

International organizations and the problem of child health, 1945-1960

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SUMMARY

1.—Models of intervention in the interwar years. 2.—International relief and post war reconstruction. 3.—International health and the politics of institutional design. 4.—UNICEF and supply driven policy. 5.—Conclusion.

ABSTRACT

Faced with planning mass relief campaigns in liberated Europe in the aftermath of the Second World War, the United Nations Relief and Rehabilitation Administration relied heavily on cheap supplies of skimmed milk from surplus production in northern Europe. The success of this approach swept aside more detailed planning around restoring national maternal and children's health services. This reliance on mass feeding continued into the post-war years. UNICEF, the agency with the most substantial financial resources, continued this supply-driven approach despite growing reservations by nutritionists in its rival agencies —the UN Food and Agricultural Organization and the World Health Organization.

Palabras clave: Alimentación infantil, UNICEF, OMS, UNRRA, FAO

Keywords: Child nutrition, UNICEF history, WHO history, UNRRA, FAO history.

In 1943 Dr Martha Eliot, the medical director of the United States Children's Bureau, urged those planning post war reconstruction of the occupied nations of Europe to remember that «In the mind of all peoples children symbolise the future (...) one of the most morale

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building forces in rallying the support of the liberated and conquered people alike, and one of the most vital factors in restoring economic and political stability, will be the steps taken to feed, protect, and care for the children» (1). The Second World War had already meted out disastrous consequences for the health of civilian populations. Measures to improve the health of children were providing a crucial test of the British and American agencies planning post war reconstruction —would the human resources and supplies be available and, as important, what influence would be given to medical views on the proper management of motherhood and the rearing of children?

There were more lasting consequences. Eliot's intervention was a shot in a long battle between United States government agencies over the shape and limits of post war reconstruction —should it take the form of temporary relief or was this a golden opportunity to «lay the foundations for national and international child health and welfare services in the post-war period»? (2). The programs that emerged out of the debate over post war reconstruction would help legitimate new forms of international action. Debates over immediate problems of crisis management were at the same time arguments over the institutional design of the social agencies to be established by the United Nations to ensure a lasting, secure and just peace.

The solutions proposed for the medical and social crises faced by children in liberated Europe set in place institutional structures that governed international health policies for the post war era. The starting point for this experiment in institutional design was the debates over nutrition and childhood initiated by the League of Nations Health Organization in the 1930s. These heavily influenced the work of the main Allied reconstruction agencies which in turn shaped the main United Nations agencies involved in public health.

(1) *Children and the United Nations. Relief and rehabilitation program*, prepared by the Children's Bureau, US Department of Labor, October 1943. Martha Eliot Papers, Schlesinger Library, Radcliffe College, Cambridge MA, Box 51 folder 702.

(2) *Children...*, note 1.

1. *MODELS OF INTERVENTION IN THE INTERWAR YEARS*

Although specific attention to child health emerged strongly in the nineteenth century it was not until the early twentieth century that paediatrics merged as a distinct medical specialty, constructing childhood as a medical condition. This new speciality was marked by a debate over the «whole child» with the conceptualisation of the child as «an independent medical object» (3) subject to «repeated examinations of normality», in a way not experienced by any other age group. This conception, in turn, owed much to non-medical developments, child welfare as well as specifically medical advances in the understanding of the gastro-enteric diseases that were the single greatest causes of infant and child mortality in the early twentieth century (4). This shift in medical knowledge was mirrored in public health bureaucracies. Instead of being subsumed within a larger set of sanitary strategies, infant feeding and the problem of maternal health were identified as a distinct area of state concern, with a concerted push to redefine child welfare as predominantly a medical question (5).

Early twentieth century developments in maternal and child health involved not just recommendations on dietary standards, but building integrated networks of clinics and home visiting devoted to the health of infants. In the United States, for example, the problem of infant mortality was redefined from a problem of milk to one of motherhood itself – persuading women to follow scientifically devised dietary and health regimens covering pregnancy and child rearing. While European models broadened attention to the economic and social context of fa-

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- (3) VINER, Russell; GOLDEN, Janet. Children's experiences of illness. In: R. Cooter; J. Pickstone (eds.), *Medicine in the twentieth century*, Amsterdam, Harwood, 2000, pp. 575-587 (pp.584, 586).
 - (4) KUNITZ, Stephen J. The historical roots and ideological functions of disease concepts in three primary care specialties. *Bulletin of the History of Medicine*, 1983, 57, 412-432.
 - (5) MARKEL, Howard. For the welfare of children: the origins of the relationship between US public health workers and pediatricians. *American Journal of Public Health*, 2000, 90, 893-899.

mily life, with targeted social as well as medical assistance programs, in the United States the resistance of the American Medical Association narrowed the focus of public health away from more comprehensive solutions (6).

Two main policy frameworks emerged in the interwar years, each strongly influenced by the new science of nutrition. The first drew on the rapidly changing understanding of the basic physiological requirements for health —the discovery of the body's requirements for vitamins, the complexity of amino acids and the significance of proteins as well as basic foods. The second drew on under-consumptionist economic theory and the scandals of the destruction of food stocks during the Great Depression of the 1930s as trade barriers and the collapse of markets left consumers short of basic foods. The most striking of the League's innovations was this attempt to unite economic and nutrition policies —the so-called «marriage of agriculture and nutrition». In 1938 the economist, F.L. McDougall, argued that

«there exists in every country of the world serious malnutrition which is due, in the main, to an inadequate consumption of protective foods, which is almost entirely the result of inability to buy, at present food prices, at the lower levels of income, a sufficiency of both energy and protective foods. Ignorance of nutritional values plays only a minor part in causing this widespread malnutrition. The solution was to lower the prices of basic energy foods, leaving more

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- (6) MECKEL, Richard. *Save the babies: American public health reform and the prevention of infant mortality*, Baltimore, Johns Hopkins University Press, 1990, pp. 220-223; APPLE, Rima. *Reaching out to mothers: Public health and child welfare*, Sheffield, EAHMH [European Association for the History of Medicine and Health Evening Lecture Series 5], 2002; MARKS, Lara. *Metropolitan maternity: Maternal and infant welfare services in early twentieth century London*, Amsterdam-Atlanta, Rodopi, 1996, pp. 245-259; MARLAND, Hilary. The medicalization of motherhood: Doctors and infant welfare in the Netherlands, 1901-1930. COMACCHIO, Cynthia R. «The infant soldier»: Early child welfare attempts in Ontario. Both in: Valerie Fildes, Lara Marks, Hilary Marland (eds.), *Women and children first: International maternal and infant welfare 1870-1945*, London, Routledge, 1992, pp.74-96, 97-120; APPLE, Rima, *Mothers and medicine: A social history of infant feeding 1890-1950*, Madison, University of Wisconsin Press, 1987, pp. 182-183.

income for the protective, in general less traded foodstuffs. Adequate nutrition could only be achieved by increasing buying power; free trade would achieve this by lowering the prices of agricultural produce» (7).

This union of the new science of nutrition with the reform of world commodity markets remained a major theme during the war years. In late 1943, Frank Boudreau, Director of the Milbank Fund, explained that a «sound nutrition policy» would increase international trade in foodstuffs and build international cooperation. «The adoption of sound food policies now, based on our knowledge of the science of nutrition, aimed at the promotion of public welfare, will do much to restore these tottering institutions and provide a common meeting ground for the nations of the world» (8).

The science of nutrition and the economics of trade were drawn together in the social medicine of the interwar years. In child health, this contraposed concentration on the narrower medical definitions of health with a concern for housing, labour conditions. The recognition that problems of nutrition were as much economic as medical questions was promoted by the Social Section of the League as well as the International Labour Organization, which played a key part in discussions on nutrition and social welfare. Voluntary organizations, such as the American Red Cross and the Save the Children Fund, emphasised that health was not a mere matter of physical hygiene, but also implied moral well-being (9). The work of the International

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- (7) MCDUGALL, F.L. Food and welfare: League of Nations studies of nutrition and national economic policy. *Geneva Studies*, 1938, 9, 9-35 (pp. 34-35); AYKROYD, W. R. *Nutrition*, Bombay, Oxford University Press, 1944, p. 29; TURNELL, Sean. F. L. McDougall: Eminence grise of Australian economic diplomacy. *Australian Economic History Review*. 2000, 40, 51-70.
- (8) BOUDREAU, Frank. Social and economic implications of freedom from want of food. *Proceedings of the American Philosophical Society*, 1943, 87, 126-132 (p. 130).
- (9) WEINDLING, Paul. The role of international organizations in setting nutritional standards in the 1920s and 1930s. In: Harmke Kamminga, Andrew Cunningham (eds.), *The science and culture of nutrition, 1840-1940*, Amsterdam-Atlanta, Rodopi, 1995, pp. 319-332; MILLER, Carol. The social section and advisory committee on social questions of the League of Nations; and ROOKE, Patricia T.; SCHNELL, Rudy L. «Uncramping child life» International children's organizations, 1918-

Health Division of the Rockefeller Foundation encouraged moves to turn the advances of laboratory medicine into standardised public health strategies that could be applied in any national context (10).

In paediatrics, in contrast, there was an emphasis on prescriptive models of «scientific feeding». Nutrition was treated less as the effects of the economic capacity of the family, but as a series of technical, educational problems requiring medical supervision of all aspects of infancy from conception through the first few years of life. A series of League of Nations Health Organization meetings of leading paediatricians and nutritionists established minimum nutritional standards at each stage of life. While there was a wide range of views on individual components of diets —and each meeting concluded with calls for a major set of research agendas— there was a consensus on the need for standardized approaches and medical control. A 1937 League Meeting proposed a standard scheme for infant feeding for each country, with only minor local variants, with strong medical supervision: «a complete ante-natal and post-natal control of every pregnant mother from as early a stage as possible in pregnancy, and a control of each child. There is no reason why this control should cease at the age of 12 or 24 months. It should continue during pre-school age and school age». While this medical supervision would vary locally, «We ought, however, to fix a common scheme for the work. When scientific progress in infant feeding is sure, we physicians are responsible for the facts being put into practice for all children» (11). As scientific advances reinforced the

1939. Both in: Paul Weindling (ed.), *International health organisations and movements 1918-1939*, Cambridge University Press, 1995, pp. 154-202; HUTCHINSON, John F. Promoting child health in the 1920s: International politics and the limits of humanitarianism. In: Esteban Rodríguez-Ocaña (ed.), *The politics of the healthy life: An international perspective*, Sheffield, European Association for the History of Medicine and Health, 2002, pp. 131-150.

- (10) LOWY, Ilana; ZYLBERMAN, Patrick. Medicine as a social instrument: Rockefeller Foundation, 1913-45. *Studies in the History and Philosophy of Biology and Biomedical Science*, 2000, 31, 365-379.
- (11) LEREBOULLET, P. L'Alimentation dans la première année, ses bases et ses règles. *Études sur Alimentation*, League of Nations Health Organization, Geneva, 17 November 1936, p. 2; M.M. Eliot, note to file, (December 1936). Eliot Papers, Box 41, folder 580.

prescriptive approach of infant welfare to mothers, the respect given to their views receded, with a shift from «counsel to direction» (12).

These tensions were played out within national health administrations—nowhere more than in the United States, where different approaches crystallized around the health care of mothers, infants and children and the new professions of paediatrics and social work. The Children's Bureau of the United States Department of Labor was established as part of the high tide of Progressivism before the First World War. From the start the Bureau was concerned with the creation of health programs targeted at women and children, but its wider concerns with social programs meant that medical questions were always inserted in a broader framework driven by social and welfare workers. From 1924, under the leadership of Dr Martha May Eliot, a Harvard medical and public health graduate, the Bureau's Division of Child and Maternal Health increased in status and public standing but even following her elevation to Assistant Director of the Bureau in 1934 it remained one section in a bureau focused on wider questions of work and family (13).

The existence of this distinct zone was always contested. The United States Public Health Service (USPHS) expanded from its origins in managing quarantine and marine hospital services, reflecting the wider scope of the federal government in the interwar years. Throughout the interwar years surgeons-general fought an unceasing battle to centralise all federal government medical services—including those run by the Children's Bureau—under their own, medical control (14). From the start, the two agencies were in open conflict for control of children's health services. The Bureau's notion of the «whole child» saw health care as but one aspect in an integrated set of welfare programs. The Children's Bureau had the advantage of a distinct bureaucratic location (in the Department of Labor) and a wide network of active supporters,

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- (12) APPLE, Rima, Constructing mothers: Scientific motherhood in the nineteenth and twentieth centuries. *Social History of Medicine*. 1995, 8, 161-178 (p. 178).
- (13) GORDON, Linda. *Pitied but not entitled: Single mothers and the history of welfare, 1890-1935*, New York, Free Press, 1994, p. 267.
- (14) LINDENMEYER, Kriste. «A Right to childhood» *the US children's Bureau and child welfare, 1912-46*, Urbana, University of Illinois Press, 1997, pp. 55-56, 165-69.

spanning party political divides and mobilized by a formidable set of political leaders. More important to its survival was its constituent model —its leading lights were all women and drew strong support from progressive women’s organizations nationally. This network had proved crucial in thwarting earlier attempts to curb the Bureau’s independence; it also provided an administrative rationale for a more integrated approach to the delivery of services to women (primarily in the capacity as mothers) and children (15). The PHS could count on the support of the medical profession, in particular the American Medical Association, despite their vituperative differences on other areas of health policy (16).

2. *INTERNATIONAL RELIEF AND POST WAR RECONSTRUCTION*

The debates over domestic maternal and child health moved to an international stage after the US entered the Second World War and took over leadership of planning for the relief of occupied Europe. The problems posed by post war relief and reconstruction provided the first real test for international action. Would the liberating forces need to actively rebuild economic (and medical) infrastructure, or was their role to be the provision of temporary relief through emergency supplies? The problems faced by children after years of shortages, in some cases malnutrition, as well as social dislocation loomed large in surveys of the tasks facing the allied powers after the defeat of Germany.

The British-dominated Allied Committee on Post War Reconstruction Requirements (the Leith Ross Committee) had concentrated on planning the relief requirements of each occupied nation. Lacking procurement powers, the Committee’s plans were an artificial exercise, ignored by the military planners who were deciding Europe’s future. Soon after

(15) LINDENMAYER, note 14, pp. 201-202.

(16) LADD-TAYLOR, Molly. «Why does Congress wish women and children to die?»: The rise and fall of public maternal and infant health care in the United States, 1921-1929. *In*: Fildes; Marks; Marland (eds.), note 6, pp. 121-132; LINDENMAYER, note 14, pp. 165-170.

entering the war, the American initiatives superseded the passive Leith Ross model. At the end of 1942 Roosevelt set up the Office of Foreign Relief and Rehabilitation Operations (OFRRO), under Herbert Lehman, New York's Democratic Party Governor (and strong supporter of the New Deal). Despite spending much of his time fighting bureaucratic battles for survival in Washington, Lehman developed a much more activist approach than his British rivals. OFRRO would do more than ship supplies, but should (he argued) plan and rebuild the shattered economies of liberated territories. The new agency proved a magnet for progressive reformers originally drawn to Washington by the New Deal who were finding the climate in Washington increasingly hostile. Where Leith Ross had concentrated on planning medical supplies, OFRRO's health section —dominated by officers loaned from the Rockefeller Foundation's International Health Division and the United States Public Health Service— was the most enthusiastic supporter of the activist model. Its first secretary was Selskar Gunn, a veteran Rockefeller man. Thomas Parran, the US Surgeon General (the head of the USPHS), had worked for Lehman in New York State before moving to Washington and became a prime architect of the new agency. The central position of the USPHS meant that the Children's Bureau was initially excluded. Only after protests from Martha Eliot, using the Bureau's network of supporters, was a separate sub-committee on maternity care and child health established with Eliot in the chair (17).

OFRRO asked the Children's Bureau to produce a «clear-cut» scheme, «a plan that would deal in some detail with a broad and flexible program that could be applied realistically in almost any

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- (17) *Meeting of public health and medical care Committee appointed by Governor Herbert H. Lehman*, 4 January 1943. UNRRA Archives, UN Archives, New York, PAG-4/1.3.1.5.0.0.:6; Commission on Children in Wartime (a body chaired by the social scientist Leonard Mayo and including most of the leading Children's Bureau figures, including Eliot), *Recommendations for the care of children in occupied territory*, 15 February, 1943. Eliot Papers, Box 51 Folder 700; Martha Eliot to Dr Henry Helmholtz, 10 March 1943, National Archives of the United States (NA), College Park, MD, RG102 A1/Entry 6, file 22-2-1-1-2; *The office of foreign relief and rehabilitation operations health program*, n.d. [late 1943] Thomas Parran Papers, University of Pittsburgh Library, Pittsburgh PA, 90/F-14 Box 132 FF 1762 N-Q, pp 9-10.

one of the countries» (18). The Bureau obliged, with detailed general plans and specific programs of relief for Italy, Yugoslavia, Albania and Greece (19). Eliot argued for a policy based on «fundamental principles and objectives which will lay the foundations for national and international child health and welfare services in the post war period». These foundations included recognition of the special needs of the mother and child to appropriate medical care, nutrition and clothing. The reconstruction of the family unit, «the right of every child to the security of family life», was the basis of successful public health. This would be achieved under medical direction —relief missions would include a child health team led by a paediatrician, with an obstetrician or nurse-midwife and social and welfare workers. Relief feeding —based on fortified milk— and medical care should all be administered through maternity and child health centres. A core proposition was that if «the supervision and practical management of medical relief were entrusted to skilled pediatricians, not only would these children receive excellent attention but the clinical material could serve for the elucidation of lessons of significance for all children of the future» (20).

The Children's Bureau had already developed some international programs in Latin America (from 1941) and Eliot had made a major survey of British wartime programs for children. Drawing on these observations, Eliot saw wartime food supply policy as a golden opportunity to impose scientifically supervised feeding programs. Post war programs, she argued, should also be driven by «Coordinated and comprehensive» planning for children, bringing together health and welfare workers (21). Relief work in the strict sense —the provision of adequate supplies—, was essential, but should be the lever to create

(18) Eliot to Lenroot, 23 February 1943. Eliot Papers, Box 51 Folder 700.

(19) *Outline for the preparation of material for the Office of Foreign Relief*, April 1, 1943. Eliot Papers, Box 52, folder 704.

(20) [M. Eliot] *General principles relating to maternal and child health and child welfare*, (October 1943), Eliot Papers, Box 51, folder 702; WOLMAN, Irving J. The child in war. *American Journal of the Medical Sciences*, 1943, 205, 858-869 (p. 868).

(21) BRADBURY, Dorothy. *Five decades of action for children*. US Department of Health Education and Welfare, 1962, p. 72; *Recommendations of the special Committee of*

a broader infrastructure of mother and infant health. Her scheme drew on the Children's Bureau's own Emergency Maternity and Infant Care Program (EMIC), which used the war crisis to develop state-run clinics and medically supervised feeding programs for the wives of US servicemen (22). These domestic wartime programs were to be projected on an international scale. The stakes were high, as acceptance of international programs could increase the legitimacy of these temporary programs when they came under attack after peace.

Relief work would focus on infant feeding programs, with the provision of cheap and reliable milk at its heart. From 1944 Eliot started sounding the alarm about the need for large reliable stocks of milk for infant feeding. The general medical aim of changing nutritional practices remained strong —Eliot's correspondence was peppered with fears that «UNRRA would go into the feeding problem on the basis of present food customs instead of trying to improve food habits through relief» (23).

The OFRRO model became the basis for a broader, multilateral planning agency, the United Nations Relief and Rehabilitation Administration (UNRRA), established by a conference of allied powers at Atlantic City in November 1943. Lehman was appointed its first director, and most of his advisors and staff followed him. The bulk of UNRRA's planning was around the question of relief supplies, and it assumed a massive task of transferring foodstuffs to the devastated economies of southern and Eastern Europe. Wilbur Sawyer, a veteran Rockefeller man, headed the health section's Washington Office. He

the Children's Bureau Commission on children in wartime, 29 Jan 1943. Eliot Papers, Box 51 folder 700.

- (22) OFRRO, *Memorandum which the United States' Children's Bureau is technically equipped to prepare on request with respect to health and welfare programs for children and mothers in liberated territories*, March 9 1943. Eliot Papers, Box 51, folder 700.
- (23) LENROOT, Katherine. *Memorandum of Interview with Mr George Radin*, 6 April 1944. Eliot Papers, Box 52, folder 704; David Weintraub (Chief of Supply, UNRRA) to Combined Food Board, Washington DC 12 June 1945. Eliot Papers, Box 52, folder 702.

was supported by a succession of highly effective British public health doctors in London directing European field operations (24).

UNRRA has been left with a very poor image. Where it is even mentioned in histories of post-war reconstruction these accounts are usually coloured by its legion of critics — especially those who objected to its relief activities in the Soviet Union and Eastern Europe. It became a target of growing US Congressional resentment of the use of American aid money for multilateral projects that seemed increasingly out of tune with the objectives of American foreign policy. UNRRA also had a difficult internal structure — particularly its distinction between supply and «area» sides. The former dealt with the procurement and shipping of relief —the function most popular with recipients— the latter with the integration of relief with local conditions, looking particularly at the effects of relief on the revival of local economies. After a bitter struggle the supply side emerged dominant —planning was to be in commodity units, not based on the needs of local economies— with all the intervention that this implied (25). These difficulties were compounded by the limited geographical scope of the relief administration. Instead of managing the rebuilding of all the liberated territories, those with substantial foreign reserves, or greater political power and ambitions —the north east European nations, led by France, rejected the strings attached to UNRRA's assistance. So, damned in northern Europe as an American Trojan horse and in the United States as a leftist, internationalist plot, its fate was sealed. With the death of Roosevelt in 1945, his successor, Harry S. Truman, moved to close UNRRA's activities. Even so, UNRRA was able to work in Greece, Italy, the Balkans, Ethiopia and China, as well as managing the massive problem of displaced people and refugees. The scale of its aid was unprecedented. Almost half its supply

(24) SAWYER, Wilbur A. Achievements of UNRRA as an international health organization. *American Journal of Public Health*, 1947, 37, 41-43.

(25) SAWYER, Wilbur A. *Functions of the health division at headquarters and the Staff needed*, 8 October 1945, UNRRA Archives, PAG-4/1.3.1.5.0.0.:1; PRICE, Harry B. Note on interview with Harlan Cleveland, 27 September 1952. In: Dennis Merrill (ed.), *Documentary history of the Truman presidency*, Bethesda, MD, University Publishers of America, 1996, vol. 13, pp. 720-721.

program was food aid, amounting to \$1,236,018,700 from mid 1945 until November 1947 (26).

With these political shackles, UNRRA found it difficult to break from the constraints of a supply-oriented emergency relief organization. Most of its budget was absorbed in supplying food and other relief to devastated allied nations. Competing with the military for scarce commodities and shipping, it concentrated on purchasing surpluses (or donated unsaleable food) from the allied powers. Most of its work was in procurement and negotiating the complex shipping and commodity controls of the Combined Boards that regulated trans-Atlantic shipping (27).

Milk became the symbol of UNRRA's successes and failures. Milk provided an obvious and quick solution to feeding mothers and children in liberated Europe. The consumption of dried whole milk, more suitable for child nutrition, had been held back by its poor keeping quality as milk fats auto-oxidized, developing an unpalatable tallowy flavour. New technologies for manufacture and packaging (gas-packing) increased its storage life and (to some extent) its palatability, even in the tropics. In the United States average annual production of dried whole milk increased from a pre-war annual average of just over 22 million pounds to almost 106 million pounds. Dried skim milk production dwarfed this, increasing from almost 428 million pounds to just under 559 million pounds. Even before the war the surplus in skimmed milk solids posed a problem for the dairy industry, especially in the United States (28). When the war ended UNRRA filled the gap —using US aid money to purchase American surpluses. An emphasis on milk in infant and school feeding programs could be easily justified through the nutritional knowledge accumulated during the 1930s, especially in

(26) WOODBRIDGE, George. *UNRRA: The history of the United Nations Relief and Rehabilitation Administration*, New York, Columbia University Press, 1950, 1, p. 409.

(27) ROSEN, S. McKee. *The combined boards of the Second World War: An experiment in international administration*, New York, Columbia University Press, 1951, pp. 165-173.

(28) HUNZIKER, Otto Frederick, *Condensed milk and milk powder prepared for factory, school and laboratory*, 6th edition, Illinois, La Grange, 1946, pp. IX, 332-335.

Europe, where emergency-feeding programs would soon be superseded as domestic industries recovered. But emergency milk feeding soon became a universal panacea.

The Rockefeller Foundation's Health Commission for Europe had been active since 1940 and had sponsored (with the cooperation of British medical research agencies) a major dietary survey based in Oxford. Although the survey's findings largely confirmed the success of British rationing policies in averting dietary deficiencies, it established a research-based model that was promoted as a solution to the problems to face the Allied forces in Europe. The Oxford survey team won Foundation support for the principle that «full use will be made of this newer knowledge of nutrition in planning post-war relief in Europe. Properly conducted clinical surveys of the state of nutrition in re-occupied territories should yield information of the greatest practical value». Mobile laboratories would ensure that relief policies were guided by «detailed surveys supported by laboratory evidence». The Rockefeller Health Commission funded and staffed two laboratories for work in the Netherlands in early 1945 (29).

Under Sawyer's leadership UNRRA was sympathetic to a laboratory science-led policy. However, despite ambitious early plans to shape food relief around the most modern nutritional theories, these advanced schemes were soon swamped by the political and commercial realities of the post war crisis. Plans were made for mobile nutrition laboratories, on the Oxford model, to build a picture of the nutritional health among populations receiving UNRRA food aid. A.P Meikeljohn, who had been in charge of the Oxford mobile teams, was appointed to head UNRRA's Nutrition Section. A year into the job he complained that he lacked «sufficient staff for anything but a makeshift program» (30). In the absence of serious research, the flood of milk continued. Even

(29) *Medical relief in Europe: Suggestions for the work of medical specialists in nutrition*, [July 1943]. Rockefeller Archive Center, Pocantico Hills, New York, RF RG700/B10/F62, Hugh Sinclair to Charles Leach, 15 February 1945, RF RG700/B10/F62.

(30) Meikeljohn to Neville Goodman, *Programme for the nutrition section, European Regional Office, for 1946*, UNRRA Archives, PAG-4/2.0.6.0.:15 H100/1/3.

sympathetic critics complained that UNRRA «swamped local initiative» with this deluge of short-term aid (31).

The strong role of the Children's Bureau in OFRRO was not repeated as easily in UNRRA. There was no distinct children's health committee; child and infant feeding became part of the more general supply problem. In part this was a personnel problem. Even had the will been there, it proved difficult to find competent trained medical staff. Instead, the Children's Bureau worked through the Standing Technical Committee on Welfare which attempted the far more difficult task of integrating child welfare and health work from outside the health service—in the eyes of UNRRA senior administrators «an unnecessary adjunct serving an ill-defined purpose» whose services were unwanted by the governments receiving UNRRA's aid (32).

UNRRA's main lesson to the United Nations technical agencies that inherited its programs was that while supplies were always eagerly sought, experts and institution-builders were rarely welcome. One UNRRA official warned those planning a new international health organization that:

«The present Central Health authorities clearly underestimate the value of international expert cooperation (...) The authorities are supply-minded. I think they have this much to justify their attitude: skilled advice is not enough for the achievement of a modern Public Health program which must be dependent upon skilled manufacture in an ever-increasing degree. I think that if an International Health Service is to be fully successful it must have connections with the world supply allocating boards. The word "priority" has probably become a permanent one in our vocabulary, and an International

(31) PHILLIPS, Ralph *et al.* *Assistance Fournie par la FAO à des Etats Membres à l'Aide du Fonds UNRRA*, Rome, Food and Agriculture Organization, 1954, p. 53.

(32) UNRRA, *Standing Committee on Welfare, Working Committee on Children, minutes*, 26 June 1946, NA, RG102 A1/Entry b file 22-2-1-4; Woodbridge, note 26, 2, pp 27-28.

Health Organization that had the power of recommending priorities would immensely gain prestige» (33).

Andrew Topping, the director of UNRRA European health work, admitted that for most recipients «the presence of our experts has been the price they have to pay for UNRRA supplies» (34).

3. *INTERNATIONAL HEALTH AND THE POLITICS OF INSTITUTIONAL DESIGN*

Increasingly debate over the future of international health policies became enmeshed in the claims of rival organizations. The collapse or discrediting of the pre-war organizations left the way open for a new set of approaches, led by the United Nations Food and Agriculture Organization (FAO). Formed at the Hot Springs, Virginia conference in May 1943, it became the first United Nations agency—but with much strong continuity with the Geneva models of the League. This was not surprising, as F.L. McDougall was one of its main initiators. FAO was given a strong nutrition division, headed by W.A. Aykroyd, formerly of the League and most recently working in India. This was underlined by the appointment of the nutritional scientist Sir John Boyd Orr as founding director general. The new organization was dedicated to improving world agriculture, forestry and fisheries, but its founders saw these production aims as part of a more general welfare objective—to end hunger and raise general standards of nutrition. Aykroyd argued «FAO is in a sense an offshoot of the modern science of nutrition and should not be cut off from its roots... It should avoid the possibility of being regarded by the public as primarily a trade or business organization»—and should not bow out of the field when the new International Health Organization is established (35).

(33) K.W.C. Sinclair-Loutit to Neville Goodman, 19 September 1946 UNRRA Archives, PAG4/1.3.1.5.0.0.:10.

(34) TOPPING, Andrew. *Memorandum on the «Run-down» of the health division*, 22 July 1946. UNRRA Archives, PAG-4/2.0.6.0.:24.

(35) AYKROYD, W.A. *Suggested organization and functions of the food and nutrition Department of an International Office of food and agriculture*, dated (1946?) in pencil,

In 1946, FAO underlined its continuity with the Geneva program and made a strong statement of its faith in concerted planning to increase world trade and overcome nutritional shortfalls. National planning of nutritional targets would be combined with increased agricultural production with freer international trade and increased productivity. The successes of wartime planning led to hopes for a new era of international planning (36). To achieve this, FAO's early objectives were tied closely to building up each nation's infrastructure: reviving the national nutrition committees set up under League auspices, developing school feeding and nutritional education programs: and building «an effective group of nutrition workers» in each country, especially those suffering from under-development (37).

The highpoint of UNRRA's activities coincided with the planning of a new world health organization. Many of UNRRA's supporters had seen it as the embryonic form of the new institution —its field programs consciously developed to maintain the Rockefeller Foundation and League of Nations tradition of active intervention. By 1946, however, UNRRA's ambitions were destroyed by the Cold War. The initial plans for a new World Health Organization were kept firmly in the hands of senior public health officials, anxious to block the emergence of a rival authority. In its planning phase WHO showed little interest in program areas such as the health of children.

Formal planning of the new international organization began when a small technical committee met in Paris in April 1946. The agenda constructed by Parran and the Chief Medical Officer of the British Ministry of Health, Wilson Jameson, set modest goals —openly repudiating the interventionist approach associated with the League of Nations Health Organization. Ludwik Rajchman, its founding director was pointedly not invited to Paris and his submission calling for a very independent international organization was ignored. The treatment

but reads as if completed earlier, most likely 1943, FAO Archives, Rome, RG57.1 Series D1.

(36) FOOD AND AGRICULTURE ORGANIZATION OF THE UNITED NATIONS. *World Food Survey*, Washington DC, FAO, 1947, pp. 11-18, 26-29.

(37) AYKROYD, W.A. *Objectives of the nutrition division*, 1 November 1948., FAO Archives, RG57.1 series C2.

of child and maternal health became a litmus test for the acceptance of interventionist policies. The drafts of Parran and Wilson allowed no scope for the new organization to become involved in questions of maternal and child health —the type of interference that had irritated national health officials in the interwar years. Despite Rajchman's absence, this was not left unchallenged. The French members, Xavier Leclainche and Andre Cavaillon, the leftist minister for health in De Gaulle's provisional government, proposed as an objective «the health protection of maternity and infancy» (38). This became part of a general attack on the Anglo-American attempt to stifle the new organization, an argument for a universal public health, rather than «hygiene» institution —going right to the heart of medical practice, the work of physicians, hospitals and medical research. Faced with strong criticism from the Europeans, Parran and Wilson accepted a compromise from Brock Chisholm, a Canadian psychiatrist (soon to become the first director general of WHO, partly because of his success in defusing these battles). His wording was characteristically vague: «The healthy development of the child towards world citizenship is of paramount importance» (39). The final draft approved by the UN Economic and Social Committee (ECOSOC) firmed the objective «to promote maternal and child health welfare» (40).

The World Health Conference in New York in July accepted and expanded Chisholm's rather waffly ideas about mental well-being —their very vagueness made them difficult to contest openly (41).

(38) CAVAILLON, A.; LECLAINCHE, X. Proposal for an international convention establishing the international health organization, 19 March 1946. In: *Minutes of technical preparatory Committee for the International Health Conference, Paris 18 March to 5 April 1946*, New York, World Health Organization (Interim Commission), 1947, p. 50.

(39) *Draft of «Preamble» to the Convention of the World Health Organization*, 21 March 1946, note 38, p. 61.

(40) «Proposals for the Constitution of the World Health Organization» (submitted to UN ECOSOC), p. 70; CAVAILLON, A. in *Procès Verbal* (draft minutes) Technical Preparatory Conference, 19 March, 1946, WHO Library, Geneva, p. 4.

(41) Summary Report on Proceedings, Minutes and Final Acts of the International Health Conference held in New York from 19 June to 22 July 1946. *Official Records of the World Health Organization*. 2, New York and Geneva, WHO (IC) June 1948, pp. 46-47.

It also expanded the Technical Planning Committee's objective to: «promote maternal and child health and welfare» to Boudreau's more ambitious: «to promote maternal and child health and welfare and to take such measures as will foster harmonious living in a changing total environment, which is essential for the healthy development of the child» (42). This caused sharp divisions in the US delegation, reviving the old battle between the Public Health Service and Children's Bureau (represented by Parran, the delegation chairman, and Martha Eliot, his deputy). Eliot later recalled that the USPHS objections went back to its interests, historically «centered in communicable disease and the environment in which they grew, [the USPHS representatives] felt that this statement in the Preamble was too broad, I think, and they also objected to the focus being on children as such» (43). Parran's objections were over ruled and WHO seemed armed with a straightforward commitment to develop programs in maternal and child health and welfare.

4. UNICEF AND SUPPLY DRIVEN POLICY

These ambitions soon vanished as the new organization struggled for acceptance. With an interim commission dependent on grants from UNRRA (tied to the continuation of existing UNRRA programs) and loans from the United Nations, WHO was unable to develop its own agenda. FAO and WHO (IC) initially co-operated, in the expectation of drawing a considerable amount of the reserve funds left over from UNRRA. In 1948 they requested \$10 million to address the world food crisis. Their expectation that they would inherit UNRRA's surplus (amounting to about 35 million dollars) and dominate future aid money was dealt an unpleasant blow (44). The

(42) Note 41, p. 49.

(43) Interviews with Martha May Eliot, November 1973-May 1974. Schlesinger-Rockefeller Oral History Project, Schlesinger Library, Radcliffe College, Cambridge Mass, p.184.

(44) WHO and FAO, *Proposal for a joint action programme to increase world food production and raise standards of health*, [Presented to Central Committee, UNRRA, September 1948], WHO Archives, Geneva, WHO1/803/1/3; WOODBRIDGE, note 26, p. 307.

entire surplus was granted to a new agency to handle the emergency needs of children. Rajchman, representing the Polish government on UNRRA's Council, warned of the crisis facing Europe's children in the coming winter, and persuaded his colleagues to devote their residual funds to an emergency children's fund. His opponents were left wrong-footed, lacking realistic alternative programs of their own. Rajchman's new organization, the United Nation's Emergency Children's Fund (UNICEF), was planned to have a limited life, but its resources vastly outweighed the new technical agencies. With the start from the UNRRA funds, UNICEF also found fundraising from governments easy—relief of children was seen as inherently non-political. In its first year the Fund raised an additional \$30 million, mainly in government contributions. By comparison, the WHO (IC) relied upon a loan of \$1 million from the UN, a further \$1 million granted by UNRRA was clawed back, and offered to WHO only on condition that it must be spent on programs approved by UNICEF (45).

Although UNICEF was required to seek the technical advice of WHO and FAO, its financial dominance—and Rajchman's strong interests in health policy—gave it a dominant role in post war international health programs. Working with the Scandinavian Red Cross, UNICEF set up mass tuberculosis immunization programs, using BCG vaccine—still controversial in British and American health circles (46). In a pattern to repeat itself, WHO was faced with the choice of developing its own approach to tuberculosis—but with no funding—or reluctantly join UNICEF's as technical adviser, on terms set by the Fund. It had little choice, and became an active participant in the BCG mass vaccination campaign.

(45) *Report of meeting of the Program Committee of the international children's emergency fund*, November 4, 1947. Eliot Papers, Box 52 folder 712; *Note by the director general of WHO on the UNRRA \$1,000,000 grant to WHO*, Joint Committee on Health Policy UNICEF/WHO, 27 May 1950, UNICEF Archives, New York, JC4/UNICEF-WHO/5.

(46) BALINSKA, Marta. *For the good of humanity: Ludwik Rajchman medical statesman*, Budapest, Central European University Press, 1998, pp. 211-214.

In July 1947 UNICEF took advantage of the presence in the United States of eminent European paediatricians at the first big post war International Paediatrics Conference in New York to assemble a joint FAO-WHO (IC) Committee to make recommendations on child nutrition. The joint committee presented a dismal picture of the state of Europe's children entering the third winter of peace. The report was dominated by UNICEF's emergency feeding agenda, emphasizing the need to make large supplies of animal protein, especially milk, available. Its recommendations did not go beyond the constituents of supplementary feeding programs (47).

UNICEF had started as a relief agency, distributing milk and other foods to children, especially through schools. As the European emergency died down, these programs were extended to other areas of the world. From 1947 UNICEF took over UNRRA's role as the largest purchaser of US surplus dried milk, much of it purchased with American aid money. During the late 1940s and through the 1950s almost a quarter of its annual budget was expended on dry skimmed milk (48). Supplies of cheap milk had created the basis for UNICEF's reliance on milk in its nutritional programs. The FAO Nutrition Division noted in 1949:

«This is a fairly clear-cut food commodity problem with many of the familiar aspects of such problems: need for a valuable food: potentialities for increased production; and unbridged gap between producers and consumers in need (...) The US government, in su-

(47) FAO and WHO (IC) *Report on child nutrition*, (prepared for UNICEF), Washington, UNICEF, 1947.

(48) FAO, WHO and UNICEF. *Dry milk production*, New York, UNICEF, 1959, p. 7; see Ruxin's estimate that nutrition occupied only a small part of UNICEF's early program, RUXIN, Joshua Nalibow. *Hunger science and politics: FAO, WHO and UNICEF nutrition policies, 1945-1978*, London, University College of London [unpublished PhD thesis], 1996, pp. 62-63. The basis of this judgment is difficult to decipher, especially as much of the US milk was effectively free. UNICEF's commitment to Asian projects, however, was more rhetoric than real during the 1950s.

pplying funds to UNICEF for the purchase of dried skimmed milk, has in effect been creating a market for its own farmers» (49).

The hand of the US Department of Agriculture was seen behind US support for UNICEF —while the Department of State had sympathised with FAO's projects of broader programs for the continuing needs of children, Agriculture, worried about the disposal of surpluses, continued support for the UNICEF feeding programs (50).

Differences soon appeared over UNICEF's concentration on milk as the core of the nutrition problem. Aykroyd later noted, «It was found, however, that the mere distribution of supplementary foods did not provide a satisfactory basis for a long-term program to improve child nutrition. As a result, UNICEF undertook its milk conservancy program in collaboration with FAO, with the object of replacing imported milk in due course by local milk of good quality». Milk conservancy programs, in turn, proved limited as many countries lack the basic ability to produce adequate milk. This in turn led to the pursuit of alternative sources of protein —a quest that again abandoned the study of local diets in a search for a universal and ultimately elusive panacea (51).

FAO confronted this problem at a conference of nutritional workers at Baguio in the Philippines. The Baguio conference underlined the irrelevance of milk as a solution to malnutrition in much of Asia. Aykroyd concluded that «child feeding programs in under-developed countries must be largely based on locally-produced foods», openly criticising the milk-based demonstration projects run by UNICEF in the Far East (52). He added that:

(49) [AYKROYD] *Note on the continuation of UNICEF activities*, 15 August 1949. FAO ARCHIVES, RG57.0 Series D2.

(50) AUTRET, M. *Memo to Aykroyd, relations FAO-UNICEF*, 2 August 1950., FAO Archives, RG12, Nutrition division Dr M. Autret Subject Files, Box 1, file: correspondences 1950-55.

(51) Aykroyd to E.J.R. Heyward (UNICEF), 24 February 1956, UNICEF Archives, Accession 62A-620, Box T041 Folder A678: Program Division.

(52) SCOTT, Marjorie L. International aspects of child feeding. *American Journal of Public Health*, 1949, 39, 1517-1521; [AYKROYD] note 49.

«The anticipated surpluses in dried milk could (...) be used as a basis for child feeding programs in many countries where the local dairy industry could at the same time be developed. However, some countries where a need for child feeding programs is particularly great offer few, if any, potentialities for promoting dairy production and have insufficient economic resources to continue importation of dried milk after outside assistance is withdrawn. This is true, for example, in most countries of the Far East where under- and malnutrition are very prevalent. Here programs along the line recommended by the Baguio Nutrition Committee (...) could advantageously be developed. It would seem very unfortunate if future activities were confined to areas where the dairy industry could be developed to the stage of self-sufficiency as in the case of UNICEF's European Program and which, I gather, is Mr Hayward [UNICEF's deputy director]'s idea» (53).

Aykroyd took this critique further over the following year, savagely attacking UNICEF's Haitian child feeding program, a practice of «supplying dried skim milk to countries without relating the supplementary feeding to a properly considered nutrition program. To call the importation and distribution of free food “the establishment of a nutrition service” is certainly alien to our ideas» (54).

Another source of dissent came from Martha Eliot. The end of the war saw the closure of the Children's Bureau's EMIC program and in the hostile atmosphere of Cold War America Eliot turned again to international activities. Moving beyond criticisms of UNICEF's milk fetish, Martha Eliot led an attempt to develop her earlier project for co-ordinated maternal and child health projects. In 1949 Eliot moved to Geneva as WHO's deputy director (55). She chaired an Expert Committee on Maternal and Child Health that called on UNICEF to shift its resources from emergency feeding to assist nations to develop infrastructure (led by paediatricians) to put child health on a scientific

(53) Aykroyd to F.W. Clements, 2 August 1949. FAO Archives, RG 57.1 Series A2.

(54) Aykroyd to A.J. Wakefield, Resident representative of the Secretary-General to UN, Port-au-Prince, Haiti, 2 August 1950. FAO Archives, RG57.1 Series A2.

(55) TERRELL, Mary Helen. «*Some kind of social doctor*». *Historical Study of Martha May Eliot*. Brandeis University [Unpublished Ph.D. thesis], 1990, p. 279.

basis (56). Although these conclusions were resoundingly ignored, under her leadership, WHO continued to warn of the dangers of relying on milk-based relief that stimulated demand and reshaped preferences in directions that could never be satisfied from local production. This remained a theme at WHO, even after Eliot resigned in 1951. A WHO report by B. D. Jelliffe raised great ire at UNICEF headquarters, as it attacked the lack of interest in local food habits. Educational efforts were singled out: «an over preoccupation with milk distribution has a bad effect on [the mothers attending MCH centres] during an impressionable period, so that they often acquire the view that animal milk is absolutely necessary for infant feeding and fail to realise the overwhelming importance of making every effort to use local methods and available food to better advantage» (57).

In 1954 WHO took this further, calling for an end to milk distribution through maternal and child health centres «because experience has shown that this interferes with the most important functions of these centres, i.e. the education of the parents in the ways and means of achieving health by their own efforts». Greater stress should be placed on locating and developing adequate foods already in local use. «Time spent distributing milk is time taken away from this long term solution of the nutritional problems of the growing child» (58). Others, such as the nutritional scientist, B.S. Platt, attacked the manner cheap skimmed milk was undermining campaigns to explain the superiority of breast feeding (59).

As criticism from the technical agencies mounted, new sources of supply entrenched UNICEF's emergency feeding model. The Truman

(56) WHO. Expert Committee on maternal and child health, 1st Session, January 1949. WHO Official Records. 19, p. 43.

(57) JELLIFFE, B.D. *Observations on the use of UNICEF dried milk in infant feeding in some tropical countries*, 29 December 1953. WHO Archives, WHO2/FN8.

(58) UNICEF-WHO Joint Committee on health policy, seventh session, *Suggestions regarding future activities in the prevention of malnutrition in infants and young children, note by the Secretariat of the World Health Organization*, 13 April 1954. UNICEF Archives, JC7/UNICEF-WHO/5.

(59) PLATT, B.S. Infant feeding practices: Breast feeding and the prevention of infant malnutrition. *Proceedings of the Nutrition Society*, 1954, 13, 94-105 (p. 95).

administration's Point Four aid program released greater resources, but within tight constraints set by US economic and political interests. This coincided with a debate about the abolition of UNICEF. With the passing of the European crisis that had given birth to the Emergency Fund, discussions raged over its future. WHO drew strong support from the US Department of State for its campaign for immediate abolition of its rival. The Department of Agriculture, however, helped rescue UNICEF. In 1950 it sold \$13 million of milk (about one third of the US surplus) to UNICEF for \$3 million, enabling the embattled agency to expand its feeding operations in the Far East (60). In the 1950s the United States continued to expand its food aid programs —through the Public Law 480 «Food for Peace» program— at little or no cost. UNICEF's main expense was freight. The attempt to balance humanitarian, political and commercial objectives was a difficult one, when conflicts arose, it was commercial calculations that usually prevailed; the program was driven by American domestic politics (61).

FAO's Nutrition Division had been sympathetic to the continuation of UNICEF as the UN system provided no other focus for «substantial and continuing international action on behalf of children» (62). This support remained tempered by doubts over the Fund's reluctance to listen to other agencies. As the focus of international aid gradually shifted to under-developed countries outside Europe in the 1950s FAO's enthusiasm for «local foods», its warning that outside Europe «milk distribution is for treatment of a few cases (...) for treatment milk will

(60) LENROOT, K. *Notes for Conference on continuing needs of children*, 4 January 1950. NA, RG59 lot file 55D429, Box 17. Department of State: Subject files of Durward V. Sandifer, 1944-1954.

(61) KAUFMAN, Burton. *Trade and aid: Eisenhower's foreign economic policy 1957-6*, Baltimore, Johns Hopkins University Press, 1982, pp. 28-29, 150; HALL, Lana. U.S. Food aid and the agricultural development of Brazil and Colombia, 1954-73. In: J.C.Super; T.C. Wright (eds.), *Food, politics and society in Latin America*, Lincoln, University of Nebraska Press, 1985, pp. 133-141; DOUGHTY, Paul. The food game in Latin America. In: D.E. McMillan (ed.), *Anthropology and food policy: Human dimensions of food policy in Africa and Latin America*, Athens, University of Georgia Press, 1991, pp. 147-156.

(62) *Note prepared by FAO on continuing needs of children*, 19 November 1949. FAO Archives, RG57.0 Series D2.

always be a drug more than a food» had greater meaning (63). Aykroyd and his colleagues argued that «The emphasis given to dried milk in UNICEF programs is in part related to the supplies available to UNICEF» (64). A FAO critic noted in the mid 50s, «There is no analysis of what sort of set-up would be most appropriate for the country, but some ideas are formulated in UNICEF Headquarters and then put before the Governments concerned» (65).

5. CONCLUSION

When change came it was not as a result of scientific criticism but from a crisis in supplies. In 1959 both the United and Canada ceased donations of skimmed milk powder to international food programs, as commercial export demand for these products now exceeded supply. The post war surplus had finally dried up and UNICEF's Executive Board was forced to ask its field offices for advice on new directions (66).

Paradoxically, this did not immediately lead to a rethinking of the emergency feeding model. As UNICEF's approach hit financial and supply problems, FAO and WHO were embracing new scientific understandings of malnutrition, derived from studies of kwashiorkor in Africa and Central America, which identified the disease as resulting from protein deficiency. Autret and Béhar's study, based on the research of the Institute of Nutrition of Central America and Panama (INCAP) in Guatemala, became the new FAO and WHO orthodoxy,

(63) M. Autret, Report on FAO-WHO-UNICEF Meeting, Paris 20-21st April 1953, FAO Archives, RG57.4 Series C1.

(64) FAO Nutrition Division. *Summary of first meeting of Interdivisional Working Party on FAO relationship with UNICEF*, February 21 1950. FAO Archives, RG3.1 Series I1. See also, AYKROYD, W.R. *Statement to the Executive Board, UNICEF*, 28 November 1950. FAO Archives, RG57.1 Series H1.

(65) A.G. Van Veen to Aykroyd, 14 April 1955, FAO Archives, RG12 Box 1, file «Milk surveys in Greece, 1954-1955».

(66) UNICEF Executive Board, *Recommendation of the Executive Director for approval of the purchase of skim milk from available funds*, 27 November 1959. UNICEF Archives, UN ECOSOC E/ICEF/R.810; Adelaide Sinclair (Dep Director, Programs, UNI-

with a renewed acceptance of the efficacy of the UNICEF program of free milk to educate the population, coupled with FAO projects to develop local dairy industries or alternative high protein food, such as fish flour (67). Like the UNRRA and UNICEF feeding programs of the 1940s this orthodoxy was based on a disease model —prioritising the search for specific causes of particular (often extreme) manifestations of malnutrition. It perpetuated the neglect of approaches to maternal and child health that took physiological health as but one aspect of child welfare.

Even so, the end of cheap supplies forced rethinking within UNICEF. In 1960 the Fund quietly dropped its logo of a child holding a cup of milk (68). In 1965 Richard Heyward, UNICEF's deputy director, wrote a searching and self-critical assessment of UNICEF's policies. He quoted Indonesia's President Sukarno: «What is UNICEF? It is powdered milk». Heyward laid blame on the lingering idea that «UNICEF should concentrate on supplying imports, rather than using grant-in-aid more generally to help the strategic elements in a country's program from the point of view of children». These problems could be traced to UNICEF's origins as UNRRA's temporary successor. As an agency set up to provide emergency relief «the countries being served were in no mood to support long and careful studies by international organizations (...) They wanted simple, practical help» (69).

The emergency measures put quickly in place in parts of liberated Europe during the closing stages of the Second World War had long term consequences, framing much of the vision of health than guided post war planners —even when they shifted their attention to less de-

CEF) *Memo to Regional, Area and Country Offices*, 13 November 1959. UNICEF Archives, EXD-940.

- (67) A.G. van Veen (FAO) to Aykroyd, 9 January 1956, FAO Archives, RG12 Box1 Nutrition Division, Registry Files Prior to 1958, file: UNICEF/FAO: collaborations; RUXIN, note 48, pp. 118-122; CARPENTER, Kenneth J. *Protein and energy*. Cambridge, Cambridge University Press, 1994, pp. 142-160.
- (68) HAZZARD, Virginia. UNICEF and women. *UNICEF History Series. Monograph VII*, New York, UNICEF, 1987, p. 2.
- (69) [HEYWARD, E.J.R.] *Notes on the History of UNICEF «Policy»*, 17 March 1965, pp. 3-12. UNICEF Archives, CF/HST/1985/O34/Anac/11.

veloped parts of the world (70). UNICEF's continuation of UNRRA's role as a supply agency, supplemented by United States aid programs, became driving forces shaping international health priorities. Despite the efforts of Martha Eliot and her colleagues on the WHO Expert Committee on Maternal and Child Health the focus remained on the providing cheap and effective food supplements. Broader social and public health contexts had been lost. Any analysis of the formation of international health policy needs to move beyond rational models that assume a «logical selection based on global burden and the availability of cost effective interventions» (71). The problems of institutional design —the role of interest groups, of conflicts between and within sponsoring governments— are as important as scientific debates on appropriate forms of treatment.

(70) This suggests a need to be cautious about approaches that assume international health policies in developing nations were simply continuations of «colonial medicine» as set out in PACKARD, Randall. Visions of postwar health and development and their impact on public health interventions in the developing world. In: Frederick Cooper; Randall Packard (eds.), *International development and the social sciences*, Berkeley, University of California Press, 1997, pp. 93-118. Even the WHO/UNICEF malaria eradication campaign, on which Packard bases much of his analysis, was an attempt to generalize UNRRA strategies developed in Italy and Greece in the 1940s.

(71) SHIFFMAN, Jeremy; BEER, Tanya; WU, Yonghong. The emergence of global disease priorities. *Health Policy and Planning*. 2002, 17, 225-234 (p. 225).