u>1960- 1969</u>	<u>1970- 1979</u>	<u>1980- 1985</u>	<u>1947- 1985</u>
-- in thousands of US dollars --					
Child health	38 590	78 772	164 049	161 279	442 690
Water sanitation	a	a	109 984	188 426	298 410
Child nutrition	5 758	22 264	53 614	72 794	154 430
Social welfare services	a	2 775	21 868	54 466	79 109
Formal education	--	12 151	104 880	70 630	187 661
Non-formal education	--	696	4 369	23 372	28 437
Emergency relief	12 437	2 379	32 230	94 513	141 559
General	--	--	23 171	60 255	83 426
Total programme aid	<u>56 785</u>	<u>119 037</u>	<u>514 165</u>	<u>725 735</u>	<u>1 415 722</u>
-- in percentages --					
Child health	68	66	32	22	31
Water and sanitation	a	a	21	26	21
Child nutrition	10	19	11	10	11
Social welfare services	a	2	4	8	6
Formal education	--	10	21	10	13
Non-formal education	--	1	1	3	2
Emergency relief	22	2	6	13	10
General	--	--	4	8	6
Total programme aid	<u>100</u>	<u>100</u>	<u>100</u>	<u>100</u>	<u>100</u>
Total as a per cent of programme expend- diture all regions	23	42	57	50	49

II. UNICEF expenditures for Asia and Pacific Islands
by countries from inception through 1985
cumulative totals with a breakdown by decades

	<u>1947-</u> <u>1959</u>	<u>1960-</u> <u>1969</u>	<u>1970-</u> <u>1979</u>	<u>1980-</u> <u>1985</u>	<u>1947</u> <u>1985</u>
-- in thousands of US dollars --					
Afghanistan	1 281	4 916	15 813	11 783	33 793
Bangladesh	--	--	91 077	79 104	170 181
Bhutan	--	--	2 877	6 389	9 266
Brunei	33	--	--	--	33
Burma	4 491	7 151	24 539	36 912	73 093
China	3 754	5 657	2 085	24 674	36 170
Hong Kong	213	289	217	--	719
India	18 672	46 836	130 469	197 208	393 185
Indonesia	7 068	11 511	37 656	65 489	121 724
Japan	1 603	266	--	--	1 869
Kampuchea	147	1 492	19 447	102 856	123 942
Korea	5 505	2 631	7 048	3 830	19 014
Laos	--	272	4 873	7 388	12 533
Malaysia	722	2 466	4 786	2 604	10 578
Maldives	15	--	887	2 101	3 003
Mongolia	--	192	639	197	1 028
Nepal	--	870	10 673	25 852	37 395
Pakistan	5 334	15 124	40 010	62 681	123 149
Papua and New Guinea	94	365	624	998	2 081
Philippines	3 738	6 977	12 835	18 434	41 984
Thailand	2 616	6 955	16 558	19 355	45 484
Singapore	84	229	153	--	466
Sri Lanka	904	1 359	13 153	21 406	36 822
Vietnam	271	2 774	29 011	32 850	64 906
Indo China Peninsula	--	--	41 026	--	41 026
Asian Refugees and Displaced Persons	--	--	2 776	17	2 793
Afghan refugees in Pakistan	--	--	1 879	--	1 879
Pacific Islands	134	679	2 294	2 437	5 544
Regional	106	24	760	1 168	2 058
Total	<u>56 785</u>	<u>119 037</u>	<u>514 165</u>	<u>725 734</u>	<u>1 415 722</u>

III. Personnel receiving training stipends in countries with
which UNICEF cooperates in Asia

	<u>Through 1969</u>	<u>1970-1979</u>	<u>1980-1985</u>	<u>Total Through 1985</u>
<u>Health</u>				
Doctors	7 233	17 438	6 210	30 881
Nurses and midwives (including auxiliaries)	19 269	55 652	34 497	109 418
Traditional birth attendants	27 376	13 422	47 756	88 554
Other health and sanitation personnel	<u>35 782</u>	<u>160 138</u>	<u>414 660</u>	<u>610 580</u>
Total health personnel	89 660	246 650	503 123	39 433
<u>Nutrition</u>				
Village volunteers	1 886	307 772	1 296 661	1 606 319
Technical and administrative personnel	<u>32 189</u>	<u>40 395</u>	<u>87 540</u>	<u>160 124</u>
Total nutrition personnel	34 075	348 167	1 384 201	1 776 443
<u>Family and child welfare</u>				
Women's education and training	26 238	44 795	140 198	211 231
Other welfare personnel	<u>23 916</u>	<u>131 295</u>	<u>464 458</u>	<u>619 669</u>
Total family and child welfare personnel	50 194	176 090	604 656	830 900
<u>Education</u>				
Teachers	49 859	382 064	208 070	639 993
Other education personnel	<u>302</u>	<u>51 680</u>	<u>65 609</u>	<u>117 591</u>
Total education personnel	50 161	433 744	273 679	757 584
<u>Pre-vocational training</u>	2 112	3 008	48 192	53 312
<u>Other</u>				
Planning personnel	1	12 868	47 800	60 669
Statisticians	144	203	574	921
Transport personnel	<u>226</u>	<u>585</u>	<u>1 274</u>	<u>2 085</u>
Total other personnel	371	13 656	49 648	63 675
Total	226 533	1 221 315	2 863 499	4 311 347

IV. Number of institutions, centres and installations
which have received UNICEF equipment and supplies
in Asia

	Through 1959	1960- 1969	1970- 1979	1980- 1985	Total through 1985
<u>Child health ^{a/}</u>					
District and referral hospitals	457	458	1 650	3 598	6 163
Urban health centres and institutions	209	1 074	2 956	6 477	10 716
Rural health centres	3 738	1 107	14 572	26 475	45 892
Sub-centres village MCH centres	8 277	18 372	38 225	112 662	177 536
Total child health	12 681	21 011	57 403	149 212	240 307
<u>Water systems ^{b/}</u>					
Open/dug wells and handpump installations	--	--	402 416	384 826	789 242
Engine driven pump installations	--	--	2 488	2 884	5 372
Piped and reticulated systems	--	--	3 089	3 097	6 186
Other ^{a/}	--	--	466	17 106	17 572
Total water systems	--	--	408 459	407 913	816 372
<u>Child nutrition ^{a/}</u>					
Demonstration centres ^{a/}	--	1 474	326 081	355 919	683 474
Support centres ^{a/}	--	894	2 472	14 555	17 921
Training centres	--	348	726	1 309	2 383
Total child nutrition	--	2 716	329 279	371 783	703 778
<u>Family and child welfare</u>					
Child welfare centres	--	1 212	29 211	144 701	175 124
Women's institutions ^{a/}	--	103	2 033	12 252	14 388
Centres for adolescents and youth	--	895	3 254	6 180	10 329
Training institutions	--	48	776	1 392	2 216
Total family and child welfare	--	2 258	35 274	164 525	202 057

<u>Formal education</u>					
Schools	--	13 670	472 693	348 053	834 416
Teacher training institutions	--	1 328	3 319	6 918	11 565
Other institutions	--	87	2 990	13 840	16 917
Total formal education	--	15 085	479 002	368 811	862 898
<hr/>					
Pre-vocational training	--	247	1 781	3 991	6 019
Total	12 681	41 317	1 311 198	1 466 235	2 831 431

- a/ Institutions receiving "replacement" and other ad hoc supplies are not included.
- b/ Data for water systems available only beginning with 1973; however data for "other" installations available only beginning with 1978.
- c/ Including spring protection, rain water collection, water treatment plants, etc.
- d/ Excluding milk and food conservation.
- e/ Including school gardens and canteens, nutrition centres, nutrition demonstration centres/clubs, community gardens.
- f/ Including seed production units, fish hatcheries, poultry hatcheries, etc.
- g/ Including community centres, co-operatives, etc.

- 182 -

BLANK BACK

INDEX

- 184 -

BLANK BACK

- "Adjustment with a human face": 144.
 Administrative organization for Asia: 17, 54-56.
 Afghanistan: 36, 39, 54, 55, 73, 109, 117.
 Africa: 26, 71, 132, 143-144.
 AIDS: 142.
 Alcohol: 142.
 All-China Women's Federation: 14.
 All-India Institute of Hygiene and Public Health: 14, 21, 39, 40, 112.
 All-India Institute of Medical Sciences: 79.
 Allocations and expenditures for Asia: 15-17, 20-21, 26, 87-88, 119, 144.
 Alma Ata Primary Health Care Conference: 91, 101.
 Amar Jyoti Charitable Trust: 126.
 Anand, India: 37.
 Applied nutrition projects: 67-68, 120-121.
 Aquino, Corazon: 137.
 Area development: 76-77, 96-99, 102-106.
 Arityaratne, A. T.: 94.
 Arole, Mabelle and Rajanikant: 102.
 ASEAN (Association of South-East Asian Nations): 138.
 Asia Institute for Economic Development & Planning: 51, 87.
 Asia regional offices: 54-55.
 Asian Conference on Children & Youth in National Development (Bangkok): 51, 52.
 Asian village: 27-28, 32, 41, 44, 96-97.
 Australia: 28, 42, 79.
 Bangladesh: 14, 55, 63, 85, 94, 105, 110-111, 114, 117, 120, 128, 129, 130, 137, 140, 141, 142, 143.
 BAPPENAS (National Development Planning Board, Indonesia): 54.
 Barefoot doctors (China): 10, 139.
 Basic Agreement: 14.
 Basic Services: 88-104, 132, 140.
 BCG vaccination: 21, 28-30, 56, 64, 115, 127, 138.
 Beerman, Victor A. M.: 75.
 Belgium: 42.
 Bellagio Conference on Children & Youth in Development Planning: 49-50.
 Bergithon, Carl: 17.
 Besa, Alberto: 109.
 Bethune, Norman: 8.
 Beyer, Martin: 107-108, 111.
 Bhutan: 55, 118, 137.
 Binamira, Ramon P.: 94, 96-99.
 Black, Maggie: 3, 27, 60, 70, 102, 107, 109, 128, 129, 131, 135.
 Blake, William: 3.
 Bokhari, Ahmed: 25.
 Borcic, Berislav: 4.
 Bowles, Newton R.: 8, 13.
 Breast-feeding: 91, 121-124, 125, 146.
 British Council: 73.
 Brunei Darussalam: 14, 55, 138.
 Burma: 14, 15, 16, 20, 35, 41, 55, 65-66, 70, 101, 113, 118-119, 127, 139, 140, 141.
 Cambodia: see Kampuchea.
 Canada: 5, 79, 122, 128.
 CARE: 79, 103.
 Carter, Gordon: 54, 107.
 Caston, Don: 126.
 Cavaglia, Giovanni: 111.
 Ceylon: see Sri Lanka.
 Ch'en Chih-ch'ien: 10.
 Child Survival and Development Revolution: 91, 136-147.
 Children in "especially difficult circumstances": 140, 142.
 China: 3-14, 17, 19, 20, 42, 43, 52, 55, 62, 70, 74, 115, 137, 138, 139, 141, 142.
 Chinese Liberated Areas Relief Association (CLARA): 7, 8, 11.
 Chinese People's National Committee for the Defence of Children: 14.
 Chou En-Lai: 11, 12.
 Chowdhury, Zafrullah: 94.
 Clavano, Natividad: 122-124.
 Community Development programme, India: 42, 59.
 Community involvement and participation: 10, 33, 69, 88-102, 113-114, 146.
 Convention on the Rights of the Child: 137, 144.

Country approach/country programming:
48-49, 76, 85-86, 143.

Country offices: 55.

Criteria for allocating UNICEF aid:
4-6, 20, 144-145.

Czechoslovakia: 20.

Darwish, Yehia: 55.

Davao Institute of Primary Health
Care: 100.

Davies, T. Glan: 17, 54.

DDT production plant, India: 35.

Debrè, Robert: 49.

Declaration of the Rights of the
Child: 48, 130.

de la Paz, Jesse: 100.

Democratic People's Republic of Korea:
19, 55.

Denmark: 20.

Development of Women & Children in
Rural Areas (DWCRA), India: 104, 114.

Dewas, Madhya Pradesh, India: 56, 115.

Diarrhoeal disease control (DDC; see also
oral rehydration therapy): 104,
136, 140, 142.

Disabled child - prevention, early
detection and treatment: 124-126.

DPT (diphtheria-pertussis-tetanus):
56, 136.

Drugs: 142.

Early childhood development: 124-126,
140, 147.

Eastern Mediterranean region: 26, 67.

Eckert, Ralph: 14.

Economic and Social Commission for Asia
and the Pacific (ESCAP; formerly
ECAFE): 51, 52, 57, 112.

Education: 58, 71-74, 99, 115-120,
139, 140, 141, 142.

Egger, Charles A.: 48, 49, 54, 76.

Eliot, Martha: 4.

Eloesser, Leo: 8-11.

Emergencies: 3-7, 20, 36, 42-43, 79,
106-107, 128-130, 135-136.

Environmental sanitation: 9-10, 62-63,
98, 109, 140, 141, 146.

Esquerro-Barry, Roberto: 55.

Europe: 3, 4, 5, 20, 26, 124, 132.

Expanded Programme of Immunization
(EPI; see also UCI; immunization):
91, 137.

Family planning: 60-62, 141.

Feeding programmes: 4-7, 15, 17, 18,
19, 20, 21, 36, 69.

Fellowship programmes: 16, 39-40.

Female illiteracy: 114, 115-116,
142, 146.

Fenn, Victor: 17.

Fiji: 143.

Floro, Charlotte: 125.

Food and Agriculture Organization
(FAO): 20, 37, 51, 57, 68,
69, 71, 87.

France: 18, 42, 49.

Functional literacy: 117, 142.

Gaan, Margaret: 114.

Galt, Edith: 11.

Gandhi, Indira: 137.

Gandhi, Rajiv: 137.

Germany: 79.

"GOBI" (growth monitoring, oral
rehydration therapy, breast-feeding,
immunization): 136.

Goitre control: 70.

Grameen Bank, Bangladesh: 110-111, 142.

"Grand Alliance for Children":

139, 144.

Grant, James P.: 14, 132, 135, 136,
139, 145.

Grant, John: 10, 18.

Growth monitoring of children: 136.

Grun, John: 54, 130.

Hackett, C. J.: 32.

Hammerman, Susan: 125.

Handpump maintenance: 108.

Hanson, Perry: 4, 7, 8, 11, 110.

Haxton, David P.: 54, 140.

Hazzard, Virginia: 112, 114.

Hemingway, Isabel: 11.

Heyward, E.J.R.: 7, 29, 31, 48, 51.

Holm, Johannes: 29.

Hong Kong: 12, 13, 14, 17, 55, 119.

Immunization (see also BCG, DPT, polio,
EPI, and UCI): 28-30, 64, 104, 136,
137, 138, 139, 140, 141, 146.

Income-generating activities:
104, 105, 106, 111-112, 142.

- India: 14, 15, 16, 17, 20, 21, 27, 28, 29, 35, 36, 37, 38, 40, 42, 53, 54, 55-56, 57, 61, 62, 63, 64, 65, 68, 69, 70, 71, 73, 77-78, 79, 94, 95, 102-104, 105, 106-108, 109, 114, 115, 116, 117, 120-121, 124, 126, 128, 130, 137, 138, 141.
- Indian Institute of Management, Ahmedabad: 120.
- Indo-China: 14, 15, 16, 18, 28, 36, 89, 128-129.
- Indonesia: 14, 16, 17, 18, 21, 31, 32, 37, 38, 40, 42, 52, 53-54, 55, 57, 59, 62, 64, 69, 70, 94, 95, 105, 110, 111, 114, 115, 121, 127, 130, 136, 137, 138, 139, 141, 142.
- Infant mortality rate (IMR): 5, 6, 14-15, 34, 95, 115-116, 123, 137, 141, 145-146.
- Integrated Child Development Services (ICDS), India: 77, 102-103, 105.
- International Atomic Energy Agency (IAEA): 109.
- International Children's Centre (ICC), Paris: 121.
- International Committee of the Red Cross (ICRC): 7, 135.
- International Council for Educational Development (ICED): 119.
- International Institute of Rural Reconstruction (IIRR): 102.
- International Labour Organization (ILO): 51, 57, 72.
- International Tuberculosis Campaign (ITC): 28, 29.
- International Women's Year (IWY), 1975: 112, 113.
- International Year of the Child (IYC): 96, 130-131.
- Iran: 57.
- Israel: 77.
- Italy: 27.
- Iwaskiewicz, Edward: 50.
- Jackson, Robert: 3, 128.
- Japan: 17, 19, 36, 43, 124.
- JCHP (WHO/UNICEF Joint Committee on Health Policy): 9, 13, 63.
- Jones, Brian: 55.
- Junod, Marcel: 7, 8, 19.
- Kampuchea: 55, 59, 79, 85, 129, 135-136.
- Kaye, Danny: 31.
- Keeny, Spurgeon M.: 18, 27-34, 35, 39, 41, 44, 55, 63, 66, 128.
- Kenya: 116.
- Kodijat, Dr.: 32.
- Korea: 3, 19, 36, 42, 43, 52, 55, 59, 60, 62, 115, 119, 141, 145.
- Labouisse, Henry R.: 14, 47, 88, 89, 90, 129, 130, 132.
- Lakshamanan, C.K.: 14, 16.
- Laos: 52, 55, 129.
- Latin America: 20, 26, 50, 67, 115, 132, 143.
- Leprosy control: 65-66, 127.
- Lie, Trygve: 11.
- Lim, Estefania Aldaba: 96, 130.
- Local procurement: 77-78.
- Magsaysay, Ramon (and Magsaysay Award): 94, 96.
- Mahadevan, Meera: 94.
- Malaria: 15, 26-27, 28, 33, 34-36, 43, 57, 67.
- Malaria Institute, New Delhi: 16.
- Malay Federation: 14, 15.
- Malaysia: 20, 28, 52, 55, 62, 101, 105, 119, 124, 138, 141.
- Maldives: 55, 117, 137.
- Malnutrition: 14-15, 36-38, 67-71, 96-99, 120-121, 125, 142.
- Mark II handpump, India: 77, 108.
- Maternal and child health (MCH): 8-11, 38-42, 59-62, 141.
- McCall, James: 17.
- McDougall, James: 130.
- Medium-Term Work Plan 1987-1991: 141.
- Memet, Titi Tanumidjaja: 55.
- Mental Feeding Programme, Philippines: 125.
- Midwifery training: 8-11, 39, 40-41, 95, 112.
- Milk conservation programmes (MCP): 70-71.
- Moerman, Joseph: 130.
- Mongolia: 55, 64.
- Montini, Ludovici: 49.
- Morley, David: 122.
- Mostefaoui, Ahmed: 55, 140.

Multiplier effect (when integrating various projects): 33, 90-91, 97-99, 119-120, 146-147.

National Commission Concerning Disabled Persons: 125.

National Committees: 88, 139.

National conferences on children and youth: 52.

National Council for Educational Research & Training (NCERT): 73, 117.

National Vaccine & Serum Institute, Beijing: 13.

Nepal: 14, 55, 77, 101, 109, 121, 137, 141.

New Zealand: 17, 79.

Nobel Peace Prize: 47, 132.

Non-discrimination (UNICEF policy of helping children on all sides of civil conflict): 7-8, 15-16, 18, 19, 22, 35, 128-129, 142.

Non-formal education: 119-120.

Non-governmental organizations (NGOs): 93-95, 101-102, 125-126, 130-131, 136, 143.

Non-supply assistance: 78.

North Borneo: 14.

"Noted" projects:

see Supplementary funding.

Nutrition: 36-38, 67-71, 96-99, 103, 120-124, 125, 136, 141, 142, 146.

Nyi Nyi: 118.

Oral rehydration therapy (ORT): 136, 139, 140, 142, 146.

Pakistan: 14, 15, 16, 17, 25, 27, 28, 29, 35, 40, 42, 52, 55, 57, 59, 60, 61, 62-63, 64, 65, 67, 70, 71, 72, 85, 105, 109, 110, 113, 115, 117, 119, 128, 130, 137, 140, 141.

Palacios, Teresita: 114.

Papua New Guinea: 55, 72, 141.

Parran, Thomas: 14, 16, 34.

Parran/Lakshmanan mission: 14-15, 18, 28, 29, 34, 36, 39, 67.

Pasteur Institute, Paris: 28.

Pate, Maurice: 4, 11-12, 13, 20, 32, 35, 87.

Pathak, Bindeshwar: 109.

Pediatric training: 40.

Peking Union Medical College: 10, 18.

Penicillin plant, Bombay: 21.

People's Health Workers Training Centre (T'ung Chow): 10, 13.

People's Republic of China (see also China): 11-14.

Philippine Foundation for the Rehabilitation of the Disabled (PFRD): 125.

Philippine Medical Women's Association (PMWA): 126.

Philippine Pediatric Society (PPS): 126.

Philippines: 3, 14, 16, 17, 28, 31, 38, 40, 41, 52, 55, 57, 59, 62, 65, 67, 91, 94, 96-99, 100, 106, 113-114, 118, 119, 121, 122-124, 125-126, 130, 137, 141, 142, 143.

Phillips, H.M.: 72, 99, 119.

Phillips, Richard: 62.

Planning for the needs of children: 47-54.

Plans of operation: 6, 9, 17-18, 21, 86.

Poland: 11, 20, 79.

Poliomyelitis: 56, 139.

Population Council: 55.

Population in Asia: 30, 57.

Poverty: 38, 95, 137, 143-144, 147.

Primary health care (PHC): 8-11, 13, 91, 92, 99-102, 114, 132, 138-139, 140.

Programme recommendations: 76, 85-86.

Project Compassion: 91, 94, 95, 96-99.

"Quiet" or "silent" emergency: 89, 135, 136, 147.

Racelis, Mary: 114.

Rajasthan women's project: 104, 114, 116.

Rajchman, Ludwik: 11, 15, 20.

Ram, Eric R.: 94.

Rao, V.K.R.V.: 49.

"Reaching the Unreached": 125-126.

Regional Director(s) for Asia: 17, 18, 27, 54.

Regional Office, Bangkok (for East Asia & Pakistan): 39, 54, 126-127.

Regional Office, New Delhi (for South Central Asia): 54-55, 127.

Rehabilitation International:
124-125.

Reporting in UNICEF: 126-127.

Rockefeller Foundation: 63.

Roosevelt, Eleanor: 25.

Rotary International: 139.

Roy, Aruna and Bunker: 102,
108, 116, 117.

Sadik, Nafis: 61.

Salah, Ahmed Ben: 49.

Samrin, Heng: 129.

Sandberg, Martin: 53-54.

Santiago, Carmen: 114.

Sarawak: 14.

Sarvodaya Shramadana Movement (Sri
Lanka): 94, 139.

Shah, P.M.: 102.

Shijiazhuang, China: 8, 11, 13.

Siam: see Thailand.

Sicault, Georges: 48.

Sinclair, Adelaide: 5, 87.

Singapore: 14, 15, 28, 55, 62, 115,
119, 138.

Singh, Tarlok: 50.

Sirohi, Alka: 56.

Sivaramakrishnan, K.C.: 94.

Social Inputs in Area Development
(SIAD), India: 103-104.

Social mobilization (see also
community involvement and
participation): 138-139, 143.

Social welfare: 74.

Société des Etudes pour le
Développement Economique et
Social (SEDES): 52.

Soeharto, General: 137.

South Africa: 42.

South Asian Association for Regional
Cooperation (SAARC): 137-138.

South Pacific Islands: 33, 55, 72.

Special Meeting on the Situation of
Children in Asia with Emphasis on
Basic Services: 93-96, 97.

Spiegelman, Judith M.: 25, 27, 47,
66, 122.

Sri Avinashilingham Home Science
College for Women, Coimbatore: 117.

Sri Lanka: 14, 21, 28, 29, 34, 54, 62,
64, 67, 70, 73, 94, 106, 118, 121,
129, 137, 138, 141, 142, 143.

State of the World's Children Reports:
115, 139, 145.

Street children: 142.

Su Chin Kwan: 8, 9-10, 16, 102.

Sub-offices in UNICEF: 55-56.

Supplementary funding: 75-76, 87,
128, 140.

Supreme Commander for the Allied
Powers (SCAP): 19.

Sweden: 60-61, 121.

Switzerland: 42, 77.

Technical approval by UN agencies:
9, 29, 31-32, 61, 74, 87.

Technical Cooperation Among
Developing Countries (TCDC): 14.

Thailand: 14, 15, 16, 17, 21, 31, 32,
35, 38, 40, 41, 43, 55, 57, 62, 65,
70, 93, 102, 106, 113, 117, 119,
120, 124, 138, 139, 141.

Thedin, Nils: 60.

Tilonia Centre for Social Work and
Research, India: 102, 108, 116.

Tinbergen, Jan: 49.

Tiu, Aurora: 125.

Trachoma control: 66-67.

Training of health personnel: 8-11,
16, 21, 37, 39, 40-41, 43, 73, 124.

Tsao, P.Y.: 12.

Tuberculosis control (see also BCG
vaccination): 13, 15, 65.

Tuli, Uma: 126.

Typhus control: 67.

Ullman, Liv: 138.

Under-Five Mortality Rate (U5MR):
145-146.

Ungsongtham, Prateep: 93, 94.

Union of Soviet Socialist Republics
(USSR): 101.

United Kingdom: 5, 20, 21, 42, 79,
106, 126.

United Kingdom Territories: 16, 17.

United Nations Children's Fund (UNICEF):

- Executive Board Meeting in Bangkok,
1964: 56-59.

- Executive Board Meeting in Manila,
1977: 99-100.

- Executive Board membership: 4,
11-12, 13, 21, 132.

United Nations Dept. of Social and
Economic Affairs: 49, 51, 74, 87.

- United Nations Development Programme (UNDP): 54, 119, 136.
- United Nations Economic and Social Council (ECOSOC): 21, 91.
- United Nations Educational, Scientific and Cultural Organization (UNESCO): 17, 51, 57, 71, 72, 73, 87, 99, 117, 119.
- United Nations Fund for Population Activities (UNFPA): 61.
- United Nations General Assembly: 3-4, 12, 13, 21, 26, 48, 49, 91-93, 130, 131.
- United Nations High Commissioner for Refugees (UNHCR): 128.
- United Nations International Children's Emergency Fund (former name of UNICEF): 3, 25.
- United Nations Relief and Rehabilitation Administration (UNRRA): 3, 4, 8, 14, 17, 27.
- United States: 4, 5, 25, 36, 61, 122, 128.
- United States bilateral aid: 18, 27, 35-36, 69, 79.
- Universal Child Immunization (UCI; see also EPI; immunization): 137, 142.
- Urban basic services: 93-94, 104, 105-106, 114, 140, 141.
- Viet Nam: 40, 55, 60, 79, 85, 89, 94, 117, 128-129, 143.
- Vitamin A deficiency: 60, 125.
- Water supply: 62-63, 98, 104, 106-112, 118, 128, 140, 141, 146, 147.
- Watt, Michael: 17, 18, 128.
- Weaning food plants: 70, 121.
- Women and Child Welfare Association, China: 10.
- Women in development: 104, 106, 111-112, 112-114, 116, 141, 142.
- World Bank (IBRD): 51, 54, 87, 106, 110, 119.
- World Food Programme (WFP): 70-71, 103.
- World Health Organization (WHO): 4, 9, 17, 28, 30, 31-32, 35, 37, 39, 40, 51, 57, 60, 61, 62, 65, 68, 70, 71, 72, 74, 87, 91, 92, 99, 101, 121, 122, 132, 136, 137.
- Xerophthalmia: 69, 125.
- Yang, Marian: 10.
- Yaws: 21, 27, 28, 30-33, 43, 57, 67, 127.
- Yen, Jimmy: 10.
- Zain, Harun: 94.