UNICEF IN AFRICA, SOUTH OF THE SAHARA:
A HISTORICAL PERSPECTIVE

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UNICEF IN AFRICA
SOUTH OF THE SAHARA

A Historical Perspective
1948 - 1986

PREFACE

It was in the late days of colonial rule in Africa, south of the Sahara, when UNICEF entered the picture as an international agency concerned with the wellbeing of children and mothers. The main concern of the colonial rulers in the fifties was the control of endemic diseases: malaria, yaws, leprosy, and tuberculosis. UNICEF aided in these campaigns, with mixed results. Material support, as well as training of personnel, was emphasized.

1960 and the years that followed brought independence to the vast majority of the African nations. A notable exception was the Portuguese-ruled countries of Angola, Mozambique, Guinea-Bissau, Cape Verde, and Sao Tomé/Principe; it was in the mid-seventies before these countries were to gain their political freedom. Independence brought with it a new spirit throughout Africa and its people had rising expectations of being relieved from the yoke of poverty, illness and ignorance. UNICEF, in close cooperation with its international partners, helped the new governments establish new health structures favoring the masses of people, especially in rural areas, a process which to date is far from complete. Maternal and child health services, and nutrition and community development became focal concerns for joint action. In the latter part of the sixties, aid to education, both formal and non-formal, came to the fore in UNICEF's concerns, reflecting the keen interest of the countries to move forward in this vital field.

While UNICEF continued to support such sectorial activities, it began to express concern with the place of children in national development and to promote, with governments, the concept of planning for children as an integral part of the process of national planning.

The process of "country programming" had begun. A session of the Executive Board held in Addis Ababa in 1966 highlighted the special needs of Africa's children and proposed strategies towards meeting them. These new concepts of planning for the needs of children and of concern with the "whole child" were more actively pursued through the decade and were intensified in the seventies. A landmark event of this later period was the convening of a conference in Lomé in 1972 which attempted to establish a basis for taking account of the specific needs of children and youth in West and Central Africa. And while the Sahelian drought, which was to soon overwhelm the region, dampened the enthusiasm for new actions, the long-term results were positive.

This decade also saw a proliferation of vigourous support to new fields: education, both formal and non-formal, water supply and sanitation, women's programmes, and experimentation into such areas as early childhood stimulation and urban children. And these programmes were being backstopped by new tools such as project support communication and appropriate technology.

Economic progress in this post-independence era was evident in most African countries, marked by a steady growth in their gross national product and by other positive economic indicators. Africa's primary commodities, agricultural and mineral, were in high demand in the industralised countries, fetching high prices. Average incomes had risen, life expectancy had increased, and infantile mortality rates began to drop. The surge of the post-independence efforts resulted in increased social progress, notably in

the expansion of education and health services. School enrollment for boys and girls nearly doubled compared to the previous decade and advances in adult literacy rates were very encouraging. These tremendous efforts by the new African governments in education and training were paying off as more and more trained personnel became available for all fields of development.

Sadly, however, by the early seventies this promising situation began to change dramatically. With the global economic recession and the "oil crisis" of 1974, a stagnation in the African nations' economies set in, marked by negative trade balances, low demand, and declining prices for their export products and growing international indebtedness. Foreign exchange reserves dwindled, GNP rates stagnated, and unemployment reached alarming levels at a time when exodus from rural areas to the cities was at its peak. Commodity prices were falling with most countries experiencing a foreign-exchange crunch. A series of severe droughts further aggravated the situation. Governments often responded by instituting belt-tightening measures, cutting back on already inadequate services to the people.

In spite of these downward trends, with sensitivity to the needs of the African nations and with flexibility in its operational methods, UNICEF made a recognized contribution to the countries' efforts to improve the wellbeing of their children and mothers.

The chronicle that follows, while by no means complete, attempts to place UNICEF and its role in the historical context of a continent striving for development against tremendous odds of political instability, climatic disasters, and the vagaries of international economies.

UNICEF BEGINNINGS 1948 - 1969

While UNICEF aid to developing countries in Asia began in 1948, and in Latin America and in the Middle East in 1949, it was not until April 1952 that UNICEF's Executive Board approved aid to Africa south of the Sahara. While the World Health Organization (WHO) and the Food and Agricultural Organization (FAO) had provided technical assistance, UNICEF inaugurated the first material aid by any United Nations body in Africa. UNICEF began with an allocation of $1 million, mainly in support of various disease control projects in the vast continent.

What caused the delay in UNICEF coming to the aid of Africa's children? Except for Ethiopia, Liberia, and the Union of South Africa, the territories of Africa south of the Sahara were administered by European countries - the Metropolitan countries, as they were referred to at the time. The major ones were France, the United Kingdom, Portugal, Belgium, and Spain. The status of the territories at the end of World War II ranged from being outright colonies to that of Trust Territories mandated by the League of Nations, mandates which were transferred to the newly established United Nations.

The Metropolitan powers at the time were reluctant to encourage "interventions" by the United Nations and its specialized agencies. They had their own plans for the development of their territories and since 1946, in the face of growing national agitation, had made funds available for ten-year programmes aimed at the development of economic resources and the raising of living standards in Africa.

In 1952 no UNICEF representative had yet visited any of the African territories. The recommendations to the Board at the time were based on preliminary field work and contacts which WHO and FAO had established with the Colonial Governments. Soon this situation was to change. Thanks to the efforts of the UNICEF Regional Office in Paris and its contacts with the authorities in Brussels, London and Paris, confidence was established and soon afterwards, UNICEF staff began to carry out frequent visits. A pioneer of that period was Dr. Roland Marti, previously a chief Delegate of the International Red Cross in Berlin during World War II. It was his dedication and enormous energy that "opened the door"[1/] for UNICEF in Africa. He initiated UNICEF offices in Brazzaville, and later on in Abidjan and Dakar. Others associated with that early period were Dr. Otto Lehner, another Swiss national, who opened the UNICEF office in Lagos, Nigeria; and Karl Barch, a Norwegian economist, who went to East Africa when an office was established in Kampala, Uganda. Dr. Charles Egger, the Regional Director for Africa, stationed in Paris, carried out a first extended visit to the continent in 1952. From that time on, he was to spend four to five months every year in visits to African countries. Maurice Pate, UNICEF's first Executive Director made an extensive visit in late 1963 that took him to several African countries.

Another frequent visitor to Africa in the fifties was Dr. Georges Sicault, a former director of health services of French Protectorate of Morocco, and by then a senior UNICEF officer. In 1957 his visits were connected with assessing UNICEF and WHO's approach to malaria control. He made a second trip in the same year to French West Africa, Nigeria, and Ghana to observe the progress being made against yaws, leprosy, and malaria.[2/]

The Colonial and Trustee powers chose to make a beginning in cooperation with such "technical" and "humanitarian" organisations of the United Nations system as WHO and UNICEF, and later with FAO and ILO. They wished these agencies to integrate their own efforts into the existing development programmes rather than initiate new efforts. For instance, in the French territories, especially in West Africa, they wanted WHO and UNICEF to strengthen the existing mobile epidemic disease control units. In the British territories they desired assistance to expand basic rural health services. No success was achieved, however, in negotiations with the Portuguese colonial powers with respect to their territories, the most important of which were Angola and Mozambique. Hence, UNICEF cooperation with those countries did not materialize until the late sixties and early seventies when they gained their independence.

For UNICEF as an organisation, and for its staff, this early period was one of observation and learning about the continent, its problems, its people and its potential for development. It was also one of experimentation, through trial and error, with methods of cooperation.

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Prevailing conditions

What were the prevailing socio-economic conditions affecting the lives of children in Africa South of the Sahara in the early fifties? In spite of the dearth of information and near total lack of statistical data, the following was generally perceived to be the case: a total population of about 171 million[3/]; a demographic situation marked by high birth and death rates; children under 15 years of age constituting about 45 percent of the population (in contrast to 21 percent in the European population); infant mortality rates ranging between 200 and 350 per thousand of live births.[4/]

Child malnutrition was widespread, including the severe form of protein deficiency known as kwashiorkor. Malaria was endemic in widespread areas and a major cause of child mortality, according to a WHO-sponsored conference in 1950. Yaws and leprosy were known to be rampant. Tuberculosis, the same conference reported, was liable to spread like wildfire because of rapid urbanisation.

The economies were at a very low ebb, with an estimated GNP per capita not exceeding US$50 as an average throughout tropical Africa. Literacy and school enrollment rates were extremely low and sanitary conditions were very poor. In addition, poor communications, lack of adequate transport facilities, and an acute shortage of trained manpower were seen as major obstacles to development.

It was against this background that UNICEF, in cooperation with its specialised agency partners, particularly WHO and FAO, launched the first programmes of aid in Africa. The problems were overwhelming.

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Early interventions: mass disease control - an introduction

It was estimated that 200,000 adults and half a million infants died from malaria each year. What records were available showed that 50 percent of hospital admissions of children under 4 years of age were diagnosed as malaria and 20 percent of recorded deaths in this age group were attributed to it.

Not surprisingly, therefore, when projects for Africa were presented to the Board in 1953, about 50 percent of the aid was earmarked for anti-malaria projects. This reflected a trend for the decade: assistance to malaria began in 1952 with $450,000 allocated for six projects, and by 1960 amounted to $4 million for projects in 15 countries. It is to be noted, however, that although the population exposed to malaria was estimated at 135 million, only a small fraction was covered. Most of the projects were designed as pilot projects, covering limited geographic areas. (See section on malaria in the following pages).

But malaria was not the only cause of high morbidity and mortality among children. Yaws was considered by governments as the second most widespread endemic disease. Initial small allocations were made by UNICEF between 1952 and 1954 for three country programmes. A WHO-sponsored conference concluded that Africa contained the world's largest reservoir of endemic yaws, with about 25 million cases, and called for a large scale offensive against yaws in Africa. So, in 1955, UNICEF joined the battle with major allocations, typical of which was $440,000 for yaws control in Nigeria. By 1964, the Board had allocated $2.4 million in this field.

Another dreaded endemic disease to contend with was leprosy. WHO estimated that of 10 million cases world-wide, one fourth were in Africa. UNICEF's first allocation was a relatively modest $50,000 in one country in 1952. By 1964, twenty countries were being aided at a cost of $3.6 million.

Tuberculosis was next on the priority list of governments as a major public health hazard requiring attention. It was regarded as an imminent rather than an existing threat. Hence the emphasis was to be on prevention rather than cure. Two TB survey teams were mounted in 1955, one in eastern/southern Africa and the other in west and central Africa, staffed by WHO and funded jointly with UNICEF.

This emphasis on the control of endemic diseases continued throughout the fifties. For example, in 1955, of UNICEF's total allocation to Africa amounting to $4.8 million, 81 percent was earmarked for mass campaigns against endemic diseases while only 7 percent was allocated for maternal and child welfare (MCW). In 1957, of UNICEF allocations to the broad field of health and nutrition, 89 percent was devoted to disease control. By the end of the decade, 1959, the proportion was still high - 82 percent.

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Evolution in public health

UNICEF entry into the field of health in Africa was dictated to a large extent by the prevailing political realities of the time including the policies of the European colonial powers: Belgium, France and the United Kingdom. In

West Africa they wished to concentrate on fighting malaria and to utilize new methods of malaria control advocated by WHO; and in Central Africa they wanted to concern themselves with the problems of child health and nutrition. No rationale was given for this dichotomy, for malaria was as much of a menace in Central Africa, and the inadequacies of child health and nutrition were prevalent in all parts of Africa. These policies were developed by the colonial powers both in the home countries and in the colonies often without the benefit of any meaningful consultation with the local population or their representatives, and appear to have been based more on economic and political factors rather than on the needs as expressed by the communities and individuals concerned. In the French controlled territories mobile epidemic disease control units, staffed by military doctors on loan to the territorial administrations, and conscripts, represented the main thrust in the health field. UNICEF's early interventions in cooperation with these programmes consisted of providing supplies and spare parts to the mobile units.

In the British-controlled territories, the approach was different. The emphasis was more on building up basic health services, sketchy as these may have been on the ground. There was relatively a greater degree of decentralization and community involvement, and the staffing of what services existed was largely by paramedical and auxiliary personnel. The latter were largely Africans, while medical and senior officers were mostly European. In many African countries, the number of qualified African doctors and nurses could be counted on two hands.

In many of the territories much of the network of existing services was made up by missionary societies of various Christian denominations. They were largely involved in curative work and provided training in nursing and for auxiliary personnel. UNICEF, in agreement with the governments concerned, developed a system of assisting these missions. The objective was to reinforce those of their activities which were broader in scope and oriented more towards prevention and community education. In many of the scattered, remote and isolated locations in some countries the only health services available were those provided by missionary societies. UNICEF came to appreciate this humanitarian effort and provided what assistance it could.

The movement away from these colonial patterns of health and medical services in the direction of newer concepts of basic health services was a gradual process and began, though in a modest way, during the colonial period and accelerated during the post-independence era. It should be noted that "basic" health services in that period meant the provision of minimal pre-natal through post-natal services for mothers and children, and extending them into rural areas to the extent possible. UNICEF learned a great deal by associating itself in that early phase with the many interesting and innovative experiences that were going on in such countries as Nigeria, Kenya, Uganda, and Senegal, where enlightened African and European doctors and public health officers have spearheaded new initiatives.

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Health programmes

UNICEF and WHO in confronting the overwhelming problems of health in Africa have had the benefit of a few years experience first in post-war Europe and soon after on a large scale in Asia and Latin America. UNICEF's mandate was that its resources should be used for "child health purposes generally". Millions of children in underdeveloped countries suffered from infectious diseases, and Africa had a great share of them. They were the most obvious and the most common health problems. The method of attack against them was the "mass campaign" a strategy that did not depend on the wide availability of medical services with their doctors, nurses, health centres, or hospitals. The medical breakthroughs from the late 19th century to the period of World War II made it feasible to attack diseases: vaccines such as those against smallpox and diphtheria and tuberculosis were already in use; new miracle drugs such as penicillin had come into wider use and were produced more cheaply; and the same applied to an insecticide, known as DDT, which was in great demand. Additionally, transportaiton and communication systems had advanced and expanded sufficiently to make it possible to reach large population with these new measures. Therefore there was the promise that over a relatively short period of time, a concentrated campaign against a disease could produce results inspite of the absence of sophisticated health or medical networks.

The existence of these technical breakthroughs was not in itself a guarantee to their utilization in confronting the mass diseases. New methods of collaboration and administration were needed to bring this about. It is in these new areas that UNICEF's contribution, and those of the collaborating agencies, were made, thus bringing the benefits of the new technologies to bear on the problems of mass diseases.

It was with this prevailing technological environment in the background and with great enthusiasm and determination that UNICEF and WHO confronted some of the major mass diseases afflicting the continent of Africa.

:Success with yaws

Yaws, a trepanosomal disease, was by the early fifties estimated to affect some 25 million people living the equatorial and tropical belts around the world, half of them in Asia, with Africa having the second largest reservoir of the disease. Transmitted largely by skin contact it spread easily from child to child, largely where poverty, lack of sanitation and poor housing conditions predominated. Its most obvious manifestations were raspberry-colored sores that would heal and erupt again all over the body including the palms of the hand and the soles of the feet. As children grow up, the disease became entrenched in the body; joints became stiff, the body immobilized, and leprosy-like deformity developed.

The most effective treatment was a form of long-acting penicillin. One shot of it would clear up the skin sores within days and a small number of injections rid the body of the disease for good. The mass campaigns in Africa, as in their successful predecessors in Asia and Latin America, relied heavily on auxiliary health personnel who were the backbone of the mobile field forces. With this manpower deployed and at work, and with strong technical support from WHO, and supplies of penicillin, medical equipment and transport from UNICEF the campaign against yaws in Africa began in earnest.

The first campaign mounted was in Nigeria in 1952/1953. Nigeria was also to be the site of the Second International Conference on yaws in 1955. (The first took place in Bangkok, Thailand in 1952.) It was becoming clear at that time that a far higher number of yaws cases existed in Africa than had been previously thought: between 20 and 25 million.

By 1955, about 2.7 million people were examined and 2.2 million were treated with penicillin. In 1958, these figures grew to 5.5 million and 3 million respectively. The effort continued, heavily concentrated in Western and Central Africa into the early sixties. The final tally appears in UNICEF statistics; up to 1959 over 13 million were treated and in the period from 1960 to 1965 another 22 million individuals received treatment. While some programmes developed faster than others and some took considerable effort to get off the ground, the back of the disease was broken and 12 years after the campaign started Maurice Pate, UNICEF's Executive Director, was able to report to the Executive Board that the disappearance of yaws from the African continent was in sight. By the mid sixties, some pockets of the disease were still to be found but was no longer to be considered a significant public health issue. Its surveillance and control became a routine function of the health services. In the process the yaws campaigns helped in the development and strengthening of the mobile preventive services and considerably extended their coverage.

:Leprosy - mixed results

When WHO and UNICEF decided in 1952 to confront leprosy, a dreaded disease known from ancient times, the prospects were not promising. Like yaws, it was a disease of poverty and poor hygiene and the traditional means of confronting it was isolation in leper colonies or leprosoria. And in that year no drug or vaccine was known to counter it. Leprosy is caused by a bacillus which invades the nervous system through the skin, producing patches of insensitive light-colored skin. It was considered highly infectious and caused ugly disfigurement in its victims who were shunned by the community which treated them as outcasts. Credit should be noted for the pioneering role of medical missionaries in such countries as Nigeria, in confronting the disease, and to the work of research institutes such as the one in Bamako, Mali.

Fortunately, one year after the two organisations decided to carry out their first leprosy project in Nigeria, WHO came up with the encouraging news that a new drug was discovered that looked promising for the treatment of the disease. The drug, diamno diephemyl sulphone, administered in the form of pills, resulted in marked improvement. Although it took several months to do so it greatly reduced the chances of infection in the long term. This new weapon, while not as dramatic and decisive as in the case of penicillin versus yaws, was welcome news nonetheless. The patient had to receive treatment every week or every month, and the patches of infected skin would disappear. At the same time, family members, especially children, would be kept under observation and would be treated for any symptoms of the disease. Here again it should be noted that the discovery of a "wonder drug" was only one element in a larger pioneering effort by governments, aided by UNICEF and WHO, in establishing relations with the patients and gaining their confidence and doing this on a large scale.

By 1955 UNICEF was assisting leprosy programmes in eight countries, four in Africa, which was considered the continent with the largest leprosy reservoir. The same campaign methods utilised depended largely on auxiliaries who travelled weekly or monthly circuits, surveying, handing out sulphone tablets at appointed places and making regular reports on patients' progress. It was no longer necessary to segregate mothers from their babies, the latter receiving prophylactic doses of sulphone.

But great difficulties were implied by the very nature of the treatment. It took three years or longer for a cure. During the first six months patients felt great improvement and it was difficult to persuade many of them to continue with the treatment for longer periods. The distances they had to travel on foot to pick up their medication was a serious hindrance, especially when the time required was to be taken away from their farming and domestic tasks. While less spectacular results were achieved than in the case of yaws and other infectious diseases, a dent was undoubtedly made against what was considered one of the most dreaded of diseases in Africa, and tens of thousands of children were spared its disfiguring effects, or worse. Only one generation after the leprosy campaigns started, much has been achieved; the leper colonies are now few and far between and the stigma associated with leprosy had all but disappeared.

:The malaria story

Malaria was the most widespread disease of Africa affecting the lives of adults and children alike, but it was more lethal to the latter. In the world, malaria was thought to strike 350 million human beings and cause one in every 100 deaths. And Africa had its full share. It affected, in various degrees, not only equatorial and tropical regions, but the vast Savannah areas of Central, Western, and Southern regions as well.

The disease is caused by a parasite which takes two common forms; vivax and falciparum. The latter is often the more dangerous variety and is widespread in Africa. The parasite is carried and transmitted to humans through the mosquito, anopheles. Historically, various attempts were made to control the mosquitos without much success until the late thirties, when an insecticide known as DDT came into wide use. It proved effective as it stayed lethal to mosquitos months after it was sprayed into the interior walls of houses. UNICEF's first assistance to countries suffering from malaria went to Europe in the last part of the decade of the forties and the early fifties. When the World Health Organization, WHO, came into being in 1949, it declared the attack on malaria as one of its top priorities. As was the case with other campaigns against diseases, WHO acted as technical advisor to UNICEF and the governments. By 1952 UNICEF was spending around $6 million a year on providing DDT and related supplies to protect about 13.5 million people in 30 countries. But the only African country to benefit from this effort in these early days was the island of Mauritius, off the east coast of the continent, and seemingly with success, sharply reducing mortality due to malaria.

In 1955 the Joint Committee on Health Policy (JCHP), which combined representatives from the Executive Boards of UNICEF and WHO, unanimously recommended the adoption of the goal of malaria eradication to replace the earlier policy of malaria control; an exception was made, however, in the case

of Africa South of the Sahara, where eradication of malaria was considered to be impractical at the time.

By 1955 UNICEF was assisting nine malaria control projects. One pilot project was around the city of Yaoundé in the Trust Territory of Cameroon; another was in Sokoto Province of Nigeria; a third was aimed at the foothills of Kilimanjaro in Tanganyika. Other projects were in Dahomey, Liberia, Kenya and Upper Volta. A very hopeful project was assisted in Southern Rhodesia, which had started a malaria control programme in 1949 on a national scale, considered a unique effort at the time and was aided by UNICEF beginning in 1954.

In 1955 it was reported to the Board that in eight countries some 1,083,000 people were protected against malaria, and the target for 1956 was set at 1,445,000 people. By 1957, about 3 million persons had their houses sprayed with insecticides in seven West African countries and territories; and in East Africa, the high plateau areas of Kenya and Tanganyika were also subjected to the same treatment.

The results led to a mixture of hopeful optimism and disappointment. In the East Africa case mentioned above, the experts reported that the house spraying appeared to have stopped transmission of the disease and the prospects of eradication were good, while in West Africa three years of residual spraying had not succeeded in preventing widespread occurrence of new infections, except in Senegal. One of the obstacles encountered was in Somaliland where the nomadic way of life of the majority of the population worked against a break in the transmission: when the nomads leave the dry areas, they follow the rain into malaria-infected areas for two to three months where they become exposed to infection. In Bechuanaland, another country with an actively mobile population, a similar phenomenon was observed.

During this period, repeated references were made to the effect that while, as a result of the malaria control work, some relief from mosquitoes was achieved for the population concerned, nevertheless, the malaria transmission continued. This was attributed to the small area covered by the projects and to active migration in and out of these areas. While optimism arose over the possibilities of eradication as a result of seemingly successful efforts in Southern Rhodesia and Swaziland and the pilot projects in eradication in Zanzibar and Sokoto, Nigeria, it was reported from Nigeria and from other areas that anopheles mosquitos may have had built up resistance to dieldrin and to DDT, the two insecticides most widely used.

In 1958 in an appraisal of the results achieved since 1953, WHO considered that, in forest areas, total coverage with DDT residual spraying could interrupt transmission. In upland hyper-endemic areas, three applications of DDT per year, in addition to single-dose distribution of anti-malarial drugs to the vulnerable population, had been shown to interrupt transmission of the disease. But in open Savannah areas, interruption had not been achieved. However, where interruption had been demonstrated as technically feasible, other requisites, such as practical feasibility, adequate administrative organization, and proper logistics had been absent. With very few exceptions, it was considered that in most African countries the fundamental elements required for the proper setting up and maintaining of a malaria eradication

campaign programme were inadequate. An attempted eradication campaign even in the isolated island of Zanzibar had failed.

In describing the protection against malaria provided by various forms of intervention to 14 million people in tropical Africa, a 1958 UNICEF Executive Board session was informed that, "...However, not only must this be described as partial in its effectiveness, but it affords no immediate prospect of reduction of annual expenditure, and it carries an ever growing danger of resistance to insecticides..."[5/] And in that year it was envisaged that 16 experiments in mass chemotherapy would be undertaken involving 650,000 persons. The general plan approved by the Executive Board in that year was based on concentration on the work already in hand, with no immediate expansion in overall coverage.

UNICEF's role in the campaigns against malaria was part of a much larger global effort involving governments, the bilateral aid agencies of developed countries, such as the United States, several UN organisations and a network of scientific research organisations. Throughout the period there were wide-ranging debates and differences of opinion on policies, approaches and techniques, and on the feasibility of the proclaimed goal of malaria eradication.

While combatting these major communicable mass diseases represented the main thrust of UNICEF's efforts in the health field during the fifties, to the extent of absorbing 85 percent of its allocations for Africa at the height of the campaigns, other aspects of health related to children and mothers were not totally neglected. As far back as 1951 some African countries, e.g., Ethiopia, Kenya, and Nigeria, were receiving some assistance from UNICEF for their budding maternal and child welfare services.

:MCW: growth of the rural health network

By 1956 UNICEF was assisting nine African countries in the development of their health services, especially the component known as maternal and child welfare, or MCW. The concepts that had already begun to develop in the Asian and Latin American regions had gained much acceptance on the part of African governments. At the centre of this concept was the rural health centre. This was conceived as providing curative services on a higher level than the dispensary system prevailing up to that time, and was to include more active maternal and child health work, midwifery and domiciliary services, pre-natal and post-natal services and, when properly functioning, was to take more responsibility for surveillance of cases after the termination of mass campaigns. In that year (1956) WHO appointed two regional consultants on MCW, and this helped to extend this trend. But why did this basic development in mother and child health care come so late to the African continent? What caused this delay? The accepted wisdom at the time, as perceived by staff members such as Dr. Roland Marti (then UNICEF Representative to West Africa), and Dr. Otto Lehner (who joined the organization in 1955), was that communicable diseases, especially malaria, yaws and leprosy, were so widespread that the top priority had to be given to control measures to stem the tide of these diseases. It was considered inconceivable and impractical to organize MCW centres and other public health measures emphasizing prevention before some impact on communicable diseases was felt. People had to be shown what could be done with modern medicine. And just to organize an

effective yaws campaign, it took all the then available manpower, even if that meant only giving one shot of penicillin to each adult and to each child. There were few doctors and therefore heavy reliance was on simply trained "sanitary personnel". Control of communicable diseases, in short, had to be the first step. And, while it required large expenditure, it produced visible results in the short term. By contrast, developing MCW services was to be a slow and tedious long-term process.

From 1956 onward, the story of MCW in Africa is told in terms of training schools and demonstration projects equipped with UNICEF supplies, and of increasing numbers of nurses, health visitors, midwives and sanitarians under training for the expansion that would follow in the next few years. This continued in spite of the major obstacle of the period, namely, the low educational standards of candidates to be trained.

Progress in the expansion of rural health centres was reported in Ghana where, in 1954, UNICEF provided equipment for 15 centres but only 10 were functioning by the end of 1956. In Kenya, 25 main health centres were operating as well as 35 "locational" health centres (the latter were more in the category of dispensaries). Pioneering work in Nigeria was being carried out by Dr. David Morley who was on the faculty of the Institute of Child Health of Makerere University in Kampala, Uganda. In Northern Rhodesia (modern-day Zambia), the training of auxiliary personnel and the building of MCW centres continued, and the first centres started to function in 1957. In Tanganyika, the intake of rural medical aid trainees was increased from twenty to forty in 1956 on completion of subsidiary training centres in Lindi, Morogoro, and Dodoma. The training of village midwives had begun in Tabora and Arusha. Throughout the continent similar expansion and extension in maternal and child welfare activities was taking place.

:Penicillin works everywhere, but advice does not

In 1958, the Board session had a detailed and interesting discussion on the subject of basic maternal and child welfare services in Africa[6/] during which the following interesting points emerged:

1. According to a sociological/anthropological analysis of the situation of the child in the African family, the welfare of a particular child might not necessarily be in the hands of only the mother. Decisions concerning children quite often rested with other members of the extended family system;

2. African societies were undergoing rapid development and change. The traditional patterns of life were being altered by increased urbanization. It was stated, by way of example, that the dislocation of the traditional educational pattern had led the government of Tanganyika to develop a community development scheme aimed at the adolescent age group in particular;

3. Special patterns for MCW services had to be developed. An early strategy was to support the public health services in giving a special place for locally appropriate MCW activities in the rural areas;

4. The tendency in Africa was towards "integrated" medicine, and the avoidance of rigid separation between curative and preventive services. It was often stated that those who came to be cured were more disposed to listen to preventive advice, "...Penicillin works everywhere, advice does not but at any rate it takes better after penicillin";

5. Cultural/traditional views about the causes of illness must be recognized. Health education therefore becomes an important task of the health services;

6. MCW services posed greater problems to governments and UNICEF than aid to campaigns aimed at the eradication of yaws, for example. Campaigns were one-shot affairs, perceived to have a beginning and an end. Maternal and child health services were to be permanent or long-term committments. The difficulty was in finding forms of assistance significant to governments to enable them in building viable MCW field structures.

In the years to follow, much energy and thought was expended by UNICEF, WHO, and the governments concerned in the development and sustenance of these structures. Technical advice, staff training and material assistance were the essential tools utilized.

UNICEF's aid to MCW did grow rapidly, although in overall financial terms the growth was relatively modest. By 1959, UNICEF was assisting 15 African countries and territories in developing their MCW services at a cost of $743,000, representing 28 per cent of all UNICEF commitments in Africa. In East and Southern Africa, 173 MCW centres were assisted in 1957; but by mid-1959, the number of centres receiving aid reached 1,037 serving some 14,000 children. The countries of West and Central Africa similarly saw an expansion of MCH activities. Notable examples were Senegal, Niger, and Nigeria.

:Environmental sanitation

The first UNICEF allocation for sanitation projects in Africa was approved in 1959 for Kenya. It supported the training of sanitarians under the guidance of experts from WHO, an approach which was to be repeated in many African countries in the coming years. These workers promoted the construction of simple human waste disposal devices such as latrines. In the same year, assistance to sanitation was approved for Tanganyika, Nigeria and Senegal. While there was a feeling prevalent among African countries that many of the health problems facing African children were related to issues of environmental sanitation (water, excreta disposal, housing), the emphasis and priority in those early years had to be given to the extension of the network of health centres. A factor to be contended within all of this was the severe shortage of trained personnel to staff the new services, and the large financial outlays required to provide effective sanitation services, even if only to meet the basic requirements.

:Paediatricians and traditional birth attendants - tackling the health manpower issue

There was broad agreement among all concerned that the expansion of maternal and child health and other related public health services would have to rely heavily on auxiliary personnel at a fairly modest level of education, and the early training efforts concentrated on achieving this goal. However, there was also severe lack at the middle level of supervisory field personnel, and at higher levels, to provide leadership for the programmes which required university training. At the latter level, training was organized on a regional basis in East Africa.

UNICEF first entered into the field of regional training in 1958 when it supported the establishment of a chair for Paediatrics at Makerere College in Kampala, Uganda. Support continued through the period when, in 1964, the college became part of the University of East Africa, with a full-fledged medical faculty which underwent tremendous expansion. The influence of the Paediatrics Department extended beyond the walls of the college and Uganda's borders when it carried out a series of inter-country seminars and a variety of training courses for various levels of personnel. Innovative approaches and adaptability to the needs of the African societies characterized the instruction and training provided by Makerere, which became a spearhead in the revolution in attitude towards the delivery of health care in developing countries. Key figures associated with Makerere, such as Derek Jellife, Maurice King, and David Morley, made great contributions to this development. In West Africa, the University of Dakar played a similar role in expanding training in the health field throughout West and Central Africa. These efforts received sustained UNICEF support. At the University of Ibadan, Nigeria, a post-basic nursing education course was established and played an important role in developing the middle level of personnel in the health field. In 1962, UNICEF supported the establishment of a chair in Paediatrics in that University.

While these institutions contributed greatly over a period of time to multiplying the national cadres of health workers both at the leadership level and at the vital intermediate levels of supervision, much of the in-country training supported by UNICEF dealt with the auxiliary level health workers. Among these were the oldest-known "health workers" at village level: the traditional birth attendants, or TBAs, and known in the Francophone countries as the "matrones", they were the only available medical assistance that could be relied upon for the vast majority of African women that were pregnant and at their time of delivery. Training programmes were devised to upgrade their skills and improve their practices from a hygienic point of view. Often at "graduation" they received the famous midwife kit that was developed by UNICEF and WHO. In the first decade of UNICEF cooperation in Africa, thousands of auxiliaries, including TBA's, were trained with UNICEF support.

It should be noted that close ties existed between UNICEF and the World Health Organization (WHO). As in other regions of the world, WHO was the acknowledged technical adviser to UNICEF in matters of health. In practice, the working relationships were intimate, and field visits were often carried out jointly by the two agencies. Governments' project proposals were jointly reviewed and technically approved by WHO, but the key partners in this process were the government officials in charge of the health services. It is

equally important to note that the co-operation with WHO was not always easy nor free from differences of view on concepts, approaches and timing. UNICEF maintained its full identity as an agency and its unique organisational structure and style of cooperation, concerned as it is with many aspects bearing on the health of children in Africa.

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Supply lines: multi-vitamins and Land-Rovers

One of the remarkable achievements of that period, though not exclusive to Africa, was UNICEF's fast-developing capacity to deliver the supplies and equipment in support of health programmes, as well as for other activities that are discussed in the following pages.

For disease control campaigns, deliveries included insecticides for malaria control, vaccines for immunization, dapsone for treatment of leprosy, penicillin for yaws, antibiotics for treatment of Tuberculosis, etc. Typical supplies in support of an MCW programme in Africa included standard basic equipment for rural health centres and expendables such as milk, soap, fish liver oil capsules, multi-vitamins and iron tablets in support of pre-natal care.

Bicycles and vehicles were provided for supervisory personnel. Vehiclesr were often of the four-wheel variety such as a Land-Rover, capable of traversing bush terrain in all kinds of weather and road conditions.

Training equipment, including audio-visual machines, was provided for training centres of various levels.

This tremendous effort can be more readily appreciated if one bears in mind the extremely difficult logistic problems of shipping supplies to a continent with the poorest transport and communications infrastructure in the world. It is true that UNICEF's obligation was only to deliver these goods to the ports of entry, and that it was thereafter the government's obligation to transport and deliver these badly needed supplies throughout their territories, but UNICEF had a stake in assuring their delivery and often had to provide assistance to ensure the safe and speedy arrival of supplies to remote rural areas not easily accessible.

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Malnutrition: the bane of Africa

:Skim milk vs. kwashiorkor

Reports to the UNICEF Board in these early days stressed the ravages of malnutrition among African children and their mothers. One of the earliest interventions by UNICEF in Africa was in relation to this problem.

In 1951, at the recommendation of FAO, UNICEF provided small quantities of skim milk to Central African countries to test its value in combating kwashiorkor, a severe form of child malnutrition. Distribution took place through the channels of hospitals, MCW Centres and other health units. And in 1952 the Board approved three supplementary programmes to extend these tests which had so far proven successful. These projects, however, proved difficult to implement. It was not until three years after their inception that they became operational, serving fewer beneficiaries than initially planned. There were many deterrents to expansion of these programmes: difficulties in packaging, transporting and distributing; communication problems; and climatic conditions. In 1955, it was reported that the peak number of children receiving milk rations was 63,000 in seven countries, and the target for the following year was reduced to 42,000, admittedly a weak response to a major problem. In 1959, the Director for Africa and Europe Regional Office reported to the Board that "...we cannot expect large-scale programmes in terms of child-feeding or the processing of food to come forward," and, "The aim will have to be directed more to preparing the ground for future development by participating in the training of staff, in spreading nutrition education, in assisting survey work in the countries concerned, and in gathering practical experience through demonstration and pilot projects."7/ Greatly underestimated at the time was the value of locally grown foods in the battle against child malnutrition.

In spite of this seeming retrenchment, some school-feeding projects were undertaken, but the greatest number of children and mothers reached were through maternal and child welfare centres, where the distribution of milk and vitamin capsules first attracted mothers to take their children to the centres. A typical project in that period is indicated by the delivery to Nigeria in 1957 of 400,000 pounds of dry skim milk for distribution to 5,000 pre-school and 7,000 school-age children. In the same period, the Fund provided skim milk to the Central African Federation (now Malawi, Zambia and Zimbabwe) for distribution through MCW centres as supplementary feeding to 3,000 infants, 1,200 school-age children and 800 expectant and nursing mothers.

The provision of milk to mothers and children was assumed to be an incentive for their regular attendance at MCW Centres, but this did not always work in practice. Several field offices reported at the time that as soon as the milk supplies were exhausted, a sharp drop in attendance was observed. It should be recalled that milk powder was donated to UNICEF by countries with milk surpluses without any assurance of a regular flow of supplies, and therefore forward planning for these supplementary feeding programmes was tenuous at best.

:Research and information about malnutrition in Africa

There was no shortage of reliable scientific information about the nutritional problems and diseases of the African population, and particularly those that affect infants, children, and pregnant women. But there was still much to be learned about their prevalence, causes and prevention. While in recent decades African scientists and institutions have played a major role in providing information, in the earlier decades expatriates from the European and North American continents played the leading role.

As far back as 1932, Dr. Cicely Williams a pioneer paediatrician, identified kwashiorkor in what is now Ghana. During the colonial periods the British established nutrition research units in the Gambia, Uganda, and Tanganyika; the Belgians in the Congo carried out commendable research work and the French established the Regional Nutrition Research Centre, ORANA, in Dakar, Senegal 8/. In the late 1950's and early 1960's, the US Interdepartmental Committee on Nutrition cooperated with the governments of Ethiopia and Nigeria in carrying out comprehensive nutrition surveys.

The Swedish International Development Authority, SIDA, helped in the establishment of the Ethiopian Nutrition Institute in 1960 which, over the years, has provided information on the food and nutrition problems of that country. The Institute continues to function to this day. In Nigeria, the London University and the University of Ibadan collaborated, with support from FAO and WHO, in establishing a Department of Food Science and Nutrition at the University of Ibadan.9/

An example of the information published in that period was a paper entitled "Culture, Social Change, and Infant Feeding" by Dr. D. B. Jelliffe, then working at Makerere University in Uganda. The paper, published in 1960, prepared for the Protein Advisory Group of FAO, WHO, and UNICEF, provided an excellent summary of the main factors causing young child malnutrition. Another publication for FAO by Dr. Michael C. Latham entitled "Human Nutrition in Tropical Africa" contained valuable information about nutrition on the continent.10/

And while there was need for much more knowledge to be revealed through investigation and research, the fact remains that even in those early days, more information on nutrition was available than has been acted upon.

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How to feed your child

After 1950, when UNICEF began to concentrate its efforts on the children of developing countries in Asia, Latin America, the Middle East, and Africa, it faced a very different set of nutritional circumstances. For one thing the number of children in need was huge, and to provide supplementary feeding required a high degree of organization and a functioning network of social, educational and health services which in many of these countries were either too weak or almost non-existent. This was especially the case for Africa, the last continent to be "entered" by UNICEF and other concerned international

organizations. Supplementary feeding schemes in Africa were therefore restricted to emergency situations with limited distributions to children who could be reached in hospitals, clinics and other community facilities where these were available. Milk was distributed as "medicine" for children showing signs of severe malnutrition. More than just a "treatment", UNICEF hoped that a practical demonstration would be made of the vital connection between nutrition and child health.

:Nutrition education

In response to the problems enumerated earlier, a policy of expanding aid to nutrition was advocated. The approach was to go beyond simple child-feeding, and was to include nutrition education, milk conservation and the production of protein-rich foods. Other programmes for nutrition through schools, home economics, school gardening, and training of health staff in nutrition were introduced in the latter half of the 1950s. In 1960, most of the countries which responded to UNICEF's suggestion to carry out national studies on the needs of children placed malnutrition among the problems requiring priority attention. But it was not until "applied nutrition" programmes were introduced that important growth in the nutrition field took place. This required action by various ministries and government departments, and here the difficulties of cooperation and coordination became pronounced. However, the response from the community was encouraging. In these efforts FAO was a key partner to UNICEF and the governments concerned, as WHO continued to be in relation to activities in the health field. In 1962 and 1963, FAO organized conferences in various African countries dealing with various aspects of nutrition and a training course took place in Marseilles, all of which helped to further the interest of government in nutrition-related activities and encourage the formulation of constructive nutrition policies more adapted to African needs. This type of applied nutrition activity reached a flowering in the early sixties and beyond. We will return to discuss them in due course.

One of the most productive aspects of nutrition activities proved to be the extension of simple nutrition education through the mothers' clubs and other community development programmes which focused on the education and orientation of women. A greater number of mothers were thus reached with immediate and direct benefit to their infants and children. In the process, an awakening was taking place in government circles about the importance of good nutrition. This was to pay dividends in the future.

:Milk conservation

One of the earliest interests of UNICEF globally was in assisting countries in Europe, Asia, the Middle East and Latin America in rebuilding and developing their dairy industries. The supplementary feeding schemes in post-World War II Europe, based on the availability then of abundant surpluses of dried skim milk, had proven their value in rescuing children from the dangers of malnutrition. The next logical development was to encourage the European countries to develop and sustain the production of dried milk products for children's consumption.

UNICEF's success in promoting milk conservation policies in Europe by 1960 had provided over 150 milk processing plants to European diaries and it was then tempted to consider promoting similar developments in the third-world countries. UNICEF was aware of the difficulties; many tropical countries had their own native breeds of cattle, but these were limited in numbers and mainly used as draught animals and produced little milk. Dairying, a sophisticated industry, required a high degree of scientific knowledge and practices; industrial, management and distribution experiences which were in short supply in these developing countries. However, UNICEF went ahead with attempts, first in Latin America and afterwards in Asia, and especially in heavily populated India. The UNICEF agreement with the countries involved in these schemes stipulated that part of the dairy plant's output be used for child-feeding to the value of one-and-a-half times UNICEF's contribution to the project concerned.

With these experiences behind it, UNICEF entered the field of assistance to milk conservation in Africa South of the Sahara. And although the indications at the time pointed to a good potential, the possibilities of development were sharply limited by lack of financing and trained personnel and by organizational and administrative difficulties. By the turn of the decade of the fifties, only four milk plants were assisted by UNICEF in Africa. The first of these was approved for Nigeria in 1954 and included the provision of a milk-drying plant in Vom (Plateau State) in the northern cattle-rich region of that country. This was to be an extension to an already existing plant owned jointly by the Government and by Cow and Gate Company. Fifty thousand dollars was allocated for that purpose. It was contemplated that high-quality skim milk, collected from the outlying stations during the "flush" season, would be dried and distributed free to some 10,000 infants and young children through clinics, hospitals and rural centres. The project became operational in late 1956.

Unlike the situation prevalent in other continents such as Asia and Latin America, Africa was considered a good potential for dairy development because of its low population density and the absence of severe pressure by man on the land. It was thought that Africa had land to spare for the cultivation of cattle feed. This thinking hinged on the hope for improved agricultural methods and animal husbandry practices and on improvements in organization, administration and training. As later developments were to prove, these early hopes were not soon to materialize. The complexities of agricultural and industrial development presented many obstacles.

One typical problem was the irregularity of milk supply from cows. As in the Nigerian case described above, cattle were herded over long distances following seasonal pasture which resulted in low milk collections. Similar situations prevailed in the high plateau countries of Ethiopia and Kenya. There were also problems with the free distribution of the milk to children, since this depended on the ups and downs of governments' funding ability, with the result that few of the poorer children benefitted from these enterprises.

But these early experiences of UNICEF's support to milk conservation efforts were not wasted as a nucleus of trained manpower was developed that was later on to result in further development of this agro-industry, for the benefit of the national economies in general, and the well-being of children in particular. Kenya is an example of such success, as will be described later.

:Protein from peanuts

One of the attractions of milk as an important food for children was that it supplied essential protein needed for their growth and well being. But with the difficulties encountered in supplying milk and distributing it on a wide enough scale, the question was being pondered as to what other alternatives could fill the supposed "protein gap". There were a number of known vegetable sources of protein, among them pulses such as beans and peas. And although cereal and legume proteins were still regarded as poor sources of protein compared to those from animal products, experiment had shown that a careful combination of some pulses could make up for their individual deficiencies. In an Asian country the production of a powdered soya milk product had met with a measure of success; and in Central America a product based on cornmeal, ground sorghum, cottonseed flour and other ingredients made its appearance as a seemingly viable commercial venture and was highly regarded.

Early interest was expressed in Africa in the development of protein-rich foods based mainly on groundnut (peanut) flour. UNICEF cooperated with FAO in developing these products and in testing their suitability as children's foods. One of these trials was in Northern Nigeria, begun in 1963, for the production of a protein rich food named Arlac. The groundnut flour component was made in a government-owned mill in Zaria. The provincial government provided funds for the free distribution of Arlac through institutions and health units, as did UNICEF which allocated $70,000 over a period of time for the same purpose. However, the discovery a toxic substance found in mould of groundnuts known as aflatoxin delayed the project for a while. It was eventually produced, and plans were made to market the product in the form of 7-ounce packets. UNICEF supported a sales campaign by means of a $4,000 grant. Although some sales were made in one area, the retail trade never really got off the ground. One of the main reasons was that the company marketing the product lacked the incentive, since Arlac was made available to the government at cost price. It was also stated at the time that the promotional campaign was badly managed.[11/]

Another trial with groundnuts, supported by UNICEF, was in Senegal where the first tests showed the presence of groundnut aflatoxin. But while further work resulted in harvesting methods in a condition that prevented mould from developing (resulting in a product free of this hazard), it had in the end the same fate as Arlac, and for similar reasons.

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The discovery of "community"

UNICEF's awareness and concern with the community as an important element in conditioning the welfare of the child was evident from the earliest programming efforts. But the deliberate use of the concept to enhance the

wellbeing of children was a gradual development, aided to a large extent by UNICEF's growing relations and co-operation with the United Nations Bureau of Social Affairs. Two of the concerns of the Bureau, namely, social welfare services and community development, became focal points for cooperation with developing countries, and the Bureau thus became a partner to the governments and UNICEF, and became a technical adviser to some of the UNICEF-supported projects that resulted from this three-way cooperation.

Social welfare services were seen as a basic core of activities including assistance to families in solving their economic and social problems; improving the status of women and youth; strengthening family relationships by promoting child welfare and facilitating adjustment to rapid social change; and helping individuals and groups in need of special care (e.g., handicapped persons, orphaned children, delinquent youth). Social surveys and social work research were seen as tools to guide the course of these activities.[12/] Community development, on the other hand, was growing as a concept and a movement, the objective of which was to encourage communities to organize themselves with a view to analyzing their own needs and seeking solutions to their basic life problems, relying on mutual assistance and cooperation from local and national government bodies.

:Women's clubs/mothercraft/homecraft

One of the early fruits of UNICEF's utilisation of these concepts in Africa was the expanded support to programmes of women's education. Generally, they took the form of women's clubs, an indigenous development organized by "natural" leaders who were given some elementary training. These clubs promoted various educative, commercial and cultural activities such as improved nutrition, personal hygiene, better housing, child care, poultry raising and improved water supply. At the beginning, these activities did little more than satisfy the women's desire to learn home-making skills, but gradually they led to self-help schemes, in which they pooled their efforts with the men in building community centres, nursery schools, and protected springs and other water supplies.

Kenya was the first country in Africa to benefit from UNICEF cooperation in this field and, as reported in 1956, where the women's clubs were seen as a vehicle to improve child rearing, pre-natal and post-natal care, child feeding, hygiene, first aid, cooking, the making of clothes and family gardens.

In the Francophone countries of West and Central Africa, the promotion of these community-based self-help efforts was known as animation rurale and were characterized by a larger element of promotion by provincial and district government officials. They resulted in the development of small projects in rural areas including construction of rural access roads, small markets, "crèches" and kindergartens, some women's income-generating activities, and construction of health posts, and huts for "matrones".

In successive Board sessions beginning in 1959, positive comments were made about women's clubs as having become rallying points in promoting educational, communal and cultural activities and services. These clubs and other community development structures such as animation rurale became prevalent throughout Africa. Growing interest in women's education was also manifest in northern Nigeria, Ghana and in some of the republics of the French community.

This "movement", though promising, was not without its weaknesses and problems. Many of the efforts undertaken by community groups could not be sustained over long periods of time. Poverty and the poor material and technological resources at the command of the people concerned were a contributing factor. Additionally, the support provided by governmental bodies, such as departments of community development and the technical ministries, proved often to be weak or inadequate.

Community development activities, however, received consistent support from UNICEF during this period and into the sixties, while technical advice and training activities continued to be provided by the UN Bureau of Social Affairs. Concern with community participation in efforts and programmes to uplift their own conditions characterized UNICEF's approach from this period of history onwards. But the focus of attention was on the role of women. It was already evident to governments and to those who had contact with the African continent that although poverty, disease and ignorance affected whole communities, women shouldered the heaviest burdens imposed by these negative forces while at the same time contributing in a large measure to family and community life. Much of the family food production was done by women and they were often obliged to work on cash crops; so were the household chores of fetching water and firewood, grinding grain and root plants to prepare meals and the caring for infants and children.

Hence, these newer forms of organization known as the women's clubs and mothers' clubs were welcomed by governments and external aid agencies, including UNICEF, for the potential they provided to impart badly needed knowledge and skills to the women. The growing number of "mothercraft/homecraft" projects from the mid-fifties on offered women a means of education, the knowledge they hungered for on food and nutrition, child care and general health, and helped to impart skills in cookery, sewing and making of garments, as well as improved production of traditional handcrafts for income generation.

The specific programmes varied greatly from country to country, and even from community to community within a country. Much depended on the interest expressed by the women themselves, the governments' objectives, the locally available raw materials and foods, and the level of leadership. Some criticism was leveled at these programmes very early on. The most common was that the activities carried out by the women often reflected aspirations of urban middle class women and were therefore not relevant to the needs of the poor rural women. Another critique was that some of the products produced were not easily marketable. But in spite of these criticisms, it appears that these activities had served an important purpose. Literacy efforts for women have their origin in these early women's clubs and homecraft/mothercraft

projects, leadership resources among women were multiplied, and were later to contribute to the enhancement of the status of women and to the transformation of the very activities themselves. In this evolution, UNICEF's support in the form of equipment, supply of materials and training undoubtedly made an important contribution to this larger goal.

:Multi-purpose workers/agents polyvalents

The activities concerned with animation rurale and community development were often based on pre-existing indigenous organizations. They were aided and abetted on the government side by the growing number of Departments of Community Development or of Social Services through which a semi-professional cadre of community development workers was developed and grew in numbers. The CD worker's role was frequently described as that of a "catalytic agent", helping to organize, stimulate and aid community groups in identifying their own problems and in seeking solutions to them. But the problems, though interrelated, varied in substance, ranging from hygiene to maternal and child welfare, to food and nutrition and water supply. Hence these workers had to deal with a variety of disciplines while functioning as generalists. One difficulty they frequently encountered was that they were unable to bring the available technical services of the government in a meaningful and timely fashion to provide the support needed by the community, be it in relation to agriculture, water supply or public works.

UNICEF's major contribution to community development was, in fact, in the area of staff training, where it influenced its content in the direction described as "multi-purpose workers", or as they were called in the French-speaking countries, agents polyvalents.

The group to benefit the most from this movement were women. Credit must be given to the pioneering role of some women leaders in such countries as Uganda, Kenya, Senegal and others who saw in community development a means to meet some of the basic needs of rural women, emphasizing their active participation in discussions and decision-making. In the beginning the resulting programmes concentrated on the traditional areas of home-making, but gradually dealt with broader issues such as local community needs (e.g., water and sanitation), education and literacy, and the gaining of skills for more productive activities. In close collaboration with governments and voluntary women's organization UNICEF was eager to provide support to these types of community development activities.

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II. A MOMENTOUS DECADE: THE SIXTIES

Independence and transition

1960 was indeed a "momentous year" for Africa, as it was described in a Board document, for in that year 18 countries attained independence. There was nothing abrupt in this political development for, in fact, it was preceded, since the end of World War II and particulary in the fifties, by national struggles and efforts to achieve various forms of autonomy. In West Africa in the countries under French jurisdiction, new institutions were created and a community of French-speaking nations was proposed in the event the nations concerned opted for full autonomy. In southern Africa, the Rhodesian Federation (consisting then of Northern Rhodesia, Southern Rhodesia and Nyasaland) was to break up and result in the creation of Malawi and Zambia as independent nations, leaving southern Rhodesia as a political issue that was not to be finally resolved until much later. Ghana had already introduced its Second Five-Year Development Plan (1959-1963). In 1959, UNICEF approved its first allocation to the Malagasy Republic, and contacts were established with Belgium to provide aid separately to the three territories it administered: Rwanda, Burundi and Congo. The latter gained its independence in 1960 and was later renamed Zaire, soon to be followed by Rwanda and Burundi.

Indicative of the change in the political environment was a reflection in 1960 by the UNICEF Deputy Executive Director in charge of programmes, Mrs. Adelaide Sinclair, who went to Ghana, Nigeria, Cameroon, Congo, Zaire and Senegal, then in federation with Mali. In a statement she addressed to the Executive Board session that year she observed that, "Politics occupy the centre of the stage in the newly independent countries. This is an exciting period for them and until certain political matters are settled other things must wait." Her visit to Dakar coincided with Independence Day in Senegal and she shared in the "gay, colourful and happy celebrations". She quoted many government officials whom she met who said, "The celebrations are over; now we must get down to work."[13/]

Independence also brought with it the first financial contributions to UNICEF from African governments. In 1960, the republics of Dahomey, Niger and Upper Volta made contributions. Before long, every independent African country benefiting from UNICEF assistance was making an annual contribution to UNICEF's general resources, modest as some of these were.

Major adjustments had to be made by UNICEF in response to the radically new situation brought about by independence. Not only was there a necessity to establish relations with many new political entities but, more importantly, to attempt to respond to their new aspirations and ambitions, dormant during the periods of political struggle leading to independence.

In reality there was a period of transition. The shift by UNICEF from cooperation in a colonial pattern of assistance to one reflecting a more genuine African pattern was to take some time. An important element in the continuation of UNICEF-aided projects in the new nations has been the readiness of the ex-metropolitan powers to continue their assistance through grants and loans, not only during the period of dependency but also thereafter. The acceleration of the pace of political and economic

development affected the rate of progress of the ongoing projects: there were major changeovers of staff, departures of many expatriate technical personnel, and time was required to work out new procedures. There was uncertainty about the availability of funds from governments as well as from metropolitan, regional and international sources. An example illustrating these problems relates to disease control activities in French West and Equatorial Africa, which were previously managed as an integrated territorial effort but now had to be broken into separate country programmes.

Countries who were previously members of the "French Community" were to benefit from a French bilateral aid programme, the "Fonds d'Assistance et de Cooperation avec les Pays d'Outre Mer" (FAC) which, in 1960, operated at a level of about $300 million, an aid programme which continues to this day. For those countries previously administered by the United Kingdom, grants were made under a "Colonial Development and Welfare Fund."

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Growth in international aid: Africa opens to the world

The coming of independence brought with it major growth in development of the African nations' relations with the non-colonial countries and with international organisations. One form welcomed by the new nations was bilateral aid, newly provided by the United States of America, the Federal Republic of Germany, USSR, Yugoslavia and others, and also from such regional groupings such as the Common Market Countries and Overseas European Development Fund (OEDF, now FED).

There was growth in the role of the United Nations and the specialized agencies. The establishment in many African countries of the Office of the Resident Representative of the United Nations Technical Assistance Board, later to become the United Nations Development Programme (UNDP), marked the widening scale of cooperation with the United Nations and its Specialized Agencies.

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Pioneering role of UNICEF

Africa was opening to the world. There was an influx of a large number of new and often competing agencies, including those of the United Nations. But the fact remains that up to that time, UNICEF, WHO and FAO had enjoyed a position which clearly distinguished them and made it possible for their pioneering efforts to make useful contributions to development, each in their specific fields of competence. This was the time of the United Nations intervention in the Congo in response to cataclysmic events in that newly independent country, when doubts were raised about the UN's effectiveness, and complaints were voiced about the slowness with which aid arrived. Naturally, UNICEF, as part of the United Nations, was not immune to these reactions. However, UNICEF's capacity for rapid response made it a more dependable instrument in assisting governments in emergencies as well as in the longer-term field of social development. UNICEF's Executive Director, the late Maurice Pate, went personally to Congo to provide UNICEF's assistance in cooperation with UN efforts at the time.

UNICEF was bound to consult and seek technical support from the specialized agencies and the UN Bureau of Social Affairs. Over the years as the practice developed it involved processes that frequently required much time when applied to individual projects. UNICEF's increasing experience and the considerable devolution of responsibilities to its field staff gave UNICEF flexibility in providing aid without undue delay and, as UNICEF saw it at that time, the practices of cooperation with the agencies required overhaul and streamlining. At this historic juncture in African history, when governments felt that everything needed to be done and carried out with dispatch, the UNICEF emphasis was to go ahead with a programme directing all efforts towards expediting implementation. Rather than holding up individual projects in order to ensure that every desirable element was in place, cooperation with technical agencies in the UN system relied more on the coordination of overall policies. Corrections and improvements could be made in the light of experiences being gained in the course of carrying out the activities. This pragmatic approach was to characterize UNICEF's actions from that time onward in Africa and elsewhere.

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New orientations

:Public health and changing priorities

The new orientation for UNICEF aid to the developing nations of Africa in the late 1950's and early 1960's resulted from a combination of its own experience at that time and from the expressed needs of the new governments. While the change in orientation, policies and approaches was not abrupt or sudden, it reflected, nonetheless, important departures. Aid to mass campaigns against endemic diseases was to be considerably reduced, and more attention was to be given to the extension of polyvalent health services in rural areas and to preventive aspects of public health. The meager resources at the disposal of the young countries, in the face of high expectations of the populations, especially for direct services, contributed to this shift in policies and practices.

The yaws programme was expected to come to an end in two or three years; leprosy control still had some time to go, but the peak number of people to be treated had been reached, and aid in this field was expected to be phased out in three to five years. More of the governments' and UNICEF's resources had to be directed towards the implementation of newly emerging health services policies. As far as UNICEF was concerned, malaria work in Africa had come to the crossroads. The pattern of traditional pilot projects and limited mass campaigns was to come to an end in 1961. The question was raised, in principle, as to whether UNICEF should continue to spend funds for the combating of a disease for which technically satisfactory eradication methods had not yet been worked out, and where the level of health services was not yet sufficient to maintain an efficient control structure.

The new programmes to be stressed were:

a) Mothercraft/homecraft, the object of which was to expand adult education opportunities for women. Many successful projects in several countries of East Africa and in Ghana were already in operation;

b) Community development and animation rurale, in support of governments' efforts to mobilize the local populations to carry out infrastructural work on a self-help basis. This was at a time when government resources were extremely limited. While questions were raised as to how long this interest, based on volunteer work, could be sustained, the CD worker became increasingly professionalised, and training of community development workers and the animateurs was strongly supported;

c) Rural education: Much interest was shown in relation to the formal education of rural children as a means of encouraging them to remain in the rural areas. The first project in support of rural science teaching was approved at that time (1962) for Upper Volta;

d) Nutrition and food production received much more attention. The emphasis was to be placed on nutrition education in the schools, on domestic science teaching, and on women's education combined with improved food production at the village level.

:Changing strategies

Support to these new types of activity necessitated new methods of work and changing strategies. They implied a greater complexity and would require the intervention of various ministries, but it was considered wise to pursue one objective at a time, to work with the one ministry that was ready to move and to bring in other bodies later on. The time for coordinated approaches had not yet come.

Many of these new policies were implemented, but not without difficulties. The shift in UNICEF's financial allocations away from, for instance, disease control, was dramatic. Of allocations to Africa in 1955, 77 per cent were earmarked for disease control; by the following year this percentage fell to 51.7 per cent, and in 1960 it dropped to 25 per cent. Integration in the health services between curative and preventive services, a move considered vital if basic health services were to expand, proved difficult, especially in Francophone West Africa. The newly independent governments of that region inherited two different cadres of health workers. On the one hand, the Assistance Médicale Africaine (AMA) for curative services, and on the other hand, the Service Générale d'Hygiène Mobile et Prophylaxis, an élite corps essentially concerned with eradication of communicable diseases.

In eastern and southern Africa, the governments were, with much UNICEF support, more readily able to move towards an expanded system of health centre operation. The move in these regions was facilitated by a growing trend towards the stabilization of the rural populations. The pattern of constantly shifting rural populations, pursuing "slash and burn" cultivation practices was countered by some of the new governments (e.g., Tanzania) by a "villagization" policy that provided incentives for the peasants to stay in fixed locations with the advantage of facilitating the provision of such services as water supply, schools and health units.

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National planning and country programming

With their national destinies in their hands, following the coming of independence to a large number of African countries, their interest in the more deliberate planning of their national development grew substantially. Emphasis was placed strongly on economic development and on education. The majority of the new national plans envisaged limited expansion in social services. The period of the early sixties was marked by wide-ranging debates on the subject of appropriate strategies for national development. One prevailing view favoured an emphasis on economic development, the rationale being that economic resources would have to be multiplied in the first instance before major expenditure on social development could be afforded. In this view, social expenditures were seen as forms of consumption. Opposing views were expressed as well, contending that social development outlays were essentially an investment in the development of human resources, without which it would be inconceivable to achieve any lasting development.

The significance of this debate for UNICEF and for all those concerned with the welfare of children was obvious, for it is in this category of national planning that determinations relevant to the welfare of children would be made. It is not, therefore, surprising that UNICEF at that time advocated a more comprehensive approach to the problems of children in the phase of active planning in which many governments had been engaged. Results from this advocacy, however, were gradual in coming. Throughout the sixties, several sectoral projects per country were still being presented as such to the Executive Board for approval, but the concept of "country programming", by which consideration was given to the support of an integrated package of activities per country, was on its way. The "package" was ideally to take account of priorities arrived at between government ministries and UNICEF.

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Years of consolidation: growing UNICEF involvement

The "momentous" events of 1960 were followed by the years of "consolidation", roughly through to 1965. The Organization of African Unity (OAU) was established, and within it specialized commissions on education, health, nutrition and sanitation, etc., started to function and deal with certain problems in the framework of African unity. These were of great relevance and interest to UNICEF. Ministerial meetings and meetings at more technical levels multiplied.

There was a growth in UNICEF's commitment to Africa in allocations, in the growing variety of projects, and in the presence of field staff. UNICEF continued to enjoy "an unrivalled reputation throughout Africa", according to the Executive Director's progress report in 1965. Allocations to African programmes in June 1963 amounted to $3.8 million and grew by June 1964 to $5.9 million. More significantly, in this latter year, 24 per cent of the allocation was in support of education, a relatively new field for UNICEF cooperation, reflecting the higher priority placed by the African governments on extending basic education. At the same time, 41 per cent was earmarked for health services in contrast to only 5.5 per cent for disease control. Nutrition was also being upgraded in priority, as indicated by the 21.6 per cent devoted to it from that years's allocation. In support of these activities, the number of field offices and staff showed a parallel growth, as will be discussed in the following pages.

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How are we doing? Assessing UNICEF's work

In 1961 and 1962, the UNICEF Executive Board emphasized the need for continuous assessment. By the mid-sixties, "assessment" had been included in all new plans of operation for UNICEF-assisted projects, even though, as reported to the Board in 1965, government ministries themselves were not ready to carry out evaluation activities. Global assessments in such fields as basic health programmes, control of communicable diseases and milk conservation had already been produced and submitted by governments and international experts. Emphasis in these reports was placed on a critical assessment of developing children's services. These included:

- Leprosy control: A team of WHO experts prepared an assessment based on field investigations in CAR, Chad, Congo (Brazzaville), Gabon and Senegal;

- Applied nutrition: Carried out by FAO experts jointly with WHO in 1964 as a result of visits to Central African countries;

- Social welfare: Experts from the UN Economic Commission for Africa (ECA) carried out visits to schools of social work in various countries to evaluate the standards of training for social development workers.[14/]

Recommendations which accompanied these assessments were then considered by the Secretariat and the Board, resulting often in modifications in strategy, programme content and funding.

The UNICEF field staff were also becoming concerned with the need for evaluation. A regional meeting of UNICEF staff in Dakar in 1964 carried out a "practical assessment" of UNICEF-assisted projects and drew general conclusions. They expressed the view that success of the programmes depended on the use of simple and concrete methods for the solution of problems, on good co-ordination with other sources of internal and external aid, on the expansion in training of personnel and on the active participation of the communities.15/

This latter point was to be a recurring theme in the years to follow. In relation to applied nutrition, for instance, it was reported that active participation of the community proved to be "the main core" of the project. Basutoland (now Lesotho), for instance, was a case in point. In that country, poultry raising and vegetable production, assisted by UNICEF, was successful because it aroused the interest of farmers. Part of the food produced was for child feeding in the schools. Training of farmers in those activities had large and enthusiastic participation.16/

Training was a key activity in the field of nutrition as well. Under UNICEF-supported Regional Nutrition Training programme, eleven seminars were held in Africa, and 14 textbooks on food and nutrition were edited and printed. For the French-speaking countries, a nutrition course was organized with the collaboration of the Paris University in late 1964, in which nine countries participated. For the English-speaking countries, similar UNICEF-supported courses in a cooperative programme between the Universities of London and Ibadan were attended by 27 students in the following year.

Success in aid to milk conservation was particularly highlighted for the projects in Kenya where, within the Rural Milk Centres programmes, 68 centres were handling 40,000 litres of milk daily. Part of this milk was turned over by the rural cooperatives to health and welfare centres and to schools for free distribution to children. This was done in return for the equipment provided by UNICEF to the dairy operators. This industry continues to this day, and free milk distribution to school children is still a main feature of governmental support to child nutrition.

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The great goal: education for all

It was after some hesitation that UNICEF entered the field of aid to education. A report presented by the Executive Director to the March 1959 session of the Executive Board, prepared in consultation with UNESCO, recommended that aid be extended to primary education on request of governments and be utilized mainly for the training of teachers, and a limited amount of funds was requested. The Board limited its approval to teacher-training in the fields of health and nutrition.[17/] In 1960-1961 the door was opened by the Board's discussion in general to cooperate in education with governments whose high priority was basic education. The actions, however, were modest. From this modest beginning, UNICEF's concern with aid to education was to grow during the decade of the sixties and beyond, to encompass pre-service and in-service training of teachers, training of home economics instructors, aid to teacher-training institutions, to certain aspects of agricultural education, production of educational materials, including textbooks, vocational and pre-vocational training (in cooperation with both UNESCO and ILO), curriculum development and educational planning. That Africa South of the Sahara was in the greatest need for these forms of aid is indicated by the fact that primary school enrollment in 1960 did not exceed 34 per cent of the primary age group, a figure that disguises great variations, with rates as low as 10 per cent for some countries. And of those children enrolled, only about one-third were girls.[18/]

At the meeting of the Organisation of African Unity (OAU) in Addis Ababa in 1961, an "Outline of a Plan for African Educational Development" was approved which aimed "to achieve the democratization and renovation of education in order to enable all African children and adults of both sexes to exercise fully their right to education, a prerequisite for the fulfillment of individual potential for the progress of society."[19/]

In March 1964, the African Ministers of Education, meeting in Abidjan, declared that education was the right of every African child and urged that top priority be given to the extension of basic education throughout the continent.

The road to fulfilling these noble goals proved to be far from smooth and was obstructed by many obstacles and pitfalls. Nearly two decades later a study by UNESCO revealed net primary school enrollment rates ranging between 21 per cent and 86 per cent.[20/] Similarly disapppointing results were reported on adult literacy.

In the post-independence era, of the issues raised repeatedly, one had to do with the adaptability of the prevailing forms of education to the needs of African children and to the requirements of national development. The roots of the problems go back to colonial times. For example, in the French colonial territories of West, Central and East Africa, two systems of education co-existed, one for the native population (autochone), largely rural, and one for the French citizens, which included some natives of the countries concerned.

In both cases "manual work" of an agricultural nature was included as an additional, after regular classroom, work. The language of instruction was French. (An interesting contrast to this was the Congo under Belgian rule, where three native languages were used, depending on the region.)[21]

During the period before full independence, a French Union was proposed for the Francophone countries and an evolution in education took place. A uniform system of education was introduced, including secondary schools, the main objective being to facilitate the "integration" of the African nations with the "mother" country, France. The curricula were an exact replica of those in France. When full independence was opted for instead of the "union", the newly independent countries attempted to break away from their colonial past and the prevailing forms of education became a target for change and "reform".[22]

The reality at the time was that for most African children, primary education was the only formal education they would receive with curricula and teaching methods which were largely academic. Therefore, one aspect of the reforms proposed was the introduction of a pre-vocational orientation in the primary school curricula. Some West African countries such as Niger, Mali, and Upper Volta promoted the concept of the "ruralization" of education. The rationale behind this was that if rural children were taught knowledge and skills relevant to the needs of their rural milieu they would be more likely to stay in their home areas and contribute to their development. Heavy migrations from rural to urban areas, however, persisted in the post-independence period, and were induced by a variety of complex factors.

Additionally, the "ruralization" movement was strongly objected to by UNESCO and by some nationals on the ground that it negated the more widely acknowledged principle of the "democratization" of education, because it created two systems, one for rural and one for urban children, with the implication of providing unequal opportunities to children of the same country.

Other problems faced education. One was the question of what happened to children after completion of primary education. A senior staff member of UNICEF in a later period quoted President Nyerere of Tanzania as saying that he was proud that 98 per cent of his country's children were enrolled in primary schools but that he did not know the percentage of children who had already forgotten how to read and write because of the lack of reading materials in their homes and communities.[23]

UNICEF's involvement in school education in the earlier period was limited to encouraging the introduction of health and nutrition education in the curricula. With the new impetus given by the concept that education is a vital factor in national development, UNICEF's support to the broader aspects of education grew dramatically. By 1965, 13 countries received assistance for education programmes, notwithstanding the difficulties inherent in any new programme. One of these was a relatively large project in Northern Nigeria involving curriculum development and teacher-training in conjunction with the creation of new states. Education absorbed a high percentage of the national budget of most African countries, ranging from 3.5 to over 10 per cent. This ratio was to increase dramatically in more recent years reaching 20 to 25 per cent of national budgets. Capital expenditures for construction of schools, teacher-training colleges, and textbook production required enormous outlays.

Bilateral aid and loans from the World Bank and other institutions covered some of these needs but still left tremendous financial burdens on the national governments. And the growing enrollment of children in schools necessitated a parallel growth in operational costs.

UNICEF support was provided to various aspects of education: to teacher-training, curriculum development, textbook production and such specialized aspects as science teaching (especially to rural children), and continuing support to health and nutrition education. UNICEF's growing involvement with education ushered with it a greater collaboration with UNESCO, which provided advice and participation in project development and implementation.

By 1965, UNICEF was assisting 19 countries in Africa in their education programmes. For example, in Ethiopia that year, with support from UNICEF, some 900 teachers graduated and an equal number of underqualified teachers benefitted from summer refresher courses. In Madagascar, 680 rural teachers were trained, and a seminar was held for senior and supervisory personnel numbering 900 from government, mission and private schools. Training activities on that scale were taking place all over the continent, since the shortage of teaching personnel was considered to be the main obstacle to expanding educational opportunities for children.

UNICEF assistance to these government efforts included tuition fees for instructors, daily subsistence for the teacher-trainees and for textbook writers and the supply of relevant literature and audio-visual equipment. Technical assistance to such projects was provided by UNESCO in conjunction with UNICEF support. Throughout Africa, by the end of 1970, UNICEF has assisted some 10,000 schools and educational institutions and provided stipends for the training of 59,000 teachers.

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The needs of children: a widened UNICEF outlook

The same year, 1960, which ushered Africa into the new era of independence, also marked new and important directions in UNICEF policies and practices. In the previous year the General Assembly had overwhelmingly approved the Declaration of the Rights of the Child, which provided moral support to a concept gaining in acceptance and strength on the important place of children in society, on the necessity of meeting their total needs whether they be physical, psychological or intellectual, and on their rights to protection by the society.

Within UNICEF the notion of meeting the needs of the "whole child" was gaining momentum. In fact, UNICEF aid to formal education, by now growing as a normal part of the aid "package", was one of the fruits of changes in programme policies and procedural practices. This acceptance did not come about easily, for in the late fifties it was hotly contested in UNICEF Board Sessions and within the Secretariat.

Surveys of the basic needs of children in many countries around the world were initiated beginning in 1961. The Secretariat report resulting from this effort was endorsed by the Executive Board and represented a turning point in UNICEF's outlook on the scope of UNICEF cooperation with countries in behalf of their children. The needs of children in a given country were to be considered on the basis of comprehensive surveys and a "hierarchy" of these needs were to be established by government ministries and UNICEF typically on the basis of age groups, from before birth to age one, the 1 - 5 age group, and the next period roughly coinciding with the primary school age, and aid to education could be included.[24/]

Following this, UNICEF began advocating planning for the needs of children as an integral part of the process of national development planning, with UNICEF assistance to a given country to be integrated, to the extent possible, into these national plans taking into account the countries' own priorities.

A high point in these developments was the roundtable conference sponsored by UNICEF at the Rockefeller Foundation Centre in Bellagio, Italy, in April, 1964. Among the participants in this conference, entitled "Planning for Children and Youth in National Development", were a number of leading development planners and economists, senior government ministers from developing countries, experts from both Eastern and Western developed countries and representatives from the UN and the Specialized Agencies. The meeting was chaired by Professor V.K.R.V. Rao of the Indian Planning Commission[25/].

On the UNICEF side, it was attended by the Executive Director, Maurice Pate, by his three Deputy Executive Directors, E.J.R. Heyward, George Sicault, and Edward Iwaskiewiez who was an economist and had been a member of the Polish Planning Commission, joining UNICEF two years earlier to promote its efforts in planning. The high-level representation on all sides indicated the seriousness with which UNICEF attempted to establish its role as an agency concerned with the issues of national development and not solely with the humanitarian aspects regarding the place of children in their nations. This landmark meeting and the series of meetings that followed on a regional basis helped establish UNICEF's credentials as a full-fledged member of the growing group of international agencies concerned with development.

:A look at the needs of the African child

The planning era in UNICEF was well on its way when the Executive Board held its meeting in Addis Ababa, Ethiopia in 1966, a session considered a landmark in UNICEF's cooperation with the African countries. By then UNICEF was cooperating with 41 nations in the continent (out of 120 world wide). The Fund's total income in that year was $35.2 million, and it had set the "ambitious" goal of $50 million for the end of the decade.

The session was preceeded by a "special meeting" on the Needs of African Children. Participants from twenty-two African countries included officials from ministries of development and finance as well as the functional ministries dealing with health, education, and social welfare. Also present were experts from the UN Economic Commision for Africa (ECA), the Organization of African Unity (OAU), and from the African Institute for Economic Development and Planning, as well as representatives from the UN Specialized Agencies.

In preparation for the Special Meeting, the Governments of Dahomey, Ethiopia, Gabon, Madagascar, Sierra Leone, Uganda, and Upper Volta submitted studies on the situation of their children and youth and on their experiences in dealing with their problems in their development plans. Prior to the Board session, some Board delegates travelled to the Ivory Coast, Kenya, Nigeria, and Tanzania at the invitation of those countries' governments and saw, first-hand, programmes designed to meet the needs of children and to observe the role of UNICEF and other agencies in support of these activities.[26/]

The country studies submitted and the debates which took place revealed that most African children and youths lived in families that were on subsistence level or below. Of about 300 million persons in Africa[27/] over 40 per cent were under fifteen years of age (compared with 25 per cent in the industrialized countries). The availability of doctors ranged between 1 per 20,000 to one per 100,000 persons and infant mortality ranged from 60 to as high as 400 per 1000 live births in some areas. And although educational facilities had been widely expanded in the last decade, it was estimated that 18 million of Africa's 32 million children of primary school-age were still not enrolled in schools; and only 7 per cent of children of secondary school-age were in school.

The meeting emphasized that programmes for children and youth in Africa should form an integral part of economic and social development strategies, should be viewed as determinants of developments and not merely as automatic benefits of economic growth. Therefore, programmes for the young should be geared to development needs, a view that reflects their importance as future human resources[28/].

A working group analyzing the situation of children outlined the necessity of identifying priority needs: from the pre-natal period to the first year, the vital priority was health protection and social welfare. In the next age-group (1-5 years), malnutrition was the major problem for the young children, and hence they saw the necessity of efforts to increase the production and consumption of protein-rich foods. For the school-age group (6-14), preparation for working life and intellectual development were the evident priority.[29/] This delineation of a "hierarchy" of needs was a theme that was to be alluded to repeatedly in future meetings and documents.

As a first step in planning, to meet these complex and overlapping needs, the meeting stressed the necessity in each country of undertaking periodic and systematic assessments of the problems affecting its children and youth. It was considered that the best means to accomplish this was the establishment of inter-ministerial committees at high level of government. Such coordinating mechanisms would have responsibility for carrying out assessments of children's problems, assigning priorities, recommending resource allocations, reviewing programmes, and generally ensuring that children's problems were given sufficient recognition in the development plans.

An interesting note was the attention the meeting drew to the role that "economic instruments", and not merely social interventions, could play in enhancing the situation of children. They pointed out that the general poverty of families and communities constituted a principal reason for the unsatisfactory conditions of children, and that if consumption levels could be

raised, this could help bring about significant improvements in the living conditions of children. Such economic policy measures would include fiscal policy, price policies and other incentives to stimulate the production and consumption of commodities essential for the child's development.

Of interest also was the discussion on the subject of family planning, perhaps for the first time in the context of UNICEF's cooperation in Africa. The meeting in Addis Ababa also brought to light the important role being played by the UN Economic Commission for Africa (ECA) in assisting the newly independent countries in the economic and social field. In fact, much of the information presented to the Executive Board session in Addis Ababa about the situation of African children was gathered and analysed by the staff of ECA, particularly by its Social Development Division. Close cooperation marked the relations between ECA and UNICEF with fruitful results, especially in the fields of community development, social services and women's programmes.

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National planning for children: is it feasible?

Almost without exception, African countries in this period had established long or medium-term national development plans. Most comprised general perspectives but without detailed investment plans; others attempted to be more specific, and based their future investment plans on a careful analysis of the economic and social resources and needs of the country and their projections into future years. But a common pattern in all cases was that financing of the plans was largely dependent on external resources. The emphasis was clearly on economic and infrastructure development.

UNICEF played a key role in calling the attention of governments to the importance of ensuring that adequate consideration in the national plans be given to the needs of children and youth as a major factor in the development of human resources. UNICEF was willing to assist governments that wished to heed this advice. First steps were taken to integrate UNICEF's assistance into the countries' own national development plans. The very fact of the establishment in most countries of an organ responsible for national planning facilitated rational approach for the planning of further UNICEF cooperation. In most instances, these machineries were also entrusted with the co-ordination of all external assistance, and hence UNICEF aid was channelled through them and became a part of the relevant plans.

To facilitate these processes, UNICEF established an Interregional Planning and Project Preparation Fund (IPPF) which, under regional ceilings, could be allotted at the discretion of the Regional Directors. It was used in the development of future projects, for preparatory studies and research carried out jointly by governments and UNICEF, for training activities of government and UNICEF staffs in social planning, for seminars and workshops and for evaluative studies. It particularly allowed for programme preparation to proceed without waiting for the next session of the Board. The records show that, in 1963, an expenditure of $18,764 was authorized for this purpose, and in 1964 another commitment of $30,000 was approved. Seemingly modest, these outlays made it possible to begin new activities in closer collaboration with the substantive and planning bodies concerned.

As the value of this device for improving the quality of programme development and project preparation, and enhancing the capacity for maintaining and evaluating UNICEF supported activities became clear, the IPPF grew over the years in importance and in financial dimensions.

The latter part of the sixties was marked in Africa by an acceleration in the pace of economic development and growth. An average annual growth in GNP of 6 to 8 per cent was not uncommon for most countries. Road and railway construction, as well as the development of electric power, was expanding, and the volume of foreign trade was making impressive gains. On the social development side, educational and training facilities were multiplying. All of this occurred in spite of the many political upheavals that took place and its resulting influx of refugees in various parts of the continent.

The UNICEF field staff network grows

A parallel growth in support from bilateral and multilateral aid sources was taking place in UNICEF. Towards the end of the sixties UNICEF was assisting 38 countries throughout the continent. The new fields of cooperation in which UNICEF was now involved, and the changing methods of work with increased emphasis on planning, assessment, and evaluation required a stronger presence by UNICEF staff in the field. Constraints on the growth in the number of UNICEF staff remained, however, due to budgetary constraints.

In 1961 one Regional Director based in Paris supervised UNICEF's work in Europe and Africa (including North Africa). The field staff in Africa South of the Sahara then numbered 33, of whom 11 were internationally recruited professionals, and serving 28 countries. A few years later a separate Office of Regional Director for Africa was established in Lagos. By 1971, however, there were three regional offices. Besides Lagos, which doubled as the Regional Office for Ghana and Nigeria, a Regional Office for West and Central Africa was located in Abidjan, the Ivory Coast, and a Regional Office for East Africa in Kampala, Uganda. The staff by then numbered 137, of whom 35 were internationally recruited professionals and the balance were locally recruited staffs. UNICEF was then serving 38 sub-Saharan countries.

The Regional Offices in Kampala and Abidjan supervised Area Offices, the latter being responsible for UNICEF activities in a group of countries. Area offices were located in Addis Ababa, Kampala and Lusaka, each headed by a Representative. The number of countries overseen by an Area Office depended on population size and the volume of UNICEF commitments. The office in Addis Ababa covered Ethiopia and Somalia; that in Lusaka was responsible for cooperation with Botswana, Lesotho, Malawi, Swaziland, Tanzania and Zambia, and Kampala looked after the 11 remaining small population countries. In western Africa, Area Offices were based in Abidjan, Brazzaville, and Dakar.

Besides a Representative, an Area Office staff complement typically included a deputy, two or three programme officers, some assistant programme officers, a food conservation specialist, a supply officer, a transport officer, and supporting staff for administrative and financial functions.[30/]

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III. CONSOLIDATION AND EXTENSION: INTO THE SECOND DEVELOPMENT DECADE

For the United Nations, the seventies ushered in the United Nations Second Development Decade. For UNICEF in Africa it was a period of consolidation of the efforts of the sixties and extension into new expanded spheres of cooperation.

Increased resources: "noted" projects

By the turn of the decade, the tremendous needs of African children had become better known, thanks in part to an improvement in statistical information and to UNICEF's own first-hand experience gained in the field and through country studies. And, while a slight upswing in the economies of African nations was observed, UNICEF's own resources were also growing, even though slowly, and, in any case, not sufficiently to increase its allocations to Africa in proportion to the needs. The procedure known as "noting" had, by now, been established. Its essence was to prepare projects in critical areas of need over and above what UNICEF could provide for any given country from general resources. When projects were "noted", i.e., approved in principle by the Executive Board, donors were then solicited to contribute the required funds, as special-purpose contributions.

UNICEF cooperation in Africa was to benefit greatly from this new funding procedure. These additional resources contributed to expansion of programmes, particularly in relation to water supply, education, and health projects. These "notings" were put forward, typically, either as extensions of existing, regular programme commitments, or as entirely new aspects of country programmes.

The new innovation in project funding did not proceed without difficulties, both for the UNICEF staff and the government officials concerned. A "noted" project required the same careful planning as a regular project. Government officials had to provide much information and data and time for negotiations, but without the assurance that funds would be forthcoming. And there was concern that this procedure would create some distortion among the categories of projects to be assisted; some unease was expressed over donors possibly favoring some countries over others. In the long run, however, "notings" added significant resources towards meeting the outstanding needs of children and women in many countries, especially those with the lowest GNP levels and higher infantile mortality rates.

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Programme scope expands

Education was already an expanding field for UNICEF cooperation with the African Countries when the decade of the seventies began. This was to grow even further, but with a changing emphasis favoring new forms described as "non-formal education". In 1970, the first UNICEF assistance to family planning services was approved in Mauritius in cooperation with the government and United Nations Fund for Population Activity (UNFPA). Along with WHO, UNICEF viewed family planning as an integral part of maternal and child health services (MCH). The new decade also witnessed a dramatic expansion of support to rural water supply schemes and environmental sanitation projects. The approach described earlier as "country programming" was firmly established and brought with it increased emphasis on the integration of services bearing on the wellbeing of children and the concept of "basic services". New programme "tools" were coming into wider use, such as project support communication (PSC) and appropriate technology. Some elaboration on the new approaches, concepts and tools will be provided in the following pages.

The UNICEF "country approach" and "country programming" became moot in 1967; it became the accepted method of programming in Africa, as it was elsewhere. Programme proposals for a given country were presented to the Board for approval in an "integrated" manner and not as separate sectoral projects. Naturally this required a more intensive period of preparation and negotiations with the government ministries, often necessitating a lead time of between one to two years between conception and project approval.

Evaluation procedures, after some initial resistance, were well established. For example, in 1967 the community development programme in Tanzania, the post-primary education project in Rwanda and Burundi and the training of health workers in Ethiopia were all subjects of evaluations carried out jointly by UNICEF and the governments concerned. The results of these evaluations were not conclusive by any means. One of the main difficulties stemmed from the fact that the plans of operations of these projects were often not sufficiently specific as to targets to be achieved, or to detailed government inputs. Hence the evaluations were carried out essentially on the basis of the overall objectives of the given project, and the latter were frequently judged as having been over-optimistic. Evaluations, however, proved valuable from a pragmatic point of view. For example, in the case of the Tanzanian community development project cited above, the evaluation pointed to weaknesses in staff training and in the maintenance of transport and equipment, and underlined the fact that the financial capacity of the government to supply all the required inputs was overestimated. As a result, action was taken jointly to correct the weaknesses. In the future, plans of operation were to delineate more carefully the specific objectives to be pursued, their target dates, and to quantify targets as specifically as possible.

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Helping children on both sides: tragedy in Biafra[31/]

Political disturbances of great significance were occurring. By 1970 in Nigeria, the attempted secession of "Biafra" had collapsed. This event in Africa, as with like events in other regions, was to be a great strain on a key principle guiding UNICEF aid policies since its inception, namely the provision of assistance to children irrespective of the political situation under which they lived.

The eastern state of Nigeria, cession in "Biafra", was declared in May 1967, and the resulting civil war lasted for two-and-a-half years until January 1970. The largely Ibo population of this Eastern part of Nigeria, estimated at the time to be 12 million in number, led by Colonel Ojukwu, were in essence attempting to create an independent state of "Biafra". The federal government, led by General Gowon, responded to this threat by force when in July 1967 they attacked the secessionist forces. The Organisation of African Unity (OAU) at a meeting in Algiers passed a resolution calling for an end to secession and requested others not to intervene in Nigeria. The United Nations General Assembly had earlier requested the Secretary General to be guided by the OAU on matters concerning Africa.

But as the embattled eastern enclave began to shrink before the federal military advance later in the year and in early 1968, a great hue and cry arose around the world about the plight of the population in the whole region, and was filed by the press and other media and by what was considered skillful appeal by Ojukwo for the "Biafran" cause. The federal government was suspicious of this clamour by the world press and by the non-governmental humanitarian organisation interpreting it as supportive of the attempted secession.

Towards the end of 1967 the International Committee of the Red Cross, the ICRC, an organisation which had the longest tradition as a neutral humanitarian assistance organisation in times of war, managed to bring in some relief materials for distribution by church missions and local health authorities. UNICEF, conscious of its status as the only organisation within the United Nations system whose mandate protected it from the charge of taking sides in a civil dispute, was seized with the need to provide assistance to Nigerian children, not to "Biafrans", and in full cooperation with the Nigerian government. UNICEF in this instance asked the ICRC to act as conduit for its emergency supplies. But it was many months before airplanes carrying supplies were permitted to fly in from the island of Fernando Po, then a Spanish colony in the Gulf of Guinea, into Port Harcourt, Biafra's main door to the outside world. According to the federal authorities those airplanes flew at "their own risk" into rebel-held areas. When in May 1968 the Federal troops captured Port Harcourt and its airport, permission to continue the flights was suspended. Enugu, the capital of the secessionists, was also in the hands of Federal troops.

The situation of the population, and particularly that of women and children, was reported at the time to have deteriorated terribly with widespread malnutrition among the children, a situation which was highly publicised in the world press and especially in Britain where the government faced opposition to its pro-federal policy. But in the midst of this international furor and confusion, the UNICEF Regional Director for Africa, Dr. Vedast Kyaruzi who was based in Lagos, had guardedly asked for urgent relief with emphasis on aiding "all Nigerian children". The Executive Board had allocated $400,000 for use by the Executive Director at his discretion.

At a meeting in Geneva in the summer of 1968 the UN Secretary General, U Thant, told UN member organisations that they should assist wherever they could but with the full cooperation of the federal authorities. Harry Labouisse, UNICEF's Executive Director, was present at the meeting and consulted with the agencies. He declared that UNICEF already had its clearance from the Nigerian authorities and needed no further invitation to provide assistance. The organisation leadership was geared for action: Charles Egger, Deputy Executive Director for programmes, went to Geneva to lend his weight aided by his Red Cross background and his Swiss nationality; Gertrude Lutz, another Swiss UNICEF official, was assigned temporarily to work with the ICRC as a liason officer, and Willie Meyer, then UNICEF Representative in Dakar, Senegal, was sent to Fernando Po to try to get into the disputed territory. Meanwhile, at New York Headquarters, Dick Heyward, Deputy Executive Director for operations, aided by the head of the Africa desk, Sasha Bacic, and Edward Bridgewater, Chief of Supply operations, were busy mobilising the required resources of funds and food supplies from every possible source. They planned the delivery of massive supplies of milk, protein-rich foods, vitamins and medical supplies.

In mid-July 1965 Labouisse made a public appeal for funds for emergency assistance to children and mothers on both sides of the conflict in Nigeria. A few days later he left for Lagos to see what he could do to facilitate the relief effort. Simultaneously, the ICRC appointed Mr. Auguste Lindt as their Commissioner for Nigerian Relief. Labouisse's negotiations with the Nigerian officials resulted in a private agreement that UNICEF shipments of foodstuffs and medical supplies would not be searched by federal troops. In meetings with General Gowon, the latter became convinced by the humanitarian concerns of UNICEF and its lack of partiality to the "Biafran" cause. He apparently was not willing to bestow confidence on the other humanitarian organisations.

It was estimated by Heyward and his team that some 5.5 million children and mothers were either totally dependent on relief or needed food supplements. This translated into a daily need of one thousand tons of supplies for all affected areas. They chartered a cargo vessel that loaded 5,000 tons of US-donated milk and high protein foods. Many other consignments were to follow.

Despite intense efforts by the ICRC in negotiations to open land routes to permit larger quantities of supplies to get through, no success was achieved. The non-governmental humanitarian organisations decided to mount an airlift from Sao Tomé island in September 1968, and 2,000 tons of UNICEF supplies were forwarded in this manner to the secessionist areas, and 3,000 tons were sent to Lagos for distribution in the affected federally-controlled

territories. At the same time, the ICRC started to fly in six planes a day from Fernando Po. While the government protested these "illegal flights" the planes were not attacked. Labouisse had been earlier assured that planes would not be shot down.

While in Lagos in August, accompanied by Louis Gendron, one of his supply experts, Labouisse toured the areas recently recovered by the federal troops and was deeply struck by the pitiful conditions he observed in the mission hospitals and in the refugee camps and by the inadequacy of supplies trickling in - in spite of all the efforts. At his initiative, UNICEF based two helicopters at Calabar to ferry supplies from dawn to dusk to areas close to the front. By then $10.6 millions in cash and in kind were raised. Still, all combined efforts fell short of meeting the needs.

Some improvement in the supply situation resulted from a United States agreement to pay freight costs, and by January 1969 had provided a fleet of 8 additional cargo planes which made it possible by April to deliver 8,000 tons of the badly needed supplies each month.

A new crisis was faced in 1969 when ICRC flights were suspended as a result of one of their flights being shot down with loss of lives. The NGO flights, however, continued but at a slower pace. Auguste Lindt, the ICRC Commissioner, was declared persona non grata and had to leave the country. The NGO's were asked by the government to channel their aid through the Nigerian Rehabilitation Commission and the Nigerian Red Cross, and not through the ICRC. The peace negotiations that had been initiated with the "rebels" earlier were being stalled, which may explain the government's action.

In December 1969 it became clear that the final collapse of "Biafra" was imminent. On 10 January 1970 the war ended. The situation of children in what was the separatist enclave was at this moment described as "slow, creeping debilitation caused by the long months of nutritional insufficiency and hunger". But now it became possible to attack the needed relief and rehabilitation effort with more vigour. Thanks to the careful and calm efforts of Labouisse, UNICEF was in a favourable position to contribute massively to the post-war relief and reconstruction effort in all the distraught territories. Labouisse undertook his second visit to Nigeria only a few days after the cease-fire, accompanied this time by Sasha Bacic and Sherry Moe.

On extensive tours he was joined by Poul Larsen, the UNICEF Representative to Nigeria, and was able to take on-the-spot actions to alleviate the situation. When he observed the horrors of the "Niger clinic", a reception center for 280 children evacuated from near Uli, immediate action was taken to bring in supplies of foodstuffs from Port Harcourt stores. He encouraged active cooperation with the ICRC, Norwegian relief, the Nigerian Red Cross, the Lutheran World Federation and other aid agencies.

Typical of these on-the-spot actions was the agreement by UNICEF to pay 1,000 Nigerian pounds for any facilities needed to accommodate children in need of treatment and rehabilitation. Fifteen tons of "K-mix II", an enriched food for treatment of severe malnutrition, were shipped from the UNICEF warehouse in Copenhagen. There were also some positive signs of recovery.

Some schools were open with "cheerful" children. Refugees were returning to their villages. There was also some good news. Before Labouisse returned to Lagos in late January 1970, he visited Port Harcourt where the ship "Calcumcille" was discharging its valuable cargo of relief supplies, when the news was received that another ship, the "Nopol Tellus", had left Lagos with 24 Bedford trucks on the way to Port Harcourt. This was excellent news, for shortage of transport was one of the worst problems facing field operations.

In April 1970 the Executive Board approved an allocation of over $7 million for rehabilitation of schools and health centers and for the expansion of children's services in Nigeria, "particularly in the areas affected by the war". A period of very intense reconstruction followed and by 1971 the programme had gradually lost its emergency character and became to all intents and purposes a programme of social development geared to the welfare of Nigeria's children.

In this same decade, and in the decade to follow, UNICEF was to be involved repeatedly in providing relief and rehabilitation in natural and manmade emergencies to children and mothers, the most vulnerable and most severely affected groups of the population by these cataclysmic events.

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Selected services; integrated services

At the 1972 session of the Executive Board, a study on "Children and Adolescents: Goals and Priorities in the Second Development Decade" was the key subject of debate.[32/] The net result of this was a call for more integration in UNICEF programming assistance; projects selected were to be mutually supportive and were to rely heavily on local support and popular participation. To make this possible, field offices were to be strengthened for planning and programming purposes. Statistics on children were to be improved and systematically gathered and utilised. For this, cooperation was to be strengthened with the UN Statistical Office, the UN specialized agencies and, in Africa, with the UN Economic Commission for Africa (ECA).

National personnel concerned with social aspects of planning, as well as UNICEF staff, were to be trained. In Africa, the institution most utilized for that purpose was the UN Institut de Développement Economique et de Planification (IDEP), which was based in Dakar, Senegal. But other global institutions were also relied on: the Institute of Social Studies in the Hague, the Institut d'Etudes Economiques et Sociales (IEDES), of the University of Paris, and the Warsaw Institute, among others. Regional planning seminars took place in East and West Africa for the benefit of government personnel engaged in the social development fields. Similar advantage was taken of regionally-based institutions such as Institut Panafricain de Développement, (IPD), in Douala in Cameroon.

The "country approach" resulted in the presentation to the Board of "country programmes" under the heading of "Selected Services for Children and Women." A rundown on some country programmes support by UNICEF in the period through 1973 illustrates the significance of this new practice.

In Ethiopia, the country programme "package" included support to dairy development as part of a broader nutrition programme and combined with developments in maternal and child health. In Kenya, a BCG vaccination effort was to be combined with smallpox vaccination, but in the context of the development of an expanded basic health services network. A rural water supply scheme and aid to education were added to the package. In Lesotho, nutrition was the focal point for the country programme; support was provided to "young farmers clubs" for vegetable production and fish farming; this was to be mutually supported by nutrition education and health services. In Uganda, where the Third Five-Year Plan (1971-1976) was adopted, an early attempt was under way to combine the services of health, agriculture, education and social services in an integrated manner in one location in each district in the country.

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Declaration of an emergency

Concerned with the effect on the world's children of the then prevailing global economic crisis, the UNICEF Executive Board at its 1974 session issued a "Declaration of an emergency for children in developing countries as a result of the recent economic crisis"[33/]. The crisis was triggered by a combination of depressed prices for primary commodities and escalating costs of petroleum. As would be expected, the African nations were the most seriously affected by this turn down of world economy. Reports on the continuing deterioration of the situation of children continued to be received in 1975. The economic difficulties were exacerbated by yet another crisis in the form of severe droughts in the Sahelian countries of West and Central Africa and in Ethiopia and Somalia in the eastern part of the continent. In response UNICEF increased its assistance to the affected countries and particularly in relation to water supplies. It also agreed to contribute to the local cost of the distribution of its supplies, which in normal times is considered a government obligation.

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Water supplies: wells, rigs and pumps

This was a time when assitance to rural water supply and sanitation was taking an enormous step forward. From a limited approach to secure safer sources of water for such institutions as schools, clinics, and hospitals, UNICEF was entering a more ambitious phase of assistance to the provision of potable water to the population in difficult rural areas. This included use of scientific ways to search for water, and the provision of more sophisticated drilling equipment and the installation pumps and construction of reservoirs.[34/] The provision of clean water to millions of people living under conditions of extreme poverty in physically difficult terrain had always presented seemingly insoluble problems.[35/] To solve these problems technology had to be developed which allowed for low-cost approaches, where the communities themselves would undertake a large part of the construction work involved, and take responsibility for the upkeep, maintenance and repair of the new installations. In the sixties, revolutionary changes in technology

of water supply allowed for rapid development in this field. These included new drilling machines - more efficient and lower in cost, improved hand pumps that could withstand heavy use by hundreds of villagers, and the introduction of plastic pipes which promised a longer life and ease of handling.

UNICEF, having gained some experience in this field in other regions of the world before the onset of the drought in Sahelian countries of Senegal, Mali, Upper Volta and Niger, cooperated with the governments of the affected countries and with UNDP and other international bodies in the development of rural water supply schemes to those countries as well as to Chad, Gambia, and Mauritania. These projects were characterized by an effort to increase the operational and technical capacity of the countries concerned in this vital field of development. In the process, the emphasis was slowly shifted from the excavation of the traditional large diameter wells to the installation of pumps in drilled tube wells, a shift that represented a radical departure in water supply technology in Africa. The traditionally dug wells were subject to pollution and other environmental hazards and were time-consuming in their construction. On the other hand, the pumps, whether manual or power driven, in spite of their obvious advantages, presented problems of maintenance and frequent breakdowns.

In the first phase of these projects in the Sahel 150 wells had been put into operation in Upper Volta and 50 in Niger. In Mali and Mauritania, the shift from the traditional wells to tube wells was the order of the day and brought undoubted benefits to the rural populations. In Senegal, three "water brigades" - mobile teams - completed 40 wells out of one hundred planned by 1976.

East Africa suffered severe droughts in the period 1972-1973, particularly affecting Ethiopia, northern Kenya and parts of Tanzania and, with tragic results, especially in Ethiopia. In this country a United Nations team of hydrologists, water engineers and technicians was assisting the Ethiopian Water Resources Agency (EWRA) and helped in developing it into an effective technical organization. UNICEF entered the picture in 1973, concentrating its efforts on the worst hit drought areas of Wollo and Tigrai in the north, later spreading to Harrarge and Ogaden near the border with Somalia. A combination of techniques were used including the drilling of water wells and provision of engine-driven pumps and the harnessing of perennial natural springs whenever conditions permitted. In the south, hand-dug wells proved to be the most practical means of providing relief for the drought-stricken population. UNICEF's assistance to Ethiopia in this field continued until the end of the decade, during which time a large number of Ethiopians were trained as drillers, engineers and technicians.

The need for potable water was so great and so widespread that certain priorities had to be established with respect to location. In Liberia, for example, the priorities went to health units, schools, and community centres. And drilling of tube wells was not always the technology of choice. Where topography and availability of water permitted, such as in Zaire, piped gravity systems were used for conducting spring water to villages in the slopes of the Western Rift Valley of that large country.[36/] Similar techniques were used in the mountainous terrains of Burundi and Rwanda.

Ambitious country-wide programmes were also attempted. In Tanzania a "crash programme" to extend safe water supplies to every village in the country by 1980[37] was to be undertaken. And while this target was not to be fully reached, important strides were made in meeting the water supply needs of the rural population.

In all of these activities, UNICEF support took the form of supplies of drilling equipment, tools, pipes and pumps and, even more importantly, technical assistance. In the complex field of water technology, the latter element of intervention was growing in size and importance. The larger of UNICEF field offices invariably included among their staff technical personnel such as hydrologists, engineers, and other technicians. This period in Africa witnessed the emergence in most countries of specialized state-supported, water supply organizations with whom UNICEF and the other external aid agencies cooperated. A constant feature of UNICEF support to these organizations was the aid given to training personnel in construction, maintenance and administration of the water supply schemes.

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Health education and sanitation

It should be made clear that these enterprises were not free from problems. It was not all smooth sailing. The 'institutionalization' of the water supply efforts, referred to above, proved to be a time-consuming and slow process; "capacity building" had its ups and downs, and important lessons were being learned. For instance, that simply bringing clean water to a community previously deprived of it does not insure its proper utilization by the people. The pollution occuring between the source of the water and its consumers was not yet addressed. A simultaneous effort of health education was necessary. "Progress was marked by periods when the fascination with the engineering and public works aspects ran ahead of public health considerations, in particular, the need to protect a safe source of water from reinfection - an inherent imbalance that has never been entirely overcome."[38]

And the increase in water consumption brought in its wake problems of "sanitation" and proper drainage, problems up to that time either totally neglected or not given enough attention. The importance of active participation of the beneficiary population in the decisions to be made with respect to their water supply dawned belatedly on governments and external aid agencies. One aspect of this participation implied the necessity of training the local population in the operation and maintenance of the new water systems.

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Basic Services - the package

A study entitled "Basic Services for Children in Developing countries"[39], which was submitted to the Executive Board in 1975, ushered in a new evolution in UNICEF's programme policies. The methodology of 'country programming' was already well established, a policy which advocated the necessity of the

provision of a package of mutually reinforcing basic services. The components of basic services were MCH services; family planning; production and consumption of better foods; water supply; basic education and appropriate technologies. The key element was that these were to be provided through more active community participation in the planning and carrying out of the services. In May of that year the Executive Board made an appeal to the UN General Assembly urging that consideration be given to the possibilities inherent in the rapid enlargement of basic services for children. The General Assembly endorsed this concept, the implication of which was to bring in other parts of UN family to contribute to it, each in their relevant field of competence.

:Food and nutrition

In the meantime, some of the key elements in the 'package' were receiving increased attention. One of these was the field of food and nutrition. The First African Nutrition Congress took place in Ibadan, Nigeria in March 1975, with some assistance from UNICEF. It strongly urged all African governments to develop food and nutrition policies, and to set up national food and nutrition bodies to advice on the development and implementation of such policies. In June of the same year a seminar on food and nutrition in the Sahelian countries, still suffering from severe droughts, was convened in Ouagadougou, Upper Volta, sponsored by the Inter-State Permanent Committee for the Fight Against Drought in the Sahel (known as CILSS). This was followed by national workshops in Mali, Niger, and other Sahelian countries.40/

UNICEF interventions on behalf of children in the field of food and nutrition by then had taken various forms. Reference has been made earlier to milk conservation, the production of protein rich foods, and to some aspects of applied nutrition programmes. In this mid-seventies period, prompted by the effects of drought and resulting hunger in the Sahel, assistance was provided to programmes aimed at the rehabilitation of seriously malnourished children. In Upper Volta, twenty 'nutrition rehabilitation' centres were set up in the region of Yako, where mothers of such children were helped in the rehabilitation of their children through the use of local foods. Similar structures were established in Senegal and Mali. Sadly, in spite of the nutritional knowledge gained by the mothers during their stay at the centres, in frequent cases the children were returned to the centres later on in bad nutritional status. The basic problem of extreme poverty, it was being learned, is behind many cases of child malnutrition.41/

However, some of the worst aspects of malnutrition could be prevented or ameliorated through timely education of mothers on proper feeding and weaning of children relying completely on locally available foods. This and other techniques were demonstrated through the work of the UNICEF Regional Nutriton Officers who were placed in key locations in the Sahel, such as Angola and Ethiopia, to work closely with their national counterparts. In this latter country, through such efforts and in cooperation with the government and FAO, it was possible to devise an "early warning system". Through the systematic gathering of information on crop yields, rain fall and other data from various parts of the country, it was possible to foresee where food shortages may arise in the future. The system worked reasonably well during "normal" years, but was defeated by the succession of severe droughts that beset that country.

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The Lomé experience: planning for children in West Africa

A highlight of the early seventies was the Lomé Conference for countries in West and Central Africa. It was felt at the time that UNICEF support to the large group of countries in that Region was relatively weak. A contributing factor was the lack of clear priorities among the policy-makers in most of the countries concerned with respect to their social development efforts, and particularly those of significance to the welfare of children, adolescents and women.

To correct this situation, it was thought that a conference at a high level of participation, and well prepared for in advance, might stimulate the policy and decision makers in the Region to take a more positive view of the broad area of social development, and provide an opportunity for a collective sorting out of priorities for action. Under the strong leadership of the then Regional Director for West and Central Africa, Cheik Hamidou Kane, a prominent African economist from Senegal, and a team of experienced UNICEF staff and consultants a two-year effort was launched, culminating in what was known as the "Lomé Conference".

In agreement with eight countries in the region,[42/] and with their full collaboration, detailed country studies were carried out. The studies described the situation of children, adolescents and women in the context of their evolving national economies and suggested priorities for national action. The areas of attention in the eight studies were: a) children aged 0-5; b) youth employment and development; c) impact of large-scale enterprises on these vulnerable groups; and d) planning for children, adolescents and women.

The studies were completed in December 1971. A conference was convened in Lomé, Togo, in July 1972, in which 12 countries from the Region participated. It was a two-part conference: the first few days were for officials at the technical level from ministries of health, education, youth, social services and planning. The last two days were at the ministerial level.

The thorough and intensive preparation proved to be fruitful. The Conference agreed on the following priority areas:

1) Emphasis to be placed on the health of mothers and children in relation to their immediate and broader environment. This implied a commitment to extend the network of health services and to train large numbers of auxiliary health workers;

2) Water supply and nutrition to receive adequate attention; interestingly enough, the priority for water came out of the debates of the conference and not from the case studies presented; it is to be recalled that the extent and impact of the Sahelian drought was not generally perceived as yet;

3) Youth employment, requiring reorientation of the education system, (training teachers of the right kind);

4) Account to be taken of the impact upon and the needs of the vulnerable groups in the planning of large-scale enterprises, both agricultural and industrial;

5) The particular needs of women in view of their heavy burdens in agricultural production, and family welfare.[43]

To cover the costs of all the far reaching activities implied in these priority areas, the policy-makers at the Conference stressed the necessity of more intensive cooperation with bilateral and multilateral sources of aid. The specialized agencies of the United Nations and key bilateral agencies participated fully in the deliberations of the Conference.

This event was to help give shape and direction to UNICEF and government efforts in West Africa for years to come. Some dramatic examples relate to the area of large-scale development projects - grandes opérations de développement - typically economic in character and objectives. The Conference had recommended that the "social" needs of the populations affected by these projects should be taken into account in the planning stages. In Mali, the development of a major agronomic project in the region of Ségou included for the first time provisions for basic health, educational and other social needs. Similar tendencies were observed in the years following Lomé in projects in the Ivory Coast, and in the neighboring countries.

The debates at Lomé repeatedly referred to the vital roles played by women in agricultural, household and child rearing pursuits and to the onerous loads they carry in fulfilling these tasks. The innovations and reforms discussed by the conferences at Lomé were considered important means of lightening women's burdens and increasing the value of their work. Increased accessibility to potable water supplies and to basic health services in rural areas were high on the list of such reforms.

The new opportunities opened up by these developments provided new entry points for more meaningful interventions by UNICEF and other external development aid agencies. Unfortunately, the combination of world economic recession and the serious long-lasting drought in the Sahelian countries, impacting strongly during the mid-seventies, diverted attention for a time from the full implementation of the Lomé recommendations. There are those who felt later that a more determined effort should have been made to mobilize the potential resources of bilateral and regional aid organizations (e.g. African Development Bank) in support of the Conference recommendations.

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New tools to solve old problems

UNICEF's concern with the place of children in national development planning and the adoption of the "country approach" and country programming brought with them an interest in new fields of cooperation and in "alternative approaches" to dealing with old problems. In the early seventies, the Executive Board debated the issues of the pre-school child, new forms of education and problems facing urban children. Out of these debates emerged new policies which were to have an impact on UNICEF's co-operation in Africa.

:Non-formal education

In 1972 the Executive Board reopened the discussion on support to education, up to that time guided by the 1968 "Joint UNICEF/UNESCO Guidelines". It recommended the phasing out of assistance to secondary education and increasing aid to the primary level, especially to basic education, formal and non-formal, for educationally deprived children. In making these decisions, the Board was motivated by new facts now coming to light: the notable economic growth that had taken place during the First Development Decade in Africa as in the rest of the developing world, had not extended downward to reduce mass poverty. This failure was also reflected in educational progress. The growth rate of primary education and the reduction of dropout rates lagged far behind that for secondary education and higher education. An absolute increase in illiteracy was taking place though the overall literacy ratio had risen slightly.44/

The new policies thus emphasized aid for the education of children deprived of educational opportunities, particularly those to be found in rural areas and in urban slums of the least developed countries. UNICEF aid would be provided to educational planning geared to these new policies, to out-of-school education, especially for girls and women, and to experiments in the field directed at new approaches to providing basic education.

The problems facing formal "school" education, leaving large numbers of children, and especially girls, without places in such schools, the high drop-out rates and the ill-adapted curricula, prompted a search for innovative means to counter these problems. In 1973 the Executive Board of UNICEF discussed an interim report of a study on non-formal education which was earlier commissioned by the Executive Director of UNICEF and was carried out by the International Council for Educational Development (ICED)45/. Non-formal education was defined as "any organized educational activity outside the established formal system -- whether operating separately or as an important feature of some broader activity -- that is intended to serve identifiable learning clientele and learning objectives."46/. The final version of the study was published in 1974 under the heading of "New Paths to Learning for Rural Children and Youth." The Executive Board again discussed the subject in its 1974 session. These debates and the resulting policy guidelines were considered of particular relevance to the African countries, several of which had already some interesting forms of non-formal education: countries such as Kenya, Ethiopia, Botswana, Senegal, Mali, Zaire, and Congo. These included education centres for out-of-school youth, schools run by farmers associations, village technology centres and women's literacy programmes.

A seminar sponsored by UNESCO and UNICEF was held in Nairobi, Kenya in August 1974 on "Basic Education", with participation of educational planning specialists from five African countries. It reviewed the experiences of the participating countries in the field of non-formal education and made recommendations for further developments in this field.

UNICEF assistance to those countries requesting aid to education was for a time guided by these new policies, and aid to non-formal educational activities was combined in an integral way with support to formal education. Non-formal education was never considered as a separate category but rather as a complement to formal education, having the objective of broadening the educational base and reaching categories of "learners", who for various reasons, were left out of the formal system. These new policies of aid to education received a mixed reaction from governments and particularly from their educational authorities. They were warmly welcomed by governments who had undertaken some notable activities of a non-formal educational nature; cautiously endorsed by others who expressed willingness to try out the new concept; and some countries either rejected them outright or simply ignored them.

There were difficulties on the UNICEF side as well. A wide and tremendously varied range of activities were proposed for support by UNICEF: such activities as vocational training for youth, cooperatives, youth clubs and brigades, adult literacy, women's clubs, etc. and UNICEF had to carefully scrutinize such requests for assistance to non-formal education against a background of continuing urgent requests for support to school education.

"Although admirable as a concept, and while new impetus had been given by UNICEF and UNESCO to a re-evaluation of the importance and relevance of primary education, 'basic education' was not applied as widely as had been hoped because of difficulties in getting it across at the country level, overcoming the resistance of traditional elements, the cost of changes, a certain lack of follow-through at the policy level by UNICEF and UNESCO."[47/]

:Reaching the young child

Infant mortality rates (IMR) had dropped noticeably in the sixties, but they still remained high, at rates 20 to 40 times higher than those in the developed countries; globally, the highest IMRs in fact were in Africa. However, by 1970/1971 UNICEF was committing about 67 per cent of its programme resources in support of maternal and child health, nutrition and child welfare areas of intervention considered to have the greatest potential in enhancing the survival of children. At about the same time voices were being raised at the Board, in the UNICEF secretariat and in some government circles that survival is not enough and that the emotional and intellectual needs of the young child deserved a greater share of attention, keeping in mind the then widely accepted philosophy that the needs of the "whole child" should be met.

The Board discussed this issue at its 1974 session following the presentation by the Executive Director of a policy document and recommendations.[48/] And while the intellectual and educational needs of the child 0-5 were recognized, only a modest increase in support to pre-school education was recommended. The Board felt that the basic needs of health protection and adequate nutrition were far from being met for the vast majority of children in the developing countries. It was recommended, however, that innovative and low-cost means for the intellectual stimulation and development of pre-school children be encouraged, and preferably where these could be integrated with health and nutrition activities.

UNICEF had for sometime provided some support to organized pre-school educational activities, generally under the heading of social welfare services, to jardins d'enfants and crèches in West and Central African countries, and to day-care centres and kindergartens in East Africa. Modest assistance was usually provided for the training of child care workers and pre-school teachers, and in the form of toys and pedagogic supplies. And such activities were especially supported where they constituted a part of a larger effort aimed at women's training, or as part of child health and nutrition programmes. An example was the support provided by UNICEF to a workshop on day-care centres in Tanzania in 1976 in cooperation with the governments of Kenya, Lesotho and Mozambique, where the participants discussed the minimum standards for the organization and administration of day-care services and the production of teaching aids and equipment. A key recommendation by the group was that day-care programmes had to be related to the way of life of the particular community. Stress was also placed on the need for close cooperation between day-care services and those of health, nutrition and education.

A growing demand for organized day-care activities in some African countries reflected the increase in the number of women in paid employment, especially in the urban communities, and changes in the structure of the African families under the impact of the prevailing political and economic transformation. But with government budgets barely able to cope with the burdens of primary education, it was out of the question for the vast majority of African countries to undertake anything but a token responsibility for pre-school education. It was left for the communities and local groups to provide such services to the extent that their means would allow it. And while UNICEF did not go as far as advocating broad support to pre-school education - crèches, nurseries and kindergartens, it encouraged innovative and low-cost approaches to achieve the desired objectives, while it continued to stress the necessity of broader measures for improved health and nutrition for infants, children and mothers.

:Children of the cities

Urban children in the African continent were beginning to receive increased attention in the 1970s, reflecting the rapid growth in urban populations. In 1950, Africa's urban population was estimated at 14.8 per cent and by the end of the seventies had increased to 23.7 per cent.[49/] UNICEF had from its early days provided assistance to urban children and mothers as an integral part of the countries' general population. The emphasis, however, was clearly in favor of the rural areas where the vast majority lived. In cooperation with the ministries concerned, UNICEF was now anxious to consider special programmes to meet the needs of urban children, especially those that inhabited slums and shantytowns. This move started in Latin American and Asia, and finally in Africa where the governments were showing increased concern with the drift of rural people into the urban areas.

Zambia was among the first African countries to benefit from UNICEF's support to urban children. It had one of the highest urbanization rates in Africa, induced in part by its growing mining industry. Lusaka, the capital, was growing at the rate of 16 per cent per year through a combination of natural

high birth rate and migration from the rural areas. In response, the Government applied for a World Bank loan to carry out a combination of "upgrading" of old neighbourhoods and "site and services" schemes to build new neighbourhoods.

Heavy reliance was to be placed on strong popular participation and self-help. American Friends Service Committee and UNICEF assistance was provided for the training of community development workers in support of this massive effort, and this proved crucial to the success of this project. The CD workers were to encourage enlightened and active participation by the people to promote, early on, the development of health and child welfare services in the upgraded and site-and-services areas, and for the proper maintenance of the new structures. Over 150,000 people benefited from this support. The results were very encouraging, and it was evident that the children in these new neighbourhoods had more wholesome environments in which to grow: better access to clean water and basic sanitation facilities, and a mushrooming of voluntary community organizations which sprang up to maintain and improve these new concepts of urban living.

In the remaining years of the seventies, UNICEF support to urban child-focused projects was provided to Cameroon, Ivory Coast, Kenya, Mauritania and Senegal.

:Project support communications

The new programmes and new "approaches" being increasingly supported in Africa required strong participation by beneficiaries of these activities and new forms of support from local and national governments. The old tools of health and nutrition education were not by themselves producing the desired impact and had to be supplemented by more sophisticated and innovative methods. Two of these innovations were to play an increasingly important role in the implementation of UNICEF-supported activities in Africa. They were "project support communications" and "appropriate technology".

The introduction of project support communications, or PSC, to African programmes was a gradual process. Successful experimentation had already taken place in Southeast Asia. So many of the programmes and activities which UNICEF supported required the active participation of the would-be beneficiaries, who were not to be considered merely the passive recipient of services. They had to participate in the planning phases of the programmes and be assisted to express and analyse their needs, and thereafter, to play an active role in implementation and evaluation. The "agents" who assisted in this process were a variety of front-line workers: the health and nutrition workers, agricultural/veterinarian extension agents, school teachers, water supply technicians, village chiefs as well as newspaper reporters, radio broadcasters and others. Their tasks were to convey new ideas, practices and habits to the people, and to do so in a convincing way; for instance to explain why and how breast-feeding, innoculations, growing of foods to which they are unaccustomed, and using growth charts were good for their children and their communities. To assist these "agents" in getting new ideas across to the population, they needed to be educated and trained in effective means of communication.

The concept of communication itself was undergoing change. It did not mean simply conveying information to people. Aimed at helping people understand why they were behaving in a certain manner and at stimulating them to improve what they were doing, starting with their present concerns. In other words, communication was considered to be a social approach to development.[50]

Old and modern means of communications - from the poster, the mimeograph machine and newspapers, to slide and film projections, to sound and videotape recorders, radio broadcasting and even communications satellites - began to be used in appropriate combinations to convey, to convince and to encourage action by the people themselves. But overemphasis on the "hardware" aspects of communication was to be avoided. A greater attention to the "software" elements was essential: understanding people's needs, helping them articulate these needs, getting them involved in the deliberations leading to a particular programme or activity, and in its implementation.[51]

At the UNICEF Regional Office for East Africa in Nairobi, a "communications service unit" was established early in the 1970s to serve the 18 countries of the region and a Regional PSC officer was appointed to it. Studies were carried out in various countries to establish a sound base for PSC activities. These included information on literacy levels, the cultures and languages prevalent in each country and the available network of communication with which it was endowed, such as national and sub-national newspapers, news agencies, radio and TV broadcasting facilities, among others.

But it was not until 1976 that a systematic effort was begun to spread the word about these new PSC techniques and to train staffs of the governments concerned and of UNICEF itself. In that year a workshop was held in Arusha, Tanzania, where the "participants suggested the possibility be explored of holding a nine-week training programme in communications focusing on basic communications research, monitoring and evaluation, with management of communications programmes another area of study."[52]

The course, considered a landmark in development of PSC in Africa, took place in 1978 at the University of Nairobi and was sponsored, in addition to UNICEF, by UNESCO, and the International Federation of Family Planning (IFFP). It was assisted by the Community and Family Study Centre of the University of Chicago, and the Institute of Adult Studies of the University of Nairobi. The 52 participants (including 15 women) represented a wide spectrum of disciplines from the social development sectors and came from 19 African countries.[53]

Further training activities at regional and national levels were co-sponsored by governments, UNICEF, and often by other interested agencies (UNDP, UNFPA, universities, etc.). They involved front-line workers, supervisors and policy-makers. Hundreds of workers were thus assisted by enhancing their capacity in carrying out their various tasks at community level.

An interesting example from that period comes from Kenya, where a very popular and successful health education programme was carried over the radio broadcasting services of that country. The health "messages" were conveyed through plays performed by a popular theatre group. The listeners easily identified with the "characters" portrayed in the radio playlets, which were broadcast in a serial fashion.

Posters, brochures, and other promotional materials produced by the newly trained workers reflected a greater sensitivity to cultural factors and hence were better received by their intended target groups. Reliance on the use of locally available materials was encouraged.

The value of these new techniques soon became evident. Almost every country programme prepared by UNICEF offices for Board approval included funds for PSC components. Several area and country office staffs included a PSC officer who was a specialist in communication techniques. Similar interest in the use of PSC was exhibited in West and Central Africa. In Abidjan, the seat of UNICEF's Regional Office for that region, a regional PSC officer became active in expanding the effective use of better means of communication for the promotion of child health and nutrition activities.

:Appropriate technologies: for whom and for what

Coinciding with the designation by the United Nations of 1975 as the International Women's Year, the growth in programme components addressed to the situation of African women, and aimed, among other objectives, at reducing their heavy burdens of cultivation, fetching of water and fuelwood, meal preparation and food storage, and child rearing, resulted in innovative ideas. The object was to reduce the drudgery involved in this work and the time it consumes. Furthermore, these onerous duties did not allow African women to devote enough time to the well-being of their children, for example by making regular visits to MCH centres, or to take advantage of the growing opportunities for participation in literacy classes and other forms of non-formal education. Hence, the growing interest in "appropriate technology".

UNICEF had always shown concern for the role of women as mothers in childbearing and in safeguarding the health of their children, but it took time for UNICEF to respond to women's needs in all of their dimensions, such as adequate preparation and education of young girls, functional literacy for adult women, the alleviation of their heavy household and farming burdens, and for skill training to expand their income-generating capacities. The promotion of this new "tool" of appropriate technologies was considered as an additional means of enhancing the role of women as active members of their communities.

Both in West and in East Africa, experiments in "appropriate technology" were taking place. In West Africa, UNICEF co-operated with other agencies in a survey throughout the region to take a look at the prevalent technologies in relation to food conservation and storage, the forms of energy used in a variety of tasks, water supply and sanitation, and health practices. The survey covered the practices of women in their households as well as those of traditional artisans. As a result, new technologies were proposed, such as the use of solar energy for food drying and conservation; for the construction of home silos for food storage; and for the preparation of infant weaning foods. In co-operation with the ministries concerned (agriculture, health, and community development), demonstrations in the uses of the improved technologies were held, and front-line workers were trained in their uses and propagation.[54/]

In Senegal, rural women's co-operatives for mechanical milling of maize developed successfully. In the same country, improved small-scale irrigation techniques near the Senegal River were demonstrated. UNICEF support to these efforts largely took the form of technical advisory and promotional services, training grants, and some essential supplies and equipment.

In East Africa, through the efforts of the Regional Office, a regional demonstration centre at Karen, near Nairobi, was developed in cooperation with the Kenyan Government. The Centre developed and demonstrated various devices for milling of grains, shelling of groundnuts, inexpensive solar drying of perishable foods, improved grain storage jars and home silos, improved farming practices, pumping of water, water purification for home consumption, and fuel-saving stoves and other cooking devices. Visits to Karen Centre by government officials, technicians and artisans from throughout the region were encouraged. Regional and national workshops on appropriate technology were held with some positive results. Practically in every country in the region, programmes in nutrition, health and water supply began to include appropriate technology components.

Women were perceived as the most immediate beneficiaries of these activities because of the implied reduction in the drudgery of their tasks, but the benefits rebounded to the family, and particularly to the children. In the Francophone countries of West and Central Africa, appropriate technology was considered to "add value" to women's work, or in other words, to make it more efficient. And because of this, most programmes aimed specifically at women and girls emphasized appropriate technology approaches. The most popular with women's groups were improved devices for the grinding of grain and the extraction of palm oil, as well as storage bins, energy-saving cooking devices and improved latrines.

The concept of "appropriate technology," however, was not accepted without challenge, both on ideological and pragmatic grounds. "Many developing nations understandably regarded appropriate technology as a condescending gesture of the rich toward the poor."[55/] Some considered it second rate or inferior. But attitudes gradually changed and appropriate technology was more widely accepted as it has come to mean something specific, namely a low-cost technology, using mainly local or easily obtainable materials and skills, which meets a recognized need and fits in closely with local attitudes and aspirations.[56/]

More difficulties arose in the application of the concept, however, especially with regard to the enhancement of the status of women. For example, when a new technology became widely accepted such as the grain mills in Senegal or corn-grinders in Kenya, the women needed access to credit and to training in management and accounting. But these were hard to come by for it is traditionally the menfolk who had easier access to these benefits. Often male entrepreneurs buy a mill and run it as a business and the poorest women cannot afford to pay the charges levied.[57/]

In spite of these real difficulties the appropriate technology "movement," combined with other efforts and innovations, brought undoubted benefits to African women. Progress in water supply and sanitation, expansion of maternal and child health services, literacy classes and income-generating activities, all made valuable contributions in this direction.

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Emergencies, natural and man-made

Natural and man-made disasters take a heavy toll on their victims, but especially on children, the most vulnerable group in these situations. Africa of the seventies had more than its fair share of cataclysmic events: droughts, floods, and civil strife and war. Without external aid many of the African countries, with fragile or weak developing economies, would have been overwhelmed in coping with these emergencies.

The major drought in 1973-1974 that ravaged the countries of the Sahelian region in West and Central Africa has been referred to earlier. Severe drought affected Ethiopia in the same period. In 1973 the Executive Director sought extra-budgetary resources in the amount of $12 million to deal with these tragic situations. The following year, due to civil strife and the influx of refugees, emergency aid was provided to Burundi, Rwanda, and Tanzania. Emergency assistance in 1975/1976 was provided to displaced persons from Angola resulting from the liberation war which was soon to lead that country to independence; similarly emergency assistance was received by refugees returning to Cape Verde at the end of its liberation struggle against Portuguese colonial rule. And once more persistent drought conditions in large parts of Ethiopia necessitated the provision of relief assistance.

In 1975, the newly independent country of Mozambique received assistance from UNICEF in the rehabilitation of three existing centres for training of auxiliary health personnel and the construction of two similar centres outside the capital, Maputo. The project was funded at a cost of about $300,000 from the Executive Director's Emergency Reserve.

One of the major relief items in emergencies is food, and this was primarily provided by the UN World Food Programme (WFP) and by bilateral food-rich donors. However, UNICEF also was often offered contributions of food for use in emergencies. These included specially enriched foods which were used for the treatment and prevention of the worst aspects of child malnutrition. From UNICEF's own resources, medical supplies, shelter materials (e.g. blankets), and equipment and supplies for water projects were expeditiously shipped to the countries in distress. It should be noted that these efforts by UNICEF were carried out in collaboration and coordination with many international agencies, both intergovernmental such as the United Nations High Commission for Refugees (UNHCR), WHO, and international voluntary organization such as the International Committee of the Red Cross, the League of Red Cross Societies, OXFAM, CARE, and many others.

In its cooperation with the ex-Portuguese colonies, now independent nations, UNICEF had an opportunity to apply lessons learned from its experiences of the early sixties. Emergency relief was quickly transformed into reconstruction and long-term programme developments.

At a special session of the Executive Board, early in 1981, UNICEF's policies and practices in emergency situations were discussed. In essence it was reiterated that while UNICEF should have an important role to play in future emergency situations, it should not in the meantime inflict damage to effectiveness of its ongoing long term activities.

A characteristic concern of UNICEF in aiding countries during emergencies was to consider the needs of children and mothers in the post-emergency period when reconstruction and rehabilitation of child-related facilities and services become so vital to long-term development efforts of the country concerned. UNICEF's policy in these situations was, whenever possible, to provide relief with an eye to addressing the longer-term needs. Thus, in cooperation with the governments concerned, it made provisions for the retraining of health, nutrition and education personnel; and for the reconstruction of facilities related to these services, facilities which are frequently destroyed or neglected during the emergencies.

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Children and mothers under the care of African liberation movements

The United Nations General Assembly in its Resolution 3118 of December 1973 and in subsequent resolutions, urged UN bodies and the UN Specialized Agencies to provide support to the African liberation movements, each in their special field of competence. The UNICEF Board responded to this appeal, when it discussed the subject at its 1974 session, approving an allocation of $815,000.[58/] By 1975, commitments in the amount of approximately $2 million were being implemented in co-operation with UNDP, WHO, UNHCR and the Organization of African Unity (OAU), in support of children and women under the care of African liberation movements. These movements at this point were those seeking independence from Portuguese colonial rule in Angola, Cape Verde, Guinea-Bissau, Mozambique and in Sao Tomé/Principe. Angolan refugees living in Congo, Zaire and Zambia numbered about one million. Support was provided to child health, nutrition, education and training. Angola attained independence in November 1975, and thereafter UNICEF aid was geared to assist the newly independent nation in the development of its services related to the welfare of children and mothers.

When agreement was reached for Cape Verde to attain its independence in July 1975, a transitional government was formed. UNICEF aid was provided in the development of health, nutrition and educational services. Similar arrangements applied to Sao Tomé/Principe, which achieved independence also in the same year.

Refugees from Guinea-Bissau, residing in neighbouring Senegal, were assisted through a specific-purpose contribution amounting to $200,000. The largest number of Mozambiquan refugees resided in Tanzania having gone there to escape the war that was raging in their mother country between the liberation fighters of the Front for the Liberation of Mozambique, known as FRELIMO and the Portuguese colonial power. When the hostilities ended in 1974, the need arose to assist in the return of the refugees to Mozambique and in their

resettlement. The Executive Director of UNICEF allocated $300,000 from the Emergency Reserve Fund to aid this humanitarian endeavour. Independence was attained in June 1975, and in that same month the Executive Board approved a commitment from regular resources for country programme co-operation with the newly independent nation.

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Primary health care: the Alma Ata Declaration (1978)

Nearly all African countries participated in the Alma Alta Conference on Primary Health Care, convened in the USSR under the joint auspices of WHO and UNICEF in 1978. The resulting Declaration of Alma Ata advocated a new and revolutionary approach to the extension of health services, symbolized by the slogan "Health for all by the year 2000." This called for active participation by all the people in developing basic health services, defined as an integrated package of preventive, curative and promotive activities to be supported in an inter-disciplinary manner by the official health authorities as well as by other governmental and non-governmental entities.[59/]

The Declaration, and the concept of primary health care, were endorsed by most African countries. As the status of health and the structure of health services varied greatly from one African country to another, each had to determine its own programme for meeting the objectives of primary health care. In this endeavour UNICEF was prepared to provide support, always in full collaboration with WHO. Several countries carried out detailed assessments of their health services, and the resulting reports were widely discussed, often on a national scale, as was the case in Ghana, Senegal, Tanzania, and Zambia. It was evident in all cases that the process of re-orienting and restructuring of the health services was going to be difficult and time-consuming. For in spite of the progress made since the early sixties, in almost every case the health services in Africa were still heavily skewed in favour of the urban populations, and in favour of curative services and costly institutional facilities such as hospitals.

One of the early moves in the direction of PHC was the recruitment and training of a new breed of auxiliary health workers, called community village health workers or health monitors. In principle, these were selected by the communities in consultation with health services and were trained by the health ministry for periods varying from a few weeks to several months before they were to be deployed in their local communities. Their training emphasized preventive aspects, such as monitoring of water and sanitation facilities, keeping an eye on the nutritional status of children and pregnant women, providing first aid and health education and the dispensing of simple medication such as anti-malarial drugs and oral rehydration salts; and the referral of needy cases to the nearest health facility.

Bringing a measure of basic health services down to the village level was not really a new concept to UNICEF, for over the years it had consistently favored this approach and acted upon it. What was new was the determination to extend the coverage as widely as possible, especially to the deprived rural areas.

Besides persistent advocacy, UNICEF's key role in this aspect of PHC was to support the required training efforts and to provide some key supply items, the most important of which were essential drugs and often bicycles for the village workers and motorcycles for those who supervised them from the nearest rural health centre or dispensary. By the end of the decade, thousands of community health workers were to be found in village communities all over Africa.

This movement brought with it a renewed interest in the upgrading of traditional birth attendants (TBAs), for these women were considerd an integral component in building the primary health care system at its peripheral level. There appeared also a growing recognition of the contributions to be made by the religious leaders and traditional healers from whom many rural and urban people alike sought help in case of physical or mental illness. Ideally, a village was to benefit from the presence of a village health worker (the vast majority were men) and a TBA. More difficult was the effort required to re-orient the government health services in the direction of primary health care. The attitudes of the health management staffs, the medical practitioners and the urban populations all had to undergo a radical change in attitudes, concepts and practices if PHC was to become a reality. The health expenditures, both from government budgets and personal expenditures, had to undergo a radical change in many cases to reflect the new orientations.60/

By the end of the decade, the various studies and assessments carried out by the governments, WHO and UNICEF, showed that some success was achieved towards the new concepts of the delivery of health services, but that countries still had a long way to go. PHC, as a component of the now more widely accepted concept of "basic services," was no longer in dispute, and most African countries were seeking ways and means of attaining the goal of "health for all by the year 2000," though it seemed a rather overambitious goal. Serious efforts were made to improve immunization programmes under the umbrella of the Expanded Programme of Immunization (EPI) launched by WHO in 1974; there was a notable increase in the provision of potable water supplies to deprived areas and populations, and a resurgence of interest in sanitation. On the management side, some African countries reformed their administrative machineries in favour of decentralization in the delivery of health services and their improved co-ordination. More attention was being paid to weaknesses in logistics, e.g., to improving transport facilities to permit better supervision and delivery of drugs and vaccines, fuels and supplies to remote rural areas. In all of these efforts, UNICEF, together with its partners in the international community, particularly WHO, the World Bank, and bilateral aid agencies stood ready to assist with technical support, supplies and funding. In fact, it could be stated that by the end of the decade, the bulk of external aid in support of Africa's social development was devoted to PHC in particular, and basic services in general.

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The Year of the Child, 1979

On December 21, 1976, the United Nations General Assembly adopted a resolution proclaiming 1979 as the International Year of the Child (IYC) to coincide with the twentieth anniversary of the Declaration of the Rights of the Child. The idea for such a "year" was in fact mooted much earlier and was strongly advocated by non-governmental organizations, under the leadership of Canon Joseph Moerman, then Secretary General of the International Catholic Child Bureau in Geneva, who is credited with initiating the idea. There was initially much resistance to the idea from various sources and for different reasons. In the United Nations itself there was a feeling of "fatigue" after a succession of "Years" dealing with issues such as refugees, population, women and environment.[61/] There was, surprisingly, resistance within UNICEF as well.

If the UN declared a year for children, the brunt of responsibility, not to mention cost, would fall on UNICEF. And it was feared that the efforts involved would divert UNICEF from its real work into activities such as parades, galas, etc. which were the hallmark of such years in the past.[62/] But with great perseverance and determination, the NGO promoters of the idea convinced all doubters that what they had in mind was action, particularly national action, rather than proclamations. Unlike the other "Years" there would be no international conference to culminate it since such conferences were costly and might lend themselves to controversy and politicization.

The decision was finally taken and UNICEF accepted the role of UN "lead agency" for IYC and set up a Secretariat for the purpose in 1977, when preparation for IYC began in earnest.

In practically every country on the continent, a high-level National Commission for the International Year of the Child was established. These commissions frequently were composed of representatives from various ministries of government, experts, non-governmental organizations and the mass media. Their main function was to stimulate nation-wide interest and action in all matters that revolve around the wellbeing of children and mothers. Surveys and studies were carried out dealing with the situation of children, the services available to them and their legal status. The mass media, particularly radio and newspapers, widely publicized the findings of these studies. Successful fund-raising efforts were undertaken to cover the cost of the Commission's work, including the cost of their modest secretariats. Government financial support was also forthcoming. UNICEF provided modest financial support to the national IYC Commissions, more often for specific projects they were carrying out. Stimulated by the visit to eleven African countries of Dr. Estefania Aldaba-Lim, Special Representative for IYC, some commissions went beyond research and advocacy, and supported community-based projects ranging from water supply in villages, to subsidizing child welfare organizations, including those that dealt with services for disabled children.

The wide range of activities undertaken was remarkable: in Guinea a national survey on the situation of children was made; Malawi set out to eradicate polio; interest in the problems of nomadic children was aroused in Senegal and Somalia; funds were raised for refugee children in Angola; the United Republic

of Tanzania held a major national symposium on early childhood education; Uganda made efforts to get children off the streets; a major child immunization programme was developed in Liberia; and care for the disabled child was stressed in the Seychelles. Togo enacted a Family Code. In March 1979, the Government of Kenya, with UNICEF support, organized a major IYC symposium for East African countries on Basic Services.

That IYC had a positive impact was evident from the final reports of the national IYC Commissions. In Africa, both governments and the people at large became more aware of the needs of children, of their place in and implications for national development. And in spite of the fact that the IYC "manifestation" took place at a time of global economic recession, severely felt in Africa, there was evidence of greater government concern with child-related issues and of some expansion of services, at a time when budgetary retrenchments were the order of the day. Some IYC commissions continued to function after 1979, re-orienting their functions as ongoing national advocates for the welfare of children.[63/]

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Southwest Africa and Zimbabwe

Liberation movements struggling for the independence of Southwest Africa (Namibia) under the South West African Peoples Organization, SWAPO, and for Zimbabwe, namely, ZANU and ZAPU,[64/] became more active in the second half of the decade. As a result of these armed conflicts, vast numbers of refugees from these countries sought shelter in the neighbouring countries. The majority went to Tanzania and Zambia, and smaller groups took refuge in Botswana, Lesotho, Swaziland, Zaire and other countries. The burdens on these host countries were enormous, adding to their already heavy responsibilities towards their own citizens.

UNICEF joined the efforts of the international community in providing aid to the countries sheltering the liberation movements' refugees, particularly to meet the basic needs of children and women. Late in 1974, about $500,000 was made available ($100,000 from regular resources and $400,000 from supplementary resources) for Tanzania. The funds were utilized to provide tents, medical supplies, and training grants. Zambia was similarly assisted to facilitate its care for refugees from Angola, Namibia and Zimbabwe.

It should be noted that the largest proportion of the UNICEF financial resources required to provide this aid came as special contributions generously donated by governments, notably, Australia, the Federal Republic of Germany, Norway, and Sweden; as well as by several National Committees for UNICEF.

Zimbabwe is born

In 1980, the seven-year struggle in Zimbabwe came to a conclusion, and agreement was reached on independence under majority rule. The newly independent state of Zimbabwe was born in April 1980. One of the first tasks facing the newly opened UNICEF office in Zimbabwe was to aid, in co-operation with UNHCR and other agencies, in the return to their homeland of thousands of

Zimbabwean refugees from Zambia, Mozambique and the other neighbouring countries. This urgent humanitarian task was accomplished with dispatch and great efficiency. By late 1980 and early 1981, UNICEF's programme of co-operation with the new nation provided support to "crash" programmes for teacher training, and for transforming the previous guerrilla fighters' medics into basic health services workers.

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IV. EPILOGUE

Measured by the improvement in infant and child mortality, progress over the past 35 years in Africa has been historically unprecedented. IMR for the developing countries as a whole dropped more than 50 per cent from 188 per 1000 live births in 1950 to 92 in 1982. But in Africa, in spite of a decline in IMR in the same period from 197 to 118, the disturbing fact remains that the absolute number of infant and child deaths has been growing.65/

For Africa the first half of the decade of the eighties was a period marked by a succession of crises. Depending on the point of view of a particular observer of the African scene, the crises were attributed to environmental stress and overpopulation, drought, the debt and economic recession, lowered export prices of primary commodities, declining food production, poor management, lack of attention to women's work and needs and the shortage of skills and technologies.66/

To many observers, however, these factors are interwoven and interrelated and have, in various combinations, contributed to the emergence of one short-term crisis after another. UNICEF shared this latter view and considered that these crises were not brought about by any one single circumstance but are a reflection of the long-term crisis of poverty and underdevelopment.

The challenge facing policy-makers both in governments and the development aid agencies, such as UNICEF, was to come up with measures that could slow the tide of deterioration threatening the lives and growth of the nation's children in the face of economic setbacks and lack of adequate resources. It was against this background that UNICEF, under the direction of its new Executive Director, James P. Grant, accelerated UNICEF's to search for solutions and to develop new strategies to assist the countries facing this crisis situation.

Malnutrition and ill health claimed the lives of nearly four million African children each year, even where there was no drought nor famine. It was what Grant and his predecessor, Henry R. Labouisse described as the "silent emergencies", in contrast with the "loud emergencies" characteristic of a severe drought or other calamity. The international response has to be addressed to both if long-lasting solutions were to be effected. Naturally, the first priority for action during both types of emergency is to protect the lives and the normal growth of children because the early years of childhood cry out for protection in the name of both alleviating immediate suffering and of protecting the "human capital" on which Africa's future will depend.

A prominent African leader highlights this issue when he states that "saving hundreds of thousands, who are at risk of dying from malnutrition and infection, is an immediate imperative. But it must only be one stage in the progress towards other activities and one element in the truly comprehensive approach which in the long run is the only way to enable Africa's children, not only to survive the current emergency but to go beyond it to development."67/

There was mounting evidence that high infant death rates could be sharply reduced in low-income countries without necessarily waiting for a turn-up in their economies. Such evidence prompted hope that despite recession, children's lives could be saved with low-cost measures. UNICEF had traditionally relied on the criteria of GNP and child population to determine its allocation to a given country, but in 1983 approval was sought from the Executive Board to add the country's infantile mortality rate (IMR) as a third criterion for determining UNICEF funding.

In late 1982, new weapons in the war that was to be declared against needless infant and child death were launched and promoted in the form of a new concept in child health that became known by the acronym GOBI*. The new strategy, which was to be a spearhead for accelerating primary health care and the full development of basic services, rested on four measures which would utilize simple but revolutionary breakthroughs as steps the towards the desired objective.

The new measures adopted and advocated by UNICEF were, by necessity, to be addressed to the most common problems facing children in poor communities. The measures included the control of dehydration due to diarrhoeal diseases, which in 1984 caused the deaths in Africa of over one million children. UNICEF and WHO promoted the use of cheap oral rehydration therapy to prevent a large number of these deaths.

With improved vaccines and more effective social mobilization, UNICEF put a major emphasis on universal immunization against the most common infectious diseases of childhood--tetanus, measles, polio, whooping cough, diphtheria, and tuberculosis.

Other cost-effective measures were growth monitoring of infants and children and the promotion of breastfeeding and good weaning practices. The former involved the monthly weighing of children and the recording of this information on growth charts, thus permitting the mothers to detect their children's faltering growth long before serious malnutrition set in and helping them to deal with it. Educating mothers on the benefits of breastfeeding and proper weaning was an important and effective approach.

These child protection techniques along with food supplementation, protection against vitamin A and iodine deficiencies, female education and child spacing as well as other measures within the framework of basic services for children and primary health care, became a part of a global strategy in the campaign to enhance child survival, health and development.

By 1983, this programme became known as the Child Survival and Development Revolution (CSDR). The four techniques described above remained central to the "package", but others were incorporated in relation to other priority problems in particular countries such as malaria, the control of acute respiratory infections, reducing perinatal mortality and parasitic diseases,

*Stands for Growth monitoring, Oral rehydration, Breast feeding and Immunization. Sometimes Food supplementation, Family planning and Female literacy are added, thus the use of the acronym GOBI-FFF.

and combatting vitamin A deficiencies. Several countries decided to concentrate initially on such limited health targets where success could be more readily achieved. Such steps could become a prelude to a more comprehensive system of basic services, including primary health care.

Universal child immunization by 1990 had been adopted as a goal by the World Health Assembly in 1977, but progress was slow, and especially because of the economic crisis its achievement seemed distant. In 1985, immunization was taken up by UNICEF as a top priority for the rest of this decade. In that year, the Secretary General of the United Nations, Javier Pérez de Cuéllar, sent a letter to heads of States asking for their personal support for achieving the goal of immunization for all the world's children by the year 1990. Following this the Ministers of Health in Africa meeting in Lusaka in September declared that 1986 should be the Year of African Immunization.

The "revolution" advocated by UNICEF focused primarily on child survival, but the child development aspects were by no means ignored or totally neglected. The International Year of the Child of 1979 had highlighted the psycho-social development needs of children and the role of early childhood education and stimulation in meeting these needs; and equally raised the issue of protecting the world's children from exploitation and abuse.

In Africa greater attention was given to the role of women, not only in assuring the survival of their children, but also in their capacity as promoters of change and development in their own communities. UNICEF continued to provide support in innovative programmes in both of these fields.

At the same time UNICEF was convinced that advances in scientific knowledge and technique are not in themselves sufficient. There must be an equivalent low-cost "social break-through" in the ways and means of putting these advances at the disposal of the people. With the expansion in many nations in the African continent of the capacity to reach out to inform and mobilize their population, via both mass media and the mobilization of other organized sources, it is now more possible to put this knowledge and these techniques at the disposal of the majority of parents.

By the mid-decade UNICEF was not only advocating these strategies but was building them into its existing resources of organization and communication, its programmes for mothers and children, its programmes for primary education and of water and sanitation.

Looking forward to the end of the century, it is clear that the African Region will remain a high priority for UNICEF for the situation will continue to be characterized by the highest mortality rates in the world, by persisting food insecurity and consequent malnutrition and by trends towards the pauperization of women, especially in rural areas.[68/]

UNICEF had already responded in a vigorous way in anticipation of these needs. From 1980 to 1985 its expenditures in Africa had doubled; in 1985 alone, Africa absorbed 38 per cent of the agency's total global programme expenditure. It had sharply increased the number of professional staff and the number of full country offices in sub-Saharan Africa.[69/]

For the immediate future concern will continue to be with the deepening economic crisis facing most African countries indicated by sharp declines in GNP per capita, and serious declines in social services affecting children and mothers.[70]

There will also be concern with the effects of apartheid, destabilization and war on children in southern Africa, and particularly in Angola and Mozambique where these events are causing a tremendous increase in infant and child deaths. It is clear that efforts at reconstruction, requiring substantial external support, should not await the end of war and destabilization. As the 1984-1985 drought emergency demonstrated, to wait until the damage is done is to wait too long and to waste the very vulnerable lives of young children.

For the short-term and in relation to emergency situations UNICEF will continue, within the overall operations of the United Nations Office of Emergency Operations in Africa (OEOA), to assume major responsibility for supporting national efforts to meet the health needs of the affected population in close cooperation with WHO; for providing support to ongoing water and sanitation activities; and for provision of relief and shelter supplies, and for supplementary feeding of vulnerable groups.

For the long term the basic objective will aim at accelerating the reduction of infant and young child mortality, to help improve the situation, well-being and status of mothers and poorer women and to protect and, wherever possible, to improve the situation and well-being of children through support to a broad range of child development activities. These goals will be pursued through its long-standing commitment to the "country programming" approach which requires the pursuit of progressively improved analyses of the situation of the children in each assisted country and the development in full cooperation with the ministries concerned, of a coordinated programme of action, with clear priorities and a time-frame.

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I. Footnotes

1/ Unpublished interview of Dr. Charles Egger of 11 October 1983, UNICEF History Project, New York.

2/ UNICEF Staff News, No. 207, 21 February 1986

3/ World Population Prospects: Estimates and Projections as Assessed in 1982 (United Nations publication, 1985).

4/ ibid.

5/ "General progress report of the Executive Director" (E/ICEF/356), 1958.

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7/ From a statement by Dr. Charles Egger to the Executive Board, 2 March 1959 (E/ICEF/59A/CRP/1).

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10/ ibid.

11/ "The use of protein-rich foods for relief of malnutrition in developing countries", Elizabeth Orr (London, Tropical Products Institute, 1972).

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20/ ibid.

21/ Unpublished interview of Isaac Gomez of 24 July 1985, UNICEF History Project, New York.

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23/ Unpublished interview of Aida Gindy of 25 August 1983, UNICEF History Project, New York.

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26/ A full report on the Special Meeting is included in UNICEF document E/ICEF/549, 1966.

27/ The figure and percentages mentioned include the Arab countries of North Africa, Egypt, Sudan, Libya, Tunisia, Algeria, and Morocco.

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29/ op. cit.

30/ "UNICEF in East Africa 1953-1982", unpublished paper prepared by Tony Meager for the UNICEF History Project, New York, February, 1983.

31/ Sources for section on Biafra are:
a) The Children and the Nations, Maggie Black, ;

b) Unpublished memo from Dan Jacobs to Henry Labouisse, New York, July 1983.

c) "Notes on a field visit to war-affected areas by Mr. Labouisse accompanied by Mr. Larsen", unpublished material by Poul Larsen, (Lagos, January 1970).

32/ "Children and adolescents: goals and priorities in the Second Development Decade -- a draft report" (E/ICEF/CRP/72-8), 1972.

33/ "Report of the Executive Board, 13-24 May 1974" (E/ICEF/633).

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35/ "Water and Sanitation in UNICEF, 1946-1985", unpublished paper prepared by Martin Beyer for the UNICEF History Project, New York, 1986.

Footnotes (cont'd)

36/ ibid.

37/ ibid.

38/ Dr. Charles Egger, op. cit.

39/ E/ICEF/L.1342.

40/ "General progress report of the Executive Director" (E/ICEF/642), 1976.

41/ ibid.

42/ Cameroon, Chad, Gabon, Ivory Coast, Mali, Mauritania, Niger and Togo.

43/ Children, Youth, Women and Development Plans: the Lomé Conference (UNICEF Abidjan, 1972).

44/ UNICEF and Education, UNICEF History series, Monograph 7, 1985.

45/ "Non-formal education for rural development" (E/ICEF/L.1284), 1973.

46/ ibid.

47/ Dr. Charles Egger, op. cit.

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54/ "Technologies villageoises en Afrique de l'ouest et du centre" (UNICEF and ENDA, Dakar, 1978).

55/ "Technology: 'Appropriate' for what and for whom?", John Balcomb, UNICEF News, No. 117 (1983).

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60/ Formulating Strategies for Health for All by the Year 2000 (Geneva, World Health Organization, 1979).

61/ The Children and the Nations, Maggie Black, from the chapter entitled "The Year of the Child" (UNICEF, 1986).

62/ ibid.

63/ For more detail on global aspects of IYC, consult "International Year of the Child - A Narrative Report" (UNICEF brochure, 1981).

64/ Respectively, Zimbabwe African National Union and Zimbabwe African People's Union.

65/ "Medium-term plan for the period 1985-1989" (E/ICEF/1986/3), 1986.

66/ "Within human reach: a future for Africa's children", James Grant, UNICEF, New York, 1985.

67/ ibid., from forward by Cheik Hamidou Kane, Minister of Planning and Cooperation, Senegal.

68/ "UNICEF expanded activities in Africa" (E/ICEF/1986/L.5), 1986.

69/ ibid.

70/ "UNICEF and the emergency in Africa" (UNICEF, New York, March 1986).

II. Statistical Tables

Table 1: UNICEF expenditures for Africa, South of the Sahara from inception through 1985[a] by main categories of programme activities

	1947-59	1960-69	1970-79	1980-85	TOTAL 1947-85
	(in thousands of $US dollars)				
Child health	8 704	21 317	83 739	116 224	229 984
Water and sanitation	b	b	22 551	93 597	116 148
Child nutrition	629	8 743	15 041	16 559	40 972
Social welfare services	b	3 700	7 781	16 294	27 775
Formal education	--	7 814	37 061	31 714	76 589
Non-formal education	--	--	12 716	24 211	36 927
Emergency relief	299	2 940	7 100	59 368	69 707
General	--	--	6 521	36 083	42 604
Total programme aid	9 632	44 514	192 510	394 050	640 706
	(in percentages)				
Child health	90	48	43	30	36
Water and sanitation	b	b	12	24	18
Child nutrition	7	20	8	4	6
Social welfare services	b	8	4	4	4
Formal education	--	17	19	8	12
Non-formal education	--	--	7	6	6
Emergency relief	3	7	4	15	11
General	--	--	3	9	7
Total programme aid	100%	100%	100%	100%	100%
TOTAL as % of programme expenditure all regions:	4%	15%	21%	27%	22%

a/ Does not include expenditures from interregional funds.

b/ Included in health services.

Table 2: Patterns of programme expenditure by sector in Africa, 1976-1985

(in thousands of $US dollars)

Sector	Eastern and Southern region		West and Central region		Total	
	$	%	$	%	$	%
Health	74 438	37	64 847	41	139 285	39.0
Water supply and sanitation	56 825	28	45 381	28	102 206	28.0
Formal education	26 402	13	19 677	12	46 079	12.5
Non-formal education	18 482	9	12 234	8	30 716	8.5
Nutrition	14 939	8	6 325	4	21 264	6.0
Community and family-based services	8 937	5	10 579	7	19 516	6.0
TOTALS	200 023	100%	159 043	100%	359 066	100.0%

Table 3: Number of institutions, centres and installations which have received UNICEF equipment and supplies in Africa, South of the Sahara

	Through 1959	1960-69	1970-79	1980-85	TOTAL through 1985
Child health[a/]					
District and referral hospitals	136	112	1 431	1 190	2 869
Urban health centres and institutions	39	496	1 041	1 728	3 304
Rural health centres	247	1 043	5 535	10 653	17 478
Sub-centres, villages MCH centres	399	2 357	13 120	20 665	36 541
TOTAL child health	821	4 008	21 127	34 236	60 192
Water systems[b/]					
Open/dug wells and handpump installations	--	--	4 221	21 134	25 355
Engine driven pump installations	--	--	306	312	618
Piped and reticulated systems	--	--	186	575	761
Others[c/]	--	--	1 168	10 849	12 017
TOTAL water systems	--	--	5 881	32 870	38 751
Child nutrition[d/]					
Demonstration centres [e/]	--	2 485	7 754	14 466	24 705
Support centres[f/]	--	1 365	352	344	2 061
Training centres	--	72	1 644	6 772	8 488
TOTAL child nutrition	--	3 922	9 750	21 582	35 254
Family and Child Welfare					
Child welfare centres	--	595	11 607	4 800	17 002
Women's institutions[g/]	--	2 437	8 091	68 072	78 600
Centres for adolescents and youth	--	1 223	3 544	48 256	53 023
Training institutions	--	274	704	1 190	2 168
TOTAL family and child welfare	--	4 529	23 946	122 318	150 793
Formal education					
Schools	--	7 205	32 920	40 615	80 740
Teacher training institutions	--	361	964	916	2 241
Other institutions	--	311	1 282	1 080	2 673
TOTAL formal education	--	7 877	35 166	42 611	85 654
Pre-vocational training	--	3	2 190	1 178	3 371
TOTAL	821	20 339	98 060	254 795	374 015

a/ Institutions receiving "replacement" and other ad hoc suppliers are not included.

b/ Data for water systems available only beginning with 1973; however data for "other" installations available only beginning with 1978.

c/ Including spring protection, rain water collection, water treatment plants, etc.

d/ Excluding milk and food conservation.

e/ Including school gardens and canteens, nutrition centres, nutrition demonstration centres/clubs, community gardens.

f/ Including seed production units, fish hatcheries, poultry hatcheries, etc.

g/ Including community centres, cooperatives, etc.

Table 4:
Number of national personnel trained with UNICEF stipends in Africa, South of the Sahara

	Through 1969	1970-1979	1980-1983	Total through 1983
Health				
Doctors	1 091	578	300	1 969
Nurses and midwives (including auxiliaries)	5 849	31 783	7 767	45 399
Traditional birth attendants	395	8 834	3 137	12 366
Other health and sanitation personnel	8 898	41 713	38 014	88 625
TOTAL health personnel	16 233	82 908	49 218	148 359
Nutrition				
Village volunteers	75 221	37 637	9 476	122 334
Technical and admin personnel	156	5 595	4 835	10 586
TOTAL nutrition personnel	75 377	43 232	14 311	132 920
Family and child welfare				
Women's education and training	1 928	29 704	23 844	55 476
Other welfare personnel	27 626	48 876	44 015	120 517
TOTAL family & child welfare personnel	29 554	78 580	67 859	175 993
Education				
Teachers	32 389	169 790	55 106	257 285
Other education personnel	124	24 101	16 375	40 600
TOTAL education personnel	32 513	193 891	71 481	297 885
Pre-vocational training	494	3 728	1 451	5 673
Other				
Planning personnel	45	394	2 293	2 732
Statisticians	--	574	1 246	1 820
Transport personnel	18	58	233	309
TOTAL other personnel	63	1 026	3 772	4 861
TOTAL	154 234	403 365	208 092	765 691

Table 5: UNICEF expenditures for Africa, South of the Sahara by countries from inception of assistance to the end of 1985

	1947-59	1960-69	1970-79	1980-85	TOTAL 1947-85
		(in thousands of $US dollars)			
Angola	--	--	8 166	17 953	26 119
Benin[b]	--	537	2 866	6 122	9 525
Botswana	46	97	1 535	1 491	3 169
Burkina Faso	23	1 178	5 534	12 196	18 931
Burundi	--	312	4 188	7 711	12 211
Cameroon	77	734	1 917	3 348	6 076
Cape Verde	--	--	1 326	1 429	2 755
Central African Republic[a]	38	625	3 851	5 297	9 811
Chad[a]	36	718	3 305	10 177	14 236
Comoro Islands	--	13	1 105	915	2 033
Congo[a]	14	746	1 120	691	2 571
Djibouti	--	--	104	4 147	4 251
Equatorial Guinea	--	--	88	968	1 056
Ethiopia	629	3 247	23 517	72 946	100 339
Gabon[a]	15	428	336	22	801
Gambia	49	246	806	1 174	2 275
Ghana	392	1 484	3 929	7 800	13 605
Guinea[b]	57	959	3 502	5 326	9 844
Guinea Bissau	--	--	2 310	3 614	5 924
Ivory Coast[b]	--	1 844	2 553	2 971	7 268
Kenya[c]	553	4 242	5 112	6 609	16 516
Lesotho	21	644	1 570	1 860	4 095
Liberia	422	415	2 540	3 501	6 878
Madagascar	--	1 205	2 799	6 132	10 136
Malawi	54	462	3 312	5 812	9 640
Mali[b]	--	1 601	4 835	11 115	17 551
Mauritania[b]	--	1 058	1 748	4 172	6 978
Mauritius	36	235	1 888	1 214	3 373
Mozambique	--	--	6 091	12 930	19 021
Niger[b]	4	991	3 951	9 242	14 188
Nigeria	1 438	6 902	20 213	25 809	54 362
Rwanda	--	496	5 529	7 978	14 003
Sao Tomé/Principe	--	--	486	367	853
Senegal[b]	66	1 374	3 175	6 537	11 152
Seychelles	--	51	140	454	645
Sierra Leone	136	636	1 325	2 635	4 732
Somalia	607	1 179	6 525	21 889	30 200

Table 5 continued...

	1947-59	1960-69	1970-79	1980-85	Total 1947-85
St. Helena	6	8	1	--	15
Swaziland	--	282	1 078	1 464	2 824
Tanzania[c/]	458	2 208	16 776	37 070	56 512
Togo	41	671	1 906	1 546	4 164
Uganda[c/]	250	1 780	3 224	30 353	35 607
Zaire	--	2 046	5 949	10 691	18 686
Zambia	25	484	2 212	2 545	5 266
Zimbabwe	18	--	--	7 976	7 994
Belgian Congo, Rwanda and Burundi	194	--	--	--	194
French Equatorial Africa	454	(38)	--	--	416
French West Africa[b/]	3 383	20	--	--	3 403
East Africa[c/]	51	--	--	--	51
Sudano-Sahelian drought	--	--	12 753	191	12 944
Regional	39	2 396	5 315	7 760	15 510
TOTAL	9 632	44 514	192 510	394 050	640 706

a/ French Equatorial Africa consisted of states which became independent in 1960: Chad, Gabon, Congo, Central African Republic.

b/ French West Africa consisted of states which became independent in either 1958 or 1960: Benin (formerly Dahomey), Guinea, Ivory Coast, Mali, Mauritania, Niger and Senegal.

c/ East Africa consisted of states which became independent: Kenya (in 1963), Tanzania (in 1961), and Uganda (in 1962).

III. Index