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UNITED NATIONS

UNITED NATIONS INTERNATIONAL CHILDREN'S EMERGENCY FUND

REPORT OF THE EXECUTIVE BOARD

(19-26 MARCH 1953)

ECONOMIC AND SOCIAL COUNCIL

OFFICIAL RECORDS : SIXTEENTH SESSION

Supplement No. 6

NEW YORK

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13 May 1953

UNITED NATIONS
ECONOMIC AND SOCIAL COUNCIL
OFFICIAL RECORDS
SIXTEENTH SESSION

SUPPLEMENT No. 6

UNITED NATIONS INTERNATIONAL CHILDREN'S EMERGENCY FUND

Report of the Executive Board (19-26 March 1953)

ATTENDANCE

1. The Executive Board held its 103rd through 110th meetings at the United Nations Headquarters, 19, 20, 25 and 26 March 1953, with the following attendance:

Chairman: Mr. A. R. Lindt (Switzerland)
Mr. J. Carasales, Mr. C. Morales (Argentina)
Mr. K. Brennan (Australia)
Mr. R. Fenaux (Belgium)
Mr. L. Soutello Alves (Brazil)
Mr. Y. Teplov (Byelorussian Soviet Socialist Republic)
Mrs. A. Sinclair (Canada)
Mr. P. Y. Tsao (China)
Mr. M. Glozar (Czechoslovakia)
Mr. P. Concha-Enriquez (Ecuador)
Prof. R. Debre, Mr. G. Amanrich (France)
Mr. S. Roussos (Greece)
Mr. B. Rajan (India)
Mr. A. Khalidy, Mr. N. Umari (Iraq)
Mrs. Z. Harman (Israel)
Mr. L. Giretti (Italy)
Mr. R. Hancke (Norway)
Mr. V. Hamdani (Pakistan)
Mr. C. Holguin de Lavalle, Mr. C. Arevalo-Carreno (Peru)
Mr. N. Reyes (Philippines)
Mr. J. Devakul (Thailand)
Mr. I. V. Chechetkin, Mr. N. A. Coraztsov (Union of Soviet Socialist Republics)
Mr. C. M. Anderson (United Kingdom of Great Britain and Northern Ireland)
Dr. M. Eliot, Miss F. Kernohan (United States of America)
Mr. E. Fabregat, Mr. C. Montero-Bustamente (Uruguay)
Mr. F. Kos (Yugoslavia)

2. Miss J. Henderson, Miss D. Kahn, and Mr. C. Litteria represented the United Nations Department of Social Affairs. Miss H. Seymour represented the United Nations Department of Finance at the 110th meeting.

3. The following representatives of specialized agencies were present at some meetings of the session:

ILO: Mr. P. Mahdavi
UNESCO: Mr. S. V. Arnaldo
FAO: Mrs. A. Sismanidis, Dr. S. H. Work, Mr. J. H. Anderson
WHO: Dr. R. L. Coigny, Dr. M. Ingalls

4. The Non-Governmental Organizations Committee on UNICEF was represented by Mr. N. Acton, Chairman. The following members of the Non-Governmental Organizations Committee on UNICEF were represented:

Agudas Israel World Organization, Dr. I. Lewin, Rabbi S. B. Friedman
All Pakistan Women's Association, Mrs. N. Hamdani
Catholic International Union for Social Service, Dr. A. P. Vergara
Consultative Council of Jewish Organizations, Mr. M. Moskowitz
Friends World Service, Mr. J. Judkyn, Mr. H. G. Barrett-Brown
International Confederation of Catholic Charities, Mr. L. Longarzo
International Council of Women, Mrs. H. Freeman
International Federation of Business and Professional Women, Mrs. E. W. Hymer
International Federation of University Women, Dr. A. Noonan
International Society for the Welfare of Cripples, Mr. D. V. Wilson, Mr. N. Acton
International Union for Child Welfare, Miss M. Dingman
Women's International League for Peace and Freedom, Mrs. G. Walser, Mrs. K. Arnett
World Federation for Mental Health, Miss H. S. Ascher
World Federation of United Nations Associations, Mr. R. Arias-Perez, Mr. Crawford
World Jewish Congress, Mr. G. Jacoby
World Union of Catholic Women's Charities, Miss C. Schaefer, Miss J. Gartlan

5. At the first meeting of the session, Mr. G. Georges-Picot, Assistant Secretary-General, Departments of Economic Affairs and Social Affairs, welcomed the members of the Board on behalf of the Secretary-General. He pointed out that the Secretary-General

had taken a very strong position in favour of the continuation of UNICEF. The Secretary-General hoped that the Fund's financial problems would be satisfactorily solved and was glad to see that many governments had increased their contributions, thus paying a real tribute to the work carried on by UNICEF.

6. At the opening of the session the representative of the Union of Soviet Socialist Republics moved "that the representative of the Kuomintang group be excluded" from the Executive Board and "that the representative of the People's Republic of China" be invited to participate in the work of the Board.

7. The representative of the United States moved adjournment of the debate on this question under rule 25 of the rules of procedure (E/ICEF/177). This motion was adopted by the Board by a vote of 21 in favour and 4 against.

AGENDA

8. The agenda of the session consisted of the following major items:

(*a*) General progress report of the Executive Director;

(*b*) Report on activities of Department of Social Affairs in the field of family and child welfare;

(*c*) Report of the NGO Committee on UNICEF and resolutions of members;

(*d*) Child nutrition;

(*e*) Report on the International Children's Centre;

(*f*) Statement by NGO's on permanent child health centres;

(*g*) Report of the Programme Committee;

(*h*) Report of the Committee on Administrative Budget;

(*i*) Report to the Social Commission;

(*j*) Election of alternate representative to fill vacancy on UNICEF/WHO Joint Committee on Health Policy;

(*k*) Other business.

SPECIAL REPORT TO THE SOCIAL COMMISSION AND THE ECONOMIC AND SOCIAL COUNCIL

9. In view of the decision of the General Assembly to discuss the future of UNICEF in 1953, and because this subject is also included on the agenda of the ninth session of the Social Commission and the sixteenth session of the Economic and Social Council, the Board deemed it useful to engage in a general discussion on the work of UNICEF. This discussion was held on 25 March 1953 (E/ICEF/SR.107, E/ICEF/SR.108).

10. A report on this discussion, summarizing the views of governments, is available in a special Executive Board report, issued as document E/ICEF/226. This report has subsequently been issued as E/2409, Economic and Social Council Official Records, Sixteenth Session, Supplement No. 6A. This report, in addition, gives a brief factual description of UNICEF, setting forth the basic principles under which the Fund operates and major programming and financial trends since the inception of the Fund.

11. The Executive Board requested the Chairman to represent the Board at the Social Commission and Economic and Social Council sessions should it be the wish of these bodies to have a Board representative at their discussions of UNICEF.

PROGRAMME TRENDS

12. The Executive Board at this session approved aid for long-range child care programmes in forty-six countries and territories, and in addition emergency aid to two countries.

13. The funds approved for these programmes by the Executive Board are shown below:

	From new funds	*From unprogrammed balances*[a]	*Total*	*Percentage distribution*
	$	$	$	
Africa	379,000	—	379,000	9.2
Asia	2,017,000	21,000	2,038,000	49.4
Eastern Mediterranean	687,000	20,000	707,000	17.2
Europe	209,000	55,000	264,000	6.4
Latin America	645,000	81,300	726,300	17.6
Programmes benefiting more than one region	10,000	—	10,000	0.2
	3,947,000	177,300	4,124,300	100.0
Emergencies	740,000	—	740,000	
Freight	662,000	—	662,000	
TOTAL	$5,349,000	$177,300	$5,526,300	

[a] Constitutes the cost of plans of operations approved for the use of funds previously allocated to a country.

14. By types of programmes, the amounts approved were as follows:

	From new funds	*From unprogrammed balances*[a]	*Total*	*Percentage distribution*
	$	$	$	
Maternal and child welfare services and training	1,720,000	118,000	1,838,000	37.8
Mass health			($1,255,100)	(25.8)
BCG anti-tuberculosis vaccination	110,000	25,100	135,100	2.8
Malaria control	150,000	—	150,000	3.1
Yaws control	678,000	—	678,000	13.9
Leprosy control	93,000	—	93,000	1.9
Control of other diseases	169,000	30,000	199,000	4.1
Child Nutrition				
Long-range Feeding	587,000	4,200	591,200	12.2
Milk Conservation	440,000	—	440,000	9.0
Emergencies	740,000	—	740,000	15.2
	4,687,000	177,300	4,864,300	100.0
Freight	662,000	—	662,000	
TOTAL	$5,349,000	$177,300	$5,526,300	

[a] Constitutes the cost of plans of operations approved for the use of funds previously allocated to a country.

15. Of the amounts approved for the long-range child care programmes slightly over half were for a continuation or expansion of previously assisted country programmes and half for programmes not hitherto aided by UNICEF.

16. The percentage distribution of funds approved for each type of long-range programme by area was as follows:

	MCW services and training	*Mass health*				*Nutrition*	
		BCG and TB	*Malaria control*	*Yaws control*	*Control of other Diseases*	*Feeding*	*Milk conservation*
	(%)	(%)	(%)	(%)	(%)	(%)	(%)
Totals	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Africa	—	—	50.0	22.1	51.4	0.7	—
Asia	70.6	40.7	44.0	76.1	9.6	12.7	—
Eastern Mediterranean	23.8	8.2	—	1.8	—	20.6	28.4
Europe	1.4	—	—	—	11.6	—	46.6
Latin America	4.2	51.1	6.0	—	27.4	66.0	22.7
Projects benefiting more than one region	—	—	—	—	—	—	2.3

17. The emphasis at this session on each of the major programmes within each area is shown in the following percentage distribution:

	Total	*MCW services and training*	*Mass health*				*Nutrition*	
			BCG and TB	*Malaria control*	*Yaws control*	*Control of other Diseases*	*Feeding*	*Milk conservation*
	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)
Africa	100.0	—	—	19.8	39.6	39.6	1.0	—
Asia	100.0	63.7	2.7	3.2	25.3	1.4	3.7	—
Eastern Mediterranean	100.0	61.8	1.5	—	1.7	—	17.3	17.7
Europe	100.0	9.5	—	—	—	12.9	—	77.6
Latin America	100.0	10.7	9.5	1.2	—	11.1	53.7	13.8
Projects benefiting more than one region	100.0	—	—	—	—	—	—	100.0

18. The emphasis on maternal and child welfare services and training constitutes a continuation of a trend which the Executive Board noted at its last session (E/ICEF/212, paragraphs 14-15). The 37.8 per cent voted for maternal and child welfare at the present session compares with 23.7 per cent approved in 1952 and 12.2 per cent in 1951. Because of the great need for trained auxiliary maternal and child care personnel, especially in rural areas, maternal and child welfare services aided by UNICEF are in most instances designed to provide training facilities as well as direct services to mothers and children.

19. The Executive Board noted that the amounts approved for maternal and child welfare at the current session include $96,500 for stipends to train auxiliary personnel in accordance with the policy set down by the Executive Board in April 1952 (E/ICEF/198, paragraph 676). The amount was distributed as follows: India, $61,250; Panama, $4,800; Philippines, $26,000; and Thailand, $4,500. In many countries there are regulatory and budgetary difficulties in the rapid development of auxiliary training programmes, particularly in providing stipends for trainees who are not government employees. UNICEF aid for stipends can be of considerable value in getting programmes initiated. The governments understand UNICEF's reluctance to spend considerable sums of local currency for this purpose. It is believed that expenditures on stipends are likely to increase for a time, but after the initial period of stimulation by UNICEF, governments will tend to take over these expenditures as rapidly as possible in order to release more of the available UNICEF funds for aid with imported supplies.

20. The increased emphasis toward aid for maternal and child welfare was noted with approval in a joint statement submitted to the Executive Board by sixteen non-governmental organizations having consultative status with the Board (E/ICEF/NGO5). The statement pointed out that the successful operation of UNICEF-assisted maternal and child welfare services frequently had an important effect in stimulating broader community developments. The NGOs, therefore, recommended the strengthening and expansion of activities in the UNICEF programme designed to make possible the establishment of child health centres as basic and permanent community institutions. The importance of such centres as a focal point for co-ordinated activity by both government and voluntary agencies was stressed. The Executive Director welcomed this statement in support of a trend in UNICEF aid which the Administration believed to be of considerable significance.

21. The Board noted that the Executive Director hopes to present to the next session of the Board progress reports, prepared with the co-operation of WHO, on maternal and child welfare programmes and BCG antituberculosis vaccination programmes aided by UNICEF. In his next general progress report he also intends to report on progress being made in anti-yaws and anti-malaria campaigns aided by UNICEF.

22. In connexion with UNICEF aid for nutrition, the Board had before it a report on "The Improvement of Child Nutrition with Special Reference to Inter-Agency Action" (E/ICEF/217). This report, prepared by the Administrative Committee on Co-ordination Technical Working Group on Long-Range Activities for Children, in which the UNICEF Administration participated, sets forth a number of ways for improving child nutrition and suggested fields of aid for international organizations. At its October 1952 session the Executive Board had expressed considerable interest in the possibilities of a new field of UNICEF/FAO collaboration in non-milk producing countries. The purpose would be to help increase the use of locally-produced protein-rich food in children's diets (E/ICEF/212, paragraphs 25-30).

23. The Executive Director of UNICEF informed the Board that the Government of Indonesia had requested aid from both FAO and UNICEF for soybean milk production, and that preliminary discussions were under way with a Latin-American country which might lead to aid for production of edible fish flour. If technical and economic problems are solved, the Executive Director expects to bring the Indonesian project to the Board for approval at its session in the second half of 1953. The Executive Board expressed the hope that this would be possible.

24. The Executive Board noted with interest a statement by Miss Julia Henderson, Director of the Division of Social Welfare, pointing out the close co-operation between the UNICEF Administration and the Division in fields of mutual interest, particularly on the questions of child nutrition, the training of auxiliary workers, and the general programme of the Division in the field of family and child welfare.

AREA DEVELOPMENTS

Currently assisted countries and territories

25. By the time all the new UNICEF-assisted programmes are in operation, the Fund will be aiding projects in sixty-nine countries and territories, as follows:[1]

Africa: 11

Belgian Congo	Morocco
Cameroons	Nigeria[2]
French Equatorial Africa	Ruanda-Urundi
French West Africa	Togoland
Liberia	Tunisia
Mauritius[2]	

Asia: 18

Afghanistan	Japan
Brunei	Malaya
Burma	North Borneo
Cambodia	Pakistan
Ceylon	Philippines
China	Sarawak
Hong Kong	Singapore
India	Thailand
Indonesia	Vietnam

Eastern Mediterranean: 11

Egypt	Lebanon
Ethiopia	Libya
Iran	Sudan
Iraq	Syria
Israel	Turkey
Jordan	

[1] In addition, formerly assisted countries and territories total fifteen, as follows: *Africa:* Algeria, Tangiers; *Eastern Mediterranean:* Aden; *Europe:* Albania, Bulgaria, Czechoslovakia, Finland, Germany, Hungary, Malta, Poland, Romania; *Latin America:* Mexico; *Asia:* Korea.

[2] Assistance approved for the first time in March 1953.

Europe: 5

Austria	Portugal
Greece	Yugoslavia
Italy	

Latin America: 24

Bolivia	Haiti
Brazil	Honduras
British Guiana	Jamaica
British Honduras[2]	Nicaragua
Chile	Panama
Colombia	Paraguay
Costa Rica	Peru
Dominican Republic	St. Kitts[2]
Ecuador	St. Lucia
El Salvador	Surinam
Grenada	Trinidad and Tobago
Guatemala	Uruguay

Special Programme: Assistance to Palestine Refugee mothers and children.

Africa[3]

26. During the course of the past eighteen months, a start has been made in UNICEF aid to the Belgian Congo, French Equatorial Africa, French West Africa, Liberia and Ruanda-Urundi in Africa south of the Sahara. Prior to that time UNICEF assistance had been limited to the countries and territories in north and north-east Africa.

27. The Executive Board, at the current session, approved aid totalling $379,000. This together with $1 million of aid approved in 1952, is going to eleven countries and territories for mass health campaigns (malaria, yaws, leprosy, trachoma), the treatment and prevention of acute nutritional deficiencies in children (kwashiorkor), and a whooping cough vaccination programme (in Mauritius).

28. The bulk of the UNICEF supplies for anti-malaria campaign in west and central Africa were delivered during the period November 1952-February 1953 in preparation for the initial sprayings in the spring of 1953. During the period, the countries concentrated on working out their detailed plans of operations in preparation for the mass campaigns and in gathering data from pilot projects. In the case of Liberia the anti-malaria project involves the establishment of an entirely new base of operations which in future years will develop into a regional health centre some 150 miles in the interior from Monrovia.

29. In Morocco the anti-trachoma project is at the beginning of its operational phase and in Tunisia it will begin in the autumn of 1953.

30. The distribution of dried milk for the anti-kwashiorkor programmes in the Belgian Congo, Ruanda-Urundi and French Equatorial Africa began in October 1952. The programmes are in their pilot phases, and a study and evaluation of the experience will be made during the next several months as a basis for the development of more comprehensive plans. It is apparent, even at this initial stage, however, that the programmes have generated a considerable interest in the active development of child nutrition programmes.

31. Aid for anti-malaria and anti-yaws campaigns will probably continue to constitute the principal forms of UNICEF assistance in the immediate future. The form of increased aid for child nutrition will be considered in the light of the practical experience of present efforts. A beginning has yet to be made in UNICEF aid for maternal and child welfare services and training, and discussions are going forward looking toward UNICEF aid in this field, particularly in rural areas.

Asia[4]

32. UNICEF has allocated a total of approximately $25,700,000 for aid to Asia. Of this amount, $9,300,000 has been for mass health programmes, $7,800,000 for maternal and child welfare training and services, $1,300,000 for long-range feeding programmes, and $5,400,000 for emergency relief. A total of $1,900,000 remains unprogrammed.

33. The current Board session continued the emphasis, begun in 1952, on aid for maternal and child welfare services and training, particularly for rural areas. Before 1952, approximately one-fifth of UNICEF aid to Asia was in this field. In 1952, 56 per cent of the amounts approved for Asia was for maternal and child welfare. At the current session, 64 per cent was voted for this purpose.

34. Maternal and child welfare aid is directed toward two objectives: training personnel and providing the physical facilities for maternal and child welfare services on a continuing basis.

35. The range of training offered by UNICEF-aided programmes in Asia runs from post-graduate social pediatrics (at the All-India Institute of Hygiene) to elementary training of rural midwives. With programmes approved at the current session, UNICEF will be aiding over 175 schools in fourteen countries or territories offering full undergraduate training to an estimated 5,500 nurses and midwives annually. In addition, refresher or short special training courses in maternal and child welfare, with UNICEF aid, are being developed in four countries. Since the full training of nurses and midwives involves the maternity and pediatrics departments of hospitals, UNICEF is providing teaching aids or special technical equipment to over eighty hospitals.

36. Because it will take many years to train enough professional nurses and midwives for Asia, UNICEF is also helping governments institute simple practical training for auxiliary personnel, mainly assistant midwives or village midwives. Programmes approved in 1952 included the objective of reaching 6,000 village midwives over a period of two or three years. As a result of current Board action, this number is increased to over 11,000.

37. Besides training personnel, governments are building up hospitals and rural health centres — which will provide services on a continuing basis. The

[3] For list of currently assisted countries in Africa, see paragraph 25.

[4] For list of currently assisted countries in Asia, see paragraph 25.

greatest emphasis in UNICEF aid is to rural maternal and child welfare centres, which, with action at the current session, has been approved for over 3,000 centres in eleven countries. Many of these centres are the training bases of the rural midwives. In addition to their pre-natal and post-natal work and "well-baby" clinics, these centres, or the polyclinics to which they are attached, provide the means for permanent follow-up work after the mass phases of the anti-malaria, yaws and BCG vaccination campaigns have passed.

38. In many of the centres, milk is provided for specially needy children and mothers. At its current session, taking advantage of the opportunity to buy dry skim milk at a favourable price, the Board approved aid which will provide approximately 3 million lb. of dry skim milk for distribution through maternal and child welfare centres, child care institutions and in school feeding programmes in six countries in Asia during the next twelve to eighteen months.

39. UNICEF interest in helping bring protein-rich foods into children's diets in non-milk producing countries is described earlier in this report (paragraphs 22-23). It is hoped that the first concrete project in this field, one for aid to Indonesia for the local production of soya bean milk powder, will be brought to the Board for action at its next session.

40. In terms of numbers of children actually helped in 1952 and to be helped in 1953, mass programmes against disease continue to play the biggest rôle. After several years of preparatory work, they are really becoming mass programmes. For example, the $650,000 voted last year for BCG work has been supplemented at the present session by only $55,000, but the number tested is expected to rise from 11 million last year to 16 million this year.

41. The number of children to be tested this year is almost as many as the 19 million done from the beginning of the programme, and in 1954, with very little more money, the number tested is planned to be at least 20 million.

42. Similarly, the number of persons treated in the area for yaws will rise this year to about 700,000 from a little more than 400,000 last year. In the anti-yaws programme, the progress is particularly satisfactory because the cost per case treated this year will be not more than half that of a year ago. This is partly due to cheaper penicillin and partly to the greater volume of work done. This year, in Asia, a case of yaws can be treated for approximately a dollar, including all costs, of which the governments pay about two-thirds.

43. In malaria control, the present session voted only $66,000 as against $470,000 last year. But the money voted last year provided the DDT for increased work this year, which will protect about 8 million children as compared with about 6 million last year. An additional number will be protected by the matching DDT provided either by governments or bilateral aid. Two UNICEF-equipped DDT plants will start production next year, thus enabling the countries to continue and expand the programme with their own resources. With the addition of further United States aid, especially in India, the anti-malaria work which WHO and UNICEF helped to develop will be carried on next year largely without United Nations aid, thus freeing UNICEF money for other urgent projects.

Eastern Mediterranean[5]

44. Since 1948, the Executive Board has allocated approximately $19,500,000 to the Eastern Mediterranean area. Of this amount, approximately $15,500,000 was for emergency relief in connexion with the Palestine refugee problem. Of the remaining approximately $4 million allocated for long-range programmes, $1,750,000 was for mass health programmes, $1,115,000 for milk conservation, $845,000 for maternal and child welfare and $290,000 for long-range feeding. More than half this amount was allocated since the beginning of 1952.

45. The first long-term aid of UNICEF in the Eastern Mediterranean area was for BCG vaccination against tuberculosis. UNICEF-aided campaigns are currently under way in Iran, Iraq, Libya and Turkey, testing some 200,000 children a month. Completed campaigns aided by UNICEF have been held in Aden, Egypt, Israel, Lebanon and Syria. A campaign is about to begin in Ethiopia. Toward the end of the year campaigns will start in Jordan and the Sudan. The total amount allocated for BCG vaccination campaigns in this area is $1,025,000. From 1949 to the end of 1952 six million children were tested and 2,100,000 vaccinated against tuberculosis, the number thus reaching roughly one-fifth of the total child population in this area.

46. Four countries are being assisted with supplies for campaigns to control malaria and other insect-borne diseases. In October 1952, UNICEF supplies were in use in the extension of the national anti-malaria campaign in Syria. In March 1953, UNICEF DDT began to be used in Lebanon, extending the previous WHO-assisted pilot project. A similar extension with UNICEF DDT will take place in Iraq in the last quarter of 1953. In the last quarter of 1953 also, the government programme in Egypt will be substantially augmented with UNICEF supplies. Building operations for the DDT plant in Egypt, to be equipped by UNICEF, will get under way during the first half of 1953.

47. Two countries are being aided in anti-bejel and pre-natal syphilis programmes. In Iraq the campaign has been going for two years and in Syria the campaign is expected to start at the beginning of 1954. UNICEF has allocated $185,000 for these programmes.

48. Next to mass health programmes, the greatest UNICEF aid for long-range programmes in this area is for milk conservation. Milk conservation projects in five countries—Egypt, Iran, Iraq, Israel and Turkey —are being aided. In all these countries the projects are at present at the stage of detailed planning and developing of plans of operations for the production, collection, processing and distribution of the milk.

49. In addition to milk conservation, UNICEF has provided $190,000 for dried milk for distribution in Iran, Iraq and Turkey prior to the completion of plants in those countries. At the present session

[5] For list of currently receiving countries in the Eastern Mediterranean see paragraph 25.

assistance to Iraq for a permanent school feeding programme was approved.

50. Aid for rural maternal and child welfare programmes is becoming increasingly important, more than three-fourths of the total allocations in this field being approved by UNICEF since the beginning of 1952. Prior to the present session, training activities and aid to maternal and child welfare centres had commenced in Lebanon, Israel and Syria and were scheduled to begin later in 1953 in Jordan, Libya and Iran. At the present session aid was approved for maternal and child welfare programmes in three additional countries, Egypt, Iraq and Turkey.

Europe[6]

51. Allocations to European country programmes have totalled $3.4 million since the beginning of 1951. The largest amount, $1.2 million, has been for emergency relief, mainly in Yugoslavia and Italy. Of the balance, $890,000 was for equipment for milk conservation plants, a number of which are now in production.

52. Long-range maternal and child welfare programmes have received considerable emphasis during the period with allocations totalling $590,000. Other types of programmes with long-range impact which have received substantial UNICEF assistance have been child feeding programmes with allocations of $440,000 and mass campaigns against important childhood diseases for which $250,000 was allocated.

53. Since the beginning of 1952, emphasis has continued to be on milk conservation and maternal and child welfare with allocations made to five countries: Austria, Greece, Italy, Portugal and Yugoslavia. It is expected that increasing attention will be focused on rural maternal and child welfare when new projects in European countries receive UNICEF assistance.

54. Under the target programme and budget for 1953 Europe may be expected to receive approximately 4.8 per cent of UNICEF aid to areas allocated during the year.

Latin America[7]

55. The first allocation for the Latin-American area was made in March 1949. Since then the Board has allocated approximately $8,100,000 for twenty-five countries and territories of which $3,700,000 was for mass health programmes, $1,300,000 for maternal and child welfare services and training, $1,400,000 for long-range feeding, $900,000 for milk conservation, and $800,000 for emergency relief.

56. Anti-malaria and anti-typhus campaigns have been aided by UNICEF in thirteen countries and territories in the Central-American and Caribbean region and four countries in South America. The total amount allocated for these programmes is $1,600,000. In eight countries the programmes have only been under way several months or will start shortly. The malaria control programmes now operating in Central America, which have protected an estimated 1,400,000 to date, in most cases are being taken over gradually by the governments, which will continue the operations with their own resources.

57. In the UNICEF-aided anti-yaws programme in Haiti, over 1,600,000 people have been treated and the mass phase is expected to be over by the middle of 1953, after which follow-up clinics will be established.

58. BCG vaccination campaigns against tuberculosis have been aided in eleven countries. In one country (Ecuador) the UNICEF-aided phase of the mass vaccination is over, and the programme is now being carried on by the Government with the help of a UNICEF-equipped vaccine production laboratory. In another country (Mexico) the internationally-aided phase of the programme has also ended, and a UNICEF-equipped laboratory is producing vaccine for Mexico and other UNICEF-assisted BCG projects in Latin America. In four countries campaigns are under way and in five others (all approved at the present Board session) they are yet to start. The total allocated for these programmes is $620,000.

59. At the present Board session, the Executive Board approved aid for smallpox vaccine production in one country (Colombia) and for a campaign against diphtheria and whooping cough and for vaccine production in another country (Peru), bringing to four the number of countries aided for campaigns and local production of vaccines against childhood communicable diseases (other countries are Brazil and Chile).

60. The total amount allocated for programmes of this type is $290,000. In addition, UNICEF allocated $285,000 to aid an antibiotics production plant in Chile.

61. Supplementary child feeding programmes are now in operation in thirteen countries. In many cases the governments are making arrangements to continue these programmes with their own resources. In six countries UNICEF is equipping plants for the pasteurization or drying of local milk supplies in order to help carry on these programmes. The possibilities of developing similar projects in a number of other countries is under consideration.

62. UNICEF is assisting maternal and child welfare services in eleven countries. Included in this aid are supplies and equipment for some 285 maternal and child welfare centres, mainly in rural areas. In most of the countries the programmes provide facilities for training of personnel as well as services to mothers and children. The centres provide a wide variety of services with the principal emphasis on prevention of disease, including education of mothers, immunizations, regular examinations, and supplemental feeding where indicated. With an initial stimulus provided by UNICEF, these new or improved services are becoming integral parts of the permanent maternal and child welfare organizations in the various countries.

Emergency situations

63. UNICEF aid for emergencies at the present session totalled approximately 15 per cent of allocations to country programmes. This was the same as the percentage in 1952 (excluding allocations for Palestine

[6] For list of currently assisted countries in Europe, see paragraph 25.

[7] For list of currently assisted countries in Latin America, see paragraph 25.

refugee mothers and children). The total amount allocated for emergencies at the present session was $740,000, of which $640,000 went for supplementary feeding of children and mothers in areas in India where crops had failed, and $100,000 for milk for refugee children and mothers in Pakistan.

FINANCIAL POSITION

64. At the close of the October 1952 Executive Board session the Fund had unallocated resources of $899,000. Since that time the Fund received the equivalent of approximately $3,306,000 in contributions and pledges from twenty-one governments, approximately $476,000 in contributions from private sources, $93,000 from UNRRA residual assets, and $381,000 in other miscellaneous income (investments, Staff Assessment plan, etc.). Together with returns of unused allocations for BCG Joint Enterprise programmes, project personnel, operational services, administrative expenditures amounting to $196,600, a total of $5,351,600 in resources was available for allocation at the present session. The allocations of $5,349,000 approved at the current session left the Fund with unallocated resources amounting to $2,600.

65. A brief summary of trends in financial support of UNICEF is contained in the special Board report, (E/ICEF/226 or E/2409, paras. 22-26). A report on "UNICEF Income from Private Sources", (E/ICEF/219), was prepared by the Executive Director for the information of the Board at its present session.

66. The Board had before it a report of the Sub-Committee on Fund Raising of the Programme Committee (E/ICEF/R.442). This report deals, among other matters, with UNICEF relations with the General Assembly Negotiating Committee on Extra-Budgetary Funds, the use of prominent personalities for fund-raising purposes, and the possibility of a World Fund-Raising Conference for UNICEF. The Executive Board, in noting this report, expressed its appreciation to the Committee for its hard and useful work.

ALLOCATIONS

General

67. As is shown in paragraph 13, the Executive Board approved allocations totalling $5,349,000. Apportionments from these allocations for country programmes as well as amounts approved from unused previous allocations in connection with the new plans of operations are described later in this report.

68. The freight allocation is based upon a recommendation of the Executive Director for $662,000 to cover the freight cost of shipping, the supplies voted at the current session (E/ICEF/R.445).

Reimbursement to WHO of certain technical assistance costs

69. The Board had before it a report by the Executive Director on a request by WHO for reimbursement of technical assistance costs in certain UNICEF-assisted projects (E/ICEF/R.447; E/ICEF/R.447/Add.1). The funds allocated to WHO for 1953 by the Technical Assistance Board in November 1952 were not enough to enable WHO to finance all projects included in the programmes approved (subject to the availability of funds) by the World Health Assembly in May of that year. In December 1952, the Director-General of WHO commenced discussion with UNICEF and other agencies as to the possibility of their taking over certain costs of jointly aided projects which would normally be financed by WHO out of its technical assistance funds.

70. Pursuant to an authority granted to it by the World Health Assembly, the Executive Board of WHO in February 1953 revised the programme approved by the World Health Assembly to bring it within the limits of funds allocated by the Technical Assistance Board. The Executive Board of WHO decided that "all projects in operation" should be completed but that "new" activities (i.e., those in respect of which technical assistance funds were not expended in 1952) be deferred and that the Director-General of WHO should continue the discussions referred to in the preceding paragraph.

71. The "new activities" which WHO decided should be deferred included some projects which have not come before the Executive Board of UNICEF previously (and in this sense were "new" to UNICEF) and some projects which were the subject of allocations already made by UNICEF, and in this sense were not "new" to UNICEF.

72. The technical assistance costs of the projects which are new to WHO and to UNICEF (i.e., new projects before this session of the UNICEF Executive Board) is approximately $37,000. The technical assistance costs of projects which are "new" to WHO but not to UNICEF amount to $186,000. Additional funds required for BCG personnel in 1953 are $65,000. The sum of all three is $288,000.

73. From the Executive Director's Report and the subsequent discussion in the Programme Committee and Executive Board the following major points emerged in connection with the request:

(*a*) WHO will continue to finance the technical assistance costs of all WHO projects in operation. These total $5,021,000. Of this total $1,813,000 is for projects jointly aided by WHO and UNICEF. Of the funds being spent by WHO on international assistance projects, 43 per cent is for projects assisted by WHO and UNICEF;

(*b*) The request is considered by WHO as a means of obtaining temporary financial assistance for its 1953 financial period. It is not to be considered as a precedent for weakening the agreed division of responsibility between UNICEF and WHO under which UNICEF finances the supplies and equipment and WHO finances the international project personnel required;

(*c*) Despite the wish of the Director-General of WHO, however, it appears not unlikely that a request for similar purposes may come before the UNICEF Executive Board at its September session. The amount likely to be requested, if any, cannot be estimated at this time. The Executive Director's report points out that if the request were along the same lines as the request for 1953 the amount would approximate $500,000 (E/ICEF/R.447, para. 19);

(*d*) The Director-General thinks it necessary that WHO should devise a system of planning which will enable the programme to be adapted more easily to the availability of resources. This may involve establishing priorities for certain programmes. The Director-General considers that projects of the type jointly aided by UNICEF and WHO are of great importance. Subject to the directives of the Technical Assistance Board and the receipt of requests from governments, he would hope that something like 40 to 45 per cent of WHO technical assistance funds will be spent on projects jointly assisted by WHO and UNICEF;

(*e*) The possibility of WHO devoting a larger share of its regular budget to projects jointly aided with UNICEF was raised. The Assistant Director-General pointed out that in addition to the amount of $174,000 referred to by the Executive Director of UNICEF as being devoted to this purpose in 1953, additional amounts in the regular budget related to UNICEF aid (including supervisory planning and liaison staff and the Tuberculosis Research Office in Copenhagen) add to a considerable sum. The general attitude of the Director-General was to do everything possible to assure high priority for jointly aided projects. In addition, substantial sums of other parts of the regular budget benefit children directly although they are not applied to joint WHO/UNICEF aid;

(*f*) The sum of $288,000 requested from UNICEF does not include international personnel required for projects for the local production of antibiotics and DDT for which UNICEF is providing equipment. The financing of this personnel for the second half of 1953 is the subject of discussion between UNTAA and WHO and will not involve a request to UNICEF;

(*g*) Except for international BCG personnel, the sum does not include cost for the Americas which is being assumed by the Pan American Sanitary Bureau.

74. In the light of the foregoing, the Board approved a ceiling allocation of $288,000 as set forth in E/ICEF/R.447, para. 16 and E/ICEF/R.447/Add.1, subject to the following understandings:

(*a*) The allocation of this sum does not constitute a precedent for a UNICEF commitment in 1954;

(*b*) The agreed relationship between UNICEF and WHO (see preceding paragraph, sub-paragraph (*b*)) should be restored as early as possible. Important questions of principle are involved when funds voluntarily contributed for one purpose are in effect diverted to another purpose for which separate financial arrangements have been constituted. The deficiencies in the financing of one programme of international assistance are met at the expense of another;

(*c*) Within the framework of long-standing arrangements recognizing WHO's technical responsibilities, the cost of personnel for projects financed from UNICEF funds should be based upon a close and continuous case-by-case examination of requirements, in which UNICEF staff participates, especially in the field, in order to assure that the utmost economy, consistent with the desired results, is achieved;

(*d*) In any recommendations submitted in the future to the Executive Board involving joint participation by UNICEF and WHO, the Executive Director is requested to ascertain whether the WHO share will be drawn from its regular budget or its expanded technical assistance budget, and if the latter, what priority will be given by WHO to financing its proposed share. The purpose of this would be to safeguard the current UNICEF methods of programme and financial planning; and to assure that requests from WHO such as were submitted to the present Board session are not recurrently submitted after programmes are approved.

75. Apportionments to country programmes based upon this decision are described in the section of this report dealing with individual country apportionments.

APPORTIONMENTS AND APPROVAL OF PLANS OF OPERATIONS

Summary

76. The apportionments approved by the Executive Board are described in detail in the next section of this report. Listed in summary form they are as follows:

		From new funds $	*From unused previous allocations* $
AFRICA			
Belgian Congo and Ruanda-Urundi	Long-range feeding	4,000	—
Mauritius	Anti-whooping cough vaccination	10,000	—
Morocco	Anti-trachoma	33,000	—

		From new funds	*From unused previous allocations*
		$	$
Nigeria	Anti-malaria	75,000	—
	Anti-yaws	150,000	—
	Anti-leprosy	93,000	—
Tunisia	Anti-trachoma	14,000	—
		379,000	—
ASIA			
Afghanistan	MCW services and training	56,000	—
	Anti-malaria	66,000	—
	BCG anti-TB vaccination	4,000	
Brunei	BCG anti-TB vaccination	1,000	—
Burma	MCW services	25,000	—
	BCG anti-TB vaccination	2,000	—
Cambodia	BCG anti-TB vaccination	3,000	—
Ceylon	MCW services and training	21,000	—
China (Taiwan)	MCW services and training	30,000	—
	Anti-trachoma	8,000	
	Anti-prenatal syphilis	27,000	
India	Anti-yaws	39,000	—
	MCW services and training	807,000	—
Indonesia	Anti-yaws	450,000	—
	MCW services	40,000	—
	BCG anti-TB vaccination	13,000	—
Japan	MCW services and training	10,000	7,000
Pakistan	MCW services and training	50,000	—
	BCG anti-TB vaccination	23,000	—
	Vaccine production	20,000	—
Philippines	MCW services and training	134,000	—
	Long-range feeding	75,000	—
	BCG anti-TB vaccination	5,000	—
Singapore	MCW services		14,000
Thailand	MCW services and training	94,000	—
Vietnam	MCW services	10,000	—
	BCG anti-TB vaccination	4,000	—
		2,017,000	21,000
EASTERN MEDITERRANEAN			
Egypt	MCW services	180,000	—
Iran	Milk conservation	125,000	—
Iraq	MCW services and training	81,000	—
	Long-range feeding	122,000	—
Israel	MCW services	30,000	20,000
Jordan	BCG anti-TB vaccination	7,000	—
Libya	MCW services and training	11,000	—
Sudan	BCG anti-TB vaccination	4,000	—
Syria	Anti-bejel	12,000	—
Turkey	MCW services and training	115,000	—
		687,000	20,000
EUROPE			
Austria	Sera and vaccine production	4,000	30,000
	MCW services	—	25,000
Yugoslavia	Milk conservation	205,000	—
		209,000	55,000
LATIN AMERICA			
Bolivia	MCW services	18,000	—
	Anti-malaria	6,000	—
	BCG anti-TB vaccination	500	
Brazil	MCW services	—	32,000
	Long-range feeding	249,000	—

		From new funds	From unused previous allocations
		$	$
British Guiana	BCG anti-TB vaccination	17,500	1,000
British Honduras	BCG anti-TB vaccination	4,000	—
Chile	Long-range feeding	24,000	—
Colombia	Vaccine production	15,000	—
Costa Rica	Milk conservation	153,000	—
Ecuador	MCW services and training	—	20,000
Grenada	BCG anti-TB vaccination	4,500	1,100
Guatemala	Long-range feeding	30,000	4,200
Haiti	Anti-malaria	3,000	—
Honduras	Long-range feeding	30,000	—
Panama	MCW training	8,000	—
Paraguay	BCG anti-TB vaccination	12,000	23,000
Peru	Anti-diphtheria, tetanus and whooping cough vaccination	65,000	—
St. Kitts	BCG anti-TB vaccination	5,500	—
		645,000	81,300
EMERGENCIES			
India		640,000	—
Pakistan		100,000	—
		740,000	—
PROGRAMMES BENEFITING MORE THAN ONE REGION			
Group Training in Milk Quality Control		10,000	—
		4,687,000	177,300

Africa

BELGIAN CONGO AND RUANDA-URUNDI

LONG-RANGE FEEDING

77. The Executive Board approved an apportionment to the Belgian Congo and Ruanda-Urundi of $4,000 from the Africa area allocation for reimbursement to WHO of expenses during 1953 connected with international personnel for the UNICEF-assisted milk programme. The plan of operations is outlined in E/ICEF/198.

78. This programme, for which UNICEF assistance amounting to $175,000 was voted in April 1952, is aimed at the prevention and curative treatment of kwashiorkor, a serious nutritional deficiency, in children from 1-5 years and pregnant and nursing mothers. This is part of a large government programme for the over-all development of Belgian Congo and Ruanda-Urundi, which includes large-scale plans for increased production of protein foods.

79. WHO and FAO are providing expert advice, as requested, on technical aspects of the programme. In view of the shortage of technical assistance funds, UNICEF will reimburse WHO for expenses incurred during 1953 in connexion with international personnel for the programme.

80. UNICEF assistance to Belgian Congo and Ruanda-Urundi totals $179,000 as follows:

	Approved	Shipped Through 1952	Shipped 1953 and after
		$	$
Long-range feeding	April 1952	81,300	93,700
Long-range feeding— WHO personnel	March 1953	—	4,000
		81,300	97,700

MAURITIUS

WHOOPING COUGH VACCINATION

81. The Executive Board approved an apportionment of $10,000 to Mauritius from the Africa area allocation for the provision of pertussis vaccine. This constitutes the first UNICEF assistance to this territory. The Executive Director was authorized to approve a plan of operations as outlined in E/ICEF/R.410.

82. The island of Mauritius is located in the Indian Ocean, some 600 miles east of Madagascar. With a population of 484,000 in an area of 720 square miles, it is one of the most densely populated areas of the world (673 people per square mile). In general, health conditions in Mauritius have greatly improved since the war, as is shown by the following statistics:

	Pre-war average 1936-38 (per 1,000)	1950 (per 1,000)
Death rate	28.3	13.9
Birth rate	34.4	49.7
Infant mortality	153.0	76.3

83. This improvement is reflected particularly in the decrease of infectious and parasitic diseases. The widespread reduction in the incidence of malaria have been the prime factor in bringing down infant mortality. Diseases of the digestive system, another principal cause of death, have also been reduced, although to a lesser extent.

84. Improved health conditions have coincided with increased expenditure on public health, which has risen from 1,477,202 rupees ($US310,200) in 1939 to 3,848,429 rupees ($US830,000) in 1950, or $1.70 *per caput;* this represented 6.2 per cent of the total government costs in 1939, 8 per cent of the total in 1950. A similar increase has been made in the education budget.

A first-class health organization has developed efficient sanitary services, improvements in water supply, general environmental sanitation, special anti-malaria work, and continual expansion of maternal and child welfare services.

85. However, in spite of the sound health structure, serious problems remain to be met. It is only since 1949 that the infant mortality rate has dropped below 100 per 1,000 live born infants.

86. The incidence of whooping cough and attendant complications reached epidemic proportions in 1948, resulting in 1,748 child deaths compared with practically none in the previous three years. This disease, when widespread, leads to a high death rate in the group under five years of age, not only directly, but indirectly through bronchitis and broncho-pneumonia, which often follow. The Government fears that a similar outbreak may occur in 1953 and 1954. While most of the children who were susceptible in 1948 have become immunized through contact with the disease, 100,000 infants and children born since 1948 are entirely susceptible.

87. In order to protect these children, the Government desires to launch an immediate large-scale immunization campaign. Protection of newly-born, susceptible infants will be continued through the maternal and child health system following the mass immunization campaign.

88. All susceptible children on the island will be vaccinated as rapidly as possible. It is expected that 100,000 children will be immunized during 1953 and 1954. A regular public health staff will direct and carry out the work through existing health facilities. The well-established smallpox vaccination teams will also assist with the campaign.

89. The Government is arranging to procure whooping cough vaccine to meet the Island's permanent requirements after UNICEF vaccine has been exhausted. Vaccination will continue on a scale to retain the immunologic level and allow careful follow-up.

UNICEF commitments

90. UNICEF will supply 100,000 immunizing doses of pertussis vaccine at an estimated cost of $10,000. Booster shots will be given to the most susceptible children who received vaccination or natural immunization during the last epidemic but who are probably immune no longer. The technical approval of WHO will be obtained for the source of the vaccine, and consideration will be given to a source accessible to the Mauritius authorities for future procurement.

WHO commitments and technical approval

91. This programme has the technical approval of WHO. WHO will assist the Government in developing the detailed plan of operations for the campaign.

Government commitments

92. The Government will administer the vaccination programme through the existing public health structure, providing syringes, needles, sterilizers, and all other additional supplies and equipment necessary for the campaign.

Target time-schedule

93. Every effort will be made to make the first delivery of vaccine so that the campaign can begin by mid-1953.

Morocco

ANTI-TRACHOMA

94. The Executive Board approved an apportionment to Morocco of $33,000 from the Africa area allocation for reimbursement to WHO of expenses incurred during 1953 for international personnel connected with the anti-trachoma campaign. The plan of operations for the campaign is outlined in E/ICEF/198.

95. Trachoma and associated eye diseases are among the most prevalent infectious diseases in Morocco. Often these infections, contracted during infancy and childhood, lead to later blindness. During the time of year when these diseases are most prevalent, it is estimated that there are from 2-3 million infected children. Many of the persons who escape permanent handicap are recurrently affected during this season.

96. The object of the campaign is the detection and treatment of all cases (estimated at 120,000-180,000) in highly endemic areas. Health education and a sanitation programme are also being undertaken. Under an earlier allocation of $100,000, UNICEF is supplying transport, drugs and other equipment and supplies. Owing to the shortage of technical assistance funds, UNICEF will assume the costs of WHO-recruited international project personnel for 1953.

97. With this action, UNICEF aid to Morocco totals $414,600 as follows:

	Approved	*Shipped*	
		Through 1952	*1953 and after*
		$	$
BCG—joint enterprise (ITC)	March 1949	281,600	—
Anti-trachoma	April 1952	—	100,000
Anti-trachoma—WHO personnel	March 1953	—	33,000
		281,600	133,000

Nigeria

98. The Executive Board approved an apportionment to Nigeria of $318,000 from the Africa area allocation as follows:

(i) *Anti-yaws:* $150,000 for the purchase of penicillin, transport and other supplies for a two-year mass campaign.

(ii) *Anti-leprosy:* $93,000 for the provision of drugs and a small amount of supplies to assist the Government to develop large-scale preventive control measures for a three-year period.

(iii) *Anti-malaria:* $75,000 for the purchase of insecticides, transport and miscellaneous supplies for a three-year pilot control project.

99. This constitutes the first UNICEF assistance to Nigeria, as well as the first UNICEF assistance to any country for control of leprosy. The Executive Director was authorized to approve plans of operations as outlined in E/ICEF/R.422 (anti-yaws), E/ICEF/R.423 and E/ICEF/R.423/Corr.1 (anti-leprosy) and E/ICEF/R.438 (anti-malaria).

GENERAL

100. Nigeria, on the west coast of Africa, is a tropical country, made up of forest, open woodland, grassland and desert. It has a population estimated at nearly 30,000,000; the population density of over 70 per square mile makes it the most populous country in Africa. Most of the people are farmers; principal exports are agricultural and forest products, hides, skins and tin ore. Chief imports are cotton piece goods and almost all types of manufactured products.

101. The country was recently divided into three regions, with the following estimated populations: Northern, 16,800,000; Western, 5,400,000; Eastern, 7,400,000. Wide legislative powers have been delegated to each region by the central government in Lagos. Medical services have been regionalized, with the Central Medical Headquarters in Lagos serving in an advisory and co-ordinating capacity.

102. The size of the territory and health problems to be dealt with place a heavy strain on the available resources. Besides general medical care, communicable disease control, elementary environmental sanitation and improved nutrition are urgently needed. The most serious communicable diseases are: malaria, trypanosomiasis (sleeping sickness), yaws, leprosy, tuberculosis and venereal infections.

103. In 1951 the Government Medical Service had 234 senior medical officers and specialists and 116 senior matrons, health visitors, nursing sisters, etc. In addition, there are nearly 1,400 nurses and midwives and 275 mission physicians and private practitioners. There were over 9,000 beds available in hospitals and maternity centres. These various facilities have been built up in little more than one generation, and are financed from a number of sources. Approximately $11,413,000 is budgeted for the coming year, equalling 38c *per caput* for health and medical services.

104. Mobile medical field units (MFU) are set up or being established in each of the regions of Nigeria to deal promptly with serious outbreaks of infectious diseases and carry out surveys and mass treatment for various endemic diseases during non-epidemic periods. Where possible, they also carry out routine vaccinations and encourage better sanitation through elementary health education. Such units usually include a medical officer, a superintendent, and twenty to thirty auxiliary personnel.

105. The establishment of a network of rural health centres, maternal and child health services, school health work, endemic disease control, village sanitation and health education is also being undertaken. Training of staff is being carried out both in the field and in basic training schools, the latter providing complete courses for doctors, nurses, sanitary inspectors and medical auxiliaries.

(i) ANTI-YAWS

106. Yaws is present throughout Nigeria, but is most widely prevalent in the eastern and southern parts. It is hyperendemic in the Eastern Region, and more common among the rural people than among the highly urbanized populations in the Western Region. It is significant to note that the disease occurs principally among the unclothed tribesmen of the south, and rarely among the Mohammedan populations wearing long, flowing garments, natives of the savannah and desert areas of the north.

107. On the basis of all surveys, and of hospital and dispensary statistics, it is estimated that the number of active yaws cases surpasses 1,000,000 in the Eastern and Western Regions and perhaps 350,000 in the Northern.

108. A local survey in a certain area of the Eastern Region showed that all the primary and secondary yaws, and half the tertiary cases were among children. It can be assumed that hundreds of thousands of children are presently suffering from this painful, crippling and highly contagious disease.

109. In accessible areas, where hospital and dispensary services have been providing much individual treatment over the last twenty years, the incidence of yaws has been somewhat reduced. However, yaws is a rural disease and the less-accessible areas suffer the most.

110. Organized treatment, on a limited scale, is now being undertaken in the north by one of the mobile units, and in the east and west by two units in each, to which two more will soon be added. The upkeep of each unit is some £10,000 ($28,000) per annum plus the cost of medicaments dispensed. To date, the recurrence of serious epidemics of cerebrospinal fever, smallpox, relapsing fever, sleeping sickness and yellow fever have made it very difficult for the MFUs to concentrate on endemic diseases such as yaws.

111. Nearly all treatment is now carried out with arsenicals and bismuth; occasionally penicillin in aqueous solution is used.

112. A WHO consultant spent two months in Nigeria late in 1952 observing conditions and advising the Government on yaws control work, with particular reference to the present plan. He was accompanied during part of his observation by the UNICEF representative for Africa.

113. The objectives of the yaws control project will be:

(*a*) To reduce the incidence of yaws in Nigeria by means of mass treatment with penicillin;

(*b*) To train local professional and auxiliary personnel in the diagnosis, modern therapy and epidemiology of yaws;

(*c*) To encourage active case-finding and treatment through existing dispensaries and hospitals, including those run by the Government, local administrations, and missions.

114. The plan envisages four special field units with a total of four medical officers, four superintendents and eighty-six injectors.

115. It is difficult to estimate the number of cases that can be examined during a two-year period, but UNICEF is supplying penicillin on the basis of a proposed examination of two million persons. Treatment will be given to an estimated 150,000 active cases, 300,000 latent cases, and 300,000 contacts in this group (all persons in the same house as the patient and all

children under 15 in the same compound). The local authorities have a considerably higher target for the period; if during the course of the first year it appears that a larger number can be reached, additional penicillin may be required.

116. In all three Regions, the mobile yaws control units will carry out a mass attack, working on a province-by-province, district-by-district, and compound-by-compound system, thus reproducing the house-to-house pattern followed successfully in other areas of the world. The personnel and facilities of existing dispensaries and hospitals, whether run by the central government, local administrations or missions, will be utilized.

117. This project may require up to five or six years for satisfactory completion; further international assistance after the initial two-year period will be subject to review at a later date by all of the parties collaborating. The special anti-yaws units will serve as the nucleus of permanent medical field units, and will carry out a variety of duties in rural areas untouched before the yaws campaign by the existing public health services, after the mass campaign is over.

118. The project will be carried out by the Government of Nigeria through medical departments of its regional governments. Re-check examinations will be made of population samples amongst whom mass treatment was carried out six months previously.

119. In the Northern Region transport will be self-supplied; for the Western Region where two special mobile yaws control units are planned, UNICEF will provide six vehicles, and for the unit in the Eastern Region, two vehicles.

UNICEF commitments

120. UNICEF will provide the following supplies and equipment for the two-year project:

	$
(*a*) 250,000 10cc vials penicillin	107,500
(*b*) Transport	20,000
(*c*) Field equipment	10,000
(*d*) Miscellaneous and reserve	12,500
TOTAL	150,000

WHO participation and technical approval

121. The plan of operations for the project was developed with the advice of WHO and has its technical approval.

International project personnel

122. WHO will recruit a technical adviser to assist the Government with this project for a two-year period. For 1953, the adviser will be financed by technical assistance funds.

Government commitments

123. The Government of the Eastern Region will contribute £35,000 ($98,000) for the two-year period for the personnel, auxiliary supplies and transport for the project. The Western Region will provide £87,400 ($244,700), and the Northern Region contribution may be estimated at £25,000 ($70,000). The Regions will thus provide a total of over $400,000 to the programme for the two years for the special yaws units alone. Auxiliary supplies will include procaine penicillin (PAM) which the Government will henceforth procure in lieu of arsenicals and bismuth. To the total government commitment must be added an undetermined sum for the anti-yaws work of MFUs and fixed institutions.

124. The Government will consolidate the achievements of the campaign, and agrees to continue yaws control activities after the termination of international assistance, by integrating them into the regional public health and medical care structure of the country.

Target time-schedule

125. It is is planned to launch the mass campaign in late 1953, shortly after the arrival of UNICEF supplies. The period of international assistance covers two years although it will take five or six years fully to complete the mass phase of the work.

(ii) ANTI-LEPROSY

126. Nigeria has one of the world's greatest leprosy problems, but is making every effort to solve it with modern methods, placing particular emphasis on preventive control and public health aspects of the problem. Estimates of the incidence of leprosy in Nigeria range in the neighbourhood of 500,000 cases: 250,000 to 300,000 for the Northern Region; 60,000 to 80,000 for the Western Region; and 100,000 for the Eastern Region.

127. Leprosy is a disease contracted in childhood and youth. Of the total number of infected patients, half are children and mothers. Leprosy workers in Nigeria are among the world's foremost authorities. They believe that a child runs the risk of contracting leprosy if left too long with infected parents, and that such children must be protected as soon as possible. This is particularly important since over a five-year period at least 50 per cent of the women leprosy patients between 20 and 40 years of age bear children; unfortunately, childbirth is commonly followed by an exacerbation of the disease, and a degeneration to a more infective type. In a recent survey in Northern Nigeria, there was at least one, and often more cases of leprosy among children in almost every school. These children are likely to affect the other children in the school, sooner or later.

128. Although leprosy is not a rapidly killing disease, it is disfiguring and disabling. Apart from its profound physical and psychological effects on the individual, leprosy robs the community of the contribution of men and women at the time of their greatest physical vigour, presenting the community, instead, with a recurring economic problem.

129. Adequate control measures include the education of patients in improved personal and communal hygiene; as these are treated and become reintegrated into the community, the standards they have learned spread to others. Leprosy is thus a key disease, and has effects far beyond those actually infected.

130. Based on the experience in leprosy control to date in the Eastern Region, the results of which are encouraging, national policy aims at early detection and

treatment, rather than the traditional segregation of leprosy cases from society. This new approach has been greatly facilitated by the recent large-scale use of sulphone drugs (DDS), which are efficacious, easily administered, and cheap, and give patients the promise of becoming symptom-free in a reasonable time. As a result, there is an unprecedented demand for treatment. The standard procedure includes free treatment, the voluntary temporary isolation of infective cases, leprosy education, and the assistance of the community in the maximum possible care and after-care of the patient.

131. Thus a new attitude towards leprosy is developing, and the disease is losing some of the fear, apathy and prejudice so long associated with it.

132. Under the Central Government's Department of Medical Services, the Leprosy Service, in conjunction with the Central Leprosy Board, carries out research, and co-ordinates and directs the work of the Regional and Provincial Leprosy Boards, and of the governments', missionary societies', and voluntary agencies' efforts. The Central Government Leprosy Service, furthermore, is directly responsible for control of the disease in the five heavily-infected provinces, which form the contiguous borders of the Eastern and Western Regions.

133. Various types of settlements and centres are run by the governmental and private groups. There are twenty-three traditional leprosy settlements in Nigeria: large centres for several hundred patients, giving complicated treatment, which in turn are the centre of a system of dispensaries and treatment centres. Four of these are in government hands, and nineteen are run by missions and voluntary agencies, assisted by subsidies from the Government.

134. The Government is now concentrating on the establishment of segregation villages, for patients who do not require the specialized care of the leprosy settlements. A segregation village, where patients are encouraged to live, is set up within walking distance of each large village or groups of small villages. Every effort is made to win the people's confidence in the medical personnel and in themselves. The local administrations provide land and comfortable, sanitary living conditions, gardens, and a dressing station, thus creating a real home for the patients. There are 172 of these model villages in existence at the present.

135. In the course of their stay in these villages the people are educated to earn their own living, enjoy new standards of hygiene, cultivate the land and build better houses. The impact of this "schooling" on the communities of Nigeria is important, for not only will the patients take back higher standards to their homes, but other villages in the vicinity are already imitating them, thus spreading basic concepts of environmental sanitation, health education, community co-operation and economic self-sufficiency.

136. The total number of patients being treated is approximately 52,000, or about 10 per cent of the estimated incidence of 500,000.

137. The objective of UNICEF aid is to enable the Government to double the number of leprosy cases receiving treatment. The provision by UNICEF of sulphone drugs to treat 100,000 patients during a three-year period will release government funds earmarked for this purpose for other uses, including equipment of treatment centres and hospitals and the provision of more personnel.

138. In the Northern Region, where only 7 per cent of the total estimated number of patients are receiving treatment, conditions are highly favourable for a rapid extension of control work. Model local anti-leprosy schemes have already been initiated, and more are planned. In every province, Missions have offered to co-operate in the control programme. Capital building grants have been made to three settlements, now under construction, while at three others preliminary negotiations are in progress. Each of these is planned to become the centre of a chain of out-stations, leading to a large extension both in the number of local treatment centres and segregation villages and in the number of patients. However, no funds are foreseen before 1956 for equipping these centres. The provision of sulphone by UNICEF will release funds for equipment and considerably advance the time when the centres can start operating.

139. In the Eastern Region, more leprosy work has been done than in the other two regions, and the 30,000 patients under treatment represent nearly one-third of the estimated total cases. Under the leprosy service, more cases were discharged symptom-free (5,031) in 1952 than were diagnosed as new cases (4,262). In the East, therefore, UNICEF aid will permit an over-all improvement of the facilities available. If control work can be developed to the full, there is every prospect of a rapid decline in the prevalence of the disease.

140. The Leprosy Service of the Central Government is attacking particularly difficult areas in the Western Region. Only 13 per cent of the estimated leprosy cases have been receiving treatment. This is the region where most work has yet to be done. It is, therefore, planned to attach a leprosy survey group to the special yaws unit in order to facilitate a survey in an area where local prejudice against leprosy runs particularly high. This survey will provide a realistic estimate of the incidence of leprosy in different localities and prepare the groundwork for a comprehensive permanent control programme.

UNICEF commitments

141. UNICEF will provide the following supplies for a three-year period (1954-1956):

	$
Sulphone tablets (DDS), 62,000,000 } Thiosemicarbazone tablets, 5,000,000 }	90,000
Diagnostic instruments	3,000
TOTAL	93,000

WHO commitments and technical approval

142. WHO advised the Government in the preparation of the plan of operations for this project and has given its technical approval. The WHO Regional Office for Africa will continue to advise the Government in connexion with the programme.

143. WHO will also grant two fellowships for field training in leprosy work to fellows from other countries, at a Leprosy Service Settlement in Nigeria. The assistance given by the fellows, as part of their training, will release an experienced medical officer to undertake the survey in the Western Region.

Government commitments

144. In the five-year period 1951-1956, a total grant from Colonial Welfare and Development funds of £1,231,500 ($US3,448,200) will be made for leprosy control. This, plus an estimated million dollars more to be expended by Missionary Societies and local administrations, is the total which can be used for leprosy, in view of many other economic and social problems which the Government is actively working to overcome. During the financial year 1951-52 a total of well over £400,000 ($US1,120,000) was contributed for leprosy control by the Government, from Colonial Welfare and Development funds and by local administration and Missions. The Government will undertake further expansion of diagnostic and preventive measures for the three Regions, as well as of the existing control services.

145. The Colonial Office and the Government have emphasized that the further economic development of Nigeria will eventually make it possible to increase local resources for control of leprosy.

Target time-schedule

146. UNICEF supplies will arrive in Nigeria in late summer 1953, and the leprosy services will immediately begin to expand to reach greater numbers of victims. The plan will cover the three years 1954-1956.

(iii) ANTI-MALARIA

147. Malaria is the predominant illness throughout Nigeria and is considered the greatest single factor influencing the high infant mortality rate. Spleen and parasite rates among children of 2 to 10 years of age are high. It is believed that control of malaria might reduce infant mortality by a third.

148. In Northern Nigeria, the limited acreage of land which can be cultivated during brief periods when it is softened by the rains, i.e., the malaria transmission period, is the bottleneck in agricultural production, and impaired working capacity during this time has a major effect on the agricultural output.

149. Efforts to combat malaria have been concentrated on the destruction of potential breeding places of larvae. The use of anti-malaria drugs is slowly expanding among more advanced communities in Africa. Residual spraying on a large scale has not yet been undertaken, although its use has begun on an individual basis in some of the bigger cities. Responsibility for anti-malaria measures rests with the Malaria Service in Yaba, which is primarily responsible for surveys and research and for training of sanitary inspectors and also advises the three Regional Health Departments on malaria problems.

150. Since 1949, a special experimental pilot project of residual spraying has been under way in the Western Region, in Ilaro, covering approximately 12,000 inhabitants in 2,300 houses. This spraying is being repeated every three months. There has been a marked decrease in malaria in the very young age group. Malaria morbidity has been considerably reduced, according to the records at the Ilaro dispensary. The Registry of Vital Statistics shows a definite increase in the number of live births, and a relative decrease of infant mortality. The scheme has been operated entirely by the Malaria Service, out of funds made available under the Colonial Welfare and Development Scheme.

151. Careful surveys will be carried out after the termination of the scheme in March 1953 among the population of Ilaro. In summer 1952, a four-month specialized training course in anti-malaria work, sponsored by WHO, took place in Ilaro. Representatives of almost all territories in West Africa attended.

152. The objective of the new project is a malaria control scheme using residual insecticides in a rural area in the savannah region of Northern Nigeria, inhabited by some 100,000 people. The long-term aims are as follows:

(*a*) To evaluate malaria control in a rural area in terms of decreased sickness and increased productivity of the population;

(*b*) To train personnel in modern methods of malaria control;

(*c*) To adapt the organizational principles of malaria control by residual spraying to existing local conditions, combining maximum economy to the degree consistent with improved health of the population;

(*d*) To set up the project as a practical model for similar schemes in other areas of Nigeria.

The Northern Region has been selected for the following reasons:

(*a*) The dense rain forests of the other Regions make a large-scale controlled rural project too difficult an undertaking at present;

(*b*) Financial limitations in the other Regions, partly caused by increased emphasis on the control of other sicknesses, likewise prohibit such a project at present;

(*c*) The brief transmission period in the north makes control of the malaria vector possible by attacking it only during this period, instead of throughout the year as would be necessary in the south;

(*d*) A single well-organized local administration exists for each district;

(*e*) It is felt locally that the projects' success will further the cause of modern public health measures;

(*f*) A WHO consultant has examined the locality and considers it well suited to a practical campaign, and also for bringing problems to light which will be basic in permanent control programmes.

153. A reconnaissance survey was completed in September 1952, to be followed by a more detailed one in March 1953. Entomological and malariometrical surveys will be made as the operation progresses. Particular emphasis will be placed on the collection of pre-control data and on comparing the results with unsprayed nearby areas. It is planned to exchange data with the malaria control projects in other areas of Africa.

154. Only residual spray methods for malaria control will be used. Every human dwelling and animal shelter in the area, consisting of round, mud-dried "bee-hive" huts, and lean-tos will be sprayed. In the first year two spraying cycles will be carried out. Three squads, each consisting of five men spraying and one recorder in charge, will execute the operations under the responsibility of a sanitary inspector. There will also be a medical officer in charge, a malariologist and an entomologist on a part-time basis, a mosquito control officer and various other personnel.

UNICEF commitments

155. UNICEF will provide the following supplies and equipment for a three-year period:

	$
Insecticides	44,400
Transport, including pick-ups, trailers, bicycles and a truck	15,640
Miscellaneous equipment	9,100
Contingency	5,860
	75,000

WHO commitments and technical approval

156. The plan of operations for this project has been developed with the technical advice of WHO and has its technical approval.

International project personnel

157. One entomologist will be provided, recruited by WHO and financed during 1953 from technical assistance funds. The estimated cost is $5,000 for 1953 and $11,000 for 1954.

Government commitments

158. The Central and Northern Region Governments will make available $92,000 for the three-year period, for the following purposes: personnel; labour and temporary staff; uniforms and protective clothing; maintenance and vehicles; office and miscellaneous; temporary buildings.

159. The administrative responsibility for the project will lie with the Northern Region Government, under the technical supervision of the Central Government Malaria Service. The project will be directly connected with the Yaba Malaria Institute, which is the major institute of its kind in West Africa.

160. After the experience gained during the first year of spraying, extension into other provinces and into the other two Regions will be considered. Control in the pilot area will be continued after the expiration of international assistance. A successful operation in this particular locality will greatly influence willingness of other areas to undertake similar programmes.

Target time-schedule

161. The following target time schedule has been agreed upon:

Personnel and supplies in place, late 1953;
First spraying cycle, November 1953—April 1954;
Beginning of second cycle, May 1954.

162. Continual evaluation of the project will be undertaken with a view to expanding it within the Region and in other Regions at the earliest possible date.

TUNISIA

ANTI-TRACHOMA

163. The Executive Board approved an apportionment to Tunisia of $14,000 from the Africa area allocation for reimbursement to WHO of expenses incurred during 1953 for international personnel connected with the anti-trachoma campaign. The plan of operations for the campaign is outlined in E/ICEF/198.

164. Under an earlier apportionment, UNICEF is providing $75,000 worth of transport, drugs and other supplies and equipment.

165. One of the most widespread health problems in Tunisia is the incidence of trachoma and related eye infections. In some regions, almost every child contracts trachoma during the first year of life, and in 1951 more than 80 per cent of all eye diseases in Tunisia were found in children under 15. It is estimated that over a million of the total population of 3,740,000 suffer from acute eye infections, including trachoma. The campaign is being undertaken as a special five-year project starting with a pilot project and expanding into a mass campaign in the areas of southern Tunisia.

166. WHO is recruiting the specialized personnel required for consultation and guidance in the first year of the campaign. Owing to the shortage of technical assistance funds, UNICEF is assuming the costs connected with this personnel during 1953.

167. With this action, UNICEF aid to Tunisia totals $186,100 as follows:

	Approved	*Shipped*	
		Through 1952	*1953 and after*
		$	$
BCG—Joint enterprise (ITC)	March 1949	97,100	—
Anti-trachoma	April 1952	—	75,000
Anti-trachoma—WHO personnel	March 1953	—	14,000
		97,100	89,000

Asia

AFGHANISTAN

168. The Executive Board approved an apportionment to Afghanistan of $126,000 from the Asia area allocation as follows:

(i) *Anti-malaria:* $66,000 for DDT and sprayers for an expansion of the malaria control programme in 1954;

(ii) *Maternal and child welfare services and training:* $56,000 for supplies and equipment for the consolidation and expansion of various maternal and child welfare services established in Kabul by the Government, with help from WHO and UNICEF, and to extend basic maternal and child welfare services to four provincial towns.

(iii) *BCG anti-tuberculosis vaccination campaign:* $4,000 to reimburse WHO for international personnel expenses during 1953.

169. The Executive Director was authorized to approve plans of operations as outlined in E/ICEF/R.403

(anti-malaria) and E/ICEF/R.404 and E/ICEF/R.404/Corr.1 (maternal and child welfare services and training). This assistance represents an extension of UNICEF aid in both cases. The BCG campaign is being carried out by the Government and UNICEF assistance is only for reimbursement to WHO for international personnel expenses in 1953.

170. With this action, UNICEF aid to Afghanistan totals $387,200 as follows:

	Approved	Shipped	
		Through 1952	1953 and after
		$	$
MCW (including feeding and VD)	Nov. 1949		
	Nov. 1951		
	Oct. 1952		
	Mar. 1953	141,500	103,500
Anti-typhus	Nov. 1951	10,700	4,600
Anti-malaria	Nov. 1951		
	Oct. 1952		
	Mar. 1953	10,900	112,000
BCG	Mar. 1953	—	4,000
		163,100	224,100

(i) ANTI-MALARIA

171. Anti-malaria measures in Afghanistan were first undertaken in 1949 on a very modest scale. Under the technical guidance of WHO, the Government rapidly developed operations until, by the end of 1952, approximately 675,000 persons were being protected: 425,000 in rural areas, by residual spraying, and 250,000 in the Kabul area, through anti-larval measures.

172. The Government is attempting to extend protection as soon as possible to at least two million people living in highly malarious areas, since the control of this disease is a prerequisite of any national public health programme. The protection plan is as follows:

1953: 975,000; increase of 300,000 over 1952;
1954: 1,375,000; increase of 400,000 over 1953;
1955: 1,875,000; increase of 500,000 over 1954.

173. For the 1953 programme UNICEF is supplying DDT to protect 300,000 persons in addition to the 675,000 protected by the Government. The Anti-Malaria Institute, essential for the planning and control of the expanded programme, has been completed by the Government with assistance from WHO, at a cost of $200,000, and will be functioning for the first time for the 1953 campaign.

174. This campaign, aided by WHO and UNICEF, has had an enthusiastic reception both from the population and from the Government.

UNICEF commitments

175. For the expanded programme, UNICEF will supply the following:

	$
DDT for protection of 700,000 persons in 1954 (approximately 93 short tons, 75 per cent wettable)	56,000
250 sprayers	6,000
Reserve	4,000
	66,000

WHO commitments and technical approval

176. The expanded programme has the technical approval of WHO, which will continue to supply technical aid to cover the cost of a full-time adviser from the India Malaria Institute now serving in Afghanistan, and who assisted in the preparation of the expanded programme.

Government commitments

177.

	Afghanis
1953	
Regular anti-malaria budget to cover costs of protecting 675,000 persons, other than costs sustained by WHO	2,600,000
Completion of Malaria Institute	3,500,000
Expansion of programme to cover costs of protecting 300,000 additional persons in 1953 (aside from WHO and UNICEF commitments)	750,000
1954	
Cost of protecting 675,000 persons, plus internal costs of transport, labour, etc., required to protect additional 700,000 persons	4,100,000
Total (approximately $US 652,000)	10,950,000

Target time-schedule

178. All supplies should reach Karachi by 1 October 1953. They will be moved hundreds of miles from Peshawar, by lorry, over roads that are impassable during part of the winter and spring, and the DDT must be in the provinces by March 1954.

(ii) MATERNAL AND CHILD WELFARE SERVICES AND TRAINING

179. Apportionments totalling $190,000 were made for this programme by the Executive Board in November 1949, November 1951 and October 1952.

The progress made in developing maternal and child welfare services in Kabul reflects great enthusiasm and support on the part of the health authorities, and demonstrates the effectiveness of international aid when given to projects for which a real need is felt.

180. In spite of many difficulties apparent at the outset, the results of two years of close collaboration between international team members and the Afghan counterparts are encouraging. The first midwifery training school in the country has been established and an existing school for nurses is being reorganized and improved. Modern diagnostic facilities are available through the diagnostic laboratory developed under this project. The Government has now established a regular training course for laboratory technicians. Through clinics and maternal and child welfare centres, pre-natal care is offered to mothers, and continuing attention to their children. Apart from treatment of specific diseases, including venereal disease, at the various clinics in Kabul, preventive work is carried on through periodic vaccinations, home visiting, and the provision of diet supplements.

181. The international personnel play an important part in teaching modern techniques of disease control and methods of organizing and managing training and health service institutions.

182. The present need in the maternal and child welfare field in Afghanistan is the consolidation and

strengthening of the programme already working in Kabul, plus the gradual development of basic maternal and child welfare services in selected provincial centres.

183. The Government's general plan for the next five years with respect to health services is to concentrate on improving and strengthening existing health institutions and services in Kabul and in selected provincial centres, and extending the preventive health services such as malaria control and typhus control now being assisted by UNICEF.

184. A general outline of the further aid required from UNICEF for the project is as follows:

(*a*) Kabul

(i) Supplementary equipment for the nurses' and midwives' training schools.

(ii) Drugs and diet supplements for use in the children's ward, the Maternity Hospital, the Policlinic, the 3 maternal and child welfare centres, and the 2 pre-natal centres.

(iii) Additional equipment and supplies to strengthen the diagnostic and teaching facilities in the diagnostic laboratory.

(*b*) Provincial centres

Additional equipment and supplies to expand services in four provincial hospitals, and to establish four maternal and child welfare centres in the following four towns:

(i) *Phul-i-khumdi*. A fast-developing industrial centre in North Afghanistan with a population of 12,300, where a hospital exists with a nucleus of medical staff. Certain of the personnel trained in Kabul will be assigned to this area.

(ii) *Kandahar*. Afghanistan's second largest town (population 65,000), the importance of which will rapidly grow in the next decade because of major development projects contemplated in the rich Helmand valley. Kandahar is linked to Kabul by a recently inaugurated air service.

(iii) *Jalalabad*. With a population of 14,750 is an important centre within Afghanistan's main southeastern agricultural belt and lies midway between Kabul and Peshawar (Pakistan).

(iv) *Mazar-i-Sharif* (population 30,000). An important trading centre within the agricultural belt of northern Afghanistan, which already has a hospital serving women and children.

(*c*) *Drugs and diet supplements*

Drugs and diet supplements are needed to continue the excellent work already being done in maternal and child welfare institutions in Kabul through the first six months of 1954.

UNICEF commitments

185. UNICEF will provide the following:

	$
(*a*) Equipment, supplies and penicillin for two provincial maternal and child welfare venereal disease clinics to be established in 1954	9,000
(*b*) Supplementary equipment for the nurses and midwives training schools at Kabul	3,000
(*c*) Drugs and diet supplements for use in various institutions and centres in Kabul	8,000
(*d*) Supplementary equipment and supplies for the diagnostic laboratory at Kabul	3,000
(*e*) Additional equipment and supplies for four provincial hospitals for the establishment of a maternity ward and a pediatric ward in each hospital	8,000
(*f*) One heavy-duty station wagon for use between Kabul and the four provincial centres	2,500
(*g*) One million fish oil capsules for use in 1954	2,800
(*h*) 50,000 lbs. of skim milk powder for use in 1954	6,000
(*i*) 20,000 lbs. of whole milk powder for use in 1953/54	6,400
(*j*) 25,000 lbs. of soap for use in 1954	2,300
(*k*) Reserve	5,000
TOTAL	56,000

WHO commitments and technical approval

186. WHO, which has given the project its technical approval, will provide technical advice and evaluation.

International project personnel

187. Nine WHO international personnel are already serving in Afghanistan for periods of from one to three years.

Government commitments

188. Capital expenditure for this programme during 1952 was estimated at 2,100,000 Afghanis (at 16.80 Afghanis to $US1, $125,000) of which 900,000 Afghanis were contributed by the Government and the remainder from other sources. To date, the Government's commitment is 4,000,000 Afghanis. Running expenses during 1952 were estimated at 1,100,000 Afghanis (approximately $US65,500), for administration, personnel, maintenance of premises, distribution of supplies, etc. Two million Afghanis will be available in 1953 for further capital expenditure, as necessary, in provincial centres and for all running expenses. In addition, the maintenance of the maternity hospital and the children's hospital will cost the Government about 1,600,000 Afghanis annually. The Government agrees to report at the end of each fiscal year its actual matching expenditures.

Target time-schedule

189. The UNICEF supplies and equipment are requested for delivery as follows:

(*a*) VD diagnostic and treatment supplies and equipment during first six months of 1954;

(*b*) Additional nurses and midwives training equipment as soon as possible;

(*c*) Drugs and diet supplements for Kabul institutions as soon as possible, with first priority to those for the maternity hospital;

(*d*) Additional laboratory equipment and supplies for Kabul as soon as possible;

(*e*) Equipment and supplies for four provincial centres: two sets during 1953 and two sets during latter half of 1954;

(*f*) Whole milk powder as soon as possible; skim milk and soap during October-November 1953; and fish oil capsules during January-February 1954;

(*g*) Station wagon during last quarter of 1953.

BCG ANTI-TUBERCULOSIS VACCINATION CAMPAIGN

190. Owing to the shortage of technical assistance funds, UNICEF will provide $4,000 for expenses during 1953 connected with BCG project personnel recruited by WHO. The Government is providing all supplies and equipment for the campaign.

BRUNEI

BCG ANTI-TUBERCULOSIS VACCINATION CAMPAIGN

191. The Executive Board approved an apportionment to Brunei of $1,000 from the Asia area allocation for the reimbursement to WHO of expenses connected with international BCG personnel during 1953. The plan of operations for the BCG campaign is outlined in E/ICEF/184, Rev.1. The BCG campaign, which is running concurrently with a campaign in Sarawak, is receiving supplies, equipment and transport from UNICEF, and got under way in March 1953. The international team, consisting of medical officers and one nurse, are dividing their time between Sarawak and Brunei. They are training local personnel in the proper methods of testing, vaccinating and record keeping. During their stay in Brunei, it is expected that 20,000 school and pre-school children will be tested and 12,000 vaccinated. Most of this work will be done by the indigenous teams.

192. Under a previous apportionment, UNICEF is providing supplies, equipment, and transport for the campaign. Owing to the shortage of technical assistance funds, UNICEF is assuming expenses connected with the WHO-recruited international personnel for 1953.

193. With this action, UNICEF aid to Brunei totals $34,200, as follows:

	Approved	Shipped: Through 1952	Shipped: 1953 and after
		$	$
Feeding	March 1950	3,100	—
MCW	August 1949	21,300	200
BCG	November 1951	2,700	5,400
	March 1953		
Under discussion			1,500
		27,100	7,100

BURMA

194. The Executive Board approved an apportionment to Burma of $27,000 from the Asia area allocation as follows:

(i) *Maternal and child welfare services and training:* $25,000 to provide 250,000 lbs. of dry skim milk;

(ii) *BCG anti-tuberculosis vaccination campaign:* $2,000 to reimburse WHO for expenses connected with BCG international project personnel during 1953.

195. In both cases, this represents an extension of previous UNICEF assistance to existing programmes. The Executive Director was authorized to approve a plan for milk distribution as outlined in E/ICEF/R.450/Rev.1. The plan of operations for the BCG campaign is outlined in E/ICEF/184/Rev.1, and E/ICEF/198.

196. With this action, UNICEF assistance to Burma totals $729,000 as follows:

	Approved	Shipped: Through 1952	Shipped: 1953 and after
		$	$
Supplementary feeding ..	May 1950	27,700	—
MCW services and training (including immunization)	May 1950		
	Nov. 1951		
	Apr. 1952		
	Oct. 1952		
	Mar. 1953	255,800	262,200
Anti-tuberculosis	May 1950		
	Apr. 1952	65,000	11,300
BCG campaign	Nov. 1951		
	Apr. 1952		
	Mar. 1953	60,800	46,200
		409,300	319,700

(i) MATERNAL AND CHILD WELFARE SERVICES AND TRAINING (MILK)

197. The Government is expanding its network of maternal and child welfare centres, aiming at establishing a total of 500. UNICEF is already providing whole and skim milk for distribution through 150 maternal and child welfare centres in 1952-1953. The Government now wishes to increase the number of centres receiving milk and also to provide milk for children in hospitals and welfare institutions. Under the present apportionment of $25,000, UNICEF will supply 250,000 lbs. of dry skim milk for this purpose.

(ii) BCG ANTI-TUBERCULOSIS VACCINATION CAMPAIGN

198. The BCG programme in Burma has as its object the testing of 1,500,000 children in the period from January 1952 to December 1953. UNICEF has supplied equipment, transport, and vaccines. An international team, recruited by WHO, consisting of a BCG medical officer and two nurses, is training twelve local teams to carry on the work without international assistance after the end of 1953. The object of the programme is to test all persons in the country under 20 within a period of five years after the beginning of the programme. Eventually, BCG vaccination will be a regular part of the country's anti-tuberculosis services. The present apportionment of $2,000 will cover additional expenses of the international team, which has heretofore been financed by WHO, during 1953.

CAMBODIA

BCG ANTI-TUBERCULOSIS VACCINATION CAMPAIGN

199. The Executive Board approved an apportionment to Cambodia of $3,000 from the Asia area allocation for reimbursement to WHO for expenses connected with international BCG project personnel during 1953. The plan of operations for the campaign is outlined in E/ICEF/198 and E/ICEF/212.

200. The long-term objectives of the campaign are to test all young people under 20 years of age in the country within ten years and to integrate BCG services with the Government's tuberculosis control scheme. An international team, consisting of a doctor and two nurses, is spending eighteen months in Cambodia and Vietnam training local teams and assisting the Government to get the campaigns started. There are to be four local teams in Cambodia, each composed of six techni-

cians, which will have as their goal the testing of 100,000 persons each year and vaccinating the negative reactors. In addition to financing the international team, which was recruited by WHO, UNICEF is providing supplies, equipment and transport.

201. With this action, UNICEF aid to Cambodia totals $32,000, all for the BCG campaign:

	Approved	Shipped: Through 1952	Shipped: 1953 and after
		$	$
BCG	Apr. 1952		
	Oct. 1952		
	Mar. 1953	7,000	25,000
		7,000	25,000

CEYLON

MATERNAL AND CHILD WELFARE SERVICES AND TRAINING

202. The Executive Board approved an apportionment of $21,000 to Ceylon from the Asia area allocation for maternal and child welfare services and training as follows:

(i) For improving nurse and midwife training and maternal and child welfare services, $15,000;

(ii) For dry skim milk for distribution through maternal and child welfare centres and hospitals, $6,000.

203. The Executive Director was authorized to approve plans of operations as outlined in E/ICEF/R.449 (services and training) and E/ICEF/R.450/Rev.1, (milk). This constitutes an extension of UNICEF aid for maternal and child welfare in Ceylon, although this is the first time that dry skim milk has been provided.

204. With this action, UNICEF aid to Ceylon totals $623,500, as follows:

	Approved	Shipped: Through 1952	Shipped: 1953 and after
		$	$
Anti-tuberculosis	Aug. 1950	41,100	—
BCG campaign	Mar. 1949	50,500	—
Anti-malaria	Nov. 1951	150,400	1,600
DDT plant	May 1951	—	250,000
MCW services and training (including feeding)	Aug. 1950		
	Oct. 1952		
	Mar. 1953	72,600	57,300
		314,600	308,900

(i) NURSE-MIDWIFE TRAINING AND MATERNAL AND CHILD WELFARE SERVICES

205. Of Ceylon's population of approximately 7 million, 1.5 million women are of child-bearing age and 1.5 million are children under the age of fifteen. The island is beginning to feel the pressure of population upon its resources. The development of the general health programme, and particularly the virtual conquest of endemic malaria, have resulted in a steady decrease in the morbidity and mortality rates of women and children, as the following table shows:

	Birth rate per 1,000 population	Infant mortality per 1,000 live births	Maternal mortality per 1,000 live births
1945	36.7	140	16.5
1950	40.3	84	5.7

206. Premature births are high, being some 30 per cent of all live births, and cause half the neo-natal deaths. Even though toddlers have shared in the general health improvement, deaths under five years of age constitute 47 per cent of the total deaths in the country.

207. The public is increasingly conscious of available health services, which results in a growing demand for both preventive and curative attention. In trying to meet this, the Government is hard-pressed both as regards training facilities and teaching personnel. Health personnel available, and their ratio to the population are as follows: doctors, 1:6,800; nurses, 1:5,000; midwives, 1:4,000; dentists, 1:25,000; apothecaries, 1:9,400; sanitary inspectors, 1:10,000.

208. Existing training facilities include the following:

(*a*) *Nurses' training.* The Nurses Training School in Colombo accommodates 230 trainees and has an annual output of seventy-five trained nurses. Vernacular training is conducted in the Lady Ridgeway Hospital, Colombo, with an annual output of fifty nurses. A new training school in Kandy, with facilities for thirty-five trainees, will turn out its first qualified nurses in 1955. By 1955, this school will be able to accommodate 220 students;

(*b*) *Midwives.* The two lying-in hospitals in Colombo now offer facilities for training 185 midwives annually on a one-year course followed by six months' district work in a health unit.

(*c*) *Children's hospital.* During 1950, the Government established with UNICEF aid a 315-bed children's hospital in Colombo costing 1.5 million rupees. This hospital is now fully occupied, providing service for infants and young children as well as a training field in pediatric nursing.

209. UNICEF and WHO have both given assistance in the development of these services. UNICEF has provided supplies and equipment for the new Children's Hospital, the Nurses Training School, the two maternity hospitals, and the Kalutara Health Unit; also for four scholarships for nurses in the field of maternal and child health. WHO contributed the services of four sister-tutors, two in pediatrics and two in midwifery.

210. The supplies and equipment have all been delivered and are in good use. Four nurses returned from a year's fellowship in England at the end of 1952 to appointments closely connected with the teaching activities of this programme. The four WHO sister-tutors arrived in Colombo in April 1951.

211. The pediatrics tutors conduct three-month courses in pediatric nursing for students from the School of Nursing. With their coaching, the under-studies assist in the training of the vernacular pupils. The tutors co-operate with the Red Cross Society in giving lectures on infant and child welfare to groups of school teachers, housewives, and senior school students, and participate in refresher lectures and demonstrations for employed personnel.

212. The midwifery tutors conduct three-month courses in maternity nursing for students from the School of Nursing and participate in the training of pupil midwives in the two lying-in hospitals.

213. In addition, WHO has assisted the Nurses School at Kandy by providing the services of a principal and a pediatrics sister-tutor and some equipment. A WHO sister-tutor also teaches in the Colombo Nursing School.

214. The Government has good reason to feel that the recent development of the health services has been sound, and is now concerned with a consolidation and extension of the existing services. The Government's own efforts, supplemented with outside assistance, have placed 1,800 midwives in the field. A fairly high standard of maternity service has been obtained, and the health authorities state that unqualified and untrained persons have virtually been driven out of midwifery practice. There remains, however, considerable scope for further improvement in the training of personnel. Equipment and supplies are particularly necessary to take full advantage of the services of international personnel.

215. In addition to items necessary for the nurses' and midwives' training centres in hospitals, health units and clinics, a matter of special importance is the provision of up-to-date diagnostic facilities at the 315-bed Children's Hospital in Colombo. To provide adequate medical service, a suitable laboratory must be established.

216. Briefly, the present objectives in extending the health services are:

(*a*) To improve nursing and midwifery training by the provision of teaching and ward demonstration equipment in selected centres for the use of both government and international personnel;

(*b*) To strengthen teaching health units with books and teaching aids, and to improve the service in five units through the provision of certain special equipment;

(*c*) To establish a proper diagnostic department in the UNICEF-assisted Children's Hospital, Colombo.

UNICEF commitments

217. UNICEF will provide teaching aids and ward demonstration equipment, maternal and child welfare equipment and drugs and diet supplements, and equipment for the diagnostic laboratory in the Children's Hospital, at a total cost of $15,000.

WHO commitments and technical approval

218. WHO has at present in Ceylon seven international personnel (three pediatrics sister-tutors, two midwifery, one nursing, and one principal of the Kandy Nurses School). WHO has also provided certain equipment for the Kandy School. Funds for two of the pediatrics sisters have been included in the WHO regular budget for 1953 ($13,000) and 1954 ($22,000). For the rest, WHO has provided in its technical assistance budget for 1953 approximately $86,000, and for 1954 approximately $60,000.

Government commitments

219. The Government of Ceylon will incur expenditure on new buildings, staff salaries, and stipends for the enlarged number of trainees in the institutions benefiting from UNICEF aid. The Government spends about 80 million rupees per year ($US16.5 million)—about one-sixth of its income—on health.

Target time-schedule

220. Since the equipment and supplies are all for existing programmes, delivery will be as soon as possible.

(ii) DRY SKIM MILK

221. In Ceylon, as throughout Asia, the inadequate supply of protein constitutes a serious problem in the health of mothers and children. The Government, therefore, has requested 60,000 lbs. of dry skim milk, which will cost UNICEF $6,000, for distribution through maternal and child welfare centres and maternity and children's hospitals. There are in Ceylon approximately 700 maternal and child welfare centres and over 100 maternity homes with an annual attendance of about 800,000 persons. Under a programme approved in October 1952, UNICEF is already supplying 5 million fish-liver oil capsules and 50 tons of soap for distribution through these channels. The addition of skim milk now will be a most useful supplement to the existing programmes.

CHINA (TAIWAN)

222. The Executive Board approved an apportionment to China (Taiwan) of $65,000 from the Asia area allocation as follows:

(i) *Maternal and child welfare services and training:* for supplies, equipment, and drugs and diet supplements for expanding and improving 50 maternal and child welfare centres in villages and small towns, $30,000;

(ii) *Anti-pre-natal syphilis:* for reimbursement to WHO for specialists during 1953, $27,000;

(iii) *Anti-trachoma:* for reimbursement to WHO for services of a trachoma control expert during 1953, $8,000.

223. The Executive Director was authorized to approve a plan of operations for maternal and child welfare services and training, as outlined in E/ICEF/R.432. Plans of operations for the anti-pre-natal syphilis programme and the anti-trachoma programme are outlined in E/ICEF/212 and E/ICEF/198, respectively. In all three cases, the apportionment represents an extension of UNICEF assistance.

224. With this action, UNICEF aid for programmes in Taiwan totals $339,000 as follows:

	Approved	*Shipped*	
		Through 1952 $	*1953 and after* $
Feeding	November 1950	10,500	—
Anti-tuberculosis (including BCG)	September 1950		
	November 1951		
	April 1952	146,100	6,900
Anti-trachoma	April 1952	600	17,400

	Approved	Shipped Through 1952	Shipped 1953 and after
		$	$
Anti-VD	October 1952		
CMF MH	March 1953	—	55,000
Vaccine production	October 1952	—	15,000
MCW	November 1951		
	October 1952		
	March 1953	28,700	58,800
		185,900	153,100

(i) MATERNAL AND CHILD WELFARE SERVICES AND TRAINING

225. At the time of the first UNICEF assistance in November 1951, the plan of action of the maternal and child welfare programme envisaged the development of a demonstration and training area in the Taichung District. Here an international team has been at work for six months, establishing a unified programme of maternal and child welfare training, both at the provincial hospital and in the surrounding rural maternal and child welfare centres, with ante- and post-natal clinics, infant and toddler clinics, school health sessions, and a domiciliary midwifery service. Trainees include doctors, midwives, nurses, medical students, and student nurses and midwives, who will be selected so as to provide a nucleus of trained personnel at strategic points, and eventually a real maternal and child welfare service in all the health stations and centres of the island.

226. A parallel national team, consisting of a doctor, a nurse, and a nurse-midwife, is being trained to replace the international team upon the withdrawal of the latter from the programme.

227. A Division of Maternal and Child Welfare was established, in August 1952, within the Taiwan Provincial Health Department especially to deal with problems of maternal and child welfare, and the training programme is its direct responsibility.

228. The international personnel arrived in September 1952 and the programme has now been in operation for six months.

229. The Government is looking toward the establishment, throughout the island, of proper maternal and child welfare services in conjunction with existing public health facilities. The objective of the present plan is to expand the scope of fifty selected health stations to include new services specifically for maternal and child welfare.

230. The fifty health stations are situated in villages, small townships, or municipal districts, each with an average population of 15,000 to 20,000. They are staffed and functioning, but without special facilities for maternal and child welfare. The Government is making structural alterations to allow space for maternal and child welfare facilities. Twenty-four of the stations have already been altered, and the rest will be ready by the end of October 1953.

231. One doctor and one nurse or midwife from each of the fifty stations will receive maternal and child welfare training at the Taichung demonstration area (total: 100 trainees). The training will start in August 1953, and the curriculum will be worked out in consultation with the international maternal and child welfare specialist. The period of training will be about three months, and it is estimated that the training of 100 persons will take twelve to eighteen months.

232. After training, these persons will return to their health stations where, in addition to their regular duties, they will conduct two half-day pre-natal and post-natal clinics and two half-day infant welfare clinics each week. In conjunction with these clinics, they will also undertake the general education of the public in maternal and child health and will, in short, develop real programmes of maternal and child welfare in their communities.

233. The Government proposes to establish two teams, each consisting of a senior medical officer and two senior public health nurses, who will make periodic visits to the fifty selected health centres to maintain routine supervision of the work.

234. This plan represents the first step in achieving the declared long-term objective of the Taichung Demonstration Programme and makes good use of the investment that UNICEF and WHO already have in this programme.

UNICEF commitments

235. UNICEF will supply fifty sets of maternal and child welfare equipment for these selected centres, plus one year's supply of drugs and diet supplements for each centre (including milk powder, but excluding fish-oil capsules which have already been supplied) at an estimated cost of $30,000.

WHO commitments and technical approval

236. WHO has three international personnel working in the Taichung training area. For these positions WHO has provided, in its tentative technical assistance budget, the sum of approximately $17,000 in 1953, and $17,000 in 1954. The programme has the technical approval of WHO.

Government commitments

		New Taiwan dollar
(a)	Structural alterations to fifty health stations: Total cost N.T.$4,600,000, of which the Joint Committee on Rural Reconstruction has contributed about N.T.$2,100,000. The Government's share of the expense is:	2,500,000
(b)	Training materials for 100 trainees	20,000
(c)	Lodging and traveling for 100 trainees	60,000
	Non-recurring cost	2,580,000
	(Approx. $US160,000)	
(d)	Allowances, over and above salary, for health station personnel who assume additional maternal and child welfare duties	420,000
(e)	Allowances, over and above salary, for two supervisory maternal and child welfare teams	33,000
(f)	Expendable supplies and equipment, calculated at N.T.$4,000 per centre per year—fifty centres	200,000
(g)	Additional maintenance cost—fifty centres	420,000
	Yearly recurring cost	1,073,000
	(Approx. $US67,000)	

Target time-schedule

237. The first group of trainees is scheduled to start training in August 1953. UNICEF supplies and equipment should start arriving in Taiwan about September 1953, so that the first sets of equipment can be issued in November.

(i) ANTI-PRE-NATAL SYPHILIS

238. The prevalence of syphilis among the general population of Taiwan is estimated at about 5 per cent. An island-wide case-finding drive is being undertaken to obtain for serologic examination as many blood specimens as possible from pregnant women, their marital contacts and children. All positive cases will be given free treatment at hospitals, health centres and health stations throughout the island. Free serologic examination will also be available for the general public, at least during the period of international assistance.

239. UNICEF, under a previous apportionment, is providing supplies and equipment at an estimated cost of $28,000. International personnel, consisting of a venereal disease control specialist and a serologist, are being recruited by WHO. In view of the shortage of technical assistance funds, the Executive Board approved an apportionment of $27,000 to enable UNICEF to finance this personnel during 1953.

(iii) ANTI-TRACHOMA

240. It is estimated that 50 per cent of all school children in Taiwan have trachoma. A campaign to treat 10,000 school children have been initiated as a preliminary step in widespread control of this disease. UNICEF is providing drugs and some equipment, for which $10,000 was apportioned in April 1952. In addition, because of the shortage of technical assistance funds, UNICEF will assume, for 1953, the costs of one trachoma control expert, recruited by WHO, to assist the Government in organizing this project.

INDIA

241. The Executive Board approved an apportionment to India of $846,000 from the Asia area allocation for the following:

(i) *Maternal and child welfare services and training:*

(*a*) $775,000 for supplies, equipment and international personnel to expand maternal and child welfare services and training in the states of West Bengal ($312,000), Bihar ($227,000) and Uttar Pradesh ($236,000).

(*b*) $32,000 for reimbursement to WHO of expenses connected with international project personnel for the maternal and child welfare programme in Hyderabad during 1953.

(ii) *Anti-yaws:* $39,000 for supplies and equipment for a yaws control programme in the states of Madhya Pradesh, Madras and Hyderabad.

242. This represents an expansion of assistance formerly given in the case of maternal and child welfare, whereas no UNICEF aid has previously been given to India for yaws control. The Executive Director was authorized to approve plans of operations as outlined in E/ICEF/R.401 and E/ICEF/R.401/Corr.1 (maternal and child welfare in West Bengal, Bihar and Uttar Pradesh) and E/ICEF/R.418 (anti-yaws). The plan of operations for maternal and child welfare in Hyderabad is outlined in E/ICEF/212.

243. In addition to the above, the Executive Board approved an apportionment of $640,000 from the Emergency Situations allocation for milk and rice to supplement the Government's contribution for relief in recognized famine or disaster areas (see paras. 872-892). With this action, including the approval of emergency assistance, UNICEF aid to India totals $8,618,800, as follows:

	Approved	*Shipped*	
		Through 1952 $	*1953 and after* $
Feeding	Aug. 1949		
	May 1950		
	Feb. 1951	220,500	—
Fellowships	Sept. 1948	64,000	27,000
TB control	June 1950		
	Apr. 1952	269,600	106,300
BCG campaign	Mar. 1949		
	Nov. 1951		
	Apr. 1952	666,900	215,700
Anti-malaria	Sept. 1949		
	Nov. 1951		
	Apr. 1952	605,400	221,600
DDT production	Nov. 1951	—	250,000
Anti-VD	Nov. 1950	63,900	43,100
Penicillin production	Nov. 1950	18,200	831,800
Emergency relief	Nov. 1950		
	May 1951		
	Nov. 1951		
	Apr. 1952		
	Aug./Oct. 1952		
	March 1953	1,146,300	740,100
Polio treatment	Jan. 1950	22,600	—
MCW services and training	June 1950		
	Nov. 1951		
	Oct. 1952		
	Mar. 1953	567,200	2,499,600
Anti-yaws	Mar. 1953	—	39,000
		3,644,600	4,974,200

(i) MATERNAL AND CHILD WELFARE SERVICES AND TRAINING

(*a*) *Maternal and child welfare services and training — West Bengal, Bihar and Uttar Pradesh*

244. UNICEF aid will include teaching equipment for new or expanded training centres; equipment and supplies for children's hospitals and rural maternal and child welfare and maternity centres; milk, drugs and diet supplements for maternal and child welfare centres; stipends for the training of *dais* (village midwives), and simple kits for those who qualify; and a small amount of transport for use by teaching staff and groups of trainees. The West Bengal aid will also include equipment and transport for school health services.

245. UNICEF aid formerly given to India for maternal and child welfare services and training totals $2,261,000, including $930,000 for the Calcutta Training Centre for maternal and child welfare workers.

246. *General situation.* Detailed current vital statistics for the three States to be aided—West Bengal, Bihar and Uttar Pradesh—are not readily available; however, minimum estimates for the entire country show infant mortality rates are high at 150 per 1,000 live births, and maternal mortality is more than twenty times that of North America. The three main contributory causes are: (1) inadequate environmental sanitation, (2) malnutrition and under-nourishment, and (3) inadequacy of medical and preventive health services.

247. The over-all objectives to the Government's plan to raise mother and child health standards are: to reduce preventable deaths among women and children; to improve and extend maternal and child welfare services, particularly in rural areas; to encourage the States in a policy of integrating maternal and child welfare services with their permanent health services; and to organize training of village *dais* and develop methods for effective supervision of their work.

248. The three States, among the major ones in India, have a total population of 128,000,000 (nearly 40 per cent of the country's total population) and occupy an area stretching more than half way across the sub-continent from Calcutta in the east to New Delhi. While the proprosed State programmes differ in certain particulars, they share the common objectives of increasing training facilities for nurses, health visitors, midwives, assistant-midwives and *dais;* of extending health services to mothers and children, particularly in rural areas; and of improving the organization and supervision of these services.

WEST BENGAL

249. West Bengal has an area of 30,775 square miles, and a population of 24,810,308, of whom 80 per cent live in villages, numbering 35,647. The State consists of fifteen districts and forty-four sub-divisions. Each sub-division is divided into a number of *thanas* (population 60,000 to 100,000); each *thana* into unions (population 10,000 to 20,000); and each union into villages. There are a total of 246 *thanas* and 2,080 unions.

250. The State has 1,033 hospitals and dispensaries with a total of 15,525 beds, of which only 1,000 are for mothers and babies. There are hospitals at each district and sub-divisional headquarters, all under state management. The city of Calcutta has five large state hospitals, with a sixth to be established shortly.

251. Local bodies are primarily responsible for public health services and sanitation in their zones. In rural areas District Boards, with grants-in-aid from the state government, maintain a public health unit in each *thana* manned by a public health inspector, a health assistant, a vaccinator, etc. Supervisors are district and sub-divisional health officers belonging to the state cadre. The State also maintains 206 mobile units for curative and preventive work. In the 1952-53 fiscal year the State provided 54,413,370 rupees (14 per cent of the total revenue expenditure) for medical and public health purposes, i.e., about 2 rupees, 3 annas *per caput,* or the equivalent of 26 U.S. cents. The State's plans for improving various maternal and child welfare services are as follows:

252. (1) *Rural maternal and child welfare.* There are twenty-one functioning *thana* health centres, with either fifty or twenty beds each, out-patient services and domiciliary midwifery services. The 118 established union centres have ten beds each, with proportionate provision for out-patient and domiciliary midwifery work. All centres have qualified medical officers serving full time. The plan is to increase the number of *thana* health centres to sixty and union health centres to 228 by 31 March 1954.

253. There are also thirty-eight maternal and child welfare centres operating in the State. Of the existing maternal and child welfare and health centres, seventy will receive equipment and drugs and diet supplements from UNICEF aid approved in October 1952. The present apportionment will provide equipment, supplies, drugs and diet supplements for an additional 256 centres, 107 existing, and 149 to be established during 1953 and early 1954.

254. (2) *School health services.* The State plans, with UNICEF aid, to reinforce existing school health services, thus far limited to Calcutta city and certain major municipal areas, and to establish services in rural areas.

255. In the Calcutta area, the plan is to expand health education programmes, and provide medical attention for school children by using existing personnel and specialized services available in the city. In rural areas, school health services with school clinics in every *thana* and union health centre will be established, with specialized services and health education programmes in *thana* centres.

256. The State has created a number of new posts for health personnel to administer the programme.

257. (3) *Training.* Additional trained health personnel are needed to strengthen existing health services. Health visitors and assistant nurse-midwives are needed for maternal and child care, particularly in outlying areas, and *dais* (village midwives) are urgently needed as auxiliaries in the state midwifery and nursing service.

Health visitors: There are at present only thirty-seven health visitors in state employ. The school training this personnel is to be transferred from Calcutta to Singur (the rural training area of the All India Institute of Hygiene near Calcutta) and the annual output increased from fifteen to thirty. The main buildings for the new school will be ready at the end of 1953. New teaching staff will be required, and it is anticipated that certain international personnel associated with the Calcutta Training Centre will also help with the training of health visitors.

Assistant nurse-midwives: To meet the demand for nursing services now being rapidly extended to rural areas, the State is providing short term (two years) basic training to young women who, on educational grounds, are not eligible for certificated nursing courses. The Government proposes to raise the output of a school for assistant nurse-midwives from fifty to 100 annually and has already provided an additional sixty-six maternity beds in new buildings at a cost of 300,000 rupees ($US63,000) to ensure adequate training facilities. In 1954 the Government will establish

a second school at Jalparguri in North Bengal, where existing buildings will be adapted for the purpose.

Dais: Regular institutional training for *dais* is planned for a continuous period of six months at thirty-eight maternal and child welfare centres in the State. The *dais* will actively associate with the trained midwives operating from these centres in their domiciliary and clinic work.

258. (4) *Maternal and child welfare activities within community project areas.* The State will establish eight "development" blocks in connexion with the Indian/United States programme of community development, each consisting of 100 villages, and with an over-all population of 60,000 to 100,000. Each block is to have a small (ten to twenty beds) hospital, two or three health centres, one or two mobile medical units, anti-malarial units (at two selected centres), and a minor fundamental environmental sanitation scheme. Maternal and child welfare and school health services will be carried out through the health centres, small hospitals and the mobile medical unit. This plan envisages, for the present, the establishment in two of the development blocks of maternal and child welfare clinics, the development of school health services and the organization of mobile medical units. These latter now operate with a medical officer and two assistants who travel, mostly on foot, from village to village treating minor ailments and giving inoculations. In many remote rural areas these mobile units provide the only available medical service. The maternal and child welfare clinic and school health activities in these two development blocks can be covered from the UNICEF apportionment of supplies and equipment approved in October 1952.

UNICEF commitments for West Bengal

UNICEF will provide:	$US
1. Maternal and child welfare equipment for 256 health centres	45,000
2. Drugs for maternal and child welfare work in health centres during 1953 and 1954, based on an average workload of 350 centres for one year	43,500
3. Milk and fish-oil capsules for 1953 and 1954 based on 350 centres for one year	145,000
4. Equipment for maternal and child welfare work in health centres, not included in standard sets of equipment	16,000
5. Equipment for school health services:	
For urban areas—examination equipment	1,000
For rural areas—dental and ophthalmic equipment	18,000
6. Teaching equipment for health visitors school	1,000
7. Teaching and ward equipment for two assistant nurse-midwives schools	2,000
8. Teaching equipment for *dais* training (thirty-eight sets)	4,000
9. Kits for 1,000 trained *dais*	20,000
10. Transport:	
For health visitors school:	
One pick-up van	2,000
Sixty-six ladies bicycles	2,000
For school health services:	
One small car	1,500
For mobile health units:	
Two jeep station wagons	4,500
11. Reimbursement to WHO for international personnel during 1953	6,000
	311,500
	(say $312,000)

WHO commitments and technical approval

259. WHO has given technical approval in principle to the development of this programme.

International project personnel

260. A public health nurse for the health visitors school and a sister-tutor in midwifery for the Burdwan and Jalparguri training centres will be recruited by WHO and, owing to the shortage of technical assistance funds, financed by UNICEF during 1953 at an estimated cost of $6,000 (see "UNICEF commitments", above).

Government commitments

261. The Government's financial commitments to this project over a two-year period are as follows:

	Capital (Rupees)	*Recurring*
1. Establishment of twelve *thana* and thirty-three union health centres by March 1953	6,900,000	2,100,000
2. Establishment of twenty-seven *thana* and seventy-seven union health centres during 1953/54	9,170,000	4,585,000
3. Expansion of school health services	—	52,000
4. New health visitors school:		
Buildings and fittings	1,400,000	—
Additional technical staff, stipends, etc.	—	21,827
5. Assistant nurse-midwives school at Burdwan:		
Residential accommodation for eighty trainees (new buildings)	600,000	—
Accommodation to be requisitioned for 120 trainees; Additional teaching staff and stipends	—	300,000
6. *Dais* training—stipends	—	10,000
7. Maternal and child welfare scheme within two development blocks, to be implemented within three years	260,000	210,000
8. Vehicle maintenance	—	21,012
9. Transportation and administration of UNICEF supplies and equipment	—	5,000
	18,330,000	7,304,839
At 21¢ (U.S.) to 1 rupee	$3,844,330	$1,534,016

Target time-schedule

	Delivery in India
Maternal and child welfare equipment and drugs and diet supplements for 200 health centres	As soon as possible
Teaching equipment for assistant nurse-midwives training schools	July 1953
Transport for mobile health units	As soon as possible

BIHAR

262. Bihar has an area of 70,368 square miles and a population of 40,225,947, 85 per cent of whom live in villages. The State consists of sixteen districts. As India's richest source of coal, iron, bauxite and other valuable minerals, Bihar has great industrial potentialities, but so far the vast bulk of the population depends on agriculture. The *per caput* income is amongst the lowest in India. The annual revenue of the State is about 280 million rupees; current expenditure on public health and medical programmes is about 20 million rupees. This means that the State spends about 8 annas or 10 US cents per person per year on health.

263. As late as 1947 only one medical college existed, which graduated forty physicians annually. (There are now two colleges which take in 160 students annually. Not until 1929 did Bihar have its first maternal and child welfare centre. Efforts towards the systematic training of all other categories of health personnel are also very recent. In rural Bihar the proportion of doctors and midwives to population is roughly 1 :40,000.

264. The medical and public health services of the State have recently been united under the Director of Health Services. At the local level, responsibility for health services is shared by several authorities.

265. The State Government is responsible for fifty-eight hospitals and thirty-four dispensaries. Local bodies maintain 123 hospitals and 336 dispensaries. Maternity cases are admitted to all hospitals. The 370 dispensaries, each manned by a qualified doctor, are the main channels of medical relief for rural areas. Accommodation for child patients is available in some of the local hospitals.

266. On the public health side, maternal and child welfare work is managed by a semi-official body, the Bihar Maternity and Child Welfare Society, established in 1928. Since 1929, thirty-three maternal and child welfare centres have been opened. With few exceptions these centres are in district or sub-divisional headquarter towns, and they are staffed usually with a health visitor and two *dais* or one midwife and *dai*. Trainee-*dais* may also serve the centres.

267. For economic reasons, and because of the shortage of trained personnel, the target of establishing a maternal and child welfare centre in every sub-division has not been achieved. However, with assistance from UNICEF, ten new centres will be opened in 1953 and ten in 1954.

268. UNICEF will also provide supplies and equipment to assist with the expansion of training programmes for various types of health personnel. Plans for expansion are as follows:

269. (1) *Nurse-midwives.* Nineteen nurses are admitted for training at the Patna and Dharbanga College hospitals each year; facilities will be expanded so that, by 1956, 120 trainees can be admitted annually. New maternity sections and accommodations for the trainees will be constructed. Domiciliary services will be developed in connexion with the training scheme and to relieve pressure on the hospitals; existing urban maternal and child welfare centres will also be used for training purposes, and pediatric training will be given the nurse-midwives in the children's wards.

270. (2) *Midwives.* Facilities at the one State Midwifery School at Gaya will be enlarged so that twenty trainees may be admitted annually, instead of the present nine for a two-year course. Two other schools will be developed in 1953 with a total accommodation for forty trainees.

271. (3) *Health visitors.* The number of trainees admitted annually to the Patna Health Visitors School will be increased from four to twelve.

272. (4) *Dais.* The expanded government training programme has a target of 400 new *dais* for the period 1953-1955; six months training will be given at district and sub-divisional headquarters hospitals for groups up to six. At the same hospitals, 1,000 practising *dais* will be given a one-month refresher course. To qualify, all these women must be literate in Hindi.

UNICEF commitments for Bihar

UNICEF will provide the following aid:

		$
1.	For nurse-midwife training schools:	
	Patna	
	Teaching equipment, charts, models, books, etc. / Demonstration ward equipment and labour ward equipment	20,000
	Dharbhanga	
	As for Patna	20,000
2.	For midwifery training schools:	
	Required for one school	
	Teaching equipment, charts, models, books, etc. / Demonstration ward equipment / Labour room equipment	12,000
	120 midwifery bags	4,200
		16,200
	Total for three schools (Gaya, Ranchi and Bettish)	48,600
3.	For Patna health visitors school:	
	Teaching and demonstration equipment and books	4,000
4.	For *dais* training in rural hospitals and maternal and child welfare centres (to train 200 *dais* per annum):	
	Ten sets of models, birth atlases, etc. at $100	1,000
	Stipends for 400 *dais* trainees at 30 rupees a month for six months	15,000
	400 *dais* kits	8,000
	Stipends for 1,000 indigenous trained *dais* attending for one month, at 30 rupees a month	6,250
	1,000 *dais* kits for above	20,000
5.	For children's ward (fifty beds) at Dharbhanga	
	Equipment and supplies	25,000
6.	For maternal and child welfare centres:	
	Equipment for twenty new centres	3,500
	Drugs for ten centres for 2 years and ten additional centres for 1 year	3,300
	Milk and fish oil capsules for same centres	12,420
	Drugs, milk and fish oil capsules for thirty-three existing maternal and child welfare centres for use in 1954	17,292
7.	Transport:	
	For health visitors school trainees and other groups of trainees:	
	One small bus and twelve bicycles	3,100
	For children's hospitals:	
	One jeep ambulance for Dharbhanga	2,300
	One Chevrolet ambulance for Patna	2,800
	For administration of maternal and child welfare programmes:	
	One jeep	1,500

	$
8. Expenses of four international personnel during 1953	12,000
	226,062
Say	227,000

WHO commitments and technical approval

273. The project has the technical approval in principle of WHO.

International project personnel

Owing to the shortage of technical assistance funds, UNICEF will finance the following personnel, recruited by WHO, during 1953 at an estimated cost of $12,000: three nurse-midwife-tutors to serve the Patna Medical College Hospital, the Dharbhanga Medical Hospital, and the midwifery schools at Gaya, Bettish and Ranchi; and one public health nurse educator for the health visitors school at Patna and the Urban Training Field (see "UNICEF commitments", above).

Government commitments

274. The major financial commitments of the Government in connexion with this proposal are summarized below:

	Capital (Rupees)	*Recurring* (Rupees)
1. Nurse-midwife training schools:		
Patna		
Residential accommodation for sixty new trainees	187,465	72,000
New maternity ward	437,694	69,466
Dharbhanga		
Residential accommodation for sixty new trainees	493,850	72,000
New hospital building including children's ward, staff quarters, etc.	1,539,500	129,856
2. Midwifery training schools at Gaya, Ranchi and Bettish	669,400	142,263
3. Health visitors school	—	31,674
4. Twenty new maternal and child welfare centres	30,000	114,000
5. Cost of new post, Assistant Director of Health Services	—	22,000
	3,357,909	653,259
At 21¢ (U.S.) to 1 rupee	$705,161	$137,184

275. The recurring expenditure for which the Government would be liable would cover salaries and allowances for additional local staff, stipends for trainees, common services, replacements of supplies, transport and fuel costs, etc.

Target time-schedule

	Delivery in India
Supplies for nurse-midwife training schools at Patna and Dharbhanga	June 1953
Supplies for the midwifery training school at Gaya	As soon as possible
For two other schools	Before end of 1953
Supplies for health visitors school	About Sept. 1953
Supplies for children's ward at Dharbhanga	July or August 1953
Equipment and supplies for ten maternal and child welfare centres	June 1953
For second ten maternal and child welfare centres	January 1954
Transport:	
For health visitors school	September 1953
For children's hospital, Patna	As soon as possible
For children's hospital, Dharbhanga	September 1953

UTTAR PRADESH

276. Uttar Pradesh has an area of 113,409 square miles and a population of 63,215,742, 86 per cent of whom live in the State's 111,722 villages. The fifty-one districts in the State have a population of over one million, and are sub-divided into *tehsils*, each with about one-quarter of a million. Agriculture is the livelihood of more than 70 per cent of the people, and a subsidiary source to a further 8 per cent. Wages of village labourers range from a rupee to a rupee and a half per day according to the season. The capital, Lucknow, has 550,000 people. Other large towns are Agra, Allababad, Benares, and Kanpur. Out of the State's 615.1 million rupees budget for the 1951-52 fiscal year, health took 20.8 million rupees ($US4,368,000, or on a *per caput* basis 5 annas or US 7¢). Four million rupees were provided for the relief and rehabilitation of displaced persons (475,000 people).

277. The State's Medical and Health Departments are under the unified control of the Director of Medical and Health Services. Single control of medical and public health work in the districts is contemplated. Of 120 municipalities, fifty-one have full-time medical officers. Fourteen municipalities also have full-time school health officers.

278. There are two medical colleges, one at Lucknow and one at Agra, which admit 125 and seventy-five students respectively each year. Twenty places at each college are reserved for women. Facilities in State medical institutions for other training of women health personnel are as follows: for nurses, 524 places; for health visitors, ten places; for midwives, forty places; for *dais*, 500 places.

279. Each district headquarters has a male and female hospital under a "civil surgeon", who also controls between fifteen and twenty general dispensaries in his district. These hospitals and dispensaries have a total of 12,000 beds.

280. The Government maintains in each district the following organization:

(1) One district medical officer for public health;
(2) One (or more) epidemic medical officer;
(3) One assistant medical officer;
(4) One (or more) epidemic assistant.

281. Each sub-district (*tehsil*) has a sanitary inspector with a labour force for essential public health and epidemic work. Malaria and kala-azar units are stationed where these diseases are hyperendemic. In addition to a sanitary inspector, each *tehsil* has an assistant superintendent of vaccination and vaccinators.

282. An Assistant Director of Medical and Health Services supervises maternal and child welfare services. At Lucknow is the State's only health visitors school, where ten health visitors and twenty-five midwives are trained each year. All are paid stipends and are required to serve the Government for at least three years after qualifying. In the rural areas there are 229 maternity centres under Government auspices, each of which is expected to be able to train up to five *dais* annually. During the current fiscal year (1952-53) ten new rural maternity centres will be established. In urban areas there are thirteen maternal and child

welfare centres, making a total of 252 for the State. Generally, these centres are staffed by a midwife, a *dai*, and a caretaker.

283. The Government is active in training *dais* in both urban and rural centres. In municipal areas, by-laws permit only trained *dais* to practise; in Lucknow for instance there are 134. The Government is endeavouring to extend similar control to rural areas, though complete control is still impossible. However, the health authorities are keen to train all *dais* that can be brought forward for instruction.

284. In consultation with representatives of WHO, UNICEF, and the National Government, the Government of Uttar Pradesh has put forward a plan for development of its maternal and child welfare services. The programme, planned on a three-year basis, envisages, with the aid of UNICEF:

(1) The establishment of 200 new maternal and child welfare centres;

(2) The expansion of facilities for the training of health visitors, midwifes and *dais*;

(3) The construction of hospital wards for children at Lucknow and Agra to be used for training medical graduates and nurses in pediatrics;

(4) The strengthening of preventive health services in rural areas and arrangements for improved supervision.

Details are as follows:

(1) *Maternal and child welfare centres.* Most of the 239 existing rural maternity centres are staffed by a midwife only, who either supervises the local practising *dais*, or conducts home deliveries herself. Few other maternal and child care services exist. The situation is better where midwives are stationed near rural dispensaries so that physicians can supervise their work and attend abnormal cases.

The Government proposes to establish 200 new centres during the next three years, staffed with midwives, but so located as to make use of the dispensary medical officers or of health visitors in State employ.

The schedule follows: 1953-54, sixty-six centres; 1954-55, sixty-seven centres; 1955-56, sixty-seven centres.

(2) *Health visitors.* In 1953 the school for health visitors at Lucknow, which now trains ten health visitors and twenty-five midwives per annum, will be converted into a school for health visitors only, with an annual output of twenty. A sub-centre will be established in Lucknow as a special training field.

(3) *Midwives.* Good facilities exist for the training of midwives at maternity homes situated at Lucknow, Kanpur and Benares. The Government proposes to train about twenty midwives yearly at each of these centres, resulting in an increase of fifty-five midwives each year over the present output of forty.

(4) *Children's hospital and pediatric unit.* The State has no children's hospital as such, or suitable facilities for teaching pediatrics, and consequently plans to build a fifty-bed children's hospital at Lucknow and to add a fifty-bed children's unit to the Lady Lyall Dufferin Hospital at Agra.

(5) *Training of rural dais.* The Government proposes to train five *dais* at each of the new maternal and child welfare centres. The training will take nine months, during which the trained midwife will give simple talks and each *dai* will attend at least twenty deliveries conducted by the midwife. During the training period the *dais* will receive stipends and, at the end of the course, simple midwifery kits. Unlike the training scheme for *dais* in Bihar, the trainees will be living in their own homes in the neighbourhood of the centre and the stipends are to help cover transportation and other costs, rather than maintenance costs as in Bihar.

The Government will provide replacement supplies for the kits through the centres at which the *dais* are trained, thus maintaining contact between the centre and the field work conducted by *dais* in the area.

(6) *Rural maternal and child welfare demonstration area.* The Government operates a rural health unit at Pratapgarh, 100 miles from Lucknow, which provides field training for sanitary inspectors, health visitors and midwives. Four health visitors and eight midwives are already attached to the unit, which has an annual budget of 39,100 rupees. To improve the training field in this area, four maternal and child welfare centres will be added, at which pre-natal, post-natal and well-baby clinics will be held. These will be supervised by health visitors.

UNICEF commitments for Uttar Pradesh

UNICEF will provide the following aid:

		$US
1.	Equipment for 200 new maternal and child welfare centres ("B" grade)	8,000
2.	Drugs and diet supplements for: Sixty-six centres for 3 years Sixty-seven centres for 2 years Sixty-seven centres for 1 year	98,000
3.	Teaching equipment, visual aids and models, books and bicycles for health visitors schools	3,000
4.	Teaching equipment, charts and models for four midwifery training centres	6,000
5.	Equipment and supplies for two children's hospitals	35,000
6.	*Dais* kits (1,000) and training equipment	20,000
7.	Stipends for *dais*	40,000
8.	Teaching equipment for health units	1,000
9.	Transport (thirteen vehicles) Ten vehicles—one for each of ten selected districts for the use of public health officers and health visitors associated with the development of new MCW centres One vehicle—for service within the Pratapgarh Health Unit One vehicle—for the use of the Health Visitors School, Lucknow One vehicle—for the use of the international staff member and understudy in the office of the Assistant Director, Health Services (MCH).	19,000
10.	Expenses of two public health nurses during 1953	6,000
		236,000

WHO commitments and technical approval

The project has WHO's technical approval in principle.

International project personnel

285. Two public health nurses will be recruited by WHO for this project and, owing to the shortage of technical assistance funds, financed by UNICEF during 1953, at a cost of $6,000. One of them will serve as adviser to the Assistant Director of Health Services and the other will assist in the health visitors training programme (see "UNICEF commitments", above).

Government commitments

286. The estimated total expenditure of the Government in respect to this programme during the next three years is summarized as follows:

	Capital	*Recurring*
	(Rupees)	
1. Establishment of 200 new maternal and child welfare centres.	100,000	1,233,900
2. Expansion of Health Visitors School, Lucknow	—	27,200
3. Establishment of four training centres for midwives and assistant midwives	20,000	198,600
4. Establishment of two children's hospitals	702,600	138,600
5. Appointment of one health visitor to each of fifty-one districts for supervising training schemes for *dais* and for providing replacements of expendable supplies for *dais'* kits:		
1953-54	—	59,000
1954-55	—	104,300
1955-56	—	149,600
6. Development of maternal and child health sector of Pratapgarh Health Unit	—	12,300
7. Maintenance and operation of vehicles	—	135,000
	822,600 ($US164,000)	2,058,500 ($US412,000)

Target time-schedule

	Delivery in India
Drugs and diet supplements for sixty-six centres	1 July 1953
Equipment for sixty-six centres	1 July 1953
Balance of drugs and diet supplements and equipment	As called forward
Teaching equipment for health visitors, midwifery schools and Pratapgarh unit	As soon as possible
Equipment for children's hospitals	1 January 1954
Six vehicles	1 July 1953
Three vehicles	1 January 1954
Four vehicles	1 July 1954

(b) Maternal and child welfare services and training—Hyderabad

287. The State of Hyderabad is making special efforts to extend maternal and child welfare services in rural areas, through expansion of training facilities for health personnel, development of home midwifery services and establishment of district health units. Under a previous apportionment, UNICEF is providing maternal and child welfare and teaching equipment, midwifery kits, drugs, diet supplements, milk, fish-liver oil capsules, soap, hospital equipment and transport. UNICEF will now assume for 1953 the costs of various international personnel recruited by WHO, but whom WHO is unable to finance because of limited technical assistance funds. The amount involved is $32,000, and the personnel are: one pediatrician, one public health nurse with midwifery experience, one pediatric nurse, one midwifery sister-tutor, and one public health nurse-instructor.

(ii) ANTI-YAWS

288. Yaws is particularly endemic in an area falling within four States in Central India: Madhya Pradesh, Madras, Hyderabad and Orissa. The population concerned is perhaps two million. The affected area is undeveloped, lacks means of communication, and is inhabited mainly by aboriginal tribes (Marias and Gonds) who live chiefly from primitive agriculture and hunting. They are almost 100 per cent illiterate. Their standards of hygiene are extremely low—the use of soap is practically unknown. Medical services are few, and the people are prey to malaria, leprosy, yaws, and the skin and other ailments inseparable from their mode of life.

289. While reliable statistics of the incidence of yaws are not available, it was estimated by the Directors of Public Health of the three States, in November 1951, that the incidence in the affected areas was 15 per cent for Madhya Pradesh, 30 per cent for Madras, and 3 per cent for Hyderabad. (The figure for Hyderabad is known to be too low, as it resulted only from a small survey carried out in the fringe areas.) In Madhya Pradesh, where information is more complete, it is further estimated that 40 per cent of the infectious cases found occur in children under 15 years of age, and 80 per cent in the group under 25 years of age. Adding to the difficulty of collecting statistics is the fact that the people are reluctant to admit to a history of yaws because the disease is considered "shameful".

290. During the last 15 years the State Governments concerned have made efforts at treating yaws. In 1951, Madhya Pradesh, with help from the Central Government, started an intensive campaign in the Chandra district. This campaign involved starting a system of education, area survey, treatment and record. Results were encouraging, but the work ceased in 1945 with the withdrawal of Central Government support. In other States mobile units, consisting of a medical officer and an assistant touring on foot or by bullock-cart, were employed. Government dispensaries in these States have all along been treating yaws cases. Treatment has been with arsenicals.

291. Under the Five-Year Plan the Government of India has made provision of approximately 1.4 rupees per head per year for the welfare of backward classes (which covers scheduled castes numbering 50 million and scheduled tribes 18 million). Assistance for yaws control had been under discussion for some time between the Government, UNICEF and WHO, when, in November 1952, a pilot project was initiated in Madhya Pradesh with WHO assistance. The project is covering three districts with a population of about 400,000. Two teams, each of eight persons supervised

by a medical officer, conduct village-by-village surveys, examining the people and treating all cases found. Other personnel are being trained and various facilities are being made available for yaws work. A control area will be established for operational research.

292. Findings to date indicate that the incidence of yaws in the tribal area is comparable to the worst areas of Indonesia or Thailand, and that, with international help and local government co-operation, a successful mass campaign is possible, with about 400,000 examinations in the first year.

293. The population live in villages varying in size from five to seventy huts, each hut accommodating a family of from five to ten people. The distances between villages vary from two to fifteen miles. Road conditions are reasonably good in the dry season, but in the rainy season (July to October) only foot travel is possible in most parts of the country, and whole areas are isolated from each other by impassable floods. Each village is ruled by a headman who maintains order, reports epidemics and registers births and deaths. The last census was taken in 1951 and the village registers are accessible.

294. Headquarters of the yaws campaign have been established at Ahiri. Two teams are in the field. The Government has appointed a counterpart for the international team leader, two medical officers, two sanitary inspectors, two health assistants, three drivers, and subordinate help. Auxiliary personnel to make up the full teams are being trained.

295. Before starting activities in a given area the purpose of the campaign is explained to the headmen of the villages. The showing of "before and after treatment" photographs has proved the most convincing approach. Once assured of the value of the campaign, the headmen are able to get the full co-operation of the villagers. On an appointed day the headman instructs his people to stay in the village, and the team examines each family, treating on the same day all cases found and family contacts of infectious cases. The one-shot method of treatment is used.

296. In the dry season, as each team moves into a new area, it will set up a sub-headquarters. Each team will work out of its camp in two sections, each consisting of four members, until the area is covered. On the basis of preliminary experience it is estimated that two teams will survey about 16,000 persons a month.

297. From 22 November up to 30 December 1952, nearly 7,300 people were examined. An average incidence of 7.5 per cent was found, the highest in any one village being 27 per cent, and the lowest 1.2 per cent. Thus far the teams had been working only in "fringe" areas. On going deeper into the aboriginal tracts the incidence was found to increase steadily.

298. WHO is supplying certain field laboratory equipment, and the government laboratory at Nagpur will be used for serological testing.

299. The objective is now to conduct a yaws control programme in the three States along the lines of the pilot project in Madhya Pradesh.

300. The areas in which operations are scheduled, and the population affected by yaws within these areas, are:

Province	*Population affected*
Madhya Pradesh	800,000
Madras	500,000
Hyderabad	Total population 1.6 million. Yaws-affected population not determined.

301. With a working year of eight months (dry season) a total coverage of 128,000 persons will be achieved during the first year in each State. It is estimated that approximately 32,000 of these will require treatment. During the four months of the wet season, the teams will split up and carry out follow-up and re-survey examinations and treatments.

302. The Governments of Madras and Hyderabad will participate in the field training scheme which has been initiated, and will be further developed at the yaws programme headquarters, Ahiri, Madhya Pradesh.

UNICEF commitments

303. The following supplies and equipment will be provided by UNICEF:

	Vials	*$US*
(1) Vehicles for each State:		
Four jeeps—one for each team section		
Two trailers—one for each team, to transport supplies to sub-headquarters		19,350
(2) Penicillin		
For Madhya Pradesh	15,000	
For Madras	10,000	
For Hyderabad	10,000	
	35,000	15,000
(3) Equipment		
Four sets of field team equipment for each State —total twelve sets		1,800
(4) Office and record equipment		
One set for each State—total three sets		300
(5) Soap		
A supply (10,000 lbs.) for issue to infectious cases		800
(6) Contingencies		1,750
		39,000

WHO commitments and technical approval

304. WHO is providing the services of an international adviser on yaws control who will work in all three provinces, as well as laboratory equipment for field use, at a cost of approximately $14,000 for 1953. The plan has the technical approval of WHO.

Government commitments

305. The Government of Madhya Pradesh has already started a yaws programme, and its commitments in the first year total 63,000 rupees ($US12,600). The Government of Madras will provide personnel, accommodation and transport maintenance during the first year, at a cost in excess of 80,000 rupees ($US16,000). During the first year the Government of Hyderabad will provide funds to the extent of 71,000 rupees minimum ($US14,200) for similar expenses. In addition, the Governments will supply penicillin for the treatment of yaws to their dispensaries (about forty) in the yaws areas.

Target time-schedule

306. The request for UNICEF assistance covers the first year of operations. Delivery of all supplies and equipment will be made as soon as possible.

INDONESIA

307. The Executive Board approved an apportionment to Indonesia of $503,000 from the Asia area allocation for the following:

(i) *Anti-yaws:* $450,000 for additional penicillin, supplies and transport for the yaws-control programme;

(ii) *Maternal and child welfare services:* $40,000 to provide 400,000 lbs. of dried milk for distribution through maternal and child welfare centres.

(iii) *BCG anti-tuberculosis vaccination campaign:* $13,000 for reimbursement to WHO of expenses for 1953 connected with an international BCG consultant.

308. The Executive Director was authorized to approve plans of operations as outlined in E/ICEF/R.424 (anti-yaws) and E/ICEF/R.450/Rev.1 (maternal and child welfare, milk feeding). The plan of operations for the BCG anti-tuberculosis vaccination campaign is outlined in E/ICEF/184/Rev.1. In all three cases, these apportionments represent further aid to projects already receiving UNICEF assistance.

309. With this action, UNICEF aid to Indonesia totals $2,874,500 as follows:

	Approved	*Shipped*	
		Through 1952	*1953 and after*
		$	$
Feeding	Sept. 1949	288,400	—
	June 1950		
BCG pilot project ...	Nov. 1951		
	Mar. 1953	9,700	25,300
MCW	Nov. 1950		
	Oct. 1952		
	Mar. 1953	544,500	322,000
Fellowships	Sept. 1948	22,500	11,500
Anti-yaws	May 1950		
	June 1950		
	Mar. 1953	855,200	795,400
		1,720,300	1,154,200

(i) ANTI-YAWS

310. With UNICEF and WHO assistance, the Indonesian Government is conducting one of the largest yaws control projects in the world in the face of considerable difficulties. The work has been possible only because of careful and exact planning.

311. The programme started in May 1950 in the Jogjakarta area. By the end of 1952, the campaign had been extended to areas with a total population of nearly 9 million. Campaign personnel numbered 420, including twenty-two medical officers and 173 para-medical personnel. The employment of such personnel in this project has been stretched to the maximum extent possible.

312. By 1 March, 1953, more than 3,500,000 people had been examined and about 600,000 cases found and treated, of which more than two-thirds were among women and children. An estimated 72 million people remain to be examined, among whom 7 million cases are expected to require treatment. UNICEF will provide penicillin to treat an additional 1,600,000 cases, of whom at least 1,000,000 can be treated in 1953 and 1954 through the organization proposed below.

313. Starting in April 1951, a re-survey, including follow-up study of all cases in the Jogjakarta area, was undertaken to check the efficacy of the methods used. A total of 358,316 people were examined or re-examined, including new-born children and newly settled families. 6.4 per cent (22,778) new cases were found among the total number examined and re-examined. The average incidence found by the mass campaign was 16.2 per cent. Patients who had received treatment during the campaign (53,568) were followed up, with the following results:

86.4 per cent (46,269) of the cases previously treated had been cured;

13.6 per cent (7,317) of the cases previously treated showed relapses or re-infections (mostly the latter, it is thought) and were re-treated.

314. In the three years since this programme was started, technical advances in the production of penicillin have reduced the price and improved the quality. On the advice of the WHO Expert Committee, the dosage is being somewhat reduced and the number of treatments reduced from two injections to one. The amount of field work is thus cut in half and the treatment of new patients speeded up. On the other hand, the importance has been stressed of treating contacts of infectious cases for latent yaws and of repeated follow-up to treat new infectious cases.

Thus it has developed that:

(*a*) With a given amount of penicillin, many more cases can be treated than was foreseen three years ago;

(*b*) The faster the work goes, the less the whole job will cost, because cures are being effected more rapidly and there will be fewer cases to treat.

315. The problems facing yaws control in Indonesia are more administrative than medical. Indonesia has a population of 75 million. There are 1,400 doctors and 5,500 *mantris* (trained nurse apothecaries). Of these, 742 doctors and 5,006 *mantris* are in the service of the Government.

316. To minimize the shortage of personnel, a simplified yaws control method has been devised which, while adhering to proper medical standards, will permit further expansion of the campaign, making maximum use of the 1,250 polyclinics existing in Indonesia. The revised plans are as follows:

(*a*) Continuation of twenty mass campaign teams;

(*b*) Establishment of localized campaigns, using personnel already employed in polyclinics;

(*c*) Distribution of penicillin to polyclinics for yaws patients who come in for treatment.

317. In areas where it is suitable, the present mass treatment teams will continue as in the past. These teams consist of five *mantris* and field clerks supervised by a senior *mantri*. In addition, area physicians are employed. With the activation of local campaigns, the number of mass campaign teams will be reduced from thirty to twenty. Ten teams will be disbanded,

freeing the *mantris* for supervisory duties in the local campaigns. The twenty remaining teams will be sufficient for essential control activities, conducting training, and carrying out operations in areas where local campaigns are not suitable. These teams will treat approximately 1000 cases a month each, or 240,000 cases a year. The local campaign method envisages the use of the *mantris* in charge of existing polyclinics, each aided by an assistant. The assistants will be full-time workers, but the *mantri's* duties will be in addition to his regular work. The principles of the local campaigns are the same as those of mass treatment teams, except for being simplified in personnel and administration. The localized campaign will be carried out as follows:

(*a*) The *mantri* and his assistant will be given special training which will last six weeks for the *mantri* and three months for the assistant.

(*b*) After training, the assistant will examine the entire population of the sub-district in which his polyclinic is situated (up to 30,000 people). This will mean a systematic person-by-person, household-by-household, and village-by-village survey, which is possible in Indonesia, where everyone in a village can be assembled in a matter of minutes when the appropriate signal is beaten on the headman's gong.

(*c*) On one day each week, all yaws cases found by the assistant will be assembled for treatment by the polyclinic *mantri*, who will also supervise recording and reporting, and from time to time check the examination methods of the assistant.

(*d*) The work of the *mantri* and his assistant will be supervised by the regency doctor. In regencies where several local campaigns are in progress, a capable senior *mantri*, experienced in yaws control, will be appointed as the doctor's assistant.

(*e*) Re-survey will be a repetition of the above procedure, combined with follow-up of those already treated.

318. Local campaigns have already been used to a considerable extent in Indonesia and have proved economical both in money and in personnel. The personnel concerned are already employed by the Government, but will receive an extra allowance for yaws control work. Both the *mantri* and the assistant need only bicycle transport, but motor transport is needed for regency doctors and/or supervising *mantris* who must cover large areas quickly.

319. The local campaign method has the highly desirable effect of immediately integrating yaws control work as part of the permanent health services. Only by repeatedly combing through the population of the more endemic areas can control be achieved. The Director of the treponematosis control programme in Indonesia estimates that about 500 cases a month can be treated in local campaigns.

320. Most of the 1,250 polyclinics have been treating yaws with arsenicals for years. Special clinic days for the treatment are held, particularly in rural areas with high prevalence. Since treatment with arsenicals is now outmoded, it is proposed to issue repository penicillin to selected polyclinics not yet ready for the local campaign where there is assurance of (*a*) adequate supervision by regency health officers and/or supervising *mantris;* (*b*) compliance with the technical aspects and principles of the treponematosis control programme; and (*c*) use of penicillin for its proper purpose. The number of polyclinics expected to qualify by the end of 1954 is 250.

UNICEF commitments

321. UNICEF will supply the following:

		$
(*a*)	Procaine penicillin G in oil, 840,000 vials (10 cc)	362,000
(*b*)	Sterilizers, syringes, needles, etc.	23,000
(*c*)	Laboratory equipment and supplies, including antigens	5,000
(*d*)	Transport: Ten jeeps with spare tires, for supervisors in large areas. $15,000	
	Four hundred bicycles.... 13,000	28,000
(*e*)	Reserve (a reserve is necessary in case the campaign expands very rapidly and for other unforeseen requirements)	32,000
		450,000

WHO commitments and technical approval

322. The proposed expansion of this programme has the technical approval of WHO, the plan having been worked out by the Government in close collaboration with the WHO Area Representative in Indonesia, who was formerly Venereal Disease Adviser to WHO's Southeast Asia Regional Office.

International project personnel

323. WHO will recruit international personnel as follows: a laboratory adviser, a statistician, a venereologist, and a serologist. The total cost for 1953 is estimated at $20,000, which will be borne by technical assistance funds.

Government commitments

324. The Government of Indonesia undertakes the following:

(*a*) To provide one-third of the penicillin required during the two years from 1 September 1953 to 30 August 1955.

(*b*) To provide the necessary personnel, including *mantris* to serve as supervisors (assisting regency medical officers), assistants for *mantris* in polyclinics, junior *montris* to replace experienced *mantris* who may be transferred from treponematosis control programme teams, and drivers. These persons are in addition to all personnel already employed in the yaws control campaign.

(*c*) The training of regency medical officers, senior polyclinic *mantris*, and polyclinic assistants prior to initiation of local campaigns; training of eight laboratory technicians; transport of personnel.

(*d*) Maintenance of vehicles.

(*e*) Allowances to medical officers and assistants.

(*f*) Replacement of worn-out equipment and purchase of additional equipment at Jogjakarta for laboratory work, training, and administration.

325. The estimated cost to the Government for operations during the two-year period covered by the extended plan is 9,000,000 rupiahs (approximately $US800,000) plus the Government's share of penicillin.

(ii) MATERNAL AND CHILD WELFARE SERVICES AND TRAINING (MILK)

326. The expansion of maternal and child welfare services has revealed widespread malnutrition in Indonesia, mainly attributable to poverty. Deficiency diseases, intestinal parasitic infections and skin infections resulting from malnutrition are common. Nutrition education is being undertaken by the maternal and child welfare centres, since ignorance on this subject is also a contributing factor to malnutrition. Milk and milk products are relatively unknown among the poorer population, and calcium deficiencies are widespread among infants and pregnant women. UNICEF milk has been a major inducement to mothers to bring their children to maternal and child welfare centres where, in addition to milk, they receive medical attention they would not otherwise have sought.

327. In October 1952, the Board approved the provision of milk for distribution through 400 maternal and child welfare centres. UNICEF milk had, in the past, been distributed through maternal and child welfare centres and also through schools, hospitals, and child-care institutions. At present, over 500 maternal and child welfare centres are receiving UNICEF milk, and the present apportionment will permit this number to be increased substantially. Milk will be made available to all centres which are well organized and adequately staffed.

UNICEF commitments

328. UNICEF will supply 400,000 lbs. of dried skim milk at a total cost of $40,000.

Government commitments

329. The Government will provide all funds necessary to receive, warehouse, and distribute this milk.

(iii) BCG ANTI-TUBERCULOSIS VACCINATION CAMPAIGN

330. The BCG campaign in Indonesia is a pilot project which started in 1952 with the object of testing 180,000 persons during the first year. To accomplish this, at least three local teams are being trained in the first year, and an international BCG consultant, recruited by WHO, will assist in organizing the campaign and training the local personnel. Under an earlier apportionment, UNICEF is providing supplies, equipment, and transport. The present apportionment of $13,000 is to reimburse WHO for expenses connected with the BCG consultant during 1953.

JAPAN

MATERNAL AND CHILD WELFARE SERVICES AND TRAINING (HANDICAPPED CHILDREN)

331. The Executive Board approved an apportionment to Japan of $10,000 from the Asia area allocation for the purchase of equipment and supplies for a rehabilitation centre for handicapped children. The centre will also serve as the main training centre in this field for doctors, nurses, and physiotherapists. The Executive Director was authorized to approve a plan of operations as outlined in E/ICEF/R.433. This constitutes the first UNICEF assistance to Japan for handicapped children. The cost of the equipment and supplies to be provided by UNICEF totals $17,000; the remaining $7,000 is available as a result of final cost records from earlier apportionments made for feeding and clothing programmes which are now completed.

332. In Japan, considerable emphasis is now being placed on children's programmes in general and on programmes for handicapped children in particular. A recently created Children's Bureau in the Ministry of Health has equal administrative status with the other Bureaus. Work for handicapped children is conducted under this Bureau and has been continuously expanded since 1949.

333. Since long before the war, the Japanese Society for Crippled Children has been conducting a campaign against the traditional attitude that crippled children are a punishment and disgrace to the family and therefore should be hidden and not given medical treatment. As a result, there has come about a gradual change in public opinion which has been given further impetus by the activities of the Children's Bureau. Cases brought to any one of the 700 health centres scattered throughout the country are transferred to one of the six new clinics (four more are under construction) for crippled children, situated strategically around the country. Special cases in these centres are transferred to the central hospital for crippled children referred to below.

334. Of Japan's child population (up to 19 years) of 36.3 millions, the Vice-Minister of Health and Welfare estimates that at least 400,000 are physically handicapped.

335. A national crippled children's hospital (Sheishi Ryogei En) is in operation at Itashashiku, Tokyo, and will serve primarily as the centre for education and demonstration of techniques. It is here that most of the UNICEF supplies and equipment will be used. It is planned to expand this hospital to a 200-bed unit. A 100-bed unit for ambulatory cases was completed in the spring of 1953. WHO is selecting five fellows who, after training, will be assigned to this hospital. Crippled children's homes and hospitals are being established at nine other centres throughout the country, varying in size from 30-200 beds. Five are in operation now. The present practice is to admit children who require care for three months or more and to provide both surgical and rehabilitation treatment. Treatment for cases which require less than three months' hospitalization is provided in one of the general hospitals without financial assistance from Government funds. The problem of inadequate out-patient service tends to lengthen the hospital stay.

336. Consideration is being given to the ways and means of developing community resources that will provide out-patient care and education for physically handicapped children not in institutions. In at least one local area, the school department is prepared to offer special education facilities, and there has been for some years a special school in Tokyo financed by the Bureau of Education for physically handicapped children.

337. There is a great deal of isolated community interest in the work, which is slowly being crystallized both by the activities of the Japanese Society for Crippled Children and by the official agencies.

338. The programme is limited to "orthopedically handicapped" children or those with major physical mal-functions who are under the age of eighteen. The objectives are to develop the central children's hospital as a centre for education and demonstration of techniques, and to further develop services to provide early recognition, diagnosis, and treatment of poliomyelitis; protection against all preventable crippling arising from bone and joint diseases, tuberculosis, etc.; development of social, educational and vocational services; training of professional and auxiliary personnel; and organization of related medical and social services, including health education, for the public.

UNICEF commitments

339. UNICEF will provide specialized hospital and orthopedic equipment costing $17,000 for the central children's hospital.

Other international participation

340. WHO has given the project its technical approval and has provided in its regular budget a sum of approximately $30,000 for:

International personnel: one expert on the rehabilitation of crippled children; one orthopedic surgeon; one orthopedic nurse; one physiotherapist.

Short-term fellowships for study in the following fields: special nursing care of poliomyelitis cases; orthopedic nursing; child psychiatry; physiotherapy; occupational therapy.

341. This project has also been reviewed and approved by the United Nations Department of Social Affairs.

Government commitments

342. The Government will provide all personnel, materials, supplies and equipment necessary for the project except those provided by UNICEF. The Ministry of Health and Welfare has requested a budget for 1953 for this purpose of 815,091,000 yen ($US2,264,000) and undertakes to continue the expansion of services. It is understood that, from this amount, the Government will itself provide the equipment needed for a brace shop and for occupational therapy.

Target time-schedule

343. The first WHO consultant has been to Japan and returned. The proposed date of arrival of other consultants is July or August 1953. UNICEF will attempt to deliver its supplies and equipment after trained personnel have returned to Japan. Training courses, with participation by international personnel, will start in the autumn of 1953.

Total UNICEF aid

344. With this action, UNICEF aid to Japan totals $579,700, as follows:

	Approved	Shipped: Through 1952	Shipped: 1953 and after
		$	$
Feeding	July 1949 Nov. 1950	268,100	—
Leather and textiles	June 1950 Nov. 1950	294,600	—
MCW (handicapped children)	Mar. 1953	—	17,000
		562,700	17,000

PAKISTAN

345. The Executive Board approved an apportionment to Pakistan of $93,000 from the Asia area allocation for the following:

(i) *Maternal and child welfare services and training:*

(*a*) $23,000 for equipment, appliances and drugs and diet supplements for the establishment of a school health service in twenty provincial centres, as a part of general maternal and child welfare services;

(*b*) $16,000 for reimbursement to WHO for expenses during 1953 of international personnel for the midwifery training programme in Karachi;

(*c*) $11,000 for reimbursement to WHO for expenses during 1953 of international personnel for the Children's Hospital Training Centre in Karachi.

(ii) *BCG anti-tuberculosis vaccination campaign:* $23,000 for supplies and equipment to extend and continue the campaign.

(iii) *Vaccine production:* $20,000 for equipment and supplies for the production of anti-diphtheria vaccine and serum.

346. The Executive Director was authorized to approve plans of operations as outlined in E/ICEF/R.409 (school health), E/ICEF/R.437, E/ICEF/R.437/Corr.1 (BCG vaccination) and E/ICEF/R.430 (vaccine production). Plans of operations for maternal and child welfare services and training, Karachi, and the Children's Hospital in Karachi, are outlined in E/ICEF/159 and E/ICEF/212 respectively. UNICEF has previously assisted programmes for maternal and child welfare and BCG anti-tuberculosis vaccination, but has not previously aided a vaccine production programme.

347. In addition, the Executive Board approved an apportionment of $100,000 from the "Emergency Situations" allocation for dried skim milk, primarily for relief of refugees (see para. 893-895).

348. With this action, including the emergency assistance, UNICEF aid to Pakistan totals $2,679,700 as follows:

	Approved	Shipped: Through 1952	Shipped: 1953 and after
		$	$
Feeding	Feb. 1949, May 1950 May 1951, Mar. 1953	208,900	2,000
TB control centres	June 1950 (Karachi) Nov. 1950 (Dacca)	158,600	92,000
BCG campaign	July 1948, Nov. 1951 Apr. 1952, Mar. 1953	296,600	106,300
Anti-malaria	Sept. 1949, Feb. 1951 Nov. 1951	454,900	115,500
DDT production	May 1951	—	250,000
Anti-kala-azar	Nov. 1951, Apr. 1952	14,500	37,500
Emergency aid	Nov. 1950 (Punjab) Nov. 1951	80,800	—
MCW	Sept. 1948, June 1950 Nov. 1950, May 1951 Apr. 1952, Oct. 1952 Mar. 1953	277,000	448,100
Emergency feeding	Mar. 1953	—	100,000
Vaccine production	Mar. 1953	—	20,000
Under discussion		—	17,000
		1,491,300	1,188,400

(i) MATERNAL AND CHILD WELFARE SERVICES AND TRAINING

349. (*a*) *School health services.* Although the Pakistan health authorities have not yet been able to establish a school health service on a national basis, they realize that very good results have been achieved in the comparatively small areas where school health services exist. More than 50 per cent of the school children in Pakistan are affected by one or more of the following ailments: worms, dysentery, malaria, skin infections, eye, ear and teeth defects, anaemia, and other deficiency diseases. Malnutrition is widespread, affecting more than 70 per cent of the children in the less fertile areas.

350. The Government has now approved 63,400 rupees to provide school health services in all secondary schools in Karachi, and a few provincial governments also run school health units.

351. Most Pakistani parents are unaware of the possibility of correcting health defects in their children. Health education in the schools is just beginning, but without the assistance of medical officers.

352. The present programme is being given high priority and is the first planned advance of the Government into the school health field. It aims to provide the following:

(1) A school health service in twenty different localities, fifteen of them in the provinces;

(2) Regular medical supervision of school environment;

(3) Health education and physical education by instructors under the supervision of school medical officers;

(4) Indirect teaching of health rules to parents, through the school children.

353. The plan is to set up twenty teams for school health service, allocating the teams geographically as follows: Karachi, five; Punjab, five; East Benal, five; North West Frontier Province, three; Sind, two.

354. Each team will consist of a school medical officer, nurse dispenser, and an untrained helper. Supplies and equipment will be provided by UNICEF and the Government to twenty units, each located in a principal town of the province concerned, where adequate medical facilities exist to carry out the programme. Each unit will serve a local student population of about 3,000, and will also provide a demonstration centre for the training of teachers and school health personnel.

355. The activities of each unit will comprise:

(1) Health and medical inspection including annual physical examinations for the control and prevention of communicable disease and for development of good health habits;

(2) Treatment of minor illnesses;

(3) Correction of physical defects (vision, hearing, dental, posture, etc.), referring the seriously ill to other institutions;

(4) Inspection and advice on sanitation aspects of construction, equipment, and maintenance of school buildings and their surrounding compounds;

(5) Regular courses given by the teachers in hygiene and related subjects, under the supervision of school medical officers;

(6) Physical education, under the supervision of a physical instructor or games teacher, to ensure healthy development and in special cases to correct physical defects.

356. The responsibility for operating the project will rest with the health departments of the provincial governments concerned, but technical procedures will be subject to approval of the Director-General of Health Services of the Federal Government.

357. The local cost of units, including salary and allowances of staff, accommodation, transport, and local purchases will be met from the budgets of the provincial governments concerned.

UNICEF commitments

UNICEF will provide the following:

	$
Supplies and equipment for twenty school health units..	13,000
Drugs and diet supplements for twenty health units...	10,000
	23,000

358. The drugs and diet supplements will be issued to the units in quantities sufficient for approximately six months.

WHO commitments and technical approval

359. This programme has the technical approval of WHO, which will provide technical guidance as required.

Government commitments

360. The Pakistan Government undertakes to provide, at a total estimated cost of 211,920 rupees (approximately $US70,000) for non-recurring expenses in the first year, and for one year's running expenses, the following:

	Annual expenditure (Pakistan rupees)	
(1) Salaries		
One school medical officer	4,596	
One nurse dispenser	2,208	
One unskilled worker	792	
		151,920
(2) Expendable supplies		
Drugs and other supplies for twenty units	30,000	
Contingency fund	10,000	
		40,000
Estimated annual recurring expenditure.		191,920
(3) Furniture for twenty units		20,000
Total estimated cost to Government for first year		211,920

Target time-schedule

361. UNICEF supplies and equipment for the first year should, if possible, arrive in Pakistan during the third quarter of 1953, to permit commencement of the programme by the end of the year.

362. (*b*) *Maternal and child welfare services and training—Karachi.* As part of the plan to expand

maternal and child health services in Karachi and neighbouring provinces, the Government is establishing a training school in Karachi where health visitors and nurses take comprehensive courses in midwifery. UNICEF has previously provided $98,000 worth of equipment, supplies and transport. Owing to the shortage of technical assistance funds, UNICEF will assume the costs during 1953 of international personnel recruited by WHO, which will amount to $16,000.

363. (*c*) *Children's Hospital—Karachi.* In order to provide a training centre for doctors and nurses in the treatment of children's diseases, and in child care and nursing, the Government is establishing a modern 100-bed children's hospital in Karachi, at the existing Jinnah hospital, which will be expanded to 300 beds as soon as possible. Under an earlier apportionment UNICEF is providing $50,000 worth of technical supplies and equipment. Owing to the shortage of technical assistance funds, UNICEF will assume expenses up to $11,000 incurred during 1953 in connexion with international personnel recruited by WHO to start the training programme.

(ii) BCG ANTI-TUBERCULOSIS VACCINATION CAMPAIGN

364. Tuberculosis is second only to malaria among the major public health problems in Pakistan. The annual death rate from this disease is estimated at 120,000 to 150,000, with probably more than 600,000 active cases in the country. Hospital accommodation for tuberculosis cases, especially among children, is very limited.

365. The Joint Enterprise introduced BCG vaccination to Pakistan in 1949. When the Joint Enterprise withdrew, at the end of June 1951, the Government requested UNICEF and WHO aid in continuing and expanding the campaign on a mass basis, with the eventual aim of testing all young persons under the age of 20 (estimated at 20 million) and vaccinating the negative reactors. The plan of operations prepared at that time envisaged the formation of field units, each consisting of twelve vaccinators, two medical officers and one medical officer-in-charge, plus drivers and clerks; each complete unit would operate as four small teams. Seven such units were to have been activated in 1952 and another six in 1953. The targets for testings were to be 1.4 million children in 1952 and 3.2 million in 1953.

366. Progress in 1952 was slower than expected for a variety of reasons, including difficult terrain and a lack of personnel. Only three of the proposed seven field units were working most of the year. By the end of 1952 there were five units at work, and a sixth was activated in January 1953.

367. Against the target of 1,400,000 tests for 1952, approximately 1,175,000 were made, but the WHO team leader believed that if the international personnel still lacking can be recruited quickly, the monthly number of tests can be increased by at least 50 per cent.

368. The BCG production laboratory at Karachi was expected to be able to meet all requirements for vaccine in Pakistan by June 1952, but again delays were encountered and the date put forward to the middle of February 1953. UNICEF, therefore, continued to supply vaccine from Copenhagen after June 1952, at a total cost of approximately $12,000, for which no provision was made in the last apportionment made by the Board for this project.

369. Some of the equipment provided by the Joint Enterprise in 1949 and 1950, such as vaccination kits, has now worn out. Replacement of these items is therefore required. A small reserve for further expansion of the campaign is also needed.

UNICEF commitments

UNICEF will supply the following:

	$
(*a*) Funds to cover the cost of BCG vaccine from 1 June 1952 through February 1953	12,000
(*b*) Replacement for vaccination kits and other equipment	2,000
(*c*) Reserve for extension of campaign	9,000
	23,000

WHO commitments and technical approval

370. WHO will continue to provide technical guidance. The project has the technical approval of WHO.

International project personnel

371. Nine international personnel for the project will be financed from technical assistance funds at a cost of $45,000.

Government commitments

372. The commitments of the Government in respect of the national campaigns are already established in the plan of operations for 1952 and 1953 and will be extended to cover any expansion made possible by the supplemental apportionment.

Target time-schedule

373. All equipment is needed as early as possible.

(iii) DIPHTHERIA VACCINE AND SERUM PRODUCTION

374. On partition there was no serum laboratory in the new national territory of Pakistan, but the Government has since established the National Serum Institute in Karachi. Production is at the moment restricted to anti-venines for snake-bite, and smallpox vaccine. There is now, however, sufficient trained staff to enable the Institute to expand, and the Government wishes to extend its work to anti-diphtheria vaccine and serum production. The Institute is established in the building of the Bureau of Laboratories, which operates under the control of the Director-General of Health.

375. The Government has had a scientist trained at the Imperial Veterinary Research Institute at Muktesswar and at the National Institute of Preventive Medicine in the United Kingdom. Under his supervision, the initial stage of immunizing horses for diphtheria serum production has been completed, but owing to the lack of certain equipment and chemicals, actual production of diphtheria vaccine has not been started.

376. While there are no statistics on diphtheria incidence, an increased prevalence has been noted. The influx of refugee populations into the towns has greatly increased the opportunities for transmission of the disease. WHO officials have called attention to the prevalence of chronic nasal diphtheria amongst toddlers in some refugee camps; cases of paralysis of the palate have also been noted. The efficacy of serum and vaccine

in treatment and in prevention is beyond question, as well as being cheap and applicable for mass treatment.

377. The objectives of the present plan are to produce anti-diphtheria serum and vaccine in sufficient quantity to permit mass immunization of children and rapid treatment of existing cases.

UNICEF commitments

378. UNICEF will provide the following:

(*a*) Equipment for the production of anti-diphtheria serum and vaccine;

(*b*) Initial supplies of certain necessary chemicals.

Total cost: $20,000.

WHO commitments and technical approval

379. The programme has the technical approval of WHO. The WHO Regional Office will give advice and guidance as may be required.

Government commitments

380. The Government will sustain the following expenses:

(*a*) All costs for establishing the production plant, including provision of additional space, purchase of local supplies and equipment, repairs, alterations, installations, etc.;

(*b*) The salaries and allowances of the staff necessary for production;

(*c*) The recurring annual production costs.

381. No estimate is available at present of the cost to the Government of this project. The Government's present recurring expenditure for the production of vaccine and sera at the Bureau of Laboratories is over 250,000 rupees ($US80,000) annually.

Target time-schedule

382. Since initial production measures are already in progress, and the necessary space can be made available without delay, delivery of the equipment and supplies will be made as soon as possible.

PHILIPPINES

383. The Executive Board approved an apportionment to the Philippines of $214,000 from the Asia area allocation for the following:

(i) *Maternal and child welfare services and long-range feeding:* $150,000 to provide 1,500,000 lbs. of dried skim milk to continue the child feeding programme.

(ii) *Maternal and child welfare training:* $59,000 for equipment, supplies and an adviser to assist in the training of midwives.

(iii) *BCG anti-tuberculosis vaccination campaign:* $5,000 to reimburse WHO for expenses connected with a BCG officer during 1953.

384. The Executive Director was authorized to approve plans of operations as outlined in E/ICEF/R.450/Rev.1 (maternal and child welfare services and long-range feeding) and E/ICEF/R.412 (maternal and child welfare training). The plan of operations for the BCG campaign is outlined in E/ICEF/178/Rev.1, E/ICEF/198 and E/ICEF/212.

385. This assistance represents an extension of UNICEF aid in the case of the child feeding programme, which has been operating continuously since the first UNICEF assistance in 1949; and in the case of the BCG campaign; the aid for training relates to previous UNICEF aid for various maternal and child welfare services and training projects.

386. With this action, UNICEF aid to the Philippines totals $1,606,800 as follows:

	Approved	*Shipped* Through 1952 $	*Shipped* 1953 and after $
Feeding	Feb. 1949, May 1950		
	May 1951, Mar. 1953	460,300	75,000
Emergency relief ...	April 1952	26,500	2,500
Anti-TB (including BCG vaccination).	Dec. 1949, May 1951		
	Apr. 1952, Oct. 1952		
	Mar. 1953	157,300	29,300
Anti-yaws	Feb. 1951, April 1952		
	Oct. 1952	104,600	163,400
Fellowships	Sept. 1948	36,200	10,800
Anti-diphtheria	Nov. 1950	31,100	2,600
Rural health training	Dec. 1949	48,000	
MCW centres	June 1950, April 1952		
	Oct. 1952, Mar. 1953	127,400	267,900
MCW training	Mar. 1953	—	59,000
Under discussion ...			4,900
		991,400	615,400

(i) MATERNAL AND CHILD WELFARE SERVICES AND LONG-RANGE FEEDING

387. UNICEF assistance will permit an extension of feeding programmes for which the Board has approved $553,000, through which an average of 100,000 children a year received a glass of milk daily from 1949-1952. In addition, approximately 9,000 mothers and infants are being aided through 229 maternal and child welfare centres with UNICEF milk under a programme that began in September 1952 and will last until August 1953.

388. The Philippines Government regards nutrition as one of the most important factors in child health. The President's Food Commission reported a shortage of 400 calories in the daily diet from available food supplies in 1950-51; the protein supply was 40 grammes daily, with as little as 7.2 grammes from animal sources, against the requirement of 60 grammes, with at least one-third derived from animal sources. The Commission further stated that it believes in a 160-gramme daily per capita consumption of milk and milk products.

389. The Government has embarked on a project to produce cows' milk locally with bilateral assistance. Breeding animals will be imported for the purpose of developing dairy herds, with a view to producing locally within five to ten years as much milk as is imported into the country at the present time. For this reason the Government intends to encourage and support the importation of milk and milk products and has removed import control on milk.

390. In 1951, the Government procured at its own expense 1,500,000 pounds of powdered skim milk valued at $75,000, more than one-half of which was distributed to puericulture centres and child-care institutions that had not previously participated in feeding

programmes. The rest of the milk was distributed to children and mothers who were victims of disasters.

391. In 1952, the Government procured at its own expense 200,000 pounds of powdered whole milk, valued at $65,000, for the feeding of infants, children, and mothers in maternity houses, hospitals, and leprosaria.

392. In 1951-52, the Government provided from the UNAC collections the equivalent of over $175,000 for public schools for the development of lunch counters and the promotion of nutrition education. The money is being administered as a revolving fund, and it is expected that more than 1,000 elementary schools will be able to organize and conduct lunch counter operations permanently. Lunch counters are now operating in 381 schools; this number is expected to increase to 479 by December 1953.

UNICEF commitments

393. UNICEF will supply 1,500,000 pounds of skim milk for distribution to the recipients for one year at the rate of 50 grammes per day, or as prescribed by physician, in the following feeding centres:

	Beneficiaries
75,000 lbs. to 479 public schools	37,000
500,000 lbs. to 500 puericulture centres	12,500
150,000 lbs. to twenty child-care institutions and six leprosaria	4,000
100,000 lbs. for rural community health and welfare centres	2,500
	56,000

Government commitments

394. The Government's commitments will include the following:

(*a*) An amount of $63,600 in the national budget for 1953-54 for the administration and operation of the programme;

(*b*) 320,000 lbs. of imported dry skim milk for distribution in maternal and child welfare programmes;

(*c*) The services of physicians, nurses, and helpers in feeding centres to distribute the supplies and administer the programme;

(*d*) Receipt, storage, and local transport of the milk, at an estimated cost of at least 2¢ a pound.

Target time-schedule

395. The feeding programme is scheduled to start on 1 July 1953, at the opening of the school year.

(ii) MATERNAL AND CHILD WELFARE TRAINING

396. The population of the Philippines is about 20 million, of whom 80 per cent live in rural areas. The pre-war infant mortality rate for the whole country was 143.9 per thousand live births; although no exact more recent figures are available, the rate is certainly no lower and may be higher. The main causes of death are congenital debility, prematurity, tetanus, and birth injuries. Maternal mortality in the city of Manila in 1951 was 1.4 per thousand live births, while in nearby rural areas it was reported as 4, which may be accepted as a minimum for rural areas generally. In 1950, more than half a million births were registered, of which less than a third were attended by qualified medical personnel; the rest were either assisted by *hilots* (indigenous midwives) or not assisted at all.

397. Before the war, the Government operated three schools for midwives. In two of these, the students were municipal fellows and were required to give at least two years' service in their home municipalities. From 1923 to 1941, these three schools turned out 1,652 midwives. Since the war, owing to lack of funds, only one of these schools (in Manila) has been re-opened.

398. With UNICEF aid the Government proposes to revive a plan that was carried on before the war for training *hilots* through puericulture centres and maternity homes.

399. Since the war, the Government has made an effort to provide care to expectant mothers by re-establishing maternity clinics, giving impetus to organization of puericulture centres, and opening maternity homes. Medical services for rural areas now consist of 1,064 maternal and child welfare centres and dispensaries with an aggregate staff of 983 physicians, 717 nurses, 266 midwives, and sixty-one dispensary attendants—a ratio of one medical attendant to 8,000 persons. Not all these personnel are full-time. Additionally, there are twenty-three maternity homes established under physicians, nurses, or midwives. There are about 1,500 physicians, nurses, and midwives in private practice in rural areas.

400. The Government attaches great importance to the work of properly trained midwives who, as well as attending births, also supervise the activities of the *hilots*. To improve this supervision, it is necessary to strengthen the one existing midwifery school in Manila.

401. The proposed plan is as follows:

(*a*) To provide equipment and supplies for the expansion of the School of Midwives in Manila; and

(*b*) To give training, within two years, to 2,000 *hilots* in rural areas, especially in provinces registering particularly high infant and maternal mortality rates.

402. The midwives' school was re-opened after the war and in 1951 was moved into larger quarters. In 1952, ten instructors were added and enrolment increased from 100 to 248. The course was expanded, and extended from twelve to eighteen months. There is urgent need for more equipment for the expanded enrolment. Delivery-room equipment, teaching aids, textbooks and reference books are needed. Transportation is required for students going to semi-urban and rural districts to get practical field experience.

403. Regarding the *hilots,* training will be offered in twenty-five maternity homes and Class A puericulture centres in nineteen provinces. The course of instruction will be three hours a week for twelve weeks. Classes will consist of ten *hilots* at a time, and each centre will train about forty *hilots* a year. If necessary, additional training centres in other provinces will be included during the second year. In each centre there will be at least two instructors—one doctor and one nurse, or one midwife—and often three instructors. Instruction will cover general principles of asepsis, technique of normal delivery, and post-natal care.

404. Upon satisfactory completion of the course, *hilots* will receive a certificate and a simple midwifery kit. In return, they will agree to report to the nearest

maternal and child welfare centre all child-births attended and to call medical assistance for all abnormal deliveries.

405. In addition to teaching-equipment and simple midwifery kits for the *hilots*, UNICEF will provide stipends for travel and meals for each *hilot* during the training, since they are not on government pay-roll and generally cannot afford the additional expense, plus the loss of twelve days' earnings.

UNICEF commitments

406. UNICEF will provide the following:

	$
(*a*) *Equipment for the Manila Midwives' School* including teaching aids for the twenty-five centres	8,000
(*b*) *For training* hilots	
(1) Extra equipment for maternity homes*	2,000
(2) Midwifery kits for 2,000 *hilots*	20,000
(3) Travel and meal allowance for 2,000 *hilots* at $1.08 per day for 12 days each	26,000
(4) Reimbursement to WHO for expenses of an adviser during 1953	3,000
	59,000

*The puericulture centres are already receiving additional UNICEF equipment under an existing programme.

WHO commitments and technical approval

407. The project has the technical approval of WHO, which has recommended that an international midwifery adviser participate in the project. In view of the shortage of technical assistance funds, UNICEF will provide funds amounting to about $3,000 to reimburse WHO for the cost of this adviser during 1953.

Government commitments

408.

	Pesos	*$US*
(*a*) *For the School of Midwives, Manila*		
(1) Repairs and alterations to the buildings	300,000	150,000
(2) Operating expenses for the year 1952-53 (including the salary of ten additional instructors)	73,600	36,500
(*b*) *For training* hilots		
(1) A minimum of two instructors in each of twenty-five training centres	14,400	7,200
(2) Re-fills for *hilot* kits	5,000	2,500
	393,000	196,000

Target time-schedule

409. (*a*) Equipment for the midwifery training school in Manila will arrive as soon as possible;

(*b*) The hilot-training project is planned for two years and the target date for commencement is 1 October 1953.

(iii) BCG ANTI-TUBERCULOSIS VACCINATION

410. The mass BCG campaign, for which the Board has previously voted $107,000 worth of assistance, has the goal of testing all 9,000,000 children under fifteen in the Philippines by the end of 1954, or soon thereafter, and vaccinating the negative reactors. An estimated 1,650,000 Filipinos have tuberculosis.

411. The mass campaign began on 1 January 1952. UNICEF is supplying transport, equipment and other supplies; the present apportionment will cover the cost of a BCG officer, recruited by WHO, during 1953. UNICEF is taking over this expense from WHO in view of the shortage of technical assistance funds.

SINGAPORE

MATERNAL AND CHILD WELFARE SERVICES (DRY SKIM MILK)

412. The Executive Board approved a plan of operations, outlined in E/ICEF/R.450/Rev.1, for the provision of dry skim milk for distribution through maternal and child welfare centres and schools. The cost to UNICEF for the 140,000 lbs. requested will be approximately $14,000, which is available from unexpended funds from earlier allocations.

413. Since mid-1950, UNICEF dry skim milk has been distributed on medical advice to selected children in maternal and child welfare centres and in schools. Approximately 4,000 children are benefiting at present, but milk supplies are nearly exhausted. The Government wishes to continue distribution for another year and to raise the number of beneficiaries to about 5,500. The ration will be 40 grams per child per day for 300 days.

UNICEF commitments

414. UNICEF will supply 140,000 lbs. of dry skim milk at a cost of about $14,000.

Government commitments

415. The Government provides, for these same children, a daily snack consisting of a vitamin-enriched bun and fruit. In addition, the milk powder is reconstituted in water to which vitamin A has been added. The expenses incurred by the Government in this connexion exceed those of UNICEF.

Target time-schedule

416. Half the milk is to be shipped immediately and the balance in 4 months.

Total UNICEF aid

417. UNICEF aid to Singapore totals $48,400 as follows:

	Approved	*Shipped*	
		Through 1952	*1953 and after*
		$	$
Feeding	May 1950	4,500	—
BCG	June 1950	10,300	500
MCW	Sept. 1948		
	March 1953	12,300	18,700
Under discussion		—	2,100
		27,100	21,300

THAILAND

MATERNAL AND CHILD WELFARE SERVICES AND TRAINING

418. The Executive Board approved an opportionment to Thailand of $94,000 from the Asia area allocation to assist in the further development of rural maternal and child welfare services. The Executive Director was authorized to approve a plan of operations as outlined in E/ICEF/R.443. This constitutes an extension of UNICEF aid in this field, and will assist the Government in reaching the second stage of

a nationwide plan to improve health services in rural areas, where 90 per cent of the population live.

419. In carrying out this long-term plan, the Government of Thailand is being assisted by the United States Mutual Security Administration, UNICEF and WHO. UNICEF's assistance will be given for the maternal and child health field; MSA and WHO are assisting in the public health and training aspects of the programme. In April and October 1952 the Board approved assistance for forty first-class and 222 second-class health centres.

420. The main objectives of the plan are to staff some 100 first-class and fifty second-class established rural health centres with competent personnel and adequate supervisory staff; to properly equip the health centres; and to provide essential drugs and diet supplements free for needy members of the communities they serve. The plan for staffing the health centres involves refresher training of all personnel already employed in the rural health services, plus the appointment as needed of newly-graduated midwives.

421. Refresher training will be given at three centres:

(*a*) The large MSA-assisted training centre at Cholburi. Here the provincial health officers and public health nurses, who will have supervisory duties, are in training. In addition, the sanitary inspectors and some of the midwives attached to rural health centres will be given training during 1953;

(*b*) The UNICEF/WHO-assisted maternal and child welfare centre in Bangkok; and

(*c*) The UNICEF/WHO-assisted maternal and child welfare training programme in Chiengmai will both give refresher training to midwives already employed. The curriculum has been agreed between the Government, MSA and WHO personnel and the time schedules determined.

422. As trained personnel become available, the health centres in which they serve will receive new equipment. Each centre will also be supplied with drugs and diet supplements for free distribution to needy members of the community.

423. To staff first-class health centres, forty public health nurses are scheduled for refresher training during 1953; they will supervise and instruct midwives and sanitary inspectors attached to second-class centres, as well as the traditional midwives in their districts.

424. For the second-class centres in the 1953 programme, the following schedule for provision of midwives has been firmly established:

(*a*) Fifty graduate midwives became available on 31 December 1952;

(*b*) Fifty more midwives will graduate 31 December 1953;

(*c*) One hundred and fifty-six midwives, already employed, will receive refresher training at the Cholburi, Chiengmai and Bangkok centres.

425. Thus 256 midwives will become available during 1953 and a maximum of 256 rural health centres could therefore be improved according to the plan of operations during the first year. During 1954 the same training schedule is planned so that a maximum of 512 health centres could be included in the programme by the end of 1954. Allowing, however, for losses in the service, for unforeseen delays and contingencies, the Government is requesting further aid in equipping 100 additional centres during 1954, bringing the total first- and second-class centres which UNICEF is assisting to 362.

426. UNICEF has already voted aid for the provision during 1953 of skim and whole milk, fish-liver oil capsules, and soap, for free distribution to mothers and children, but further assistance of this type is needed in 1954 for approximately 225 health centres to be equipped during 1953, and for the 100 additional centres.

427. UNICEF is providing stipends for approximately 200 of the midwives and public health nurses who will receive refresher training in 1953, and will now provide funds for additional stipends for 100 midwives who will take refresher training during 1954.

428. The refresher course lasts six weeks. It has been worked out by the Government, WHO and MSA expert personnel. The following is an outline of the schedule:

(*a*) Two weeks are spent on deliveries. It is expected that each trainee will deliver three babies during this period of in-service training;

(*b*) Two weeks are spent in pre- and post-partum clinics and on home visiting and home midwifery. Each trainee takes her turn to be on call for home deliveries, in which she is supervised by a nurse-midwife tutor. Each trainee is expected to attend five of these deliveries;

(*c*) Two weeks are spent in rotating through supporting clinics—infant and child care, medical, school visits, health education, nutrition, sanitation, venereal disease.

429. The curriculum also includes instruction on the use of drugs and diet supplements and the control and accounting of supplies.

430. As soon as the first shipments of equipment arrive a set will be sent to each of the training centres for demonstration purposes.

UNICEF commitments

431. UNICEF will supply, for the second year of operations:

	$US
(*a*) Equipment and supplies, including midwifery kits and bicycles, for 100 second-class health centres	30,000
(*b*) Stipends for 100 midwives to be given refresher training in 1954	4,500
(*c*) 70,000 lbs. whole milk powder for distribution to about 1,300 selected infants through 322 maternal and child welfare centres (about four infants per centre) at 80 grammes each daily for 300 days	22,500
(*d*) 100,000 lbs. skim milk powder for distribution to 3,000 selected children and mothers through 322 maternal and child welfare centres (about ten per centre) at 50 grammes daily for 300 days	10,000
(*e*) 3.5 million fish-liver oil capsules for distribution to children through health centres	10,500

(*f*) 75,000 lbs. of soap for distribution to mothers and children through maternal and child welfare centres	7,500
(*g*) General reserve	9,000
	94,000

432. The quantities shown above are subject to adjustment in the light of experience during 1953.

Other international participation

433. WHO commitments to the Bangkok and Chiengmai maternal and child welfare training programmes are in terms of teaching staff:

In Bangkok: pediatrician, midwifery tutor, public health nurse, for three years; sanitarian, for two years; another public health nurse, for one year.

In Chiengmai: pediatrician, for three years; public health nurse, for three years; another public health nurse, for two years.

The programme has the technical approval of WHO.

434. Mutual Security Administration health officials were closely associated with the Government, UNICEF and WHO in the preparation of the expansion of this plan. MSA will continue to participate in the training of the health centres' staff and in providing equipment and transport.

Government commitments

435. The Government will make provision in the 1954 budget of at least 2,000,000 baht (approximately $US125,000) to meet the new expenses in connexion with the expansion of this project during that year. This budget will be devoted entirely to the following purposes:

	Approx. baht
(*a*) Necessary repairs to second-class health centres	500,000
(*b*) Living quarters or improvements to same for staff of centres	200,000
(*c*) Drugs and other expendable items	1,300,000
	2,000,000
	($US125,000)

436. The above is in addition to the funds already budgeted for the operation of other maternal and child welfare projects and for handling and distribution of UNICEF supplies.

Target time-schedule

437. Equipment for maternal and child welfare centres is expected to arrive in Thailand by the end of 1953. Milk, fish-oil capsules, and soap will be called forward as required. It is expected that by the end of 1954 a total of 322 second-class health centres will be working according to the plan of operations.

Total UNICEF aid

438. With this action, UNICEF aid to Thailand totals $1,405,000 as follows:

	Approved	*Shipped* Through 1952 $	*Shipped* 1953 and after $
Feeding	May 1950	70,100	—
Anti-yaws	May 1950		
	Nov. 1950		
	Apr. 1952	482,800	296,800
Tuberculosis control	June 1950	56,600	900
BCG campaign	Apr. 1952	37,600	61,400
Anti-malaria	July 1949	44,100	—
MCW	Sept. 1948		
	June 1950		
	Feb. 1951		
	Apr. 1952		
	Oct. 1952		
	Mar. 1953	119,400	235,300
		810,600	594,400

VIETNAM

439. The Executive Board approved an apportionment to Vietnam of $14,000 from the Asia area allocation as follows:

(i) *Maternal and child welfare services:* $10,000 for reimbursement to WHO for expenses during 1953 of a maternal and child health expert who is assisting with the running of a children's hospital;

(ii) *BCG anti-tuberculosis vaccination campaign:* $4,000 for reimbursement to WHO of expenses connected with BCG international project personnel during 1953.

440. In both cases this represents an extension of previous UNICEF assistance for these projects. Plans of operations for these programmes are outlined in E/ICEF/212 and E/ICEF/198 respectively.

Total UNICEF aid

441. With this action, UNICEF assistance to Vietnam is $120,000 as follows:

	Approved	*Shipped* Through 1952 $	*Shipped* 1953 and after $
MCW services and training	Apr. 1952		
	Oct. 1952		
	Mar. 1953	100	86,900
Anti-TB	Apr. 1952		
	Mar. 1953	10,900	22,100
		11,000	109,000

(i) MATERNAL AND CHILD WELFARE SERVICES (CHILDREN'S HOSPITAL)

442. The first children's hospital in Vietnam is being constructed half-way between the twin cities of Saigon and Cholon with UNICEF assistance. The country has a population of about 20,000,000 people, of whom an estimated 30 per cent are children under 12 years of age. The most important children's diseases are gastro-enteritis, dysentery and intestinal parasites. The hospital will have 250 beds for children under 12, and will provide general medical care, including separate wards for contagious diseases, but excluding surgery which is available at a nearby hospital. The doctor, who will be director of the hospital, has recently been on a pediatric fellowship in France, and there will be adequate nursing and technical staff. A maternal and child health expert, recruited by WHO, will assist in running the hospital, which is scheduled to open on 1 July 1953. In addition to financing this expert during

1953, at a cost of $10,000, UNICEF is supplying a variety of ward equipment, X-ray and other laboratory equipment, drugs, diet supplements and milk powder, etc.

443. The hospital will have an out-patient department serving from 150 to 200 children daily, and facilities for pediatric training. It is attached to the Faculty of Medicine of Saigon, University of Hanoi.

(ii) BCG ANTI-TUBERCULOSIS VACCINATION CAMPAIGN

444. Next to malaria, tuberculosis is the most significant social disease in Vietnam. BCG vaccination offers the only way of protecting children, since there is no tuberculosis hospital or other provision for segregating open cases. The long-term objectives of the campaign are to test all young people under 20 within ten years, and to integrate BCG vaccination as a permanent part of the Government's anti-tuberculosis services. To achieve this, at least four local teams, each composed of a doctor and four nurses and/or technicians, are being trained; each team will test a minimum of 100,000 persons a year and vaccinate the negative reactors. In addition to financing for the year 1953 the international team of one doctor and two nurses, who are spending eighteen months between Vietnam and Cambodia, UNICEF has provided transport, equipment and supplies to assist the campaign.

Eastern Mediterranean

EGYPT

MATERNAL AND CHILD WELFARE SERVICES

445. The Executive Board approved an apportionment to Egypt of $180,000 from the Eastern Mediterranean area allocation for the provision of equipment, milk, drugs and diet supplements, and soap for 233 rural and urban maternal and child welfare centres. The Executive Director was authorized to approve a plan of operations as outlined in E/ICEF/R.421. This constitutes the first UNICEF assistance to Egypt for this type of pragramme.

446. Egypt has 1,000,000 square kilometres of which only 34,824 have a settled population. The population of somewhat over 21,000,000 lives mainly in villages and rural areas (70 per cent), where there are on the average 540 persons per square kilometre, making a population density exceeding that of some of the most thickly inhabited countries in western Europe. Egypt possesses rich soil and a mild year-round climate which permits three crops a year, mostly with relatively high yields. The *per caput* output is low, however, because of the relatively small amount of cultivated land. The average *per caput* income is between $100 and $150 a year (36 to 53 Egyption pounds); for the rural population (fellahin) the average is probably one-third to two-fifths of this amount.

447. Social and health problems must be viewed against this background. The birth rate per 1,000 of population is between 40 and 45 annually, one of the world's highest, while the death rate is also high, between 20 and 21 annually. Thus, the population increases yearly by some 400,000 to 450,000 and is a relatively "young" population: according to the 1947 census, the percentage of children from 0 through 14 years of age was 38.1 per cent.

448. There is a high incidence of malnutrition and disease. The average diet, based largely on grains and starchy foodstuffs, is deficient in protein. Pellagra, a nutrition deficiency disease, is frequently found in Egypt. The chief causes of ill health are widely prevalent endemic diseases: bilharzia, enteric diseases (including typhoid fever), insect-borne diseases, trachoma and other eye diseases, intestinal parasites and dysenteries. These diseases lower resistance to more fatal illnesses and result in a generally reduced working capacity. At certain times of the year, malaria is widely prevalent. There is a high incidence of tuberculosis and syphilis, the former a leading cause of death. Poverty, inadequate environmental hygiene, and very poor housing conditions are contributing causes to these diseases and represent a grave threat to maternal and child health, as is reflected in very high infant mortality.

449. The infant mortality rate in 1949 was officially recorded at 175 per 1,000 live births, but rates of well over 200 have been recorded in rural areas, with even higher rates in some city areas. Major causes (as shown by localities where health records are kept) are intestinal disorders and diarrhoea, accounting for 54 per cent of all infant deaths. In some urban areas, rates have been lower among the population using maternal and child welfare centres. Comparatively high mortality rates prevail until the third and fourth year of life.

450. In 1951, less than 25 per cent of about 800,000 births occurring were attended by qualified midwives or doctors. The remainder were attended by local *dyahs* (traditional midwives) or other unregistered and relatively unqualified persons. Almost all births took place at home.

451. Infants face exposure to the usual childhood diseases, but diarrhoea and intestinal diseases are particular hazards resulting from poor nutrition, inadequate sanitation, and lack of education of the mothers. Although most babies are breast-fed, the mother's milk is often limited, so that infants do not gain properly after the fifth or sixth month. Breast feeding, which often continues through the second year, requires early supplementation both in milk and starchy foods. In spite of the sunny climate, rickets is common in Egypt.

452. Health services have improved during the last twenty years, but are still inadequate. In 1950, there was one doctor per 4,000 inhabitants, but only one midwife per 20,000. Nurses, numbering more than 5,000, were almost exclusively in hospitals, which had one bed per 900 population. Over 300 doctors are graduated annually, but the lack of midwives and nurses is a severe handicap to maternal and child health services. At present, about 200 girls are trained annually as assistant midwives, the majority now being directed toward work in rural areas. However, a large loss of staff occurs each year through marriage, difficulties of rural life, and low pay scales.

453. Maternal and child health services are based on child welfare centres in cities and towns, operated by the Maternal and Child Health Department of the Ministry of Health, and rural health centres with special maternal and child health sections in the villages,

operated by the Department of Rural Hygiene. Similar activities on a smaller scale are carried on in the 151 rural social centres by the Ministry of Social Affairs through its Fellah (farmer) Department. In 1952 there were under the Health Ministry eighty urban maternal and child welfare centres in operation, 153 rural health centres with maternal and child welfare sections, and another sixty-four rural health centres without maternal and child welfare sections. A city maternal and child welfare centre is intended to serve a population of 50,000, and a rural centre approximately 20,000. Even at this inadequate level, a total of 120 city centres and 800 rural would be required to serve the population. Maternal and child welfare centres have increased their activities and now reach 30 to 40 per cent of the population they are supposed to serve, which is a considerable achievement.

454. The staff for a typical city maternal and child welfare centre includes a doctor in charge, with an assistant doctor if it is a large and busy centre; a "Hakima" or head nurse, sometimes with an additional nurse; a number of assistant midwives, a pharmacist, clerks, maids and porters. The present over-all staff in the eighty city maternal and child welfare centres is approximately eighty doctors, twenty-five pharmacists, ninety *Hakimas*, 432 assistant midwives, and eighteen nurses' aides.

455. The routine of work at these centres is well standardized and complete records are kept. Each day is scheduled for a particular type of service. Prescriptions are issued by the centre, and drugs, vitamins, etc., are issued to a limited number of patients unable to pay for them. Some centres have beds for child-birth for use when private dwellings are completely unsuitable, or in emergencies. Complicated cases are referred to the nearest general hospital. All medical care at the centre is free of charge.

456. Mothers are encouraged to bring infants regularly to the centre, at least through the second year of life. All babies receive normal vaccinations, but the centres generally prescribe and issue fish-liver oil and milk only for severe cases of rickets and malnutrition. Therefore, once vaccinations have been given, there is little inducement for mothers with relatively healthy babies to attend centres for advice and consultation.

457. Approximately 4 per cent of pregnancies require treatment for syphilis, chiefly with arsenicals. Treatment with bismuth and arsenicals is long and drawn-out. Relapses occur frenquently because injection treatments are not completed. The use of penicillin would greatly improve the situation and would also facilitate treatment of contacts, especially fathers in rural areas who cannot leave their work for prolonged treatments.

458. Work in the maternal and child welfare sections of rural health centres is patterned after that in the city centres, but with important differences. Rural health centres offer a variety of services and are generally designed for the purpose, comprising a group of buildings joined together in a U or L shape, allowing open space for groups of waiting patients and separate facilities for the well and ill, the mothers and children, etc. Sometimes centres include, or adjoin, an environmental sanitation unit with sample latrines, public water source, baths, a public laundry or malaria control station.

459. Among the principal tasks of the centre's outpatient department is treatment of endemic diseases, especially bilharzia and other parasitic diseases. The in-patient department handles cases not requiring serious operations or intricate hospital care, e.g., pellagra cases, bilharzia complicated by anaemia, jaundice, minor operations, etc., and there may be a number of beds reserved for maternity cases. Since the doctor in charge of a rural centre cannot devote all of his time to maternal and child welfare work, the *Hakimas* and assistant midwives carry the main burden of this work. The average daily attendance of mothers and children at rural centres is 50 per cent lower than in cities.

460. The typical staff of a rural centre includes the centre doctor, one sanitary inspector, one dispenser or pharmacy attendant, one or two laboratory assistants and, especially for the maternal and child welfare work, one *Hakima* and two assistant midwives. The 153 centres with maternal and child welfare sections operating in 1952 employed twenty-six *Hakimas* and 365 assistant midwives. Experienced assistant midwives were designated to make up for the lack of *Hakimas*.

461. The existing structure of maternal and child welfare sections in city and rural health centres forms the basis for the proposed plan: to increase the material inducement to mothers to visit the centres regularly; and to improve service through the provision of additional equipment and supplies of various sorts. The country-wide maternal and child welfare system, including the eighty city and 153 rural maternal and child welfare centres, will be strengthened on the following lines:

(*a*) *Milk:* Dried milk from UNICEF will be provided on medical indication for undernourished infants, as supplementary feeding when the mother's milk is insufficient. Distribution will be partly in liquid form and partly as dry rations under controlled conditions if sanitary home preparation can be reasonably expected. Dry milk will also be provided for a number of nursing mothers whose need is certified by the doctor. The Government will continue as far as possible to provide these centres with dried milk bought with its own funds.

(*b*) *Vitamins:* Vitamin A and D fish-liver oil capsules will be issued at each visit to mothers for infant feeding, in quantities to last until the next scheduled visit. Priority will be given to cases of rickets or incipient rickets, but as far as possible, vitamins will be issued to all infants under one year of age as a prophylactic measure. The Government will continue to provide vitamin concentrates to the centres. It is thus expected that a large percentage of infants served by the centres will receive vitamins.

(*c*) *Soap:* Soap provided by UNICEF will be issued primarily to mothers on the birth of a child. Other issues may be made upon subsequent visits to the centre.

(*d*) *Penicillin:* Penicillin provided by UNICEF will be used primarily in the treatment of syphilis in

mothers and infants under the care of the centres and secondarily for other serious illnesses of young children as prescribed by the centre's physician. The Government will begin to provide penicillin also to replace bismuth and arsenicals for treatment of adult males and paternal contacts.

(*e*) *Equipment:* Work of the centres will be improved by replacements for outworn or inadequate basic equipment (e.g., scales), as well as simple kitchen equipment and utensils for the safe preparation of liquid milk.

UNICEF commitments

462. Supplies and equipment to be provided by UNICEF, including expendables calculated to last for one year, are estimated to cost $180,000, as follows:

	$
Milk	90,000
Fish-liver oil capsules	34,000
Soap, 270,000 pounds	21,000
Penicillin, 13,000 vials	6,000
Equipment (detailed requirements of 233 MCW centres to be worked out by WHO MCH consultants)	25,000
Reserve	4,000
	180,000

WHO commitments and technical approval

463. WHO has given its technical approval to the project. Necessary consultant services for the development of this programme will be provided by the WHO Regional Office, located in Alexandria, Egypt. With WHO aid, a rural public health area is being organized to devise new and improved public health organization and practical working methods suited to specific Egyptian problems and resources.

Government commitments

464. The Government of Egypt will undertake the following:

(*a*) To maintain staff and facilities at all existing city and rural maternal and child health centres to make proper use of UNICEF aid;

(*b*) To maintain or increase present scale of provision of certain expendables to the centres;

(*c*) To provide penicillin for the treatment of male contacts of the mothers and children affected with syphilis;

(*d*) To increase government funds available for milk and fish-liver oil after cessation of UNICEF assistance to the extent that its over-all budgetary situation permits;

(*e*) To extend the number of rural health centres carrying on maternal and child health work;

(*f*) To improve and expend its training programme and increase the staff for maternal and child health work.

Target time-schedule

465. It is expected that a detailed plan of operations will be worked out by the summer of 1953. The supplies from UNICEF should therefore be delivered in Egypt by the end of the summer 1953. Equipment for the centres should be delivered later in 1953.

Total UNICEF aid

466. With this action, UNICEF aid to Egypt totals $1,226,000, as follows:

	Approved	Shipped: Through 1952	Shipped: 1953 and after
		$	$
BCG	Nov. 1949; May Nov. 1951	287,700	18,300
DDT production	Nov. 1951	—	250,000
Anti-malaria	Apr. 1952	—	165,000
Emergency feeding	Oct. 1952	6,100	193,900
MCP	Oct. 1952	—	125,000
MCW	Mar. 1953	—	180,000
		293,800	932,200

IRAN

MILK CONSERVATION

467. The Executive Board approved an apportionment to Iran of $125,000 from the Eastern Mediterranean area allocation for additional equipment for the milk conservation programme and to cover underpricing of items already authorized for procurement. The Executive Director was authorized to approve a revised plan of operations as outlined in E/ICEF/R.440. This represents an extension of UNICEF assistance for the milk conservation programme in Iran.

468. The Executive Board, at its November 1951 session, allocated $275,000 for a large milk pasteurization and yoghurt plant, plus $25,000 for a limited amount of dried milk to initiate a milk distribution system prior to the plant's opening. The dairy is to have a daily capacity of 80,000 litres of cows' and sheep milk and will produce bottled milk, yoghurt, butter and other products. It will process nearly all of the milk produced in and near Teheran.

469. A detailed study has now been made of all the technical aspects of the plant. From this it appears that a more economical method of operation could be adopted than originally envisaged, by spreading the daily operating cycle over a longer period. This requires an increase in milk storage capacity, but reduces the total requirements for refrigeration and electricity, and consequently reduces operating costs. It is also proposed to add two bottle sizes more than originally planned, which requires a corresponding increase in jar and bottle washing and filling facilities. In addition to these modifications, UNICEF has been requested to provide supplementary conveyor systems and an annealing lehr for glass bottles. Another factor necessitating the allocation of additional funds is the increase in prices of some milk conservation equipment since the original estimates were made.

470. Steps already taken to implement this project include the following:

(*a*) Under an FAO fellowship, the Iranian architect visited dairies in France and England preparatory to drafting the final building plans. Equipment and building experts were consulted and a UNICEF engineer worked with the architect throughout his visit. All necessary drawings for the erection of the building were completed in November 1952.

(*b*) A local technical committee composed of representatives of the Iranian Government, FAO, WHO,

and the Technical Co-operation Administration of the United States have been working on the plan for more than a year.

(*c*) The building site has been purchased by the Government. In addition, the Government has requested assistance from TCA in procuring certain imported building materials.

(*d*) UNICEF has placed contracts for milk processing and refrigerating equipment to a total value of $92,000.

(*e*) Several visits have been made to Iran by UNICEF engineers. In February 1953 a joint FAO/UNICEF team conferred with Government representatives in Teheran making detailed plans for implementing this project.

UNICEF commitments

471. UNICEF will supply additional milk-weighing and milk-storage facilities, bottle-washing and filling machinery, supplementary conveyor systems and annealing lehr for glass bottles. The estimated cost of the foregoing, and the underpricing of already authorized equipment is $125,000.

FAO technical approval

472. FAO has given technical approval to the project.

Government commitments

473. On its part, the Government has already increased its contribution to the project from 20 million rials to 40 million rials ($1,230,000) to provide for increased building costs within the country.

Total UNICEF aid

474. With this action UNICEF aid to Iran totals $677,000 as follows:

	Approved	*Shipped* Through 1952	*Shipped* 1953 and after
		$	$
BCG	May 1951	99,700	77,300
MCW	Oct. 1952	—	75,000
MCP	Nov. 1951		
	Mar. 1953	25,300	399,700
		125,000	552,000

IRAQ

475. The Executive Board aproved an apportionment to Iraq of $203,000 from the Eastern Mediterranean area allocation for the following:

(i) *Long-range feeding:* $122,000 for dried skim milk and fish-liver oil for a permanent supplementary school feeding programme initiated during the present school year;

(ii) *Maternal and child welfare services and training:* $75,000 for equipment and supplies, including drug and diet supplements for maternal and child welfare centres, teaching equipment for training centres, and supplies for country-wide community midwives service; and $6,000 for reimbursement to WHO for expenses of international personnel during 1953.

476. The Executive Director was authorized to approve plans of operations as outlined in E/ICEF/R.431 (long-range feeding) and E/ICEF/R.419 (maternal and child welfare services and training). This apportionment represents the first UNICEF assistance to Iraq for either type of project, although milk and cod-liver oil for use in maternal and child welfare centres, as well as equipment for a milk conservation project, are being supplied under previous apportionments.

477. With this action, UNICEF aid to Iraq totals $686,300, as follows:

	Approved	*Shipped* Through 1952	*Shipped* 1953 and after
		$	$
Anti-bejel syphilis	June 1950	95,700	27,600
BCG	May 1951	25,600	64,400
Anti-malaria	Apr. 1952	—	85,000
MCP	Oct. 1952	—	185,000
MCW	Mar. 1953	—	81,000
Feeding	Mar. 1953	—	122,000
		121,300	565,000

(i) LONG-RANGE FEEDING

478. There are in Iraq an estimated 750,000 children of primary school age, i.e., in the age group 6-13 years, of whom 175,000 are actually attending primary school. Free compulsory primary education is gradually being introduced, but the process is slow because of insufficient school buildings and teaching staff in certain areas, the fact that many children of poorer families are kept at home to work, and the mobility of the semi-nomadic population.

479. Malnutrition appears to be general among children, including the 175,000 now attending primary schools. An FAO nutrition consultant who visited Iraq in early 1952 had occasion to survey the nutritional status of children in a number of schools throughout the country. An over-all caloric inadequacy is apparent. The daily ration, consisting mainly of bread, onions, and dates, is estimated to contain 1,200 calories, with a shortage of protein and carbohydrates. Retarded growth is general in schools attended by pre-adolescent children from low income families. Ignorance of proper food habits also contributes to malnutrition among children.

480. In order to improve nutrition standards, the Government is availing itself of the technical assistance provided by international and bilateral agencies in several related fields; for example, rural and fundamental education; home economics, fisheries, and milk conservation. In order to co-ordinate the many factors in a nutrition improvement programme, a National Committee was formed in 1952. The Government is now establishing a Nutrition Institute at Baghdad which will study the present level of nutrition and undertake a programme of nutrition education.

481. The FAO consultant recommended the organization of a model school lunch scheme for provincial schools attended by very poor children; a planning committee under the Ministry of Education subsequently set up a limited school feeding scheme during the school year 1952/53. For this purpose a total of 48,100 Iraqi dinars ($134,650) were allotted in ten of the fourteen provinces to provide a simple daily meal to 20,000 primary school children, selected on the basis of medical examination, for 150 feeding days. Each meal, valued at 16 fils (4.5¢), consists at present

of bread plus either eggs, cheese, vegetables or fruit, depending upon seasonal availability. On the basis of this modest but effective beginning, and following the recommendation of the FAO consultant, the Government now wishes for assistance in continuing the project.

482. The assistance proposed for this programme is designed to meet the following long-term objectives:

(*a*) The development of a permanent school feeding programme;

(*b*) Gradual improvement of nutrition throughout Iraq, and for this purpose the co-ordination of all interested Ministries and institutions;

(*c*) Increased community and family interest and participation in the educational, social and health aspects of child nutrition.

483. The present school feeding scheme will be expanded, and a technical and administrative supervisory staff will be organized to ensure its effective development. Over-all supervision and co-ordination will be undertaken by the Ministries of Education and Health, while the immediate responsibility for the programme will rest with the Director of School Health Services of the Ministry of Education.

484. The number of beneficiaries will be increased in the course of the next two years (1953-55) from the present level of 20,000 to 60,000: 40,000 children for the 180 school days of the school year 1953/54, and the full 60,000 in 1954/55. Nutritional needs and economic status of the areas will determine the selection of schools to benefit. Organization and inspection of the school feeding, at the local level, will be entrusted to the School Health Medical Officers of the Ministry of Education. Procurement of locally available foodstuffs and supervision of the feeding will be undertaken by the municipalities and committees of teachers and parents. The school principals will be responsible for the distribution in each school and will arrange to provide personnel and facilities for proper preparation of the meals.

UNICEF commitments

485. UNICEF will share with the Government the provision of dry skim milk and fish-liver oil for the two school years 1953/54 and 1954/55 by supplying:

	$
(*a*) *Dry skim milk:* Half of the total two-year requirement, i.e., 800,000 lbs.	80,000
(*b*) *Fish-liver oil:* The full ration for the first year and half the requirements for the second	42,000
	122,000

Government commitments

486. The Government undertakes the following commitments:

(*a*) The Central and Provincial Governments will undertake to provide:

	$
Half the amount of dry skim milk required over the two-year period, namely, 800,000 lbs., estimated at	80,000
Half the amount of fish-liver oil required for the second year, estimated at	20,000
Local foods approximately $US0.05 per ration per day for two years to the equivalent of	600,000

All equipment and supplies required for preparing and serving the milk and other foods, that the communities are unable to provide.

Cost of warehousing and internal freight.

Technical and administrative supervisory staff.

Necessary facilities for nutrition education related to the programme.

(*b*) The school meal will be free of charge.

(*c*) Steps will be taken to provide for continuing the school feeding programme on a permanent basis, relating it where applicable to the milk conservation programme.

(*d*) The National Nutrition Board and the Nutrition Institute will co-operate with the responsible Ministeries in the implementation of the school feeding programme and in planning for its continuation and expansion.

Target time-schedule

487. UNICEF supplies will arrive in Iraq late in 1953 and the augmented programme will be carried out beginning in the school year 1953/54.

(ii) MATERNAL AND CHILD WELFARE SERVICES AND TRAINING

488. A basic problem in Iraq is the very high infant and child mortality. Although no reliable statistics are available, all information points to an infant mortality rate of 200 to 300 per 1,000 live births, with as high as 400 in some areas.

489. The immediate post-weaning period is the most dangerous for young children. The length of breast feeding varies from one year to two or even three years. The children are then weaned very suddenly, which causes deterioration in their health and a high incidence of mortality and morbidity from intestinal disturbances. The lack of maternal and child welfare services and trained personnel are severe handicaps to a solution of this problem. It is therefore felt that the first step should be training sub-professional personnel and gradually building services on that foundation.

490. Beginning with the founding of the Child Welfare Society in 1931 by a private group, including certain government officials, maternal and child welfare services in Iraq have been largely the concern of philanthropic groups. One of the first actions of the Child Welfare Society was the establishment of a public dispensary for sick children, now the main pavilion of the Baghdad Children's Hospital.

491. In 1951, the Iraq Red Crescent Society constructed a thirty-two-bed hospital dispensary for children in a needy section of Baghdad, financed from voluntary sources. After the war, the Child Welfare Society established four modern children's dispensaries in Baghdad, and during the past five years a number of children's dispensaries and hospitals have been constructed or partially completed by member branches of the Society in ten of Iraq's major towns. In a few cities the Red Crescent Society has also opened children's dispensaries. Through local initiative by the communities, small hospitals and dispensaries have been established in nearly every provincial town of Iraq, generally with funds from voluntary or local

community sources. Operating costs and the provision of personnel have since been taken over by the governments, with operations under the direct supervision of the provincial health authorities.

492. A section for maternal and child health services has existed on paper in the organization charts of the Iraqi Directorate of Public Health since 1947, but was not actually established. With the creation of the new Ministry of Health by parliamentary decree in April 1952, the Government began to take a more active role in establishing such services.

493. As an emergency measure, the Government has put into operation in the past two years four parallel midwifery courses, each of one year's duration. As a result, some seventy-five midwives have been trained for service in rural communities, and the Government plans to expand this training both qualitatively and quantitatively.

494. Under the United States Technical Cooperation Administration, a consultant on maternal and child health was attached in 1951 to the Directorate of Health (later the Ministry of Health), and has, in an advisory capacity to the Government and in co-operation with visiting WHO experts, carried out surveys to determine the basic needs in the field of maternal and child welfare.

495. The Government plans now to establish, under the supervision of the Maternal and Child Health Section of the Ministry of Health, an expanded maternal and child welfare system including the following:

(*a*) A model maternal and child welfare demonstration and training centre at Baghdad and smaller centres at Basrah and Mosul for the training of pediatricians, nurses, and community nurse-midwives;

(*b*) A rural health demonstration and training area, the location of which is still to be determined;

(*c*) Services for the care of children and expectant mothers, which will also provide rural training possibilities, in the rural district surrounding Samawa village;

(*d*) Government-supported maternal and child welfare services throughout the country, to be located principally in rural areas. Pre-natal and post-natal services and midwifery will be provided, as well as the preventive health care of infants and young children. To provide personnel for these services, the existing emergency courses for rural midwives will be upgraded and extended;

(*e*) The essential feature of the early phase of this entire programme will be the training of community nurse-midwives which will take place at the city and rural centres referred to above. Three hundred such workers will receive training in the Baghdad, Basrah and Mosul centres in the next three years.

496. The courses to be given in the three city centres will serve three sections of the country: Mosul is in the extreme north, Baghdad in the center, and Basrah in the south. The rural training course will, whenever feasible, take place in connexion with rural health projects being developed with WHO and TCA aid; otherwise, wherever adequate supervision can be arranged.

497. The training course for community midwives will be supervised by qualified personnel and is planned to last for eighteen months. The Government expects to train ninety midwives at the Baghdad centre and thirty each in Mosul and Basrah. The course will cover both theoretical and practical work in general nursing, midwifery, public health, child nursing, as well as practical work in preventive health services and practical work under rural conditions.

498. Upon completion of training, the community midwives will be required to serve as full-time government employees for a period of at least three to five years, working under the authority of the Chief Medical Officers and under the direct supervision of a qualified nurse-midwife. They will be assigned chiefly to rural areas and will operate from dispensaries or simple village maternal and child welfare stations. The plan is to attach one full-time nurse-midwife to each province.

UNICEF commitments

499. UNICEF will provide the following supplies and equipment, and will finance international personnel during 1953, at an estimated total cost of $81,000:

(*a*) Equipment for the Maternal and Child Welfare Demonstration and Training Centre at Baghdad; also drugs and diet supplements, including milk and soap for one year's distribution;

(*b*) Teaching and training equipment for the centres at Baghdad, Basrah, and Mosul;

(*c*) Basic equipment for 150 new maternal and child welfare village and provincial stations or posts to be staffed by the graduating nurse-midwives;

(*d*) Three hundred simple midwives' kits, one for each graduating community midwife in groups from Baghdad, Basrah and Mosul;

(*e*) Reimbursement to WHO for 1953 international project personnel expenses.

WHO commitments and technical approval

500. In addition to WHO experts already envisaged for the Maternal and Child Welfare Demonstration and Training Centre at Baghdad, WHO will recruit two nurse-midwife tutors for the community midwife course and the maternal and child welfare centres in Basrah and Mosul. Owing to the shortage of technical assistance funds, UNICEF will assume the cost of this personnel for 1953. The amount involved will be $6,000.

501. WHO participated in developing the plan of operations for this project and has given its technical approval. WHO will also make available the services of its Regional Office personnel and consultants as may be required.

Co-operation with United States Technical Cooperation Administration

502. UNICEF and WHO will collaborate closely with the United States Technical Cooperation Administration in order to co-ordinate all aspects of international assistance to the programme. The training centre at Samawa will be set up with the co-operation of US/TCA.

Government commitments

503. The Government undertakes to provide all personnel, materials, premises, supplies and equipment necessary for the project, except as provided for under WHO and UNICEF commitments. Specifically, the Government's commitments will include the following:

(*a*) *Personnel:* Two nurse-midwife tutors for the course at Basrah and Mosul as understudies, to succeed the international tutors upon their withdrawal; teaching staff for the training courses; one or more part-time doctors to undertake preventive health work at the maternal and child welfare centres at Basrah and Mosul; one or more full-time nurse-midwives; three or more home visitors; necessary service staff; and qualified nurse-midwife supervisors to assist and supervise the newly trained community midwives.

(*b*) *Premises:* Suitable accommodation for the courses, as well as the necessary premises for the maternal and child welfare centres in Basrah and Mosul; working facilities for graduated nurse-midwives in dispensaries or maternal and child welfare stations.

(*c*) *Equipment and supplies:* Furniture and all necessary supplies and equipment which can be locally acquired.

(*d*) *Remuneration to trainees:* Free board and lodging, or an allowance to cover such costs, and travel costs and allowances, when necessary, for all community midwife trainees for the period of their training. The government commitments for personnel, travel costs and allowances for the first three years, i.e., for the first two consecutive training courses, are expected to cost 42,500 Iraqi dinars ($119,000).

Target time-schedule

504. Commencement of this project is foreseen for November 1953.

Israel

(i) MATERNAL AND CHILD WELFARE SERVICES

505. The Executive Board approved the following assistance for maternal and child welfare services in Israel:

(i) *Expansion of existing services:* A $30,000 apportionment from the Eastern Mediterranean area allocation to provide supplies and equipment for additional maternal and child welfare centres; soap and fish-oil capsules for existing centres; and equipment and supplies for a maternity home;

(ii) *Handicapped children's programme:* A plan of operations, for which $20,000 is available from an earlier allocation, for the provision of transport; equipment for a rehabilitation centre; and supplies and equipment for making orthopaedic appliances.

506. The Executive Director was authorized to approve a plan of operations for assistance to maternal and child welfare services, as outlined in E/ICEF/R.413. The plan of operations for the handicapped children's programme is outlined in E/ICEF/R.420. In the case of maternal and child welfare services, this assistance is for extending a programme previously aided by UNICEF and already in operation. In the case of handicapped children, this is the first UNICEF aid to Israel.

With this action, UNICEF aid to Israel totals $959,000, as follows:

	Approved	Shipped: Through 1952	Shipped: 1953 and after
		$	$
BCG	Mar. 1949	84,000	—
Feeding and nutrition	Nov. 1949, June 1950		
	Nov. 1950, May 1951	393,200	—
Leather and textiles,	June 1950	22,800	—
MCW	Nov. 1949, Nov. 1951		
	Mar. 1953	92,500	46,800
MCP	Apr. 1952	—	300,000
Handicapped children	Mar. 1953	—	19,700
		592,500	366,500

(ii) EXPANSION OF EXISTING SERVICES

507. Since the end of 1950, the population of Israel has increased by more than 250,000 and now totals over 1,500,000. (This figure includes a large number of immigrants.) Births have risen from 36,000 in 1950 to an annual average of 50,000 in 1951 and 1952. The Government has maintained its policy of developing preventive health services for mothers and children and, despite severe economic problems, has attempted to keep pace with the rapid population expansion. There are at present 270 infant welfare centres. The need for additional work in this field in rural areas, especially in the new immigrant settlements, is demonstrated by the fact that the infant mortality rate is rising. The highest rate in 1951 occurred in rural areas settled by immigrants, which registered 82 per 1,000 live births compared with 39.02 for the whole country and 17 for the collective settlements (*kibbutsim*). Much of the infant morbidity and mortality could be prevented by a greater knowledge by mothers of hygiene and basic child care principles.

508. Previous UNICEF assistance to Israel for maternal and child welfare provided transport to serve 120 maternal and child welfare centres, and a small amount of equipment. Practically all of these supplies were delivered by the end of 1952, and have already been put to good use.

509. The Government now proposes to direct its main efforts towards expanding the existing network of infant welfare centres for maternal and child health, with special emphasis on preventive work in rural areas. An additional thirty such centres are planned for the financial years 1953/54, about one-third in each of the southern, central and northern areas. This will bring the total of functioning stations in the country to 300. Some of the new centres in the Galilee region will be opened in Arab villages where no adequate services have been available hitherto. These centres will each serve a population of about 100 pregnant women, 150 to 170 infants, 500 to 600 children aged 1 to 6 years, and 800 schoolchildren. Five of the twenty larger centres in settlements will be supervised by one public health nurse and a visiting obstetrician and a pediatrician. Twenty of the centres will be staffed by two fully qualified public health nurses and one nursery nurse as an aide, with a pediatrician, an obstetrician and an eye specialist as visiting doctors. A home midwifery service is planned for the Galilee region and one or

two new settlements. Although hitherto more than 90 per cent of births in Israel have taken place in institutions, in certain areas the scarcity and cost of transportation to hospital, lack of telephone service and prejudices against institutional deliveries have caused an increase in home deliveries. It is significant that there has been a sharp increase in infant mortality from tetanus, indicating complications resulting from untrained assistance at confinements.

510. In the Galilee area, near Tiberias, a ten-bed maternity home is planned to serve a large new immigrant settlement adjoining a camp of some 8,000 immigrants. Personnel and buildings are already available. The local municipal council will share with the Government the cost of maintenance expenses. There will be a staff of two midwives, a visiting obstetrician and pediatrician, and supporting personnel.

UNICEF commitments

511. UNICEF will provide:

	$
Standard equipment and expendable supplies for one year for thirty additional maternal and child welfare centres including midwifery kits and incidentals for five maternal and child welfare centres	19,700
13,000 lbs. of soap, and 2,600,000 fish-liver oil capsules for 100 existing centres	8,300
Equipment and supplies for ten-bed maternity home..	2,000
	30,000

Other international participation

512. The programme has the technical approval of WHO. WHO will continue in close consultation and will aid in determining final supply specifications. The United Nations Welfare Adviser for the Eastern Mediterranean Area has been consulted on social welfare aspects of the project and will co-operate as necessary during the implementation of the plan of operations.

Government commitments

513. The Government undertakes the following commitments:

(*a*) The construction of thirty centres and the maternity home. Several of the buildings are already available. Estimated capital cost: £120,000 (approximately $US336,000).

(*b*) An annual budget for the upkeep of buildings, maintenance of transport and salaries of the staff. This budget will become part of the permanent financial provisions of the Ministry of Health. Estimated annual cost: £120,000 (approximately $US336,000).

Target time-schedule

514. The equipment and supplies will be delivered as the centres are ready with facilities and staff, starting in the last quarter of 1953.

(ii) HANDICAPPED CHILDREN

515. In its maternal and child health programme, the Government has from the beginning emphasized preventive rather than curative measures with priority given to campaigns against infectious diseases, correcting disorders due to malnutrition, and the extension of maternal and child welfare services. Although emergency requirements still exist, the Government now feels that the major effort must be focused on the long-range needs of the child population.

516. The physically and mentally handicapped child is one of the most serious child welfare problems in the country. No exact statistics exist, but the mass immigration to Israel, largely from under-developed countries, produced a significant increase in the number of handicapped children. No immigrant was barred because of physical handicap.

517. An important cause of child handicaps is poliomyelitis, which has been endemic in Israel for some years, but assumed epidemic proportions for the first time in the spring and summer of 1950. The number of cases fell during the autumn and winter of 1950/51, but increased in the following spring and summer. Eighty cases were reported monthly from the winter of 1951/52 until the end of July 1952, the most vulnerable age group being from ten to thirty months. Eighty per cent of the cases were among children below five years of age. The percentage of paralytic cases and the fatality rate were exceptionally high. Necessary treatment measures were applied in the early stages of the epidemic and UNICEF air-shipped two iron lungs to Israel in May 1950, to assist the Government in meeting the emergency.

518. The concept of rehabilitation is well developed in Israel. Facilities and personnel for high quality care of the handicapped exist in hospitals, special rehabilitation and physical medicine departments and in sheltered workshops. But the demand for such services is so great that considerable expansion is needed.

519. Ambulatory treatment is available in all large towns, and special government-sponsored out-patient clinics for polio patients have been established at a number of hospitals. A special ward for the prolonged treatment of severely paralyzed patients is also maintained at the Government Hospital in Sarafand. At present 180 beds are available for children needing institutional care during rehabilitation, but this number is far from adequate.

520. A general rehabilitation centre is now being constructed at the Sarafand General Hospital near Tel Aviv. In addition to treatment facilities, the centre will include a school for physiotherapy, various sections for vocational and class-room training, a social welfare section and a special polio wing. The Government has purchased prefabricated buildings from Finland to house the centre.

521. The polio out-patient department of the Sarafand Hospital will be transferred to the rehabilitation centre, which will be able to care for fifty physically handicapped out-patients of all types per day. This department will be responsible for follow-up of children from the hospital and for polio cases requiring only ambulatory treatment. Children requiring out-patient care will be brought by bus to the rehabilitation centre where they will be kept in a special day nursery pending treatment. A workshop and fitting room for prosthetic appliances will be set up for the large numbers of children requiring braces and splints.

522. The present thirty-five polio beds at the Sarafand Hospital will also be transferred to the rehabilita-

tion centre, and a further forty-five beds will be added for polio victims.

UNICEF commitments

523. UNICEF will supply the following at an estimated cost of $20,000:

(*a*) A bus to transport out-patients from the surrounding towns and villages to the rehabilitation centre and back;

(*b*) Equipment for the polio wing of the Sarafand rehabilitation centre, including electro- and hydrotherapy apparatus and equipment for the remedial exercise gymnasium;

(*c*) Tools and certain raw materials for making orthopaedic appliances.

Other international participation

524. WHO will provide from its regular budget the following in connexion with establishment of the rehabilitation centre at Sarafand:

(*a*) International project personnel: one physiotherapist in charge of the centre; one teacher of physiotherapy;

(*b*) Fellowships for the Government's director of the rehabilitation centre and for the director in charge of technical medicine.

525. The estimated cost to WHO will be about $22,000. The proposed programme was originally investigated by a special WHO consultant in the third quarter of 1952. The plan has the technical approval of WHO.

526. The plan has been reviewed by the United Nations Department of Social Affairs and has its agreement. The United Nations Eastern Mediterranean Area Social Welfare Adviser has also been consulted and will co-operate further during its implementation.

Government commitments

527. The government will supply:

(*a*) Prefabricated houses;

(*b*) Technical and lay personnel;

(*c*) Hospitalization costs;

(*d*) Space and facilities for the prosthetic workshop and fitting room.

528. The cost of the prefabricated buildings will be $223,000, the estimated cost for erection and installations $280,000, a total of $403,000 of which approximately 50 per cent may be considered as for handicapped children alone. Recurrent costs of the programme are estimated at Israel £6 per bed per day for eighty children's beds ($16.86 per bed per day) or an estimated annual cost of $492,000. The total cost to the Government, therefore, for initial investment and operating costs will be approximately $693,000 for the first year of the programme.

Target time-schedule

529. Construction of the rehabilitation centre is well advanced and UNICEF supplies will be put to use upon delivery, which is planned for early summer 1953.

JORDAN

BCG ANTI-TUBERCULOSIS VACCINATION CAMPAIGN

530. The Executive Board approved an apportionment to Jordan of $7,000 from the Eastern Mediterranean area allocation for the reimbursement to WHO of expenses incurred during 1953 in connexion with international personnel for the BCG campaign. The plan of operation for the campaign is outlined in E/ICEF/212.

531. The aim of the campaign is to test the entire indigenous child population to the extent possible, vaccinating the negative reactors. It is estimated that from 150,000 to 200,000 children will be covered within the 12-month period of the campaign. It is also planned to establish a permanent BCG vaccination service. UNICCEF, under a previous apportionment, is providing $15,000 worth of tuberculin, vaccine, vehicles and other supplies and equipment. The campaign is scheduled to start in October 1953. WHO is recruiting international personnel (a doctor and a nurse); owing to the shortage of technical assistance funds they will be financed by UNICEF during 1953.

With this action, UNICEF aid to Jordan totals $475,000, as follows:

	Approved	*Shipped*	
		Through 1952	*1953 and after*
		$	$
Feeding	Oct. 1952	202,100	187,900
BCG	Oct. 1952	—	15,000
BCG personnel	Mar. 1953	—	7,000
MCW	Oct. 1952	—	63,000
		202,100	272,900

LIBYA

MATERNAL AND CHILD WELFARE SERVICES AND TRAINING

532. The Executive Board approved an apportionment to Libya of $11,000 from the Eastern Mediterranean area allocation for reimbursement to WHO for expenses for 1953 of international personnel connected with the maternal and child welfare services and training programme. The plan of operations is outlined in E/ICEF/212.

533. The Government is establishing a maternal and child welfare demonstration and training centre in the town of Yefren, some 100 miles from Tripoli. Yefren is the centre for a population of some 800,000. In former barracks buildings, a training school, maternal and child welfare centre, hospital, dispensary and health centre are being established. One of the major features of this project will be field training of rural community midwives, of which there are very few in Libya. After training, the midwives will be attached to rural health centres. A midwifery school will be established later.

534. Under an earlier apportionment of $43,000, UNICEF is providing various supplies and equipment for the project, as well as stipends for midwife training. Owing to the shortage of technical assistance funds, UNICEF will now assume expenses for 1953 connected with WHO-recruited international maternal and child welfare personnel.

535. With this action, UNICEF assistance to Libya is $154,000, as follows:

	Approved	Shipped Through 1952	Shipped 1953 and after
		$	$
BCG	May 1951	11,000	49,000
MCW	May 1951		
	Oct. 1952	29,900	53,100
MCW personnel	Mar. 1953	—	11,000
		40,900	113,100

Sudan

BCG anti-tuberculosis vaccination campaign

536. The Executive Board approved an apportionment to the Sudan of $4,000 from the Eastern Mediterranean area allocation for reimbursement to WHO of expenses for 1953 connected with international BCG personnel. The plan of operations for the BCG campaign is outlined in E/ICEF/212.

537. Tuberculosis is one of the major health problems of the Sudan. The Government is undertaking, among other measures, the establishment of a tuberculosis demonstration and training centre. BCG vaccination services will be integrated with the preventive aspects of this centre. The campaign is scheduled to start in October 1953. WHO is recruiting an international team consisting of a doctor and a nurse, for whom, owing to the shortage of technical assistance funds, UNICEF will assume the financing for 1953. Under a previous allocation of $25,000 UNICEF is providing vaccine, tuberculin, vehicles and other supplies and equipment.

538. With this action UNICEF aid to the Sudan totals $29,000, all for the BCG vaccination campaign:

	Approved	Shipped Through 1952	Shipped 1953 and after
			$
BCG	Oct. 1953	—	25,000
BCG personnel	Mar. 1953	—	4,000
			29,000

Syria

Anti-bejel/syphilis

539. The Executive Board approved an apportionment to Syria of $12,000 from the Eastern Mediterranean area allocation for reimbursement to WHO of expenses connected with international personnel for the anti-bejel/syphilis campaign during 1953. The plan of operations for the campaign is outlined in E/ICEF/184/Rev.1.

540. Bejel/syphilis is extremely prevalent in northern Syria where it is estimated that about 25 per cent of the children in rural areas are infected, and about four-fifths of all cases with infectious lesions are in children under 18. The Government has organized field teams to assist in carrying out a mass campaign in the area. All afflicted children and pregnant women are being treated. The campaign's aim is to examine 250,000 and treat 50,000 in a two-year period. Professional personnel will receive training to continue efforts to control the disease after the mass campaign is over.

541. UNICEF is providing laboratory and clinical equipment and supplies, penicillin, transport, etc., under a previous allocation. Owing to the shortage of technical assistance funds, UNICEF will assume expenses incurred during 1953 by international personnel recruited for the campaign by WHO.

542. With this action, UNICEF aid to Syria totals $202,700 as follows:

	Approved	Shipped Through 1952	Shipped 1953 and after
		$	$
BCG	Mar. 1949	48,400	1,400
MCW	Apr. 1952		
	Oct. 1952	14,100	41,800
Anti-bejel/syphilis	Apr. 1952	—	50,000
Anti-bejel/syphilis personnel	Mar. 1953	—	12,000
Anti-malaria	Apr. 1952	9,500	25,500
		72,000	130,700

Turkey

Maternal and child welfare services and training

543. The Executive Board approved an apportionment to Turkey of $115,000 from the Eastern Mediterranean area allocation to provide equipment, transport and diet supplements for maternal and child welfare services and training over a three-year period. This represents the first UNICEF assistance of this type to Turkey. The Executive Director was authorized to approve a plan of operations as outlined in E/ICEF/R.426.

544. Turkey has a population of over 21,000,000 of whom 75 per cent live in rural villages. There are nearly 40,000 villages, half of the village population living in villages of under 500 people. Only five cities in the country have a population of over 100,000. Istanbul is by far the largest, with over one million inhabitants. Average population density is about 25 per square kilometre.

545. Although no fighting took place on Turkish soil during the Second World War, the heavy mobilization of man-power resulted in epidemics of malaria, typhus, smallpox and plague. A special malaria control organization was established, which is today waging a successful fight against this disease. The most important infectious diseases still causing disproportionate morbidity and mortality in Turkey are tuberculosis, malaria, trachoma (which is widespread among children in certain regions of Southeast Turkey), and diseases resulting from poor sanitation.

546. The Government has made great efforts to provide hospitals and dispensaries in cities and in leading towns in rural areas. Significant progress has also been made in the training of *cotors* at the universities of Istanbul and Ankara. Training schools for nurses, sanitarians and country midwives have likewise been established. With the assistance of the Rockefeller Foundation a central hygiene institute has grown up at Ankara where nearly all of the sera and vaccines required for public health services are produced.

547. Public health efforts have been concentrated chiefly, however, in the field of disease control in the more populated parts of the country. Social and eco-

nomic progress in rural areas is still slow and in these areas the standards of maternal and child health are those of a relatively under-developed country.

548. Villages are usually situated at considerable distances from one another, often connected only by foot or donkey paths. Proper water supplies and sanitation are generally lacking. Access to doctors is limited (except in the case of the special malaria control campaign area). For mothers and children there are no special services except those provided by country midwives, and maternities and hospitals in some smaller towns. These limited health services are handicapped by lack of transport available for the small number of trained personnel. The only notable progress in the villages has been the increase in the number of village schools brought about by a vigorous government programme.

549. Although no reliable national statistics on birth and infant mortality rates exist, the increase in population of 415,000 yearly between 1945 and 1950 suggests a national birth rate of close to 35 per thousand per year. Between 35 per cent and 40 per cent of the total population are in the age-group 0-14. The infant mortality rate probably averages not less than 200 per 1,000 live births, and may be considerably higher in rural areas.

550. Up to 80 per cent of the births in the country are not attended by registered and qualified midwives or medical personnel, a fact that results in many infant and maternal deaths. The ignorance of most mothers concerning hygienic methods of food preparation results, every summer, in many cases of infant diarrhoea, a leading cause of infant mortality. Another cause is lack of proper environmental sanitation. The infant wrapping custom, and the severe winters in many areas, limit the amount of sunshine that most children receive, which means a considerable incidence of rickets. Regular epidemics of measles and diphtheria cause a significant number of infant deaths.

551. The national health budgets in Turkey have been as follows over the past four years:

Year	*Total*	*Per cent of total budget*
1950/51	56 million T.L. ($US 2,000,000)	3.8
1951/52	59 million T.L. ($US 2,035,000)	4.6
1952/53	73 million T.L. ($US 2,607,000)	5.3
1953/54 (proposal) .	80 million T.L. ($US 2,857,000)	—

552. The *per caput* annual public expenditure for child health and welfare is about 30 Turkish piastres (11¢). Until recently, there was no Maternal and Child Health Department in the Ministry of Health and Social Welfare. In the main provincial cities, there are 950 maternity beds under Ministerial or Municipal direction, ninety-two private beds and 570 maternity beds in other hospitals. Services are free, unless patients are able to pay. Most of the maternities provide pre-natal care for mothers residing in the towns.

553. Health centres in cities or rural areas work, where possible, in collaboration with a nearby maternity. In country areas there are now ninety Rural Health Centres located in the largest villages or small towns. These centres, each serving, theoretically, a population of 20,000, were designed to offer a range of public health services, including pre- and post-natal consultations, well baby clinics, environmental sanitation, as well as treatment of the sick; but many of them lack supplies and staff. Often they are limited to curative services because of the heavy demand and extremely limited personnel. Only a very small proportion of the population benefits from these restricted services.

554. The only other health services for mothers and children in rural areas are provided by 1,200 licensed rural midwives and 3,000 village sanitarians. The midwives have had a year's formal training and work in their own, or neighbouring, villages under the loose supervision of the county public health doctor. The village sanitarians, who have had one or two years' training, are in fact male nurses, but as such, are not able to assist much in the general field of maternal and child health. Their principal activity is acting as auxiliaries to the doctors, giving vaccinations, dispensing medicines, enforcing quarantine measures, etc. Large quantities of anti-malaria and sulpha drugs are dispensed free to the rural population.

555. Although the number of doctors is high (6,000) compared with many other countries in this region, few have been engaged in public health or preventive services, and most of them are concentrated in the large cities. There are 315 obstetricians; 170 in government service and the rest in private practice, and 170 pediatricians who work mainly in Istanbul. There is an acute shortage of nurses and midwives.

556. By the end of 1953, ten schools for nurses, city midwives and country midwives are expected to be operating with approximately 700 students enrolled. Since September 1952, two WHO nurses have been conducting courses for nurse-tutors at the School of Nursing in Ankara. These schools all require improved curricula and better teaching facilities. A number of visits have been made by WHO maternal and child health consultants to Turkey in connexion with discussions on improving and expanding preventive health services for mothers and children.

557. The Government gives high priority to maternal and child health work, and is now organizing a new Department for Maternal and Child Health in the Ministry of Health and Social Welfare. To increase the numbers and quality of personnel, particularly midwives, nurses and doctors, the following measures will be taken:

(*a*) The Government will re-open the School of Public Hygiene in Ankara, which has been closed since the beginning of the Second World War. This school will train all public health officers. Two refresher courses will be inaugurated in the summer of 1953 and the first full course will begin before the end of the year;

(*b*) A maternal and child health and training centre will be opened in Ankara and will work together with an excellent rural centre at nearby Etimesgut to undertake the post graduate training of doctors and nurse-midwives who will be working in rural areas as directors of rural health centres and nurse-midwives. Public health officers attending the School of Hygiene will

also attend certain courses at the MCW School. The Government will assign yearly to the centre, thirty qualified general nurses for six months' training in maternal and child health, who will be assigned, on graduation, mainly to rural centres. Training will also be provided for midwives practising in Ankara and other towns, and for district health officers from rural areas, students from the Ankara Medical School, and post-graduate training will be provided for qualified doctors;

(*c*) The curricula in the ten schools for nurses and midwives will be improved and re-oriented toward public health nursing and care of young children. Of these, the two schools for country midwives will be re-opened and the study course extended from twelve to eighteen months. There will be places for 140 students in these two schools;

(*d*) On completion of training, the Government will place the newly trained and retrained personnel; as staff becomes available, UNICEF equipment and expendable supplies will be provided for health centres during an initial period of one year;

(*e*) At five selected health centres and/or maternities simple mobile maternal and child health teams will be organized, each consisting of a doctor, a nurse-midwife and a driver, who will make regular trips to outlying villages. These mobile units will also supervise the work of the village midwives;

(*f*) Health education activities will be carried on through the organized centres. A WHO health education consultant will assist in developing a plan for this phase of the programme;

(*g*) Essential equipment and expendable supplies will be provided for ninety health centres.

UNICEF commitments

558. UNICEF will provide supplies and equipment as follows:

	$
(*a*) Instructional aids for ten nurse, midwife and country midwife schools	10,000
(*b*) Midwife bags:	
280 simple midwife bags for country midwife graduates	5,600
100 advanced midwife bags for ninety health centres and 10 maternities	4,000
(*c*) Equipment and supplies for ninety health centres	26,400
(*d*) Drug and diet supplements, including dried milk and fish-liver oil capsules, for ninety centres	45,000
(*e*) Five vehicles with strong chassis, semi-ambulance body	12,500
(*f*) Supplies for health education	5,000
(*g*) Contingency reserve	6,500
	115,000

WHO commitments and technical approval

559. WHO has given technical approval to the plan and will provide international personnel and certain supplies for Ankara Maternal and Child Health Centre and the School of Hygiene. The WHO resident public health consultant in Turkey has taken an active part in the planning and will continue to advise on the project.

Government commitments

560. The Government undertakes the following commitments in connection with this project:

(*a*) To organize and operate the School of Hygiene and the model MCW Centre in Ankara;

(*b*) To organize and operate ten nurse-midwife training centres, 656,278 T.L. ($US235,000);

(*c*) To employ graduates of these courses, assigning them with special emphasis on rural centres;

(*d*) To provide necessary funds for improving ninety health centres as staff becomes available; to employ requisite personnel to man the mobile teams attached to ten selected centres, 2,669,982 T.L. ($US 954,000);

(*e*) To provide necessary personnel and facilities for health education activities as planned with the advice of the WHO consultant.

Target time-schedule

561. It is expected that the Ankara Maternal and Child Welfare Centre and the School of Hygiene will be fully operating by late 1953. The supplies for the ten nurse-midwife training schools and some of the midwife bags should be delivered during the third quarter of 1953. Supplies for some health centres and vehicles may be delivered late in 1953, but the major portion will be required later. The timing of delivery of the supplies, and their internal distribution within Turkey, will be determined by UNICEF in collaboration with the Government and with the appropriate WHO personnel.

Total UNICEF aid

562. With this action, UNICEF aid to Turkey totals $437,000 as follows:

	Approved	Shipped: Through 1952	Shipped: 1953 and after
		$	$
BCG	May 1951		
	Nov. 1951	62,700	54,300
Feeding	May 1951	44,200	800
MCP	Oct.. 1952	—	160,000
MCW	Mar. 1953	—	115,000
		106,900	330,100

Europe

AUSTRIA

563. The Executive Board approved the following assistance to Austria:

(i) *Vaccine production:* A plan of operations covering the provision of supplies and equipment for the production of diphtheria, pertussis and tetanus vaccine, of which the cost to UNICEF, $30,000, is available from an unprogrammed balance; and a new apportionment of $4,000 from the Europe area allocation for reimbursement to WHO of expenses during 1953 of international personnel and fellowships connected with the programme.

(ii) *Maternal and child welfare services:* A plan of operations covering the provision of supplies and equipment for the National Rehabilitation and Training Centre for Handicapped Children at Wiener Neu-

stadt, at a total cost to UNICEF of $25,000, which is available from an unprogrammed balance.

564. Plans of operations for these programmes are outlined in E/ICEF/R.408 (vaccine production) and E/ICEF/R.407 (maternal and child welfare services).

This represents the first UNICEF assistance to Austria for vaccine production and an extension of aid to the handicapped children programme, for which the Board approved $15,000 in June 1950.

565. Total UNICEF aid to Austria is $6,231,400.

(i) DIPHTHERIA, PERTUSSIS AND TETANUS VACCINE PRODUCTION

566. The high infant mortality and general child morbidity in Austria, caused by diphtheria, whooping cough and tetanus has made it urgent for the Government to expand its child vaccination programme against diphtheria, and to initiate large-scale vaccination against whooping cough and tetanus, there being virtually none at present.

567. *Diphtheria:* According to a recent survey in Europe, Austria had the highest "all ages" mortality from diphtheria of all countries reviewed, with a rate of 5.29 out of 100,000 population. From a peak of 22,425 diphtheria cases with 1,473 deaths in 1943, the cases fell to 14,392 with 1,691 deaths in 1945; 10,846 cases with 425 deaths in 1948; and 7,414 cases with 218 deaths in 1951. The decline in 1948 and thereafter was in part cyclical, but essentially due to the beginning of anti-diphtheria vaccination. Unless this is intensified, however, a new peak is expected in 1954. Death from diphtheria strikes principally at small children.

568. *Pertussis* (whooping cough): The incidence of whooping cough, following also a cyclical pattern, is now steadily increasing again. The post-war "all ages" figure of 5,164 cases and 239 deaths in 1946, followed by small fluctuations in the ensuing years, dropped to 4,635 cases with 135 deaths in 1950 and then rose to 7,350 cases with 179 deaths in 1951, the highest morbidity rate in the past eleven years. Rates of broncho-pneumonia, often a direct consequence of whooping cough, are not included as no reliable figures are available.

569. *Tetanus:* Although tetanus is a less serious health problem than diphtheria or pertussis, ninety-four deaths were reported in 1951. Since reporting on tetanus is not compulsory, no accurate statistics concerning its incidence exist.

570. Since 1948-49, the Public Health Organization of the Austrian *Land* (provincial) Governments have carried out limited diphtheria vaccination programmes. It is estimated that 25 per cent of the children are now being protected. The quality of the vaccine now produced, however, is not satisfactory. Local methods for producing pertussis and tetanus vaccines likewise require considerable improvement. Meanwhile, almost no vaccination is undertaken against these diseases.

571. In order to expand the child vaccination programme, the Government has requested UNICEF's assistance in the form of essential equipment for production laboratories at the State Serum Institute, and has developed a plan of operations with the assistance of WHO and UNICEF.

572. The objectives of the proposed programme are as follows:

(*a*) To improve the production of sera and vaccines for the protection of children from childhood diseases, so as to meet the highest technical standards of quality, and to produce enough to give adequate protection to all Austrian children;

(*b*) From early 1953, to extend the present limited vaccination operations to cover all Austrian children as rapidly as possible, and to keep at least 70 per cent immunized against diphtheria and pertussis;

(*c*) To integrate services for vaccination against diphtheria, pertussis and tetanus as a permanent part of the Public Health Organization of Austria;

(*d*) To co-ordinate *Land* and Federal vaccination programmes to ensure uniformity of standards, procedures, record-keeping and reporting, throughout Austria.

573. The extended diphtheria and tetanus vaccination programme will be carried out through the *Land* Government public health agencies. Anti-pertussis vaccination will be added to the services in 1954, when the improved vaccine becomes available. Vaccines produced by the State Serum Institute, with equipment supplied by UNICEF, will be purchased by the Federal Ministry of Social Affairs which has set aside 600,000 schillings (approximately $US28,000) for the purpose. The vaccines will then be turned over to the *Land* public health agencies. Funds required for the administration, education, and local supplies for the *Land* campaigns have already been budgeted. The Ministry of Social Affairs will ensure national uniformity of procedures, reporting, and record-keeping. It is expected that some 200,000 children will be vaccinated in 1953.

574. The vaccines will be supplied entirely from the State Serum Institute.

UNICEF commitments

575. UNICEF will provide, at a cost of approximately $30,000, equipment for improvement of vaccine production and testing methods, equipment for purification of toxoid and for final standardization of the products, sterilization equipment, and equipment for automatic bottling and filling of the liquid product, and 1,000 platinum irridium needles for the vaccination campaign.

576. UNICEF will also reimburse WHO for expenses of an expert and a fellowship during 1953, at a cost of $4,000.

WHO commitments and technical approval

577. The project has the technical approval of WHO. WHO will recruit an expert in vaccine production, and will administer a fellowship for the director of the serum control section. Owing to the shortage of technical assistance funds, expenses for 1953 connected with the above will be borne by UNICEF.

Government commitments

578. The Austrian Government will undertake the following:

For production of sera and vaccines:

(*a*) Provide the necessary space and installations in the State Serum Institute, and install all UNICEF equipment;

(*b*) Provide the necessary trained personnel, facilities and services;

(*c*) Provide from the Institute, as the installation and operation of the new equipment permits, the necessary quantities of diphtheria, pertussis and tetanus vaccine;

(*d*) Appoint a trained director for the Serum Control Station.

For carrying out expanded vaccination programme:

(*e*) Ensure that sufficient funds and trained staff are available throughout Austria to carry out the public education and vaccination programme and to maintain necessary records;

(*f*) Make available from the Ministry of Social Affairs budget the sum of 600,000 schillings ($US28,000) to buy diphtheria and tetanus vaccine in 1953, and to assist the *Land* Governments in carrying out public health education in connexion with the programme. This sum will be increased, if necessary;

(*g*) Ensure that each *Land* will sustain expenses not borne by the Federal Government or the participating international organizations, particularly for extensive public health education, for recurrent costs of vaccination and local supplies, and for adequate record-keeping;

(*h*) Ensure that children will be vaccinated without payment through the Public Health Organization or those institutions collaborating with them;

(*i*) Supervise the execution of the programme by the *Land* governments to ensure its meeting the technical standards of WHO;

(*j*) Provide in its budget for 1954 on, the necessary sums to purchase platinum iridium needles to meet the needs of the permanent programme.

Target time-schedule

579. It is expected that the UNICEF equipment will be installed and in operation by the end of 1953, and that the plan of operations will continue through 1954 and 1955.

(ii) MATERNAL AND CHILD WELFARE SERVICES (HANDICAPPED CHILDREN)

580. Modern conceptions of treatment of physically handicapped children have a wide acceptance in Austria; the Government and private groups are rapidly developing facilities in this field. Among the basic problems are severe shortages of equipment and supplies to meet the greatly increased post-war needs, and the training of staff. Through WHO, the United Nations Department of Social Affairs and UNICEF, an attempt has been made to help Austria fill these needs.

581. United Nations and WHO consultants visited Austria in 1950 and 1951 and assisted the Government in establishing a rehabilitation programme, selecting institutions and reviewing staff and supply requirements. UNICEF supplies for physical therapy, gymnasia, bone and hip surgery and special hearing, speaking and seeing aids were in due course assigned to two hospitals and two special schools in Vienna and a rehabilitation hospital in Hermagor, Carinthia.

582. In the spring of 1951, a training course in the care of handicapped children in the United Kingdom was attended by professional staff from Austria's specialized institutions. The course was jointly sponsored by UNICEF, the United Nations Department of Social Affairs, the Technical Assistance Administration and WHO.

583. Visits to Austria during the past two and a half years have confirmed that UNICEF supplies have been put to effective use. However, it was realized by the Government and by the co-operating United Nations agencies that improving facilities in a number of different schools and institutions would not solve the over-all problem, since each centre operates as an autonomous unit, only very loosely related through the Federal Ministries of Education and Social Affairs, and through the National Society for the Welfare of the Handicapped.

584. The creation of a National Training and Rehabilitation Centre was therefore decided upon, whose aims and activities were planned with the help of United Nations and WHO consultants and UNICEF representatives in the course of 1951 and 1952. The Centre was opened in Wiener Neustadt on 1 November 1952 with a total of thirty-four children in residence and an additional thirty-seven children accepted for admittance when completion of building reconditioning and construction permitted. The regular number of children in residence will range from 100 to 120. Only children of normal intelligence for whom the facilities of a non-resident special school are inadequate and who give promise of achieving mobility and independence will be accepted.

585. This Centre should greatly assist in raising the standard of services for handicapped children by ensuring the close co-operation of seven *Land* governments with the National Society for the Welfare of the Handicapped, and with the Ministries of the Federal Government.

586. The objectives now are threefold:

(*a*) To strengthen and expand facilities for the care and rehabilitation of handicapped children;

(*b*) To establish a national training centre for personnel attached to other institutions for handicapped children in Austria;

(*c*) To provide a central point for the co-ordination and integration of handicapped children's services throughout the country.

587. The programme will focus on the correction of physical abnormalities and on individual educational and vocational training to fit the children for a life of independence. The Centre will also demonstrate modern methods of training personnel. Comprehensive plans have been developed to check on children who have left the school, to ensure their successful integration into society. An expert staff has been assigned to carry out the programme.

588. The Centre is administered by the Education Department of the *Land* Government of Lower Austria. A policy board will consist of representatives of the Federal Ministries of Education and Social Welfare, the National Society for the Welfare of the Handicapped, and the *Land* Government of Lower Austria. Seven of the *Land* governments of Austria are participating in the financing of the Centre, each having made an initial contribution of 5,634 schillings per child it is entitled to send, plus 30 schillings per child per day. By this means, some 400,000 schillings (approximately $US19,000) were available for operations at the time of opening the Centre.

UNICEF commitments

589. UNICEF will provide supplies and equipment, worth approximately $US25,000, for the following:

(*a*) The remedial gymnasium (e.g., walking frames, suspension apparatus, orthopaedic bicycles);

(*b*) The physiotherapy departments (e.g., springs, slings, lamps, whirlpool bath, adjustable chairs);

(*c*) The vocational training shops (e.g., sewing, weaving, metal work, woodwork lathes, grinding machines, benches).

Other international participation

590. The project has the technical approval of WHO and approval from the United Nations Department of Social Affairs, both of which participated in its development. The Government has requested the services of an international consulting physiotherapist for a period of six months, as well as fellowships for personnel of the Centre to study abroad. Discussions concerning these requests are taking place with WHO. Costs would be borne partly by WHO (regular budget) and partly by technical assistance funds.

Government commitments

591. The Government undertakes the following commitments in connexion with this project:

(*a*) To provide for new construction and reconstruction of buildings at the Centre as necessary;

(*b*) To make available sufficient trained personnel for the proper use of the facilities and equipment;

(*c*) To provide all local supplies and equipment necessary;

(*d*) To ensure that the requisite funds will be available for the continuing operation of the Centre.

Target time-schedule

592. It is anticipated that UNICEF supplies and equipment can be in place in the latter part of 1953.

YUGOSLAVIA

MILK CONSERVATION

593. The Executive Board approved an apportionment to Yugoslavia of $205,000 from the Europe area allocation for the purchase of equipment to reinforce the milk conservation programme and to permit expansion of the programme into two important milk producing areas. This represents an extension of UNICEF aid for milk conservation. The Executive Director was authorized to approve an amended plan of operations as outlined in E/ICEF/R.436.

594. The first UNICEF allocation for milk conservation for Yugoslavia was made in February 1949. Since then, succeeding allocations have been made for three drying plants and seven pasteurization plants, including milk testing laboratories.

595. The present status of these projects is as follows:

Milk drying plants	*Daily output in litres*	
Osijek	16,000 (2,900 lbs. of dried milk, 5,500 pasteurized)	In operation since October 1951
Zupanja	13,500 (2,400 lbs. of dried milk)	In operation since June 1952
Murska Sobota		Due to start operating in September 1953
Central dairies		
Belgrade (old dairy)	54,300	New equipment operating since October 1951
Ljubljana (old dairy)	22,000	New equipment operating since April 1951. A new building is under construction, and the equipment should be transferred and operating in the new premises in December 1953
Rijeka (old dairy)	—	New equipment due to start operating in modernized premises in August 1953.
Novi Sad (new dairy)	23,000	In operation since March 1952
Zagreb (new dairy)	38,000	In operation since August 1952
Skoplje (new dairy)	18,500	In operation since October 1952
Sarajevo (new dairy)	—	Dairy completed at the end of 1952 and due to start operating in March 1953
Central Laboratory, Belgrade		Under construction. Due to start operating early in 1954

596. *Collecting Centres.* UNICEF is equipping sixty-one collecting centres for the above-mentioned dairies with low temperature milk cooling facilities. By the end of 1952, forty-seven collecting centres were in operation, seven were due to start operating in the early part of 1953, and seven were at the building and erection stage.

597. In the development of a milk conservation programme UNICEF has assisted in stimulating a demand that good quality milk be made available to children on a permanent basis. Marked improvement has already been achieved in the largest cities, where pasteurized fluid milk is being distributed. Powdered whole milk is going to the more remote areas of the country, but large numbers of children are not yet reached. Distribution arrangements are not yet balanced with the production capacity of the dairies and the raw milk supply available.

598. An FAO survey, undertaken in the latter part of 1952, showed that malnutrition due to lack of proteins in the diet, coupled with milk-borne gastro-intestinal diseases, are still the main causes of the high sickness and death rate of infants and children.

599. UNICEF engineers and FAO consultants have kept in constant touch with the development of the past programmes, and have noted the tremendous advance that has been achieved since the original UNICEF-assisted projects were started in 1949. However, it is also apparent that there are still various difficulties to be overcome before the plants already installed can operate at full capacity, and before the population can derive the maximum benefit from those installations which are already operating.

600. For example, since milk is sometimes spoiled during its passage from the production plant to the processing dairy, owing to very hot summers, special attention must be given to improving collection systems. In addition, as the dairies approach maximum production, difficulties in distribution are becoming apparent. In many cases milk is being distributed over wide areas, and in cases where there is a single distributing point, i.e., the cold store at the dairy, steps must be taken to reduce the period between the time when the milk leaves refrigerated cold storage and the time when it reaches the ultimate consumers.

601. The Government's three-year plan has the objective of making safe milk available to all children throughout the country. This will require three milk-drying plants and ten pasteurizing centres in addition to those dairies and dry milk plants which are already in operation. One of the drying plants and one pasteurizing centre were provided for through action of the Board in April 1952.

602. The next step is to improve milk collection and distribution facilities, and to establish new dairies in potentially good dairy production areas not previously equipped.

603. This expansion of the dairy industry will involve a large amount of processing equipment and transport. The Government is building up a dairy equipment manufacturing industry which will meet some of the requirements, and locally-built trucks will also be available.

604. A Central Control Board, recently established by presidential decree, is responsible for planning, co-ordinating and improving milk production, milk handling and distribution. The Board will advise on milk regulations and supervise the enforcement of milk standards, an essential factor in the success of the UNICEF-assisted milk programme.

605. The present plan provides for the following:

(1) *Reinforcement of existing programme*

(*a*) Refrigeration equipment for six collecting centres and three distributing depots to increase use of existing pasteurizing capacity;

(*b*) Two bottle fillers and cappers for erection in existing dairies in Skoplje and Osijek;

(*c*) Fifteen trucks to be distributed amongst existing and new dairies.

(2) *Limited extension of the over-all programme*

Equipment for two new fluid milk dairies situated at Nish and Banja Luka.

606. Milk collection and distribution facilities in Belgrade will be improved through the installation of refrigeration equipment in producing centres and establishment of a refrigerated distribution depot within the city from which retail distribution can be effected.

607. Two other plants still to be finally selected will be provided with distribution depots.

608. In the Skoplje area, some of the milk which is transported direct from production points to the UNICEF-equipped dairy is spoiled on arrival because of the distance involved, and inadequate cooling. Establishment of three additional collecting centres in the villages will enable the milk to be deep cooled before transportation, and ensure its arrival at the dairy in good condition.

609. When the Skoplje and Osijek dairies were originally set up they were equipped with bottle fillers of small capacity, available in the country. The bottling capacity of these dairies must now be extended, and bottle filling and capping machinery adequate for present requirements will be supplied. The bottle washing machinery is being manufactured locally, and is some of the first of its kind to be manufactured by the new Yugoslav dairy equipment industry. All machines being replaced at Osijek and Skoplje will be transferred to smaller dairies being equipped by the Yugoslav Government.

610. The Yugoslav Government has stated that the automobile industry will, in two years' time, be able to supply all the transport requirements for the dairy industry thereafter. At the present stage only fifteen locally produced trucks can be be made available, which is not sufficient for the steadily increasing output of the dairies. UNICEF will, therefore, supply chassis for fifteen additional ones for which the Government will provide the bodies.

611. The areas of Nish and Banja Luka are known to be potentially good milk production areas. There are some 80,000 inhabitants in the Nish area and some

50,000 in the area around Banja Luka. Neither town has any facilities for processing existing milk supplies. Therefore local processing dairies will be installed in each of these towns, not only to fill the requirements of the towns themselves, but to pre-heat and cool any surplus to enable it to be transported to dairies in milk-deficient areas.

UNICEF commitments

612. (*a*) For three distribution depots: refrigeration units.

(*b*) For six collecting centres: refrigeration plants, complete.

(*c*) For the existing dairies at Skoplje and Osijek: bottle filling and capping equipment.

(*d*) For the new dairies of Nish and Banja Luka: equipment for weighing, clarifying, pasteurizing, bottling and capping, refrigeration, refrigeration for collecting centres, laboratory equipment, and interconnecting piping.

(*e*) For the whole programme: fifteen trucks without bodies.

Total estimated cost of this equipment: $205,000.

FAO technical approval

613. FAO has actively collaborated in the formulation of the plan, when taking part in joint FAO/UNICEF surveys, and the scheme has the technical approval of FAO.

Government commitments

614. The Government of Yugoslavia undertakes to complete these various projects as follows:

(*a*) *Capital costs,* estimated at 450,000,000 dinars ($US1,500,000) to provide: land, buildings, cold store insulation, water, steam, electrical and sewerage services, labour, storage tanks, bottle washers, can washers, churns, crates, bottles, conveyors, butter churns, coolers, water pumps, and fifteen transport trucks;

(*b*) *Milk distribution,* at an estimated cost of 150,000,000 dinars ($US500,000). The Government will ensure free milk distribution, in addition to schemes already undertaken in connexion with previous UNICEF assistance, to approximately 10,000 children, who will receive ¼ litre of milk a day, 300 days a year for five years, either at subsidized prices or free, in the areas of Nish and Banja Luka:

(*c*) *Availability of safe milk.* The present project will make available safe milk to an additional 100,000 persons, largely women and children;

(*d*) *Transport.* The Government will provide fifteen new trucks of domestic manufacture for assignment to dairies assisted by UNICEF, and the bodies for the fifteen new UNICEF truck chassis;

(*e*) *Distribution of fresh milk.* With the establishment of three refrigeration depots, the Government will reorganize the retail distribution of milk in three areas in different cities, with special attention to meeting the needs of children and mothers for fresh safe milk.

(*f*) *Quality of raw milk.* With the improvement of the collection arrangements, the Government will take steps to improve the quality of milk at the source of production.

Duration of the plan of operations

615. The present detailed plan of operations, signed on 23 October 1952, will be extended and supplemented as necessary.

Target time-schedule

616. Target dates for this project are as follows:

Agreement on amended plan of operations, July 1953;

Placing of contracts, Aug. 1953;

Completion of buildings and services ready for reception of the UNICEF equipment, August 1954;

Delivery of equipment, Sept. 1954;

Installation completed, Dec. 1954;

Start-up of plans, Jan. 1955;

Start-up of distribution to beneficiaries, Feb. 1955.

617. Where buildings are already in existence, much equipment will be supplied earlier.

Total UNICEF aid

618. With this action, UNICEF aid to Yugoslavia totals $15,459,300 as follows:

	Approved	*Shipped* Through 1952 $	*Shipped* 1953 and after $
Feeding	$885,000 in 1951 Rest prior to 1951	10,123,800	—
Materials for shoes and clothing	Prior to 1951	1,271,600	—
Anti-syphilis	$40,000 in 1951 Rest prior to 1951	367,000	3,300
Antibiotics production	May 1951	40,700	49,300
MCW	$253,000 in 1952 Rest prior to 1951	1,470,800	266,100
MCP	$205,000 March 1953 $210,000 in 1952, $ 40,000 in 1951, Rest prior to 1951	898,700	445,300
BCG-Joint Enterprise (ITC)	March 1948	277,300	—
Miscellaneous emergency supplies (soap)	Prior to 1951	191,200	—
Transport	April 1951	21,200	28,800
Under discussion ...			4,200
		14,662,300	797,000

Latin America

Bolivia

619. The Executive Board approved an apportionment to Bolivia of $24,500 from the Latin America area allocation for the following:

(i) *Maternal and child welfare services:* $18,000 for equipment, transport and supplies for rural maternal and child welfare services in the areas of Tarija and Oruro.

(ii) *Anti-malaria:* $6,000 for reimbursement to WHO of international project personnel for 1953.

(iii) *BCG anti-tuberculosis vaccination campaign:* $500 for reimbursement to WHO of international project personnel for 1953.

620. The Executive Director was authorized to approve a plan of operations for maternal and child welfare services as outlined in E/ICEF/R.400. The plan of operations for the anti-malaria campaign is outlined in E/ICEF/212. The BCG campaign is being carried out by the Government, and UNICEF assistance is only for reimbursement to WHO for international personnel expenses in 1953.

621. This constitutes the first UNICEC assistance to maternal and child welfare work in rural areas of Bolivia, although UNICEF has previously provided equipment for a children's hospital in La Paz. The BCG campaign has not previously been aided by UNICEF whereas the anti-malaria campaign received an apportionment of $42,000 in October 1952.

622. With this action, UNICEF aid to Bolivia totals $242,500 as follows:

	Approved	Shipped	
		Through 1952	*1953 and after*
		$	$
Anti-typhus	Nov. 1949	48,300	1,500
Anti-malaria	Oct. 1952		
	Mar. 1953	—	48,000
Soap	Oct. 1952	4,500	—
MCW	June 1950		
	Mar. 1953	32,100	103,400
BCG campaign	Mar. 1953	—	500
Under discussion			4,200
		84,900	157,600

(i) MATERNAL AND CHILD WELFARE SERVICES

623. Partial statistics indicate an infant mortality rate in the neighbourhood of 230 per 1,000 live births. Figures from some official sources seem to indicate a lower figure, but the Government believes the higher one is more accurate.

624. Causes of death vary greatly with the locality, but the principal cause, nutritional disturbances and respiratory infections, are particularly responsive to improved infant care. The danger from malaria, whooping cough, gastroenteritis, smallpox and prematurity, also important causes of death, can likewise be greatly reduced by preventive care.

625. A suitable programme of maternal and infant care can also do much to reduce the neglect and ignorance present in rural areas, where medical facilities are generally insufficient and often non-existent.

626. As one step in improving national health services, the Government has created a Department of Mother and Child Services, which operates the following:

(*a*) Infant dispensaries in the capitals of the several Departments, most of which are inadequate to provide all the services required. Plans are under study to improve them;

(*b*) Children's wards in the principal hospitals which contain, however, a total of only 100 beds for the whole country;

(*c*) Children's Hospital of forty beds in the city of Santa Cruz;

(*d*) Twelve health centres and two mobile health units operated by the Inter-American Cooperative Service for Public Health (SCISP), which the Government assists financially, and a large portion of whose work is with mothers and children.

627. The Government also has under construction a children's hospital in La Paz which is scheduled for completion this year and which has already received UNICEF assistance.

628. A series of rural maternal and child welfare centres is now proposed for an area within fifty to one hundred kilometres of the cities of Tarija and Oruro. These localities are not now served by adequate maternal and child welfare services. The population lives largely in small communities accessible from the urban centres by all-weather roads so that service, once set up, can be maintained uninterruptedly. Tarija is also the seat of a school of midwifery and thus provides training facilities. Oruro is a thickly populated mining district where the need for development of maternal and child welfare services is keenly felt. Six rural centres will be set up in each of the two areas.

629. In the Tarija area these will be located in six villages and will serve a rural population of about 15,000 people, of whom a little over one-third are children under 15, and about 600 will, at any one time, be pregnant women. The population served by each centre will vary from about 2,000 to 5,000 and it is estimated that the six centres will serve some 720 patients per month or over 8,500 per year.

630. The Tarija area is in a mountain valley with a sub-tropical climate. The town itself has an altitude of about 1,900 metres (6,232 feet). The whole area is in a malarial zone which is included in the anti-malaria campaign now receiving UNICEF assistance. Gastroenteric disorders are widespread; intestinal parasites are generally prevalent resulting in a high frequency of anemia of ferrous deficiency type, especially among children. However, reliable statistics as to the incidence of these diseases are not available.

631. A fully trained midwife, who will reside permanently in the locality and provide regular services, will be in charge of each rural centre. One doctor and one trained nurse working out of the health centre in Tarija will make two visits per week to each centre in rotation. The centres will provide pre-natal and post-natal care and home delivery service, as well as care of the new-born (both sick and well-baby clinics) and general health control of pre-school and school age children. Services will include controls of growth and general health, together with advice on care, feeding, preventive vaccinations, etc.

632. The Government intends to carry on a health education campaign throughout the area, on an individual basis with each patient in the rural centres, while in addition the doctor or nurse will give lectures on various aspects of health in all major population centres. To fit them for this work they will be given courses in educational methods by the Department of Health Education.

633. In the Oruro area, the rural centres will also be set up in six villages. This zone is situated on the high plateau; the town of Oruro itself is some 3,500

metres (11,840 feet) above sea level. The centres will serve a rural population of about 60,000 inhabitants of whom some 21,000 will be children under 15 years of age and about 2,400 will be pregnant women. It is estimated that the six centres will serve some 1,800 patients per month or over 21,000 per year.

634. The area around Oruro is above the level at which malaria is found, but suffers from recurrent outbreaks of typhus. Intestinal parasites, some gastro-enteritis and a high incidence of respiratory disorders, including whooping cough and broncho-pneumonia, exist, though exact statistics as to incidence are not available.

635. The organization of the work in the Oruro zone will be identical with that in Tarija, with a fully trained licensed resident midwife in charge of each centre, and semi-weekly visits of a doctor and a trained nurse. Identical services and an identical health education programme will be provided.

636. Direct responsibility for the administration and execution of the programme will lie with the Directors of the SCISP Health Centres at Tarija and Oruro. Over-all administrative responsibility will lie with the Ministry of Hygiene and Health.

UNICEF commitments

637. At an estimated total cost of $18,000 UNICEF will provide the following:

(*a*) Station wagons for transport of doctors, nurses and to move emergency cases from the rural areas to the urban health centres;

(*b*) Midwife kits and bicycles for the midwives, minimum equipment and drugs for twelve rural type maternal and child health centres;

(*c*) Kits for two doctors and two nurses, and other miscellaneous supplies.

Other international participation

638. The plan has the technical approval in principle of WHO. The Inter-American Cooperative Service for Public Health will co-operate by providing the services of their laboratories, X-ray and vaccination services, health educators, and environmental sanitation programme, now existing at Tarija and shortly to be opened at Oruro, as required by the rural centres. SCISP will also undertake, through these health centres, the special training for work in rural areas required by the professional personnel.

Government commitments

639. In addition to its present expenditure for rural health purposes, the Government is including in its 1953 budget, and has undertaken to budget annually hereafter, a sum of 4,300,000 bolivianos (approximately $US72,000) for personnel and operating costs for the twelve rural centres. This sum will, in addition to costs of equipment, rental, light, heat, expendables for centres, travel of personnel, upkeep of vehicles, etc., permit the engagement of the following additional personnel for the purposes of this programme: two doctors; two trained public health nurses; twelve trained licensed midwives; and two drivers (it is expected that the other vehicles can be driven by a doctor or nurse).

Target time-schedule

640. These centres can come into operation as soon as supplies arrive. Organization of satellite rural centres in the Oruro zone will not take place until after July 1953, at which time the main health centre is expected to be in operation.

(ii) ANTI-MALARIA

641. For over two years the Government has been carrying on a limited campaign against malaria, which is found in endemic or epidemic form in over 25 per cent of the country's area. The campaign is now being expanded to cover the entire malaria zone and will protect some 160,000 people. Under an earlier apportionment UNICEF is providing DDT, transport and other equipment. WHO has recruited an expert malariologist who, owing to the shortage of technical assistance funds, will be financed by UNICEF during 1953 at a cost of $6,000.

(iii) BCG ANTI-TUBERCULOSIS VACCINATION CAMPAIGN

642. Owing to the shortage of technical assistance funds, UNICEF will provide $500 for expenses during 1953 connected with BCG international personnel recruited by WHO. The Government is providing all supplies and equipment for the campaign.

BRAZIL

643. The Executive Board approved assistance for Brazil as follows:

(i) *Long-range feeding:* $249,000 from the Latin America area allocation to continue the child feeding programme in the north-eastern states;

(ii) *Maternal and child welfare services:* A plan of operations covering the provision of basic maternal and child welfare equipment for health centres, and milk and fish-liver oil capsules, for the states of Para and Amazonas; the cost to UNICEF, $32,000, is available from an earlier allocation for similar aid in adjoining north-eastern states.

644. The Executive Director was authorized to approve a plan of operations for long-range feeding as outlined in E/ICEF/R.425. The plan of operations for maternal and child welfare services is outlined in E/ICEF/R.427. This represents an extension of UNICEF assistance to both types of programmes.

645. With this action, UNICEF aid to Brazil totals $1,849,000 as follows:

	Approved	Shipped	
		Through 1952	*1953 and after*
		$	$
MCW and feeding	Mar. 1950	448,400	10,000
MCW	Nov. 1951		
	Mar. 1953	63,000	190,300
MCP and feeding	Nov. 1951	—	330,000
Emergency	Apr. 1952	513,300	36,700
Feeding	Mar. 1953	—	249,000
Under discussion			8,300
		1,024,700	824,300

(i) LONG-RANGE FEEDING

646. This represents a continuation of UNICEF assistance to an emergency feeding programme approved by the Executive Board in April 1952. Further aid is needed to provide immediate relief in the present drought situation. It is expected that by mid-1954 the Government will be able to maintain a long-range feeding programme from its own resources.

647. Severe droughts periodically affect the interior of a number of states in north-east Brazil, namely, Piaui, Ceara, Rio Grande do Norte, Paraiba, Pernambuco, Alagoas and Sergipe, and the northern part of the interior of Bahia. The population of this area is about 16 million persons.

648. The effects of the drought cause considerable numbers of people to move to the coast. In the past, many have died during the journey; moreover, there is no food surplus in the coastal zone. In spite of government efforts to prevent this migration, through the organization of relief projects such as the construction of dams, it continues unabated.

649. The aid approved in April 1952 went to help combat the effects of the present drought, which at that time had continued for two years. Although some rain has fallen since, the drought continues.

650. It has been exceptional for its length and extent, and also in its effect on the state budgets. While certain states, such as Alagoas, have maintained the level of their tax revenues, others with more complex economies such as Pernambuco and Bahia, will be unable to avoid serious budgetary deficits for 1952 and 1953.

651. Other developments have aggravated the situation, notably the recent fall in the relative prices of raw materials, which is felt particularly by the states of Bahia, Pernambuco, Paraiba and Ceara.

652. Increased social welfare costs resulting from the drought are a severe strain on the local economy. Some aid in this situation has been given through federal contribution. A law approved in 1952 provides for 34,200,000 cruzeiros ($US1,710,000) to be used for aid to emigrants, and for public works to stabilize the economy and thus the population in the north-east.

653. The Brazilian Congress approved a special appropriation of 10,000,000 cruzeiros ($US500,000) for the extension of maternal and child welfare centres and services assisted by UNICEF. The appropriation is to be used in part to complete construction of maternities and child care centres and to help the states with initial maintenance costs. The rise in construction costs in Brazil renders this work urgent. While a portion of the budget of the National Department of Child Welfare will be used for milk, it is undesirable to divert too many funds from the long-range objectives into large expenditures for milk.

654. The first UNICEF apportionment provided dry skim milk powder, and fish-liver oil capsules which were distributed to some 100,000 beneficiaries in the area, primarily through health centres, maternities and milk distribution posts. This has made possible a control of relief distribution, and at the same time has given it long-range feeding assistance possibilities. The authorities have been gradually reducing the number of beneficiaries to a level at which feeding could be continued from Brazilian resources. Beneficiaries in December 1952 numbered 70,000, and it is proposed to continue the programme at this level for the next year, with a daily ration of 40 grammes per head per day. As to the effects of the UNICEF milk, the Governor of the state of Paraiba has stated that "UNICEF milk has saved the lives of a generation of infants".

655. Distribution of the milk and capsules will continue to be made to mothers and children through health centres, maternities, and milk distribution posts as at present. The states included are Maranhao, Piaui, Ceara, Rio Grande do Norte, Paraiba, Pernambuco, Alagoas and Bahia.

656. It is expected that this will be the last UNICEF contribution of milk for this programme and that from June 1954 on the Government will continue distribution from its own resources.

UNICEF commitments

657. UNICEF will provide 1,900,000 lbs. of dry skim milk at an estimated cost of $190,000, and 21,000,000 fish-liver oil capsules at an estimated cost of $59,000.

Government commitments

658. The Government will continue to bear all costs of reception, warehousing and internal distribution of the milk and capsules.

659. Immediate steps will be taken to prepare financially to carry on the feeding programme at the same level after UNICEF aid ceases in mid-1954. The National Department of Child Welfare has 1,000,000 cruzeiros ($US50,000) in its 1953 budget for the purchase of milk. With this it is planned to procure semi-skimmed milk for some infants. The Department has agreed to ask for 6,000,000 cruzeiros ($US300,000) in its 1954 budget for milk during the last five months of 1954, and 16,000,000 cruzeiros ($US800,000) for 1955.

Target time-schedule

660. Present stocks of UNICEF milk will be exhausted by mid-1953. It is planned to have additional stocks in place by that time to enable unbroken distribution until mid-1954.

(ii) MATERNAL AND CHILD WELFARE SERVICES

661. The states of Para and Amazonas have relatively under-developed services for mothers and children. A total population of 1,700,000 lives in an area of 2,800,000 square kilometres, 3 per cent of the population of the whole country living in 33 per cent of the total area. Twenty per cent of the population of Para is concentrated in the capital, Belem, and 15 per cent of the population of Amazonas lives in the capital city, Manaus.

662. The climate is hot and humid with an average temperature of 80 degrees Fahrenheit. Enormous natural resources are largely unexploited and the people live chiefly from extractive industries and subsistence agriculture. Alternate flooding and drying up of the rivers and the constant struggle against the

invading forest make agriculture and husbandry extremely difficult.

663. Low standards of living prevail. There is a general deficiency of proteins, vitamins, and mineral salts in the diet. Milk is scarce and of poor quality. The usual diet consists of manioc flour, sweet potatoes, corn, some fish and limited quantities of hunted meat. In Para the legal minimum daily wage of a labourer is 20 cruzeiros (approximately $US1.00). Meat costs 12 to 15 cruzeiros per kilo; one egg costs 2 cruzeiros; a litre of milk 6 cruzeiros.

664. Reports of infant mortality in 1950 show very high rates: in Belem 250, in Manaus 393, per 1,000 live births.

665. The principal agency attacking the health problems of the Amazon Valley is the Special Public Health Service (SESP), a joint organization of the Institute of Inter-American Affairs and the Brazilian Government. In 1952 SESP was operating sixteen health centres providing maternal and child health services in Para and Amazonas, as well as other public health activities, including malaria control, environmental sanitation programmes, etc. Its budget for activities in the Amazon area is 41,000,000 cruzeiros per year ($US2,210,000).

666. In the two states there are a total of seven maternities, six child care posts, six nurseries, and three children's hospitals operated by the state governments or by various voluntary religious organizations. Some assistance is received from the Federal Government; between 1946 and 1951 approximately 4,700,000 cruzeiros ($US253,000) in federal funds went to the two states largely for construction of new buildings and advisory services.

667. It is now proposed to strengthen the maternal and child health structure in Para and Amazonas by providing equipment and expendable supplies, mainly milk, for distribution through existing health centres.

668. Non-expendable basic equipment will be provided for centres operated by the states in a plan worked out with the advice of WHO. Some equipment will go to private centres, providing the State Public Health Departments or the National Department of Child Welfare undertake to supply funds and personnel and to assure proper use of the equipment, in accordance with basic UNICEF policies.

669. Milk and fish-liver oil capsules will be provided for distribution to 430 mothers and 870 infants through twenty-six outlets in the two states, fourteen operated by SESP and twelve by the State Public Health Departments. The SESP organization in both states and the Secretary of State for Public Health in Para have agreed to continue distribution of milk at this level after one year of UNICEF assistance.

UNICEF commitments

670. UNICEF will provide basic equipment for maternal and child health centres, and for maternal and child welfare sections of general health centres, to the approximate value of $20,000. In addition, milk and fish-liver oil capsules will be provided for 1,300 mothers and infants for one year at a cost of $9,000. A reserve of $3,000 makes up the total of $32,000.

WHO technical approval

671. WHO has given its technical approval to the plan of operations.

Government commitments

672. The Government agrees to finance all costs of reception and distribution of the supplies; to provide necessary qualified personnel to utilize the UNICEF equipment; and to continue the distribution of milk at the same level after one year of UNICEF assistance.

Target time-schedule

673. It is anticipated that UNICEF supplies will be in place late in 1953.

British Guiana

BCG anti-tuberculosis vaccination campaign

674. The Executive Board approved assistance to British Guiana for a mass BCG anti-tuberculosis vaccination campaign as follows:

(i) An apportionment of $17,500 from the Latin America area allocation for tuberculin, vaccine and other supplies and equipment, and for reimbursement to WHO for expenses of a technical adviser during 1953;

(ii) $1,000 for fellowships for two public health nurses from an existing Latin America area allocation for BCG observers.

675. The Executive Director was authorized to approve a plan of operations as outlined in E/ICEF/R.402 and E/ICEF/R.402/Corr.1. This constitutes the first UNICEF assistance to British Guiana.

676. British Guiana is approximately the size of Great Britain. It has a seaboard of roughly 270 miles and a total area of 83,000 square miles of which only 250 square miles along the coast and up the rivers are cultivated. The population of the colony is approximately 425,000, of which 44 per cent are East Indians, 38 per cent Africans, 10 per cent mixed, 4 per cent Amerindians and the balance Europeans, Chinese and others. The birth rate is 40.4 per thousand; the death rate 14.8 per thousand. Eighty-six out of every 1,000 live born infants die in the first year.

677. Amerindians, Africans and East Indians are the groups most susceptible to tuberculosis and comprise 86 per cent of the population. With the Amerindians and Africans, the disease is apt to be acute, while with the East Indians, who are somewhat less susceptible, it is more apt to be chronic.

678. Malaria, previously the most important public health problem, has been brought under control in recent years, while tuberculosis, according to a recent report of the Director of Medical Services, has become one of the principal causes of death.

679. A temporary medical service was established for the Amerindians in the interior of British Guiana in 1949; later it was made a permanent part of the Medical Service of the Colony. This service performs useful functions, including treatment of parasitic and insect-

borne diseases and training in elementary nursing and aseptic midwifery procedures.

680. A BCG anti-tuberculosis vaccination campaign was started among the Amerindians in the interior in 1951 and is still under way, but the results have been disappointing because of unsatisfactory vaccine. The total cost of the campaign is borne by the local government of the colony.

681. Services available for control of tuberculosis consist of diagnostic, treatment and laboratory facilities, as well as a dozen government medical officers and health visitors. Treatment facilities at three hospitals cost the Government $BG240,240 (approximately $US141,320) per year.

682. In response to the Government's request, WHO and UNICEF have assisted the Director of Medical Services to develop a plan for expanding the limited BCG campaign into a mass campaign for the whole country. In order to reach the population most affected by tuberculosis, the plan is for a campaign in the coastland and river estuaries, with a ribbon distribution along the coastal roads and river banks, to reach an estimated 240,000 persons, or 60 per cent of the population of the colony. The campaign should be completed within nine to twelve months. Administrative responsibility for the programme will lie with the Director of Medical Services of British Guiana, with technical advice from WHO.

UNICEF commitments

683. UNICEF will provide:

(*a*) Supplies and equipment estimated to cost $13,000, as follows: tuberculin solution and BCG vaccine to test 240,000 persons and vaccinate as required; vaccination kits and field equipment for two teams; propaganda material and record cards; two vehicles;

(*b*) Reimbursement to WHO for cost of BCG consultant during 1953, estimated at $4,500;

(*c*) Fellowships for two public health nurses to study six weeks in Jamaica or Trinidad, the estimated cost of $1,000 to be paid from the existing area allocation for BCG observers. These nurses will become the leaders of the two vaccination teams to be provided by the Government.

WHO commitments and technical approval

684. This plan has been developed with the technical advice of WHO. Formal technical approval is expected.

International project personnel

685. A technical adviser will be appointed by WHO to advise the Government for a period of three months concerning the organization and implementation of the campaign. Owing to the shortage of technical assistance funds, the cost for this consultant will be borne by UNICEF.

Government commitments

686. The Government undertakes to provide the following, in addition to its present health expenditures:

(*a*) *Personnel:* one campaign director, two public health nurses to serve as team leaders, four nurses, two drivers, one supply officer, one secretary-statistician, two clerks, one messenger;

(*b*) *Transport:* operation and maintenance for two vehicles;

(*c*) *Office and services:* supplies, postage, telephone, telegraph, rent, light, water, etc.;

(*d*) *Campaign supplies:* available locally, such as alcohol, cotton, scouring powder, etc.

687. The estimated cost to the Government is approximately $BG17,500 ($US10,000). The Government will undertake, after termination of international aid, to continue this programme as a part of the regular public health services of the colony.

Target time-schedule

688. It is intended that the mass campaign start in July 1953 and be completed within nine to twelve months. In the interval between March and July, the two nurses are scheduled to go on fellowships to Jamaica or Trinidad and on their return to train other members of the teams.

British Honduras

BCG anti-tuberculosis vaccination campaign

689. The Executive Board approved an apportionment of $4,000 to British Honduras from the Latin America area allocation for the provision of supplies and two fellowships for a mass BCG anti-tuberculosis vaccination campaign. This constitutes the first assistance of this type to British Honduras. The Executive Director was authorized to approve a plan of operations as outlined in E/ICEF/R.414.

690. British Honduras has an estimated population of 69,650 inhabitants of whom 31,200 live in the capital, and the remainder in five other districts. The concentration of population in the capital causes certain health problems, particularly tuberculosis which is causing the authorities serious concern.

691. Tuberculosis mortality in the colony has been more or less stationary during the past five years. Official records indicate 71 deaths from tuberculosis per 100,000 inhabitants in 1948, 50 per 100,000 in 1949, rising to 53 per 100,000 in 1951 for the colony as a whole. All deaths from tuberculosis reported in 1951 were in Belize, Stann Creek and Cayo, the rate for the capital city alone being 93 per 100,000 inhabitants.

692. Only one of the six hospitals in the colony has facilities for care of tuberculosis patients, with a total of twenty-four beds, and nearby ten small individual houses for patients with advanced tuberculosis. Treatment includes the use of antibiotics and some pneumothorax. So far the health services have not attempted vaccination with BCG.

693. Tuberculosis control work is co-ordinated in the following manner: when the Department of Public Health learns of a case of tuberculosis, a nurse goes to the patient's home, where she lists all the contacts. These are sent to the laboratory of the General Hospital for a tuberculin test and after forty-eight hours to the hospital where a doctor reads the reaction. Positives are examined radioscopically and negative cases re-

corded for possible future examination. The public health nurse is notified of the results of the tuberculin tests and radioscopic examinations, and is responsible for the contacts' adequate treatment or supervision.

694. A BCG vaccination campaign is now planned, with the following objectives :

(*a*) To test 40,000 persons and vaccinate all negative reactors with BCG;

(*b*) To train local professional and auxiliary personnel in the techniques of testing and vaccination, evaluation of results, maintenance of records, etc.;

(*c*) To establish a file of tuberculin positives so that when equipment and other clinical facilities become available, they may be further investigated radiologically and bacteriologically, with treatment provided where necessary;

(*d*) To integrate the BCG campaign into the overall tuberculosis control programme so that BCG may be available to the new-borne and other tuberculin non-reactors, as part of the colony's general health services.

695. The campaign will be directed by the Medical Tuberculosis Officer of the Health Department, on behalf of the Director of Medical Services. He will be assisted by one public health nurse. Both the directing officer and the nurse will receive three months' training in Trinidad concerning organizational procedures and techniques to be employed in the campaign, after which they will train the auxiliary personnel needed for the project.

UNICEF commitments

696. UNICEF will provide the following at an estimated cost of $4,000:

(*a*) Tuberculin dilution and BCG vaccine to test 40,000 persons and vaccinate a corresponding number;

(*b*) Vaccination kits and field equipment for one team;

(*c*) Propaganda material and record cards;

(*d*) Two fellowships for a doctor and a nurse.

WHO commitments and technical approval

697. The plan of operations for this project was developed with the assistance of WHO and has its technical approval. During the inception of the project and periodically throughout the campaign, the WHO Area Tuberculosis Adviser will give technical advice to the Government.

International fellowships

698. Owing to the shortage of technical assistance funds, UNICEF will assume the costs for fellowships for a doctor and a nurse to study BCG techniques for three months in Trinidad. The amount involved is about $2,000.

Government commitments

699. The Government of British Honduras will provide all personnel, materials, supplies and equipment except as provided by WHO and UNICEF. The estimated cost of the Government's commitments is $BH12,924 (approximately $US9,100), which includes the estimated cost of the following for a period of nine to twelve months:

(*a*) *Personnel:* One medical officer, one public health nurse, one junior nurse, one statistical clerk, one messenger, and drivers;

(*b*) *Facilities:* Office and storeroom space, supplies, communications, etc.;

(*c*) *Transport:* Motor vehicles, fuel, lubricants and maintenance, to move the personnel from one district to another in the course of the campaign.

Target time-schedule

700. The plan envisages a mass campaign covering a period of nine to twelve months. Supplies will be shipped to permit initiation of the project in July 1953. Meanwhile, the doctor and his nurse assistant will be sent to Trinidad for training.

Total UNICEF aid

701. With this action, UNICEF aid to British Honduras totals $70,000 as follows:

	Approved	*Shipped*	
		Through 1952	*1953 and after*
		$	$
Feeding	June 1950		
	May 1951		
	Apr. 1952	40,600	2,600
Insect control	Mar. 1950	22,800	—
BCG campaign	Mar. 1953	—	4,000
		63,400	6,600

CHILE

LONG-RANGE FEEDING

702. The Executive Board approved an apportionment to Chile of $24,000 from the Latin America area allocation for the purchase of skim milk to continue a child feeding programme being carried out in connexion with the milk conservation project.

703. The Executive Director was authorized to approve a plan of operations as outlined in E/ICEF/R.417.

704. This assistance represents an extension of UNICEF assistance to a programme already operating as a complement to the UNICEF-assisted milk conservation project.

705. Under an earlier apportionment, UNICEF provided milk for a limited number of mothers and children for a period of five months, or until the expected date of operation of the milk drying plant at San Fernando, which is designed to provide a long-term solution to the feeding problem in the areas in which UNICEF-assisted maternal and child welfare services have been set up.

706. Various factors, unforeseen at the time, have unavoidably delayed the date of the full operation of the milk drying plant, which is now foreseen for September 1953. The Government wishes to continue the limited feeding programme until that date, when milk from the plant will ensure its permanent continuation.

707. Distributions which were begun on a small scale in June 1952 through the health centres at Cerro Baron,

San Felipe, Puente Alto and Temuco have now reached the full number of beneficiaries originally foreseen for the programme, and are continuing on a basis of about 15,000 beneficiaries, to whom some 17,000 kg of dry skim milk are being distributed monthly.

708. It is now proposed to continue distribution at this level, through the end of September 1953, without any change in methods or channels of distribution which, from that date, will become the permanent distribution channels for dry skim milk produced by the San Fernando plant.

UNICEF commitments

709. UNICEF will supply 240,000 lbs. of dry skim milk at an estimated cost of $24,000.

Government commitments

710. The Government will continue to cover all costs of internal warehousing, transportation and distribution. By October 1953 the programme will be continued on a permanent basis by milk from the UNICEF-assisted milk drying plant at San Fernando.

Total UNICEF aid

711. With this action, UNICEF aid to Chile totals $700,000 as follows:

	Approved	Shipped: Through 1952	Shipped: 1953 and after
		$	$
Diphtheria/pertussis	Nov. 1949	84,100	4,300
MCW	June 1950	106,400	3,000
MCP	Nov. 1950	106,100	28,900
Feeding	Apr. 1952 – Mar. 1953	44,200	37,100
Penicillin plant	Apr. 1952	—	285,000
Under discussion			900
		340,800	359,200

COLOMBIA

SMALLPOX VACCINE PRODUCTION

712. The Executive Board approved an apportionment to Colombia of $15,000 from the Latin America area allocation for the purchase of laboratory equipment for the production of smallpox vaccine. The Executive Director was authorized to approve a plan of operations as outlined in E/ICEF/R.411. This constitutes the first UNICEF assistance for the production of smallpox vaccine, but is to some degree an extension of assistance given to the Samper Martínez laboratory for the production of diphtheria/pertussis vaccine and for a mass vaccination campaign.

713. Although vaccination against smallpox is obligatory, this disease continues a constant and serious source of morbidity and mortality. During the period 1947-1951 the following cases were reported:

1947	4,903
1948	7,356
1949	3,040
1950	4,818
1951	3,844
TOTAL	23,961

The average mortality from smallpox is 7 to 10 per 100 reported cases; 65 to 70 per cent of the total mortality occurs in children under 10 years of age.

714. One million vaccinations were effected in 1951. Climatic and geographical conditions raise a number of obstacles to the successful operation of a mass vaccination campaign. In the tropical areas, liquid vaccine deteriorates rapidly, and while air shipments may be made to certain parts of the country, several days of transport by rail, car or horseback are required to maintain the supply in other areas. Although the mountainous areas are not tropical, difficulties in transport may cause a loss of potency in the vaccine before it reaches mountain destinations. Thus, the use of glycerinated smallpox vaccine outside of the cities, and particularly in tropical areas, is impractical unless transportation and refrigeration improve. The Government desires, therefore, to set up suitable facilities for expansion of the present production of vaccine, and for provision of dried vaccine which can be used in the tropical areas or where rapid transportation is not available.

715. The objective of the campaign is to vaccinate 80 per cent of the entire population in a five-year cycle. It is estimated that the Instituto Samper Martínez will need a production capacity of 2,000,000 doses of vaccine per year. This laboratory has had long experience in vaccine production work, and since October 1951 has been producing combined diphtheria/pertussis vaccine of high international standard for the UNICEF-assisted campaign. Excellent facilities exist for the production of glycerinated vaccine, but adequate equipment for expanded production and for the preparation of dry vaccine is lacking.

716. In the smallpox vaccination campaign the Government plans to use the organization and personnel now operating the mass vaccination campaign against diphtheria and pertussis. As far as possible the campaign will be carried out in the health centres, but where this is not possible teams of trained vaccinators will be used.

717. The Department of Health will add 100 vaccinators, twenty inspectors and two or three doctors to the diphtheria/pertussis campaign services to carry out the smallpox vaccinations. An intensive campaign of two or three years should reduce the incidence of smallpox so that vaccination can be given thereafter through the permanent health centres.

UNICEF commitments

718. UNICEF will supply certain laboratory equipment at an estimated cost of $15,000 to expand production of smallpox vaccine, and equipment for the preparation of dry vaccine. A provisional list of equipment has been prepared but will be reviewed by a technical expert selected by WHO.

Other international participation

719. The plan of operations for this project was developed with the assistance of WHO and has its technical approval. An expert in smallpox vaccine production will visit Colombia to finalize the list of requirements and further advise the Government. The

cost of this visit will be paid from Pan American Sanitary Bureau funds.

Government commitments

720. The sum of 273,680 pesos (approximately $US124,000) is already provided in the 1953 budget to continue the diphtheria/pertussis vaccination programme, and for vaccinations against smallpox. The Government plans to increase this by another 150,000 pesos in 1953 and to budget 700,000 pesos ($US320,000) for 1954. The vaccine, which will be provided free for the campaign, will be manufactured at the Instituto Samper Martínez under the direction of a physician trained in the production of glycerinated vaccine with two full-time laboratory assistants. Additional assistance will be provided by the general staff of the Institute as necessary.

Target time-schedule

721. The diphtheria/pertussis vaccination campaign is now in progress and the Institute is already producing a certain amount of smallpox vaccine. As soon as the supplies requested from UNICEF are available for use, the production of vaccine will be expanded and the production of dry vaccine begun.

Total UNICEF aid

722. With this action, UNICEF assistance to Colombia totals $293,000 as follows:

	Approved	*Shipped* Through 1952	*Shipped* 1953 and after
		$	$
Diphtheria/pertussis ...	Nov. 1949	89,900	—
MCW	Nov. 1950	44,400	23,100
Anti-malaria	Nov. 1951		
	Apr. 1952	111,300	200
Smallpox vaccine production	Mar. 1953	—	15,000
Under discussion			9,100
		245,600	47,400

Costa Rica

MILK CONSERVATION AND LONG-RANGE FEEDING

723. The Executive Board approved an apportionment to Costa Rica of $153,000 from the Latin America area allocation, for equipment for a milk drying plant and the continuation of the present feeding programme until the plant can be brought into operation. The Executive Director was authorized to approve a plan of operations as outlined in E/ICEF/R.415. This constitutes the first UNICEF assistance to Costa Rica for a milk conservation project. UNICEF has previously aided child feeding programmes with apportionments totalling $94,000.

724. A permanent solution to the problem of nutritional deficiencies among Costa Rican children is proposed in the form of a milk drying plant producing sufficient powdered skim milk to continue the present child feeding programmes as part of the permanent nutrition programme.

725. The Government has also taken other active steps to improve the nutrition of the children. The child feeding programme now receiving UNICEF assistance, for example, provides milk distribution three times per week; on the other days the Government provides a dish of meat and vegetables. Some 10,000 children are already receiving locally produced liquid milk. Part of the cost of this supplementary feeding programme is covered by a special tax of 0.25 colones (approximately $US.04) per fanega (1 Spanish fanega equals 55½ litres) on all coffee produced in the country.

726. The Ministry of Health has created a special Nutrition Division to promote improved nutrition through school feeding programmes and nutrition education. Steps taken to improve the quantity and quality of local milk include the creation of new plants for heat treatment of milk and improvement of production through better breeding, feeding and dairy management practices. FAO has assisted the Government by providing an expert in milk marketing and a resident nutritionist, who is working on general nutrition problems.

727. Milk production in Costa Rica, as in many Latin-American countries, suffers from considerable seasonal fluctuations. There is a "normal" shortage of milk during the dry season, roughtly from December through April, and an over-production, much of which is wasted, during the peak production season from June through September. A major factor in the waste of peak production milk is the difficulty of reaching the children in isolated communities. Thus the problem is to conserve milk during flush production period for use during the shortage period, and in the isolated areas throughout the year.

728. A National Production Council has been established by the Government with a basic capital of 13,045,000 colones (approximately $US2,100,000) to stabilize prices and improve marketing conditions. This Council, whose Board of Directors consists of the Ministers of Agriculture, Labor, Economy and Finance, and the Chairman of the Board of the National Bank, has already been successful in improving the marketing of corn, meat, peanuts, sugar, beans, rice and other products. It has also assisted the dairy industry through helping finance a small privately owned milk sterilizing plant and a pasteurization plant operated by the Cooperative of Milk Producers, which is open to membership by all producers. The Government is the major stockholder of this latter plant, which opened for operation in 1952, but intends to relinquish the controlling interest when the plant comes into full-scale operations.

729. The long-range objective of the present project is to provide skim milk powder from local milk for school feeding, for pre-school and kindergarten children, and for expectant and nursing mothers. This will permit continuation on a permanent basis of the UNICEF-assisted supplementary feeding programme of free milk. From the national standpoint, an increase in milk consumption offers the most promising solution to the problems of protein deficiency among children.

730. The immediate objective is to establish a milk drying plant adjacent to the new milk pasteurization plant of the Cooperative of Milk Producers, at San Jose. The plant will have a capacity of approximately 150 kg. of milk powder per hour. The facilities of the

newly constructed milk pasteurization plant will be used also for the reception, clarifying and pasteurizing of the milk for the drying plant.

731. To house this drying plant, an enlargement or annex to the existing plant will be built, which will be owned and constructed by the National Production Council, but operated by the Cooperative of Milk Producers under agreement with the Council. The present staff of the pasteurizing plant, with further training and with the addition of certain key personnel will be well qualified to operate the drying plant.

732. All the milk powder produced by the plant and required for the Government feeding programme will be sold to the Government at a price to be fixed by the National Production Council in agreement with the Ministry of Health. The price will reflect the lower cost of production based on the drying of surplus milk, and will include no profits for the dairy plant operation. It is expected that during the first year of operation at least, the full production of the plant will be required for the Government's school feeding programmes. When production rises beyond this point, the surplus will be sold at ordinary market prices. The present plan is for the Government to buy 400,000 lbs. of skim milk powder per year.

733. Estimated production of the milk shed serving the plant is now about 180,000 lbs. of raw milk daily, reaching 200,000 lbs. daily during July. This area, known as the Meseta Central, is traversed by the Pan American Highway and has the city of San Jose at its centre. It is a good dairying region but largely owing to lack of a market during the flush season, it has not been fully developed. A drying plant within reach of the area should result in expanded production and the creation of further plant facilities in the area, through both Government and private initiative.

734. Present conditions of handling milk from producer to plant vary, but the Cooperative rejects milk which fails to meet minimum standards. In addition, the Government is planning an educational campaign among producers to improve milk handling. The Ministry of Health has the responsibility for enforcing milk quality standards.

UNICEF commitments

735. UNICEF will provide equipment for the milk drying plant, and sufficient dry skim milk powder to continue the present programme until the plant comes into operation, as follows:

(*a*) For the plant, a complete milk drying unit with a capacity of approximately 1,500 litres of milk input per hour; three storage tanks; refrigeration for the milk powder storeroom; a boiler to operate the drying plant; a plate type milk cooler, and sanitary pipe and fittings, the total costing about $100,000;

(*b*) 500,000 lbs. of skim milk, at a cost of about $53,000 to continue the present programme for 50,000 beneficiaries until August 1954.

FAO commitments and technical approval

736. FAO assisted in developing the plan and has approved it from the technical point of view. FAO has dairy and nutrition experts in Costa Rica and has expressed its willingness to consider requests for technical assistance providing additional experts, and fellowships.

Government commitments

737. The Government of Costa Rica undertakes to provide:

(*a*) Land and buildings for the plant;

(*b*) Necessary local services (water, drainage, electricity, etc.);

(*c*) Personnel necessary to the proper operation of the plant;

(*d*) Containers for the distribution of dry milk powder and any other essential items not provided by UNICEF;

(*e*) Inland freight, storage and handling charges on all equipment provided by UNICEF;

(*f*) Installation costs of all equipment.

738. Towards the cost of the above items 200,000 colones (approximately $US35,000) has been included in the budget for 1953. Further expenses are anticipated in 1954.

739. The Government undertakes to purchase milk powder up to 400,000 lbs. per year for five years for free distribution to children and mothers in the same manner now being followed by the UNICEF-assisted feeding programme. The estimated cost, including costs of distribution, is 500,000 colones per year (approximately $US81,000) or the equivalent of $405,000 for a five-year period. Distribution of the dry milk will be continued along the same lines as those now being followed. For 1953 the Government is increasing the budget of its Nutrition Department by 248,940 colones (approximately $US40,000). This higher level is expected to continue. A part of the increase will cover permanent improvements in the distribution set-up, including enlarged premises for the Nutrition Department, enlargement of warehousing space for storage of milk powder, improvement of equipment for the reconstitution of milk in San Jose, installation of improved kitchen facilities for the distribution centres, etc.

740. Total government expenditures are, therefore, estimated to be the equivalent of approximately $500,000 for five years.

Target time-schedule

741. The target time-schedule for this project is as follows:

(*a*) Approval of apportionment by UNICEF Board, March 1953;

(*b*) Placing of contracts by UNICEF, April 1953;

(*c*) Approval of plans of operations, June 1953;

(*d*) New building for plant to begin, Aug. 1953;

(*e*) Completion of building, Dec. 1953;

(*f*) Installation of equipment to start, Jan. 1954;

(*g*) Plant to start up, July 1954;

(*h*) Milk powder to be available for feeding programme, Aug. 1954.

742. The duration of the plan of operations will be five years from the time the plant starts operating.

Total UNICEF aid

743. With this action, UNICEF aid to Costa Rica totals $376,000 as follows:

	Approved	Shipped: Through 1952	Shipped: 1953 and after
		$	$
Feeding	Nov. 1949		
	Nov. 1950	87,700	—
Anti-malaria	Mar. 1950	73,700	1,700
BCG observers	Nov. 1950	3,000	—
BCG	Feb. 1951	23,000	21,600
MCP (including feeding)	Mar. 1953	—	153,000
Under discussion			12,300
		187,400	188,600

ECUADOR

MATERNAL AND CHILD WELFARE SERVICES AND TRAINING

744. The Executive Board approved a plan of operations (outlined in E/ICEF/R.428, E/ICEF/R.428/Add.1 and E/ICEF/R.428/Corr.1) through which UNICEF will provide equipment and supplies costing $20,000 for maternal and child welfare services and training in Ecuador. This sum is available from an earlier apportionment for eathquake relief to Ecuador. This represents the first UNICEF assistance to Ecuador for a maternal and child welfare programme, although $71,000 out of the apportionment for earthquake relief was used to provide equipment for a group of hospitals and child care centres in the earthquake area.

745. A large proportion of mothers and children, especially in the rural zones of Ecuador, receive practically no benefit from public health services. Poor environmental sanitation, and the lack of elemental knowledge of hygiene and health care, results in a generally low level of health among mothers and children. Some idea of the extent of infant mortality is illustrated by figures from Quito and Guayaquil. In 1949, the rate of infant mortality in Quito was 130 per 1,000 live births, in Guayaquil 128.3 per 1,000. In 1948, an analysis of the causes of infant mortality in Guayaquil showed that nearly half—563—were due to gastro-enteritis. Other important causes were congenital debility, pneumonia and broncho-pneumonia; malaria; bronchitis; tuberculosis; syphilis; and prematurity. An extremely high proportion of infant deaths is due to preventable causes, and an effective programme of mother and child welfare is urgently needed.

746. The governmental public health services in Ecuador are under the control of the Director General of Health in Guayaquil. The principal departments are Epidemiology and Vital Statistics; Communicable Diseases; Vaccination; Venereal Diseases; Mother and Child Welfare. For purposes of administration, the country is divided into three health zones, each with an organization parallel to that of the Guayaquil office, with a Chief Zone Inspector in charge, assisted by a series of department heads for the various aspects of public health. Each province has a health officer with limited staff.

747. The organization of the provincial health offices varies greatly, but it may be said generally that they are hampered by lack of equipment, funds, and suitably trained personnel. Nursing and auxiliary personnel are particularly lacking, as are training facilities, and in many cases nursing positions are held by completely untrained persons. The capacity of existing nursing schools in Ecuador is not nearly adequate to fill the national requirement for nurses, and nurses who are fully trained often prefer private employment because of the poor standards prevailing in government institutions.

748. The health centres in Quito and Guayaquil have a good standard of mother and child welfare work. Outside of these two cities there are at present no services for care of mothers and children.

749. The Government has set up a new department under the Director General of Health, known as the Department of Mother and Child Health, School Hygiene and Health Education, which establishes the standards and co-ordinating services for all mother and child welfare work throughout the country. The basic aims of the department are as follows:

(*a*) To improve the registration and analysis of vital statistics, with particular reference to registration of births, analysis of the causes of infant and child deaths, incidence of diseases among children and causes of maternal deaths;

(*b*) To reorganize and co-ordinate all existing services for mother and child welfare;

(*c*) To establish minimum standards of mother and child care, to be applied throughout the country through centres in each province;

(*d*) To provide, through these maternal and child welfare centres, the framework of a health education system with particular emphasis on the basic rules of hygiene, child feeding, and child care;

(*e*) To set up a training system for professional and auxiliary personnel for the maternal and child welfare centres.

750. While the general reorganization is under way, the improvement of services for mothers and children requires outside aid.

751. After suitable improvement of the existing maternal and child welfare centres in Guayaquil and Quito, it is proposed, during 1953, to use them as training centres for midwives, and for doctors in the provincial health offices, to fit them for maternal and child welfare work. Courses of a month's duration, plus practical experience in the training centres, will prepare twenty-four midwives, plus doctors for five centres, during 1953. Twelve of the midwives will work in new maternal and child welfare centres still to be established; the other twelve are to serve in municipally operated maternal and child welfare services already established in the provinces.

752. As a second step, also during 1953, it is proposed to set up five new mother and child welfare centres in Portoviejo, Babahoyo, Ambato, Cuenca and Sangolqui. Each centre will provide pre-natal and post-natal consultations; clinics for infants, pre-school and school children, both sick and well; and home visiting by nurses and midwives. Each centre will have at least one physician in charge, one trained midwife and one to four nurses or nurses' aides. Other services,

such as dentistry, will be provided where necessary and possible.

753. During 1954, it is proposed to extend the establishment of maternal and child welfare centres in the remaining provinces so that by the end of the year a total of sixteen centres will be in operation throughout the country. Each centre will have an operating fund for supplies and expendables, which will average approximately 2,000 sucres ($US120) per centre per month. Once these centres are set up and working properly, it is proposed that the doctor in charge, as part of his duties, pay regular visits to small municipal centres within his area. A certain number of municipal centres are already in existence; they are run entirely out of municipal budgets and at present adhere to no fixed standard. By a system of regular visits their services will be raised to a national minimum standard and their work co-ordinated with that of the nationally run centres.

754. The aim of the programme proposed by the Ecuadorean Government is basically the better use of existing personnel and budgetary allocations, adding such extra personnel and operating funds as the reorganization requires. It is the opinion of the Government that relatively small additional funds, amounting to 200,000 sucres (about $US11,400) in 1953 plus a further increase of 600,000 sucres (about $US34,300) in 1954, will suffice to permit satisfactory provision of maternal and child welfare services throughout the provincial areas of Ecuador.

UNICEF commitments

755. As its contribution to this scheme, UNICEF will provide the following:

(*a*) Minimum equipment for the training of nurses, doctors and midwives for the health centres in the rural areas;

(*b*) A vehicle for supervision and inspection of rural and municipal mother and child welfare centres;

(*c*) Midwife kits for the midwives trained for the health centres;

(*d*) Sets of equipment, one for each centre to be set up, comprising minimum equipment for mother and child care in the centres;

(*e*) A limited quantity of penicillin for use in the centres for the treatment of acute respiratory infections among infants.

Total estimated cost of these supplies and equipment is about $20,000.

Other international participation

756. WHO has worked closely with the Government in preparing the plan of operations for this project, and has given its technical approval to the plan as outlined above. The United Nations Department of Social Affairs and the Technical Assistance Administration have also participated in the planning, and United Nations social welfare advisers have studied the situation in Ecuador and conferred with WHO and UNICEF while the plans were being developed.

757. The plan has been set up to provide for the integration of social welfare services with the proposed health services. Such assistance as is furnished under the advisory social welfare services programme will be the subject of a separate agreement between the United Nations Technical Assistance Administration and the Government.

International project personnel

758. WHO will recruit two consultants for this project—one in public health administration and one in public health nursing. These will be financed from technical assistance funds at an estimated cost of $7,600 for four months in 1953. The cost of international personnel for eight months in 1954 will be approximately $11,000.

Government commitments

759. The Government will undertake the following commitments in connexion with the expanded scheme for maternal and child welfare services:

(*a*) An annual budget of 200,000 sucres (approximately $US13,000) for the new Department of Mother and Child Health;

(*b*) The Government has also undertaken to ask Congress for an additional 600,000 sucres ($US40,000) to increase the services in provincial maternal and child welfare centres in 1954.

Target time-schedule

760. The Government has set up the following target time-schedule:

(*a*) Organization of the Mother and Child Health Department under the Director General of Health, August 1952;

(*b*) Co-ordination and integration of all existing services under Mother and Child Health Department, to be completed, April 1953;

(*c*) Training courses in Quito and Guayaquil, to begin May 1953;

(*d*) Five maternal and child welfare centres, to be opened in rural areas July/August 1953;

(*e*) Eleven further centres to open in rural areas, at intervals, January/September 1954.

761. UNICEF supplies for the maternal and child welfare centres should arrive in each case at least one month before the scheduled time for opening the centre.

Total UNICEF aid

762. UNICEF aid to Ecuador totals $869,400 as follows:

	Approved	Shipped	
		Through 1952	1953 and after
		$	$
Earthquake	Sept./Nov. 1949	221,900	11,900
MCW	Nov. 1949	71,100	—
BCG (ITC)	Mar. 1950	273,400	—
BCG (UNICEF/WHO)	Nov. 1951	8,400	15,600
TB laboratory	Nov. 1950	62,100	12,900
MCP	Nov. 1951	—	160,000
MCW and training	Mar. 1953	—	20,000
Under discussion			12,100
		636,900	232,500

GRENADA

BCG ANTI-TUBERCULOSIS VACCINATION CAMPAIGN

763. The Executive Board approved assistance for a BCG anti-tuberculosis vaccination campaign in Grenada as follows:

(i) An apportionment of $4,500 from the Latin America area allocation for supplies, equipment and training in Trinidad of a team of observers;

(ii) An apportionment of $1,100 from an existing Latin America area allocation for BCG observers, to pay part of the costs of the team referred to under (i), above.

764. The Executive Director was authorized to approve a plan of operations as outlined in E/ICEF/R.434. This constitutes the first UNICEF assistance to Grenada for tuberculosis control.

765. Grenada is the seat of government of the British Windward Islands group which also includes St. Lucia, St. Vincent, the Grenadines and Dominica. This group has one Governor but is not a federal colony; each island has a separate medical administration.

766. Grenada is 240 square miles in area, rising to 2,700 feet. The population of the island is about 80,000, the great majority, 80 per cent, living in rural areas. In the towns the closely crowded houses are small wooden dwellings often of one room only, accommodating a large number of persons. Sanitation is generally unsatisfactory. The same is true of rural dwellings, which are often of poorer construction, and also small and crowded.

767. Pulmonary tuberculosis is a growing problem. The known death rate is between 80 and 90 per 100,000, but it is certain that incidence is higher than can be deduced from this rate. The twenty-four-bed Marie Louise Hospital, formerly adequate for segregation of infectious cases who cannot be isolated in their own homes, is now totally inadequate, although it is proposed to double the number of beds. Many infectious cases have to stay at home, under wholly unsatisfactory conditions, where children of all ages are exposed to the danger of contracting the disease. In general, the amount of systematic treatment available is negligible.

768. A plan has now been made to test with tuberculin all persons in the urban areas of Grenada up to the age of 25, and all persons in rural areas up to 45 years of age. It is estimated that this will cover some 40,000 people, and will require about six months. Tuberculin non-reactors will be vaccinated with BCG. A file will be kept of the tuberculin positives so that as equipment and other clinical facilities become available they may be further investigated radiologically and bacteriologically, as required, and treatment provided where necessary.

769. Local professional and auxiliary personnel will be trained in the conduct of a BCG campaign, and also to evaluate results, and maintain records, so that BCG can continue as a regular part of tuberculosis control services. The project will be conducted under the direction of the Senior Medical Officer of the Health Department of the island. In its initial stage the Senior Medical Officer will be assisted by the WHO technical adviser and—at the request of the Health Department—by the WHO Regional or Area Tuberculosis Adviser at periodic intervals thereafter.

770. One team, consisting of a doctor and two nurses, will receive training in Trinidad for three months in the procedure and techniques to be used in the campaign.

UNICEF commitments

771. UNICEF will provide 20,000 cc. PPD dilution, 5,000 cc. BCG vaccine, five vaccination kits, a jeep, and various other items at an estimated cost of $3,100. UNICEF will also finance the training in Trinidad of the team of observers, at an estimated cost of $2,500. Of this, $1,100 can be paid from the existing general allocation for the BCG observers.

WHO commitments and technical approval

772. WHO has advised in the development of the project and will continue advice periodically for the duration of the campaign. The project has the technical approval of WHO.

Government commitments

773. The Government of Grenada will provide one Medical Officer, as director of the programme, and two nurses, who will be trained in Trinidad, drivers, administrative and clerical staff, vehicle maintenance, office supplies, space and communications. It is estimated that this will cost the Government the equivalent of $US10,000.

Target time-schedule

774. It is expected that the programme will be started as soon as the team has completed its training in late 1953.

Total UNICEF aid

775. With this action, UNICEF aid to Grenada totals $32,600 as follows:

	Approved	*Shipped*	
		Through 1952	*1953 and after*
		$	$
Anti-malaria	April 1952	17,600	9,400
BCG	March 1953	—	5,600
		17,600	15,000

GUATEMALA

LONG-RANGE FEEDING

776. The Executive Board approved an apportionment to Guatemala of $30,000 from the Latin America area allocation for the continuation of a long-range feeding programme for one year. The total cost to UNICEF will be $34,200 of which $4,200 is available from an earlier allocation. The Executive Director was authorized to approve a plan of operations as outlined in E/ICEF/R.439. This represents an extension of UNICEF assistance for child feeding in Guatemala.

777. Malnutrition of children in Guatemala is widespread. Maize and beans being the diet staples, there is a widespread deficiency of proteins, which is most severely felt in the children of pre-school age. However, observations in schools indicate that two-thirds of the pupils urgently need supplementary feeding.

778. The UNICEF-assisted feeding programme started in Guatemala in mid-1950 and reached a peak number of 50,000 beneficiaries through schools and clinics in April 1951. Supplies for the programme were exhausted in December 1952, when UNICEF milk was distributed to approximately 11,000 beneficiaries.

779. The programmes of child feeding, which were inaugurated with UNICEF assistance, have somewhat lessened the acuteness of the problem, but have also brought to light the need for a permanent solution. At present studies are being made of the possibility of setting up a permanent feeding scheme based on the use of soy bean products to be produced in the country, but these are not sufficiently advanced to offer an immediate solution.

780. It is now planned to continue the milk distribution at a lower and more stable level, consistent with the ability of the Government to carry it on in future. Medical controls will be introduced as a factor in the choice of beneficiaries. Beneficiaries will be limited to children up to 6 years of age.

781. Distribution will be carried out through health centres and kindergartens. In the former, whole milk will be given to 1,435 infants under one year of age at a ration of 60 grammes a day. In the kindergartens, and for children over one year attending the clinics, skim milk will be provided at a ration of 40 grammes a day for 5,350 children. For all feeding through health centres distribution will be calculated at 365 days a year. In the kindergartens each child will receive milk on 200 days a year.

UNICEF commitments

782. UNICEF will provide the necessary skim and whole milk for one year, amounting to 63,600 lbs. of whole milk, and 116,700 lbs. of skim milk, at an estimated cost of about $34,200.

Government commitments

783. The Government will provide for all receiving, warehousing and distribution costs, and, from 1954 on, will budget a sum sufficient to continue distribution at the same level as is provided for during 1953 with UNICEF assistance.

Total UNICEF aid

784. With this action, UNICEF aid to Guatemala totals $208,000 as follows:

	Approved	Shipped: Through 1952	Shipped: 1953 and after
		$	$
Feeding	Nov. 1949		
	Mar. 1953	51,300	34,200
Anti-malaria	Nov. 1950		
	Nov. 1951	121,600	—
Under discussion			900
		172,900	35,100

HAITI

ANTI-MALARIA

785. The Executive Board approved an apportionment to Haiti of $3,000 from the Latin America area allocation for reimbursement to WHO of expenses incurred during 1953 for international personnel connected with the anti-malaria campaign. The plan of operations for the campaign is outlined in E/ICEF/212.

786. Malaria is considered Haiti's most pressing public health problem. The object of the campaign is residual spraying with DDT of all malarious areas, attacking yellow fever and other insect-borne diseases as well as malaria. The plan is to spray some 373,000 houses in the affected areas, thereby protecting approximately 1,667,000 people. Under an earlier apportionment, UNICEF is providing DDT, equipment and transport for a two-year period. Owing to the shortage of technical assistance funds, UNICEF will assume, for 1953, expenses amounting to $3,000 connected with the international personnel recruited by WHO.

Total UNICEF aid

787. With this action, UNICEF aid to Haiti totals $748,000 as follows:

	Approved	Shipped: Through 1952	Shipped: 1953 and after
		$	$
Anti-yaws	Nov. 1949		
	Apr. 1952	452,200	127,800
Anti-malaria	Oct. 1952		
	Mar. 1953	14,500	153,500
		466,700	281,300

HONDURAS

LONG-RANGE FEEDING

788. The Executive Board approved an apportionment of $30,000 to Honduras from the Latin America area allocation to permit continuation of a child feeding programme until the milk drying plant now under construction can be completed. The Executive Director was authorized to approve a plan of operations as outlined in E/ICEF/R.416. This represents an extension of assistance totalling $65,000 granted previously for this purpose by the Board.

789. An estimated 68 per cent of school children in Honduras are undernourished. Studies carried out by the Institute of Nutrition for Central America and Panama indicate that as a result of this undernourishment there is a high incidence of various deficiency diseases, ranging from avitaminoses through congenital debility, rickets and even contagious diseases, against which the undernourished bodies are too weak to fight.

790. The school feeding programme carried out since 1949 with UNICEF assistance is responsible for a greater realization of the extent and importance of malnutrition. The Government is taking steps to solve the problem, the most important of which is the decision to build a milk drying plant at San Pedro Sula to supply dry milk powder for a permanent continuation of the school feeding programme. It is expected that this plant, which is receiving UNICEF assistance, will be in production by May 1954.

791. When feeding demonstrations were first undertaken, there was a limited knowledge of the extent of the malnutrition problem or approaches toward solving it. During the past three years, the programme

undertaken by the Government with UNICEF assistance to demonstrate the value of feeding projects has borne fruit, as is shown by the investments which the Government is now making in a milk plant and in plans for generally raising the nutritional level of children.

792. It is proposed to continue the present school feeding programme for 30,000 beneficiaries, which is approximately the number now being reached, and the number to be reached when the plant comes into operation. This programme will be continued until nationally produced dry milk becomes available, i.e., about eleven months, of which two months are taken up by school holidays. The ration will continue at the present level of 40 grammes a child a day. Total requirements of milk for this period will be about 520,000 lbs. of which half will be supplied by UNICEF and half by the Government.

UNICEF commitments

793. UNICEF will provide 260,000 lbs. of dry skim milk powder, at an approximate cost of $30,000.

Other international participation

794. FAO is providing expert advice in nutrition to the Government of Honduras in connexion with this programme, as part of its over-all advisory service on nutritional problems in Honduras. Honduras is also a member of the Institute of Nutrition for Central America and Panama, which is assisting the Government to improve the country's nutrition standards.

Government commitments

795. In addition to the commitments for the present school feeding programmes, the Government will match the UNICEF contribution by procuring 260,000 lbs. of skim milk to make up the total quantity required until the milk drying plant comes into operation.

Total UNICEF aid

796. With this action, UNICEF aid to Honduras totals $367,000 as follows:

	Approved	Shipped: Through 1952	Shipped: 1953 and after
		$	$
Feeding	Nov. 1949, Nov. 1950 Apr. 1952, Mar. 1953	62,900	30,000
Anti-malaria	Mar. 1950, Nov. 1951 Apr. 1952	109,100	2,500
Health education	Nov. 1951	1,400	8,600
Milk conservation	Oct. 1952	—	145,000
Under discussion			7,500
		173,400	193,600

Panama

MATERNAL AND CHILD WELFARE TRAINING

797. The Executive Board approved an apportionment to Panama of $8,000 from the Latin America area allocation for the purchase of supplies and equipment and payment of internal scholarships for a maternal and child welfare training programme in Panama. The Executive Director was authorized to approve a plan of operations as outlined in E/ICEF/R.451.

798. This constitutes the first UNICEF assistance specifically for training in Panama, although the programme will tie in with the existing maternal and child welfare programme for which funds were apportioned in October 1952.

799. The population of Panama is approximately 800,000, of whom 190,000 live in the cities of Panama and Colon, and the rest in rural and semi-rural areas. The children of Panama are subject to the usual diseases of tropical under-developed areas; a very high infant mortality rate, exceeding 200 in some areas, is characteristic of the country. It is estimated that 21,000 births, or 80 per cent of the total births per year, take place without medical attention.

800. One of the main difficulties in extending maternal and child welfare services to the rural zones is the lack of trained professional and auxiliary personnel. At the present time, 320 graduate nurses are employed by the Government, of whom 260 are working in hospitals and sixty in health centres. Of these sixty, thirty are in the city of Panama, four in Colon and only twenty-six in outlying areas.

801. In addition to this personnel, the National Public Health Department employs twenty-two rural midwives and twelve clinic assistants. All hospitals employ nursing auxiliaries, although in the main they have had no previous training. At present there are 195 of these auxiliaries.

802. There is one public health nurse for every 23,000 persons living in rural areas and one for every 5,600 in the larger cities.

803. In recent years, the Government has been unable to conduct training courses for auxiliary personnel, but now wishes to undertake such training with the assistance of UNICEF and WHO.

804. The Government is engaged in a considerable effort to extend general public health services, including maternal and child welfare to rural areas. Eighteen health centres will be established throughout the country, each with three or four sub-units dependent on the main centre. Both WHO and UNICEF are assisting the Government in this programme. WHO has provided a public health doctor, public health nurse, a sanitary engineer and a laboratory technician under the Technical Assistance programme, as well as some fellowships. UNICEF has provided clinical and obstetrical supplies, and transport.

805. The budgets for the rural health units were increased in 1952 to 445,800 balboas from 375,400 balboas in 1951 (1 balboa equals $US1). For 1953 the Government has again increased the budget by 150,000 balboas for the exclusive purpose of improving these rural services.

806. Plans have been made for training professional public health personnel who are at present working in rural areas, and consideration is being given to the training of local practicing midwives.

807. The present plan involves two training courses for auxiliary health personnel to work in the rural health centres. The functions of the trained auxiliary personnel will be to assist in home deliveries, pre- and post-natal clinics, health education, immunizations, and home visiting. Each course will train twenty auxiliaries.

808. The courses will consist of both classroom work and field practice in health centres. During the first course, the group will have their supervised field practice in the La Chorrera health unit, which is receiving UNICEF supplies. During the second and future courses, the trainees will be distributed among the other centres as the centres are ready to take them.

809. The candidates will be selected by a special committee from the rural areas to which they will return to work. Thus the trainees in the first course will come from the area served by La Chorrera health unit. Each trainee will sign a contract for three years' service with the Public Health Department, effective as soon as the course is finished. A minimum of three years' employment by the Public Health Department in the rural health centres will follow.

UNICEF commitments

810. UNICEF will provide the programme with funds for internal scholarships for forty trainees, training supplies and one vehicle. These are estimated to cost approximately $8,000.

WHO commitments and technical approval

811. WHO has participated in the development of the plan, and as noted above, is already participating substantially in the over-all rural public health programme. The WHO technical adviser in Panama will continue to assist in the development of the training courses and the selection of trainees.

812. The WHO zone representative in the area concurs with this plan and technical approval from the WHO Regional Office is expected.

Government commitments

813. The Government will provide all necessary facilities for the training, including classrooms and laboratories, as well as training supplies available locally. In addition, the Government will pay the salaries of instructors and will provide such specialized personnel as are necessary to conduct the training.

814. After the first two courses the Government will include in the budget of the Public Health Department the necessary funds for continuation of the training programme.

Target time-schedule

815. The first training course will be inaugurated as soon as UNICEF supplies arrive in Panama, which will be in the latter part of 1953.

Total UNICEF aid

816. With this action, UNICEF aid to Panama totals $128,000 as follows:

	Approved	Shipped: Through 1952	Shipped: 1953 and after
		$	$
Feeding	May 1951	71,500	11,500
MCW	Oct. 1952 – Mar. 1953	—	45,000
		71,500	56,500

PARAGUAY

BCG ANTI-TUBERCULOSIS VACCINATION CAMPAIGN

817. The Executive Board approved assistance to Paraguay for a BCG anti-tuberculosis vaccination campaign as follows:

(i) An apportionment of $12,000 from the Latin America area allocation for reimbursement to WHO of expenses for international personnel during 1953;

(ii) A plan of operations covering the provision of supplies and equipment for a national mass campaign, of which the cost to UNICEF, $23,000, is available from an apportionment for maternal and child welfare made in 1950.

818. The plan of operations for the campaign is outlined in E/ICEF/R.405. This constitutes the first UNICEF assistance of this type to Paraguay.

819. The Government considers tuberculosis the chief health problem with respect to direct causes of death. Official statistics are available for Asunción only, but further investigation shows that these figures may reveal only a slightly higher incidence than prevails throughout the rest of the country. The most recent official statistics (1941) indicate a tuberculosis mortality rate of 200 per 100,000 inhabitants, with a further 200 deaths per 100,000 caused by "other pulmonary disease". Probably a large proportion of these deaths are actually from tuberculosis. The 1941 statistics show that 15 per cent of all deaths in Asunción were from tuberculosis, with the percentage rising. The importance of the problem is confirmed by some fragmentary statistics for 1944.

820. Since 1941 the Government has been doing some very limited work in tuberculosis control and BCG vaccination. In 1951 an agreement was reached with WHO for study of the problem, and for a nationwide campaign against tuberculosis. This programme has been developing slowly owing to the Government's inability to carry out an effective BCG vaccination campaign on its own.

821. The objectives of the mass campaign are as follows:

(*a*) To undertake a countrywide tubercular testing and BCG vaccination campaign;

(*b*) To train Paraguayan doctors and nurses so that at the conclusion of the mass programme (one year) sufficient trained national staff will be available to continue the programme on a permanent basis.

822. A Paraguayan team consisting of one doctor and two nurses financed by UNICEF has already spent some time in El Salvador and Jamaica studying techniques employed in the vaccination campaign in those countries. This team, working with an international team, will undertake the training of four additional national teams who will carry out the mass campaign. Existing health centres, dispensaries and other services will take care of testing and vaccination during the mass campaign and afterwards will provide permanent continuing vaccination services.

823. Each of the five teams will consist of a doctor and two nurses who will, during the one year of the mass campaign, be able to cover the whole of the

territory of Paraguay, testing an estimated 350,000 persons between the ages of 1 and 30 years, and vaccinating about half that number.

UNICEF commitments

824. UNICEF will provide supplies and equipment, including vehicles, BCG, tuberculin, needles, syringes and educational materials to the value of $23,000. In addition, UNICEF will reimburse WHO for the services of international personnel during 1953 at a cost of $12,000.

WHO commitments and technical approval

825. WHO participated in developing the plan of operations for this project and has given its technical approval. It will continue to give advice as needed through Regional and Zonal offices.

International project personnel

826. WHO will recruit a doctor and two nurses to act as advisers to the Government and to local personnel conducting the campaign. Owing to the shortage of technical assistance funds, UNICEF will assume the cost of these advisers for 1953 (see "UNICEF commitments", above).

Government commitments

827. The Government will provide all local personnel, supplies and equipment required for the execution of the programme, including: one Director of the programme (the Director of the Tuberculosis Department of the Ministry of Health); one Assistant Director of the programme (who has already received training in the mass BCG campaign techniques); four vaccination teams, each consisting of one doctor and two nurses; drivers, typists, statisticians, etc., as required; all office supplies required, communications, vehicle maintenance and local campaign supplies.

828. For this purpose the Government has budgeted an amount in national currency equivalent to $45,000 (668,000 guaranis).

Target time-schedule

829. The Government will begin the mass campaign on a full scale as soon as the supplies arrive. This should be in the latter part of 1953.

Total UNICEF aid

830. With this action, UNICEF aid to Paraguay is $191,500 as follows:

	Approved	Shipped Through 1952 $	Shipped 1953 and after $
MCW and feeding	June 1950	41,700	31,300
MCW	Oct. 1952	—	25,000
Anti-malaria	Nov. 1950	47,700	2,300
BCG observers	May 1951	4,500	—
BCG campaign	Mar. 1953	—	35,000
Under discussion			4,000
		93,900	97,600

PERU

DIPHTHERIA/WHOOPING COUGH VACCINATION AND VACCINE PRODUCTION

831. The Executive Board approved an apportionment to Peru of $65,000 from the Latin America area allocation, for supplies and equipment for a new vaccination campaign against diphtheria and whooping cough, and for the production of vaccine. The Executive Director was authorized to approve a plan of operations as outlined in E/ICEF/R.429 and E/ICEF/R.429/Corr.1. This represents the first assistance to Peru for vaccine production. Some diphtheria-pertussis vaccine was provided earlier for the maternal and child welfare programme in the Lima-Pativilca area.

832. Over 83,000 cases of whooping cough were reported in Peru during the five-year period from 1946 through 1950. Among communicable diseases it has been surpassed in prevalence only by malaria and tuberculosis. However, since malaria is rapidly being brought under control with UNICEF assistance, whooping cough may now be considered the second most frequent communicable disease of childhood in Peru. In 1951, for example, 17,365 cases of malaria were reported against 18,999 cases of whooping cough. Among children under 5 years of age no single disease is more frequent.

833. A particular problem is presented by the rarefied atmosphere in the mountainous areas, where the disease has a particularly high mortality rate, not only of itself but also through pulmonary complications, especially broncho-pneumonias.

834. While both incidence of and mortality from diphtheria are much lower than for whooping cough, it also constitutes a definite public health problem.

835. The National Institute of Hygiene and Public Health, an organ of the Ministry of Public Health and Social Welfare, has for some time been producing experimental quantities of both diphtheria antigen and pertussis vaccine, and has even experimented recently with the manufacture of a combined vaccine. While the laboratory is satisfied with the quality of this experimental product, no attempt has yet been made to check it against international reference vaccines. Some limited vaccination with human subjects has been carried on with the experimental vaccines given separately, but the present capacity of the laboratory will not permit production either of the separate vaccines or of combined vaccine, on the scale required for a nationwide mass campaign. The Government now wishes to carry out such a campaign.

836. The basic purpose of the scheme is to vaccinate as much of the child population of Peru as possible against diphtheria and whooping cough. This requires that production facilities of the present small laboratory of the National Institute of Hygiene be increased.

837. It is therefore proposed to set up production of combined diphtheria-pertussis vaccine on a scale to produce the requirements of the mass campaign: 60,000 to 80,000 doses a month.

838. For the purpose of the campaign, the whole of Peru has been divided into four areas. Of a total population of some 8,492,873 persons, it is estimated that there are 1,698,573 children between the ages of 3 months and 7 years. It is expected that the mass campaign will reach at least 60 per cent of them, or just over a million children.

839. After the mass campaign, vaccination will in principle be limited to infants from three months to one year, and to booster vaccination of children on their first attendance at school. Any children who may have escaped vaccination during the mass sweep will, of course, also be vaccinated.

840. The campaign will be started with mixed diphtheria/pertussis vaccine provided by UNICEF. The National Institute of Hygiene will be able to produce sufficient vaccine within six months of the beginning of the mass campaign, which is to be completed within two and a half years. After the campaign a full study of morbidity and mortality rates and a complete evaluation of results will be made.

841. The Division of Communicable Diseases will employ 178 vaccinators to carry out the work; should there be an unexpected delay, additional mobile teams will be used to bring the campaign up to schedule.

842. Mass vaccination will begin simultaneously in the departments of Tumbez, Lambayeque, Piura, Cuzco and Ayacucho where mass smallpox vaccination campaigns have already been carried out and the terrain is already well-known. From these Departments the vaccinations will spread to others as rapidly as possible.

843. Vaccinations will be given through schools and institutions for child care, supplemented by house-to-house coverage to reach children who might otherwise be missed. During the house-to-house visiting, smallpox vaccination will also be given to children and to such adults as may require it. This will be done entirely by the Government with its own means.

UNICEF commitments

844. UNICEF will provide equipment necessary to expand the production capacity of the laboratory of the National Institute of Hygiene; 200,000 doses of 2 cc. of diptheria/pertussis vaccine to begin the campaign; and field equipment, including syringes, needles, sterilizing equipment and three vehicles. The estimated cost of the equipment required for these two aspects of the programme is $65,000.

WHO commitments and technical approval

845. This project has been developed with WHO assistance and has its technical approval. WHO will arrange for testing and official approval of the vaccine produced by the laboratory.

International project personnel and fellowship

846. An expert adviser will be recruited by WHO for a period of two to four weeks to assist with installing and starting the laboratory. A fellowship will also be provided for a technician to study vaccine production abroad for three months. The total cost of the above, $4,100, will be borne by technical assistance funds.

Government commitments

847. The amounts of new expenditures which the Government is prepared to undertake for the diphtheria/pertussis programme during 1953 amount to the following:

	Soles
Special budget of the Institute	30,040
Remodelling of the premises	35,000
Regular budget of the vaccination service	64,753
Grant of the National Social Welfare Fund	2,904,787
	3,034,580

(approximately $US202,000)

848. The Government undertakes to continue a maintenance campaign at the end of the mass sweep, as part of its regular public health policy to stamp out whooping cough.

849. In approving the apportionment for this project, the Executive Board noted that it would be desirable to include, simultaneously, protection against tetanus. This is done in other programmes of this nature assisted by UNICEF, and the Board suggested that the Government of Peru might wish to consider the desirability of an expansion in this direction.

Target time-schedule

850. It is expected that a final list of laboratory requirements can be drawn up and begin to arrive by September. Between March and September a Peruvian laboratory specialist will be sent abroad on a fellowship, so that by October 1953 the laboratory for vaccine production can be set up and ready to work.

851. On this schedule, vaccination will begin in the field in July 1953, with vaccine provided by UNICEF; by the end of 1953 the campaign will be able to continue with locally produced vaccine. The mass campaign will be completed by the end of 1955, after which the programme will be carried on at a maintenance level.

Total UNICEF aid

852. With this action, UNICEF aid to Peru totals $648,000 as follows:

	Approved	*Shipped*	
		Through 1952	*1953 and after*
		$	$
Anti-typhus	Oct. 1949	86,500	11,700
MCW	June 1950		
	Feb. 1951	149,900	94,900
BCG observers	May 1951	2,400	600
Anti-malaria	Apr. 1952	74,600	25,400
Feeding	June 1950		
	Apr. 1952	103,800	12,400
Soap	Oct. 1952	12,600	—
Diphtheria/whooping cough	Mar. 1953	—	65,000
Under discussion			8,200
		429,800	218,200

St. Kitts, Leeward Islands

BCG anti-tuberculosis vaccination campaign

853. The Executive Board approved an apportionment to the Presidency of St. Kitts, Leeward Islands, British West Indies, of $5,500 from the Latin America area allocation for the purchase of supplies and equipment for a BCG anti-tuberculosis vaccination campaign, and for two fellowships in BCG techniques for a medical officer and a public health nurse. This constitutes the first UNICEF assistance to the Presidency of St. Kitts. The Executive Director was authorized

to approve a plan of operations as outlined in E/ICEF/R.406.

854. The Presidency of St. Kitts consists of the islands of St. Kitts, Anguilla and Nevis, with a total population of 50,000. In recent years the tuberculosis death rate in St. Kitts has been about 100 per 100,000 of population. On St. Kitts itself, with a population of nearly 31,000, the rate is somewhat higher, while in the islands of Nevis, with about 13,600 people, and Anguilla, with some 6,300, the rate has been slightly lower. Little statistical information is available as to the rate of infection. A tuberculin survey conducted in the town of Basseterre in 1952 indicated some 39 per cent of positive reactors in the age group 7 through 14 and 61 per cent positive in the population over 15. The rate for rural areas is somewhat lower than for urban centres.

855. For financial reasons, a large expansion of tuberculosis control measures is impossible, but it is felt that BCG vaccination can be applied successfully and without undue strain on the available funds.

856. The work now being done aims almost entirely at early case finding and isolation and treatment of cases. Facilities, however, are far from adequate, although they have recently been improved with the assistance of the WHO Regional Tuberculosis Adviser.

857. A chest clinic recently started at the Basseterre Health Clinic has an experienced medical officer and suitable X-ray and laboratory facilities, as well as an adequate staff of public health nurses. In 1951 this group traced down 143 contacts of the thirty-eight new cases found during the year, had 117 of these contacts X-rayed, and made home visits to some forty-five tubercular patients. The staff of nurses has, over recent years, been expanded from one to ten.

858. The Cunningham Hospital has twenty-four beds reserved for tubercular cases and a bronchoscope and a pneumothorax apparatus. The hospital's medical superintendent recently spent two months in Jamaica observing the surgical treatment of tuberculosis.

859. New drugs for chemotherapy of tuberculosis, such as streptomycin, para amino salicylic acid and isonicotinic acid hydrazide, are available in the Presidency.

860. Efforts are being made to alleviate the deficiencies in nutrition and housing, which are the principal causative factors of tuberculosis, and also to educate the public through talks, films, press articles, etc. There is, however, no tuberculosis association in the Presidency.

861. Two public health nurses from the Presidency have been trained in Jamaica in the techniques of BCG vaccination, and in 1952, in a very limited campaign, 1,257 persons were tested and 633, including hospital nurses and medical staff, vaccinated with BCG.

862. The plan now is to test all persons in the three islands comprising the Presidency, up to the age of 25 years in the urban areas and up to the age of 45 in rural zones. This will cover an estimated 30,000 persons. All tuberculin negative reactors will be vaccinated with BCG. A record will be kept of all positive reactors, so that they can be further investigated, and eventually treated if necessary.

863. Key staff for this programme will be trained in Trinidad, and the programme as a whole integrated with other tuberculosis work, to constitute one phase of an over-all programme.

UNICEF commitments

864. UNICEF will provide:

(*a*) Supplies and equipment at a cost of $3,500, as follows: one vehicle; PPD dilution; BCG vaccine; standard vaccination kit; steel and platinum needles; loudspeakers, propaganda leaflets, record cards, etc.;

(*b*) Two fellowships to study BCG techniques in Jamaica during a period of three months, estimated to cost $2,000.

WHO commitments and technical approval

865. The programme has the technical approval of WHO, which also assisted with its development.

International fellowships

866. Owing to the shortage of technical assistance funds, UNICEF will take over from WHO the financing of two fellowships for a medical officer and a public health nurse to study BCG techniques for three months in Jamaica.

Government commitments

867. The Government will provide the necessary personnel, premises and supplies not provided by UNICEF. This commitment is estimated at $BWI 9,180 (approximately $US5,400).

868. The Government also accepts responsibility for internal transport of international personnel, and for damage or injury to third persons including local staff members, incurred in the execution of the programme.

869. The Government further will undertake the necessary follow-up measures to maintain the benefits of the mass campaign.

Target time-schedule

870. It is proposed to send trainees to Jamaica at once, so that when the UNICEF supplies arrive, the personnel will be ready to begin testing and vaccination. Working with a single team, it is expected that the campaign can be completed within four months.

Emergency situations

INDIA

EMERGENCY FEEDING ASSISTANCE

871. The Executive Board approved an apportionment to India of $640,000 from the "Emergency Situations" allocation for assistance in the supplementary feeding of the neediest mothers and children in distress areas caused by crop failures. The Executive Director was authorized to approve a plan of operations as outlined in E/ICEF/R.444 and E/ICEF/R.444/Corr.1.

872. This aid is additional to emergency relief previously approved by the Board, bringing the total value of such assistance to $1,845,000.

873. India has changed from an exporter of food, in the first quarter of this century, to a large-scale food importer. The food situation is the primary consideration of the Central and State Governments, and the

Government view is that India must produce sufficient to feed herself. The hope is that this will be achieved within the period of the Five-Year Plan. In the meantime, India must import approximately 3 million tons of food grains again during 1953.

874. Since little new territory can be brought under cultivation, the solution must lie in raising the productivity of the cultivated land by providing incentive to the farmers through new irrigation policies, restoring exhausted soil, and introducing new techniques.

875. India is now operating the largest fertilizer plant in Asia, at Sindri. Under the Five-Year Plan, 17 million additional acres are to be irrigated. The Government has also instituted a Central Tractor Organization, which makes modern agricultural machinery available on loan to individual States.

876. In the procurement and distribution of food an extensive system of controls is in operation, but the Government's aim is to remove controls when domestic production has been increased by 7.5 million tons per annum.

877. A sum of 150 million rupees ($31,500,000) will be available within the Five-Year Plan from central revenues for assistance in famine areas. State Governments will provide further funds. In addition to providing direct relief, the general policy will be to attack the fundamental causes of food scarcity through irrigation, engineering projects, and improvement of roads.

878. Considerable attention is being paid to current distress areas. Some 3 million persons in the Bombay area are suffering as a result of drought. Scarcity of rain-fall during the two previous seasons appears to have exhausted local reserves, and State action is needed. Provision has been made by the Government for the expenditure of 17.5 million rupees ($3,675,000) on relief works, while 28.3 million rupees ($5,943,000) will be released as loans to agriculturalists.

879. In Madhya Bharat, in Central India, conditions are such that revenue collection will be suspended in certain areas for the period of the emergency.

880. Distress is still widespread in the Rayalaseema District of Madras and in certain parts of the contiguous States of Mysore and Hyderabad.

881. In the Sunderbans and adjacent areas of West Bengal some 2 million persons have been affected by unseasonable rainfall or tidal floods. During 1952, the State Government's expenditure on relief in this area was $348,000.

882. During 1952, the Executive Board approved $751,000 for emergency relief for India, mostly skim milk and rice. By the end of January 1953, 1,900 metric tons of rice and 550 short tons of skim milk had been distributed in the following areas: Madras, West Bengal, Saurashtra, Bombay, Travancore, Cochin and Assam. The rice, together with government supplies, will reach 237,000 beneficiaries for four months. The UNICEF milk will be distributed to 183,000 children, for periods varying from two to five months, depending on the plan for the particular district.

883. A balance of 700 tons of skim milk powder remains, of which 200 tons will be kept as an emergency reserve and 500 tons distributed over a period of four months, as follows:

State	*Expected Beneficiaries*
Madras	22,500
Bihar	22,500
Uttar Pradesh	22,500
Mysore	6,750
Rajasthan	15,750
Madhya Bharat	9,000
Bombay	13,500
	112,500

884. On the basis of past experience, it is certain that scarcity and distress will afflict some parts of India this year. In the first month of the year, there were already warnings of serious situations in Central and Southern India. In addition to the Government's general relief programme, there will be a need for special feeding and care of mothers and children in the affected areas.

885. UNICEF supplies will, in the main, be exhausted by the middle of the year, and a further allocation of 1,500 short tons of milk and 2,200 metric tons of rice is needed for distribution to selected mothers and children, as a supplement to Government relief in recognized famine or disaster areas.

886. As in the case of previous allotments, the UNICEF supplies will be assigned to various areas of distress, having regard to:

(*a*) The acuteness of the need;

(*b*) The amount of other relief work;

(*c*) The period needed to allow the afflicted population to adjust itself to changed conditions (usually four months);

(*d*) The feasibility of distributing UNICEF supplies only to children and mothers.

887. Supplies will be distributed under the same conditions as have applied in the current relief operations. The rice and milk will be issued in cooked or re-constituted form wherever possible, but the issue of dry rations will be necessary where families are widely scattered. The findings of previous Famine Enquiry Commissions stress the value of permitting women-folk to retain some semblance of their normal home lives by preparing meals for themselves and their children, rather than bringing their young families long distances in search of prepared food.

888. As in the past, up to a quarter of the supplies will be held temporarily in reserve against further emergencies.

889. The 2,200 metric tons of rice will be enough for a daily ration of 8 ounces to 54,000 persons for 180 days. The 1,500 short tons of milk will be enough for a daily ration of 40 grammes to 190,000 persons for 180 days.

UNICEF commitments

890. UNICEF will provide:

	$
(*a*) 2,200 metric tons rice at $155 per ton	340,000
(*b*) 1,500 short tons skim milk at $200 per ton	300,000
	640,000

Government commitments

891. In emergency situations, the State Government concerned and the Central Government immediately institute relief measures for the afflicted area. In connexion with UNICEF assistance the Government provides all local funds for transportation, storage and distribution. The Central Government has given assurance that funds will be made immediately available so that delays will be avoided. It is agreed that UNICEF food will go only to areas where other relief measures are also being undertaken by Central or State Governments.

Target time-schedule

892. The supplies are to be delivered as soon as possible.

Note: For other UNICEF assistance to India approved at this session, see paragraphs 241-306.

PAKISTAN

EMERGENCY FEEDING ASSISTANCE

893. The Executive Board approved an apportionment to Pakistan of $100,000 from the "emergency situations" allocation for the purchase of 1,000,000 lbs. of dry skim milk primarily for refugee relief. The Executive Director was authorized to approve a plan of operations as outlined in E/ICEF/R.450/Rev.1.

894. UNICEF provided Pakistan with 8,700,000 lbs. of dry skim milk in 1950-51, which was used principally for relief to refugees. UNICEF has also provided smaller quantities of both skim and whole milk for distribution through maternal and child welfare centres.

895. The additional 1,000,000 lbs. will be distributed chiefly to refugees, large numbers of whom have yet to be permanently resettled in both East and West Pakistan. Some distribution will also be made through hospitals and child care institutions.

Note: For other UNICEF assistance to Pakistan approved at this session, see paragraphs 345-411.

Projects benefiting more than one region

GROUP TRAINING IN MILK QUALITY CONTROL

896. The Executive Board approved an apportionment of $10,000 from the allocation for "Projects Benefiting More than One Region" for a four-weeks group training course on milk quality control, jointly sponsored by FAO, WHO and UNICEF. The course, which will be concerned with milk quality control in relation to human health and disease, will be attended by teams of public health officials and technicians in the milk production industry from fourteen countries in Europe and the Eastern Mediterranean area, which UNICEF has aided or is currently aiding in the development of milk conservation programmes. FAO and WHO will provide funds for this undertaking in the form of fellowships for participants, and certain other expenses.

897. From the beginning FAO has advised UNICEF on the broad lines of milk conservation developments and from time to time has made available special consultants, particularly for initial surveys in new areas and countries. All milk conservation proposals coming before the Board have the technical approval of FAO. Now that an increasing number of milk plants are operating, WHO has become directly interested in the public health aspects of these projects, particularly as regards the nutritional importance of milk, and the prevention of disease transmission through bad quality milk.

898. The aim of all countries in developing a proper, coordinated and enforceable system of legislation and standards for milk quality control may be summarized as follows:

(i) There must be a good supply of milk to process;

(ii) The milk must be processed under the best possible conditions;

(iii) After processing it must be protected against spoilage and recontamination until it is consumed.

899. The rapid development of the UNICEF-aided milk conservation programmes confirms the necessity for a group training course as one step in a long-range programme for dealing with problems of milk quality control.

900. The course has been planned jointly by representatives of FAO, WHO, and UNICEF for persons such as representatives of government departments responsible for milk quality control, health officers from areas of UNICEF-aided plants, milk production specialists, plant managers, etc. It will provide an opportunity for the exchange of experience and study of the relationship between good systems of dairy legislation and the technical phases of producing good quality milk; the responsibilities of public health authorities regarding prevention of disease caused by bad quality milk; and improvement of health standards by fostering consumption of adequate quantities of safe milk.

901. The course will take place in Rome, Italy, beginning approximately 21 October 1953 and lasting for a period of four weeks.

902. Invitations will be sent to the governments of fourteen countries in Europe and the Eastern Mediterranean area where UNICEF milk plants have been or are being installed: Austria, Czechoslovakia, Egypt, Finland, France, Greece, Iran, Iraq, Israel, Italy, Malta, Poland, Turkey and Yugoslavia. A maximum of three persons, in principle two technicians and one regulatory official, will be nominated by each government, making a total of forty-two participants.

903. FAO and WHO will recruit authorities in their respective fields to lecture at the course. UNICEF milk technicians will also be part of the faculty. The programme for the course will include theoretical and practical work. There will be lectures, discussions and working visits to relevant institutions in Rome such as dairies, producers of dairy plant equipment and to dairy farms. The primary responsibility for making the necessary administrative arrangements for the course will devolve upon FAO Headquarters in Rome. Certain laboratory arrangements will be handled by the Italian National Research Council and the cooperation and support of the Italian National Milk Committee has been obtained.

904. It is estimated that the cost of the course will be about $25,000. Originally it was expected that each sponsoring agency would pay the cost of its respective lecturers and fellowships and that all other expenses might be borne by FAO. However, because of the reduction of funds from Technical Assistance sources, FAO and WHO will be unable to participate as fully as foreseen. Thus FAO and WHO will provide some $15,000 towards the expenses of the course, with FAO furnishing from the residual UNRRA funds a total of $12,500. UNICEF will provide the remaining funds required, up to $10,000. The Board, while appreciating the importance of this course to UNICEF, believes that training of this type is, as a matter of principle, more appropriately financed from Technical Assistance funds and therefore does not consider the present apportionment as a precedent for future financing by UNICEF of similar schemes.

REPORT OF COMMITTEE ON ADMINISTRATIVE BUDGET

905. The Board had before it a report of the Committee on Administrative Budget (E/ICEF/R.454). The Board noted that the Committee had elected as its Chairman for 1953 Mr. Awni Khalidy of Iraq.

Reimbursement to United Nations of out-of-pocket expenses for office space

906. The Executive Board considered the request of the Secretary-General that UNICEF include in the preparation of its administrative requirements for 1954 the amount of $23,100 for reimbursement to the United Nations of estimated charges to be incurred on behalf of UNICEF during 1954 in respect of maintenance of office space, utilities, and rental of telephone, and extra local messages (E/ICEF/R.448). In October 1952 the Executive Board agreed to include in the administrative budget estimate for the New York Headquarters the amount of $6,440 for reimbursement to the United Nations for rental of telephones and extra local messages. The inclusion of this item in the 1953 budget was separately approved by the Board without prejudice as to action in the future on similar items (E/ICEF/212, para. 668).

907. The Executive Board decided to refer to the General Assembly the question of principle as to whether UNICEF should be required, in the light of resolution 57 (I), to include in its estimates of administrative requirements for 1954 the reimbursement to the United Nations of estimated charges in respect of maintenance, utilities and telephone rental and extra local messages.

Greeting Card Fund for 1953

908. The Board noted that, while not all financial returns have as yet been received, it is estimated that the surplus of income over expenditure in the 1952 project is approximately $70,000. The Board also noted that the Committee on Administrative Budget had authorized the Administration to transfer $25,000 to the general resources of the Fund consisting of (i) the net surplus of the 1951 greeting card project amounting to $16,274.15; and (ii) a sum of $8,725.85 out of the proceeds of the 1952 greeting card project.

909. Approximately 1,500,000 cards have been sold in 1952 compared with 450,000 in 1951. In view of the success of the 1952 greeting card project both from the public information and financial points of view, the Board approved a greeting card project for 1953. It authorized for this project the establishment of a working capital consisting of (i) the balance of approximately $60,000 remaining in the 1951-52 greeting card projects' account (after transfer of $25,000 to the general resources of the Fund); and (ii) the addition to the greeting card working capital of further income, if any, which may still be received in respect of the 1952 project. The Board agreed that should any funds be required from outside sources for working capital to finance the 1953 project, such funds would be repaid out of the first proceeds of the sale of the cards.

MISCELLANEOUS QUESTIONS

Approval in principle of UNICEF contribution to International Children's Centre 1954-1956

910. The Executive Board had before it three documents relating to the International Children's Centre ("Programme of the International Children's Centre for 1953", E/ICEF/215 and Corr.1; "Report of the International Children's Centre on its Activities during the Year 1952" E/ICEF/216; and "Proposed UNICEF Contribution to the International Children's Centre, for Operations during the Three-Year Period 1954-1956", E/ICEF/220.)

911. In this latter paper the Executive Director recommended that the Board accept in principle the responsibility to share with the French Government the cost of operation of the International Children's Centre for the three years 1954-56, UNICEF providing 60 per cent and the French Government 40 per cent of the budget. UNICEF assistance would be subject, as in the past, to prior approval by the Board of the annual programme and plan of expenditure of the Centre in accordance with the procedure adopted by the Board in November 1949.

912. Previous UNICEF allocations to the Centre total $1,660,000, including an allocation approved in April 1952 for 1953 operations (E/ICEF/R.331). This sum was originally intended to cover three years, but has been stretched, with the aid of 25,000,000 francs (approximately $US70,000) contributed to the Centre by the Government of France for 1953, to cover the four years 1950-53.

913. When the Centre was established it was hoped that if it developed successfully it would become a permanent institution, although the UNICEF Board took no commitment to finance it beyond the first three years. Now the Centre has developed successfully and it fills a specific and useful function of international service. The international character of the Centre is reflected in the composition of the Governing Body whose ten members are of eight nationalities, the participation of non-French nationals in the research and teaching work of the Centre, the special planning of the training for non-French people, and the direction of research and information to problems of international interest.

914. The Centre has to be in a position to make commitments for recruitment of personnel to serve for a period of years, to undertake research programmes extending over several years, and to plan educational activities at least one year in advance to give proper notice of courses and recruit the most useful candidates. Consequently it needs an assurance of financial support for a period of years. It is not proposed to make formal changes in the relation of the Centre with other international agencies. The responsibility for the development of policy of the Centre and for the execution of its programme would remain with the Centre's Governing Body whose members possess technical qualifications for these functions. The Governing Body would continue to have the advice of the Technical Advisory Committee comprising officials of the UN and the Specialized Agencies (ILO, FAO, WHO, UNESCO) and it is proposed to strengthen the working of this Committee.

915. The World Health Organization will continue to give its technical approval to projects involving expenditure of funds contributed by UNICEF, and the Director-General of WHO envisages closer working collaboration with the Centre in the future. A prospectus of the Centre's programme for the period 1954-56 is contained in E/ICEF/220 (annex B). The Director-General of WHO believes this prospectus is technically sound and provides a good basis for the development of a detailed long-term programme with WHO and other interested agencies.

916. The French Government has committed itself to include in its budget estimates to Parliament, for each of the three years 1954-56, an appropriation corresponding to 40 per cent of the approved budget of the ICC on condition that UNICEF undertakes to defray 60 per cent of the budget.

917. The annual budget levels have not yet been determined. The amounts under discussion have ranged between $350,000, which is close to the actual levels of operational expenditure in 1951 and 1952, and $500,000, which is the full amount of the budget estimates for 1953. These sums may be taken as the lower and upper limits of any proposal, and UNICEF's 60 per cent share would therefore amount to between $210,000 and $300,000 annually. The French Government has indicated its readiness to contribute up to $200,000 anually.

918. The 1954 budget estimates for the Centre would be developed in July in the course of consultations between representatives of the French Centre and of the Fund, and, in the light of actual expenditures during the first half of the year, a recommendation for an allocation for 1954 would be made to the second session of the Board in 1953.

919. In the discussion of the recommendation while all representatives expressed their appreciation of the work of the Centre, several questions of principle were raised. One was whether the Fund would be morally bound to give priority to aid to the Centre over direct aid to children if the recommendation were approved. Another was whether it would not be more desirable to take a decision of this nature involving a commitment for three years at the next Board session when the future of the Fund would be clearer. A third question was whether the total contributions to the support of the Centre as a "national" organization, from all sources in France, would at least equal the percentage amount requested from UNICEF under the plan under consideration.

920. It was pointed out on the other hand that the future of UNICEF may not be more clearly known by the time the Board meets next September. Moreover, a delay would have serious consequences on plans for the Centre, and also make difficult the inclusion of the French Government's share in its budget which will be drawn up before next September. In any event, the commitment taken by the Executive Board would be subject to the continuation of the Fund and the availability of resources. It was further pointed out that contributions from all sources (including governmental and non-governmental) in France to the Centre at least equalled that expected from UNICEF. As for the question of priorities, it was generally agreed that this commitment would not have a priority to exclude direct aid to children. It was the belief that if there were adequate resources to warrant continuation of UNICEF in the future, funds would be available for direct aid to children as well as for the Centre.

921. The Executive Board agreed subject to the continuation of the Fund and to the availability of resources, to share the costs of operation of the International Children's Centre for the years 1954-56 on the basis of 40 per cent of the costs to be paid by the French Government and 60 per cent by UNICEF within the financial limits mentioned in paragraph 917 above. Apportionments would come from Board allocations for "projects benefiting more than one region".

UNICEF/WHO Joint Committee on Health Policy

922. The Board elected as an alternate UNICEF Board representative on the UNICEF/WHO Joint Committee on Health Policy, Mr. Cecilio J. Morales (Argentina). The UNICEF representation is now as follows:

The Chairman of the Executive Board, Mr. A. R. Lindt (Switzerland)

The Chairman of the Programme Committee, Mr. K. G. Brennan (Australia)

Professor Robert Debré (France)

Dr. S. Daengsvang (Thailand)

Dr. Martha Eliot (United States of America)
Alternates: Mr. C. Morales (Argentina), Mr. R. Pleic (Yugoslavia).

923. The Executive Board authorized the Executive Director to pay the travelling expenses and subsistence allowances of the representatives of the UNICEF Board attending the meetings of the JCHP, charging this to the "travel" allotment account of the UNICEF administrative budget.

924. The Executive Board noted that at its last session the UNICEF/WHO Joint Committee on Health Policy had considered the question of UNICEF aid for anti-leprosy programmes (E/ICEF/192, paras. 46-48). The Executive Board at its present session had approved UNICEF aid for a leprosy programme in Nigeria on the basis of the merits of the programme. The Board decided, however, to have a fuller discussion in the JCHP on the general question of UNICEF aid for anti-leprosy projects. It therefore decided that no further leprosy programmes should be brought forward until the Board has had an opportunity to discuss the JCHP report on this subject.

Policy on aid for new types of programmes

925. The Executive Board agreed as a general policy that proposals for aid to projects in types of programmes not hitherto approved by it be submitted only after there has been a formal prior Board authorization in principle. In the health field, in accordance with normal practice, this would be preceded by a recommendation in principle by the UNICEF/WHO Joint Committee on Health Policy.

Relations with non-governmental organizations

926. The Executive Board received a statement from the NGO Committee on UNICEF[1] which set forth the revised terms of reference of the Committee and informed the Board of the future programme which had been approved by the Committee to make effective the support of its member organizations for UNICEF. Resolutions in support of UNICEF were received from non-governmental organizations having consultative status with the Executive Board[2] and a joint statement by sixteen of the NGOs, recommending increased emphasis on the development of child health centres as basic and permanent community institutions, was before the Board[3] (see para. 20).

927. The Executive Board expressed its appreciation for the close co-operation of the non-governmental organizations and for the activities of the NGO Committee on UNICEF which it felt had enabled UNICEF and the NGOs to focus with increased effectiveness their co-operative efforts toward the accomplishment of common objectives. The Executive Board noted with approval the inauguration of an E/ICEF/NGO series of papers to the Board and expressed the wish that this and other means of collaboration with the NGOs be continued.

Adoption of Spanish as a working language in UNICEF

928. The Executive Board decided in principle that its rules of procedure would be revised to conform with the decision of the fifteenth session of the Economic and Social Council regarding the adoption of Spanish as a working language. The purpose of this decision was to assure that the present arrangements with the United Nations Bureau of Documents for services to UNICEF with regard to working languages would be extended to Spanish for the next Board session, if ECOSOC action approved the use of Spanish as a working language for ECOSOC and its functional commissions.

Date of next Board session

929. The Executive Board set 8 September 1953 as the opening date of its next session.

[1] E/ICEF/NGO1. Statement submitted by the NGO Committee on UNICEF to the UNICEF Executive Board.

[2] E/ICEF/NGO2. International Federation of Business and Professional Women: resolution on UNICEF.
E/ICEF/NGO3. World Federation of UN Associations, Geneva, Switzerland: UN Associations' support for UNICEF.
E/ICEF/NGO4. World Union of Catholic Women's Organizations: resolution on co-operation with UNICEF.
E/ICEF/NGO6. International Council of Women: resolution in support of UNICEF.

[3] E/ICEF/NGO5. Recommendation for expansion of UNICEF programme to develop permanent child health centres: joint statement by sixteen NGO's having consultative status with the UNICEF Executive Board.

ANNEXES

TABLE I

UNICEF allocations approved at March 1953 Executive Board session and cumulative through March 1953

(In United States dollars)

Country (1)	*Allocations cumulative 1947/1952* (2)	*Action taken in March 1953* — *Allocations to cover* — *Long-range aid* (3)	*Action taken in March 1953* — *Allocations to cover* — *Emergencies* (4)	*Allocations returned*[a] (5)	*Allocations cumulative through March 1953*[b] (6)
I. Africa	1,378,700	379,000	—	—	1,757,700
II. Asia	23,045,700	2,038,000	740,000	55,600	25,768,100
III. Eastern Mediterranean	18,833,500	707,000	—	46,700	19,493,800
IV. Europe	89,470,200	264,000	—	55,000	89,679,200
V. Latin America	7,473,200	726,300	—	81,300	8,118,200
VI. Assistance benefiting more than one region..	2,332,000	10,000	—	3,800	2,338,200
TOTAL I-VI	142,533,300	4,124,300	740,000	242,400	147,155,200
VII. Other assistance					
Freight	16,595,000	662,000		—	17,257,000
Operational services	609,000	—		15,400	593,600
VIII. Administration	12,927,600	—		68,800	12,858,800
TOTAL VII-VIII	30,131,600	662,000		84,200	30,709,400
GRAND TOTALS	172,664,900	5,526,300		326,600	177,864,600
I. AFRICA					
Belgian Congo and Ruanda-Urundi	175,000	4,000	—	—	179,000
French Equatorial Africa	150,000	—	—	—	150,000
French West Africa, Togoland and the Cameroons	400,000	—	—	—	400,000
Liberia	100,000	—	—	—	100,000
Mauritius	—	10,000	—	—	10,000
Morocco	381,600	33,000	—	—	414,600
Nigeria	—	318,000	—	—	318,000
Tunisia	172,100	14,000	—	—	186,100
	1,378,700	379,000	—	—	1,757,700
II. ASIA					
Afghanistan	262,000	126,000	—	800	387,200
Brunei	33,000	1,000	—	(200)	34,200
Burma	715,900	27,000	—	13,900	729,000
Cambodia	29,000	3,000	—	—	32,000
Ceylon	602,500	21,000	—	—	623,500
China	3,253,700	—	—	—	3,253,700
China (Taiwan)	274,000	65,000	—	—	339,000
Hongkong	202,000	—	—	—	202,000
India	7,134,600	846,000	640,000	1,800	8,618,800
Indonesia	2,371,100	503,000	—	(400)	2,874,500
Japan	570,000	17,000	—	7,000	580,000
Korea	1,552,000	—	—	—	1,552,000
Malaya	207,000	—	—	4,700	202,300
North Borneo	90,000	—	—	6,600	83,400

TABLE I (*continued*)

Country (1)	Allocations cumulative 1947/1952 (2)	Action taken in March 1953: Allocations to cover — Long-range aid (3)	Action taken in March 1953: Allocations to cover — Emergencies (4)	Action taken in March 1953: Allocations returned[a] (5)	Allocations cumulative through March 1953[b] (6)
Pakistan	2,492,900	93,000	100,000	6,200	2,679,700
Philippines	1,392,900	214,000	—	100	1,606,800
Sarawak	74,000	—	—	300	73,700
Singapore	48,600	14,000	—	14,200	48,400
Thailand	1,311,600	94,000	—	600	1,405,000
Vietnam	106,000	14,000	—	—	120,000
Indochina (unapportioned)	322,900	—	—	—	322,900
	23,045,700	2,038,000	740,000	55,600	25,768,100
III. EASTERN MEDITERRANEAN					
Aden	13,000	—	—	—	13,000
Egypt	1,046,000	180,000	—	—	1,226,000
Ethiopia	52,000	—	—	—	52,000
Iran	552,000	125,000	—	—	677,000
Iraq	510,000	203,000	—	26,700	686,300
Israel	929,000	50,000	—	20,000	959,000
Jordan	468,000	7,000	—	—	475,000
Lebanon	56,100	—	—	—	56,100
Libya	143,000	11,000	—	—	154,000
Sudan	25,000	4,000	—	—	29,000
Syria	190,700	12,000	—	—	202,700
Turkey	322,000	115,000	—	—	437,000
Palestine refugees	14,526,700	—	—	—	14,526,700
	18,833,500	707,000	—	46,700	19,493,800
IV. EUROPE					
Albania	289,500	—	—	—	289,500
Austria	6,227,400	59,000	—	55,000	6,231,400
Bulgaria	4,930,900	—	—	—	4,930,900
Czechoslovakia	5,041,000	—	—	—	5,041,000
Finland	1,653,600	—	—	—	1,653,600
France	2,467,200	—	—	—	2,467,200
Germany	2,710,000	—	—	—	2,710,000
Greece	8,553,300	—	—	—	8,553,300
Hungary	1,826,600	—	—	—	1,826,600
Italy	16,883,400	—	—	—	16,883,400
Malta	169,000	—	—	—	169,000
Poland	16,999,400	—	—	—	16,999,400
Portugal	50,000	—	—	—	50,000
Romania	6,414,600	—	—	—	6,414,600
Yugoslavia	15,254,300	205,000	—	—	15,459,300
	89,470,200	264,000	—	55,000	89,679,200
V. LATIN AMERICA					
Bolivia	218,000	24,500	—	—	242,500
Brazil	1,600,000	281,000	—	32,000	1,849,000
British Guiana	—	18,500	—	—	18,500
British Honduras	66,000	4,000	—	—	70,000
Chile	676,000	24,000	—	—	700,000
Colombia	278,000	15,000	—	—	293,000
Costa Rica	223,000	153,000	—	—	376,000
Dominican Republic	124,000	—	—	—	124,000
Ecuador	869,400	20,000	—	20,000	869,400
El Salvador	411,000	—	—	—	411,000
Grenada	27,000	5,600	—	—	32,600
Guatemala	178,000	34,200	—	4,200	208,000
Haiti	745,000	3,000	—	—	748,000
Honduras	337,000	30,000	—	—	367,000

TABLE I (*continued*)

Country (1)	Allocations cumulative 1947/1952 (2)	Action taken in March 1953			Allocations cumulative through March 1953[b] (6)
		Allocations to cover		Allocations returned[a] (5)	
		Long-range aid (3)	Emergencies (4)		
Jamaica	159,000	—	—	—	159,000
Mexico	57,800	—	—	—	57,800
Nicaragua	434,000	—	—	—	434,000
Panama	120,000	8,000	—	—	128,000
Paraguay	179,500	35,000	—	23,000	191,500
Peru	583,000	65,000	—	—	648,000
St. Kitts, Leeward Islands	—	5,500	—	—	5,500
St. Lucia	25,000	—	—	—	25,000
Surinam	37,000	—	—	—	37,000
Trinidad and Tobago	81,400	—	—	—	81,400
Uruguay	42,000	—	—	—	42,000
BCG Fellowships reserve	2,100	—	—	2,100	—
	7,473,200	726,300	—	81,300	8,118,200
VI. ASSISTANCE BENEFITING MORE THAN ONE REGION					
Group training courses	580,000	10,000	—	—	590,000
WHO regional BCG advisers and SKIVE project	75,500	—	—	3,800	71,700
International Children's Centre	1,676,500	—	—	—	1,676,500
	2,332,000	10,000	—	3,800	2,338,200

[a] Consists of:

Funds returned from previous allocations	
For project personnel	$ 65,100
For operational services	15,400
For administration	68,800
Cost of plans of operation approved for use of funds previously allocated to country	177,300
	$326,600

(The last item of $177,300 is included in the total of allocations in column 3.)

[b] Equals sum of columns 2 plus 3 plus 4 minus 5.

TABLE II

UNICEF allocations and plans of operation approved for long-range programmes at March 1953 Executive Board session, by type of programme

(In United States dollars)

Country	MCW					Mass health programmes							Child nutrition		Grand total (15)
	Basic MCW programmes			Training[a] programmes (4)	Sub-total (5)	Combating insect-borne diseases (6)	Production of antibiotics, insecticides, sera and vaccines (7)	Control of bejel, yaws, VD (8)	BCG anti-tuberculosis vaccination campaigns (9)	Anti-trachoma work (10)	Control of other communicable diseases (11)	Sub-total (12)	Long-range feeding assistance (13)	MCP (14)	
	MCW centres (1)	School health services (2)	Other MCW projects (3)												
AFRICA															
Belgian Congo	—	—	—	—	—	—	—	—	—	—	—	—	4,000	—	4,000
Mauritius	—	—	—	—	—	—	—	—	—	—	10,000	10,000	—	—	10,000
Morocco	—	—	—	—	—	—	—	—	—	33,000	—	33,000	—	—	33,000
Nigeria	—	—	—	—	—	75,000	—	150,000	—	—	93,000	318,000	—	—	318,000
Tunisia	—	—	—	—	—	—	—	—	—	14,000	—	14,000	—	—	14,000
AREA TOTAL	—	—	—	—	—	75,000	—	150,000	—	47,000	103,000	375,000	4,000	—	379,000
ASIA															
Afghanistan	56,000	—	—	—	56,000	66,000	—	—	4,000	—	—	70,000	—	—	126,000
Brunei	—	—	—	—	—	—	—	—	1,000	—	—	1,000	—	—	1,000
Burma	25,000	—	—	—	25,000	—	—	—	2,000	—	—	2,000	—	—	27,000
Cambodia	—	—	—	—	—	—	—	—	3,000	—	—	3,000	—	—	3,000
Ceylon	—	—	—	21,000	21,000	—	—	—	—	—	—	—	—	—	21,000
China-Taiwan	30,000	—	—	—	30,000	—	—	27,000	—	8,000	—	35,000	—	—	65,000
India	537,000	21,000	—	249,000	807,000	—	—	39,000	—	—	—	39,000	—	—	846,000
Indonesia	40,000	—	—	—	40,000	—	—	450,000	13,000	—	—	463,000	—	—	503,000
Japan	—	—	17,000	—	17,000	—	—	—	—	—	—	—	—	—	17,000
Pakistan	16,000	23,000	11,000	—	50,000	—	20,000	—	23,000	—	—	43,000	—	—	93,000
Philippines	75,000	—	—	59,000	134,000	—	—	—	5,000	—	—	5,000	75,000	—	214,000
Singapore	—	—	14,000	—	14,000	—	—	—	—	—	—	—	—	—	14,000
Thailand	90,000	—	—	4,000	94,000	—	—	—	—	—	—	—	—	—	94,000
Vietnam	10,000	—	—	—	10,000	—	—	—	4,000	—	—	4,000	—	—	14,000
AREA TOTAL	879,000	44,000	42,000	333,000	1,298,000	66,000	20,000	516,000	55,000	8,000	—	665,000	75,000	—	2,038,000
EASTERN MEDITERRANEAN REGION															
Egypt	180,000	—	—	—	180,000	—	—	—	—	—	—	—	—	—	180,000
Iran	—	—	—	—	—	—	—	—	—	—	—	—	—	125,000	125,000
Iraq	44,000	—	—	37,000	81,000	—	—	—	—	—	—	—	122,000	—	203,000
Israel	30,000	—	20,000	—	50,000	—	—	—	—	—	—	—	—	—	50,000
Jordan	—	—	—	—	—	—	—	—	7,000	—	—	7,000	—	—	7,000
Libya	11,000	—	—	—	11,000	—	—	—	—	—	—	—	—	—	11,000
Sudan	—	—	—	—	—	—	—	—	4,000	—	—	4,000	—	—	4,000
Syria	—	—	—	—	—	—	—	12,000	—	—	—	12,000	—	—	12,000
Turkey	105,000	—	—	10,000	115,000	—	—	—	—	—	—	—	—	—	115,000
AREA TOTAL	370,000	—	20,000	47,000	437,000	—	—	12,000	11,000	—	—	23,000	122,000	125,000	707,000

EUROPE															
Austria	—	—	25,000	—	25,000	—	34,000	—	—	—	—	34,000	—	—	59,000
Yugoslavia	—	—	—	—	—	—	—	—	—	—	—	—	—	205,000	205,000
AREA TOTAL	—	—	25,000	—	25,000	—	34,000	—	—	—	—	34,000	—	205,000	264,000
LATIN AMERICA															
Bolivia	18,000	—	—	—	18,000	6,000	—	—	0,500	—	—	6,500	—	—	24,500
Brazil	32,000	—	—	—	32,000	—	—	—	—	—	—	—	249,000	—	281,000
British Guiana	—	—	—	—	—	—	—	—	18,500	—	—	18,500	—	—	18,500
British Honduras	—	—	—	—	—	—	—	—	4,000	—	—	4,000	—	—	4,000
Chile	—	—	—	—	—	—	—	—	—	—	—	—	24,000	—	24,000
Colombia	—	—	—	—	—	—	15,000	—	—	—	—	15,000	—	—	15,000
Costa Rica	—	—	—	—	—	—	—	—	—	—	—	—	53,000	100,000	153,000
Ecuador	20,000	—	—	—	20,000	—	—	—	—	—	—	—	—	—	20,000
Grenada	—	—	—	—	—	—	—	—	5,600	—	—	5,600	—	—	5,600
Guatemala	—	—	—	—	—	—	—	—	—	—	—	—	34,200	—	34,200
Haiti	—	—	—	—	—	3,000	—	—	—	—	—	3,000	—	—	3,000
Honduras	—	—	—	—	—	—	—	—	—	—	—	—	30,000	—	30,000
Panama	—	—	—	8,000	8,000	—	—	—	—	—	—	—	—	—	8,000
Paraguay	—	—	—	—	—	—	—	—	35,000	—	—	35,000	—	—	35,000
Peru	—	—	—	—	—	—	45,000	—	—	—	20,000	65,000	—	—	65,000
St. Kitts	—	—	—	—	—	—	—	—	5,500	—	—	5,500	—	—	5,500
AREA TOTAL	70,000	—	—	8,000	78,000	9.000	60,000	—	69,100	—	20,000	158,100	390,200	100,000	726,300
ASSISTANCE BENEFITING MORE THAN ONE REGION															
Milk Conservation Group Training	—	—	—	—	—	—	—	—	—	—	—	—	—	10,000	10,000
GRAND TOTAL	1,319,000	44,000	87,000	388,000	1,838,000	150,000	114,000	678,000	135,100	55,000	123,000	1,255,100	591,200	440,000	4,124,300

[a] Other than included in columns 1-3.

TABLE III

UNICEF allocations and plans of operation approved for long-range programmes in 1952, by type of programme

(In United States dollars)

Country	MCW: Basic MCW programmes: MCW centres (1)	MCW: Basic MCW programmes: Other MCW projects (2)	MCW: Basic MCW programmes: Training[a] programmes (3)	MCW: Sub-total (4)	Mass health programmes: Combating insect-borne diseases (5)	Mass health programmes: Production of antibiotics, insecticides, sera and vaccines (6)	Mass health programmes: Control of bejel, yaws, VD (7)	Mass health programmes: BCG anti-tuberculosis vaccination campaigns (8)	Mass health programmes: Tuberculosis control (9)	Mass health programmes: Anti-trachoma work (10)	Mass health programmes: Control of other communicable diseases (11)	Mass health programmes: Sub-total (12)	Child nutrition: Long-range feeding assistance (13)	Child nutrition: MCP (14)	Grand total (15)
AFRICA															
Belgian Congo and Ruanda-Urundi	—	—	—	—	—	—	—	—	—	—	—	—	175,000	—	175,000
French Equatorial Africa	—	—	—	—	—	—	—	—	—	—	—	—	150,000	—	150,000
French West Africa, Togoland and the Cameroons	—	—	—	—	400,000	—	—	—	—	—	—	400,000	—	—	400,000
Liberia	—	—	—	—	50,000	—	50,000	—	—	—	—	100,000	—	—	100,000
Morocco	—	—	—	—	—	—	—	—	—	100,000	—	100,000	—	—	100,000
Tunisia	—	—	—	—	—	—	—	—	—	75,000	—	75,000	—	—	75,000
AREA TOTAL	—	—	—	—	450,000	—	50,000	—	—	175,000	—	675,000	325,000	—	1,000,000
ASIA															
Afghanistan	54,000	—	—	54,000	53,000	—	—	—	—	—	—	53,000	—	—	107,000
Burma	216,000	—	—	216,000	—	—	—	34,000	15,000	—	—	49,000	—	—	265,000
Cambodia	—	—	—	—	—	—	—	29,000	—	—	—	29,000	—	—	29,000
Ceylon	24,000	—	—	24,000	—	—	—	—	—	—	—	—	—	—	24,000
China-Taiwan	23,000	—	—	23,000	—	15,000	28,000	40,000	—	10,000	—	93,000	—	—	116,000
Hongkong	70,000	—	—	70,000	—	—	—	19,000	—	—	8,000	27,000	—	—	97,000
India	815,000	—	31,000	846,000	424,000	—	—	135,000	31,000	—	—	590,000	—	—	1,436,000
Indonesia	19,000	—	—	19,000	—	—	—	—	—	—	—	—	—	—	19,000
Pakistan	391,000	—	24,000	415,000	37,000	—	—	146,000	—	—	—	183,000	—	—	598,000
Philippines	290,000	—	—	290,000	—	—	122,000	73,000	—	—	—	195,000	—	—	485,000
Thailand	127,000	—	26,000	153,000	—	—	368,000	99,000	—	—	—	467,000	—	—	620,000
Vietnam	77,000	—	—	77,000	—	—	—	29,000	—	—	—	29,000	—	—	106,000
AREA TOTAL	2,106,000	—	81,000	2,187,000	514,000	15,000	518,000	604,000	46,000	10,000	8,000	1,715,000	—	—	3,902,000
EASTERN MEDITERRANEAN															
Egypt	—	—	—	—	165,000	—	—	—	—	—	—	165,000	—	125,000	290,000
Ethiopia	—	—	—	—	—	—	—	52,000	—	—	—	52,000	—	—	52,000
Iran	75,000	—	—	75,000	—	—	—	—	—	—	—	—	—	—	75,000
Iraq	—	—	—	—	85,000	—	—	—	—	—	—	85,000	35,000	150,000	270,000
Israel	—	—	—	—	—	—	—	—	—	—	—	—	—	300,000	300,000
Jordan	63,000	—	—	63,000	—	—	—	15,000	—	—	—	15,000	—	—	78,000
Lebanon	—	—	—	—	8,000	—	—	—	—	—	—	8,000	—	—	8,000
Libya	43,000	—	—	43,000	—	—	—	—	—	—	—	—	—	—	43,000

Sudan	—	—	—	—	—	—	—	25,000	—	—	—	25,000	—	—	25,000
Syria	35,000	—	—	35,000	35,000	—	—	—	—	—	—	35,000	—	—	70,000
Turkey	—	—	—	—	—	—	—	—	—	—	—	—	20,000	140,000	160,000
AREA TOTAL	216,000	—	—	216,000	293,000	—	—	92,000	—	—	—	385,000	55,000	715,000	1,371,000
EUROPE															
Greece	63,000	—	—	63,000	—	—	—	—	—	—	—	—	—	—	63,000
Italy	—	—	—	—	—	—	—	—	—	—	—	—	—	290,000	290,000
Portugal	50,000	—	—	50,000	—	—	—	—	—	—	—	—	—	—	50,000
Yugoslavia	253,000	50,000	—	303,000	—	—	—	—	—	—	—	—	—	210,000	513,000
AREA TOTAL	366,000	50,000	—	416,000	—	—	—	—	—	—	—	—	—	500,000	916,000
LATIN AMERICA															
Bolivia	—	—	—	—	48,000	—	—	—	—	—	—	48,000	—	—	48,000
British Honduras	—	—	—	—	—	—	—	—	—	—	—	—	16,000	—	16,000
Chile	—	—	—	—	—	285,000	—	—	—	—	—	285,000	49,000	—	334,000
Colombia	—	—	—	—	8,000	—	—	—	—	—	—	8,000	—	—	8,000
Grenada	—	—	—	—	27,000	—	—	—	—	—	—	27,000	—	—	27,000
Haiti	—	—	—	—	165,000	—	260,000	—	—	—	—	425,000	—	—	425,000
Honduras	—	—	—	—	26,000	—	—	—	—	—	—	26,000	23,000	145,000	194,000
Jamaica	—	—	—	—	46,000	—	—	—	—	—	—	46,000	—	—	46,000
Nicaragua	—	—	—	—	—	—	—	—	—	—	—	—	30,000	—	30,000
Panama	37,000	—	—	37,000	—	—	—	—	—	—	—	—	—	—	37,000
Paraguay	25,000	—	—	25,000	—	—	—	0,500	—	—	—	0,500	—	—	25,500
Peru	—	—	—	—	117,000	—	—	—	—	—	—	117,000	68,000	—	185,000
St. Lucia	—	—	—	—	25,000	—	—	—	—	—	—	25,000	—	—	25,000
Surinam	—	—	—	—	37,000	—	—	—	—	—	—	37,000	—	—	37,000
Trinidad and Tobago	—	—	—	—	38,000	—	—	—	8,000	—	—	46,000	—	—	46,000
AREA TOTAL	62,000	—	—	62,000	537,000	285,000	260,000	0,500	8,000	—	—	1,090,500	186,000	145,000	1,483,500
ASSISTANCE BENEFITING MORE THAN ONE REGION															
SKIVE Anti-Tuberculosis Project	—	—	—	—	—	—	—	40,000	—	—	—	40,000	—	—	40,000
International Children's Centre	—	—	330,000	330,000	—	—	—	—	—	—	—	—	—	—	330,000
	—	—	330,000	330,000	—	—	—	40,000	—	—	—	40,000	—	—	370,000
GRAND TOTAL	2,750,000	50,000	411,000	3,211,000	1,794,000	300,000	828,000	736,500	54,000	185,000	8,000	3,905,500	566,000	1,360,000	9,042,500[b]

[a] Other than included in columns 1 and 2.

[b] The total excludes $17,000 to cover an underestimation in the cost of food supplies for a programme for Czechoslovakia approved prior to 1950.

TABLE IV

UNICEF-approved assistance by area and type of programme, 1947 through March 1953

(In United States dollars)

	1947 through 1950						1951 through March 1953						Cumulative 1947 through March, 1953
	Africa	*Asia*	*Eastern Mediterranean*	*Europe*	*Latin America*	*Sub-total*	*Africa*	*Asia*	*Eastern Mediterranean*	*Europe*	*Latin America*	*Sub-total*	*Total*
A. LONG-RANGE AID													
I. *MCW*[a]													
i) Basic MCW programmes:													
MCW centres	—	—	—	—	—	—	—	3,199,300	638,800	366,000	410,600	4,614,700	—
School health services	—	—	—	—	—	—	—	44,000	—	—	—	44,000	—
Other MCW projects	—	—	—	—	—	—	—	170,700	60,000	225,400	20,000	476,100	—
ii) MCW training[b]	—	—	—	—	—	—	—	510,700	93,900	—	46,000	650,600	—
SUB-TOTAL, MCW	—	3,869,800	54,000	2,493,100	748,500	7,165,400	—	3,924,700	792,700	591,400	476,600	5,785,400	12,950,800
II. *Mass health programmes*													
i) Combating insect-borne diseases	—	284,700	—	613,600	742,400	1,640,700	525,000	1,537,000	293,000	—	865,700	3,220,700	4,861,400
ii) Production of antibiotics, insecticides, sera and vaccine	—	850,000	—	705,600	—	1,555,600	—	786,100	250,000	164,000	345,000	1,545,100	3,100,700
iii) Control of bejel, yaws and VD	—	1,717,600	123,300	862,700	394,000	3,097,600	200,000	1,130,600	62,000	62,000	260,000	1,774,600	4,872,200
iv) BCG anti-tuberculosis vaccination[c]	378,700	569,700	383,800	1,766,100	342,200	3,440,500	—	1,349,400	640,600	—	280,500	2,270,500	5,711,000
v) Tuberculosis control[c]..	—	973,900	—	1,905,800	95,000	2,974,700	—	72,100	—	17,700	94,000	183,800	3,158,500
vi) Anti-trachoma work ..	—	—	—	—	—	—	222,000	18,000	—	—	—	240,000	240,000
vii) Control of other communicable diseases ...	—	—	—	162,000	245,100	407,100	103,000	8,700	—	1,900	31,800	145,400	552,500
SUB-TOTAL, MASS HEALTH	378,700	4,395,900	507,100	6,015,800	1,818,700	13,116,200	1,050,000	4,961,900	1,245,600	245,600	1,877,000	9,380,100	22,496,300
III. *Child nutrition*													
i) Long-range feeding assistance	—	1,157,100	—	—	628,900	1,786,000	329,000	186,500	291,100	440,000	794,500	2,041,100	3,827,100
ii) Milk conservation[d]....	—	—	—	3,818,000	135,000	3,953,000	—	—	1,115,000	891,000	755,000	2,761,000	6,714,000
SUB-TOTAL, CHILD NUTRITION	—	1,157,100	—	3,818,000	763,900	5,739,000	329,000	186,500	1,406,100	1,331,000	1,549,500	4,802,100	10,541,100
TOTAL, LONG-RANGE AID	378,700	9,422,800	561,100	12,326,900	3,331,100	26,020,600	1,379,000	9,073,100	3,444,400	2,168,000	3,903,100	19,967,600	45,988,200

B. EMERGENCY AID													
I. Feeding	—	1,469,000	9,684,300	65,526,200	140,900	76,820,400	—	1,943,300	3,495,200	973,000	592,200	7,003,700	83,824,100
II. Raw materials (clothing, shoes, blankets, etc.)	—	764,600	432,700	6,340,500	79,400	7,617,200	—	956,100	338,000	245,000	—	1,539,100	9,156,300
III. Miscellaneous	—	179,000	792,500	2,005,900	13,600	2,991,000	—	53,000	745,000	12,000	7,800	817,800	3,808,800
TOTAL, EMERGENCY AID	—	2,412,600	10,909,500	73,872,600	233,900	87,428,600	—	2,952,400	4,578,200	1,230,000	600,000	9,360,600	96,789,200
TOTAL, AREAS	378,700	11,835,400	11,470,600	86,199,500	3,565,000	113,449,200	1,379,000	12,025,500	8,022,600	3,398,000	4,503,100	29,328,200	142,777,400
C. ASSISTANCE BENEFITING MORE THAN ONE REGION													
I. Group training courses...	—	—	—	—	—	580,000	—	—	—	—	—	10,000	590,000
II. WHO regional BCG advisers and SKIVE project	—	—	—	—	—	31,700	—	—	—	—	—	40,000	71,700
III. International Children's Centre	—	—	—	—	—	1,016,500	—	—	—	—	—	660,000	1,676,500
TOTAL, ASSISTANCE BENEFITING MORE THAN ONE REGION	—	—	—	—	—	1,628,200	—	—	—	—	—	710,000	2,338,200
GRAND TOTAL	—	—	—	—	—	115,077,400	—	—	—	—	—	30,038,200	145,115,600[e]

[a] See also C I, "Group training courses", and C III, "International Children's Centre".

[b] Comprises aid specifically for training; supplies to be used both for service and training projects are included in A I i).

[c] See also C II, "WHO regional BCG advisers and SKIVE Project".

[d] See also C I, "Group training courses".

[e] In addition to the amount of $145,115,600 there is an unprogrammed amount of $2,039,600 bringing the total for programmes to $147,155,200. This unprogrammed amount is broken down by areas, as follows: Asia, $1,907,200; Eastern Mediterranean, $600; Europe, $81,700; and Latin America, $50,100. Total allocations are as follows:

Total for programmes	$147,155,200
Freight	17,257,000
Operational services	593,600
Administration	12,858,800
TOTAL ALLOCATIONS	$177,864,600

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