CF/HST/MON/1989-001

UNICEF IN THE MIDDLE EAST AND NORTH AFRICA:

A HISTORICAL PERSPECTIVE

UNICEF HISTORY SERIES
MONOGRAPH XII

(87p)

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PREFACE

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

UNICEF's main preoccupation after its establishment in the Post-World War II era was the provision of relief to the children of war-torn Europe and Asia, a task it accomplished with great energy and with benefit to millions of children. In 1948, dramatic events were taking place in the Eastern Mediterranean region, when war broke out in the aftermath of the partition of Palestine and the establishment of the State of Israel, under a United Nations resolution. Masses of Palestinians fled the hostilities into the West Bank and Gaza and to the neighboring countries. UNICEF entered the picture providing aid to children and mothers among the Palestinian refugees, and to those new immigrants to Israel. Even after the UN General Assembly created UNRRA in December 1949, an agency to especially look after the Palestinian refugees, UNICEF continued to provide assistance to Palestinian children and mothers. Conflict between the two sides erupted again and again: in 1956 (the Suez War), in 1967 and in 1973, each time aggravating an already bad situation; and in each instance UNICEF offered what assistance it could to alleviate the suffering.

The decade of the fifties, however, was for UNICEF a period of combatting some of the most common infectious diseases, particularly those affecting children. Both in the Eastern Mediterranean, and in North Africa, an energetic anti-tuberculosis campaign was carried out, whose main weapon was the screening of children, and the immunization by BCG vaccine. By mid-1955 it was estimated that some 15 million children were tested and 5.7 million had been vaccinated in the Region.

About this same time a world-wide effort to control malaria was under way. Because it was the most widespread disease in the world, and particularly because of its highly negative impact on children, UNICEF joined in the campaigns, advised by WHO on the technical aspects. In the Middle East, UNICEF supported malaria control efforts in the most affected countries, Turkey, Iran, and Iraq, through the supply of insecticides (DDT) for residual spraying, related equipment, and transport. Other countries to benefit from malaria control, and later on "eradication" efforts were Egypt, Israel, Jordan, Lebanon, and Syria. Various technical and administrative set-backs faced the malaria campaigns, but in the process a large number of auxiliary health personnel involved were trained to become an important element in the future development of basic health services.

Trachoma and other infectious eye diseases affected the lives of large numbers of children in the Eastern Mediterranean and North Africa. UNICEF joined WHO in supporting governments' efforts in combatting these diseases which required massive case finding, prophylaxis and treatment with an

antibiotic ointment, health education and environmental sanitation measures. The largest campaigns supported by UNICEF in this field were conducted in the Magreb countries: Algeria, Morocco and Tunisia; in Egypt and to a lesser extent in every other country in the Region. These projects were supported materially and technically between 1952 and 1962. Other diseases were also under attack although on a smaller scale, including bejel/syphilis, mycosis and bilharziosis.

As these campaigns against specific diseases became gradually integrated into the preventive and curative public health services, UNICEF shifted its attention to the support of the developing maternal and child health services (MCH). Practically every country in the Region was beginning to develop MCH services starting in the early fifties and accelerating into the next decade. UNICEF supported governments' efforts in the extension, as rapidly as possible, of simple and practical measures to benefit the health of mothers and their children, especially in rural areas. These included the training of traditional birth attendants and auxiliary health workers; support to training institutions for nurses and midwives; transport; and basic health centre equipment and supplies. The expansion of MCH services faced many difficulties and set-backs. Noted among these were inadequate educational levels to permit sufficient recruitment of health personnel, and traditionalism related to the role of women in society which discouraged females from entering public service functions as nurses. The most rapid expansion in MCH services took place in Egypt, Turkey, Algeria and Morocco. Support to MCH services became a long term commitment by UNICEF, with shifts of emphasis, in the forms and extent of support, as time went on.

UNICEF's early concern with nutrition was reflected in its large programme of powdered skim milk distribution as a means of supplementary feeding, directed as a priority to post-weaning and pre-school age children and to pregnant and nursing mothers. In that era of huge surpluses of the milk powder, the channels for distribution were the health centres at all levels, and for a while primary schools. The latter was soon abandoned as local resources to manage it proved inadequate.

From milk distribution the emphasis shifted to milk "conservation", considered a means of promoting self sufficiency by countries for a food commodity of importance to children's health. One of the first countries in the region to benefit was Israel beginning in 1951. Eventually three Israeli dairies were aided by UNICEF equipment and technical support towards full production some four years later. By 1955 about 20 per cent of UNICEF's allocation in the Region went for support of milk conservation in Egypt, Iran, Iraq, Israel and Turkey. In return for UNICEF support the beneficiary countries committed themselves to free, or highly subsidized, milk distribution to children of the vulnerable populations. These efforts went on into the mid-sixties when a widening approach to the problems of nutrition was adopted jointly by UNICEF, the governments concerned and by FAO, UNICEF's technical adviser on food and nutrition.

National nutrition surveys were carried out in various countries. Nutrition education became an important avenue to spread knowledge about infant and children's nutritional needs, and the means to meet them. The target of these efforts in the first place were the providers of health, education and welfare services. Through training courses for their personnel, seminars and conferences for policy makers, it was hoped that national awareness of the problems would lead to long-term solutions. Progress in all of these efforts related to nutrition was uneven, but both UNICEF and countries concerned learned important lessons which proved to be of great value later on.

The decade of the sixties ushered in two important developments related to UNICEF cooperation with the countries of the Middle East and North Africa. As most countries adopted systematic national development planning as a means of charting their avenues of growth and development, UNICEF adopted the "country approach" by which its assistance was to be planned in response to the countries' own priorities, relevant to children, as stated in their national development plans.

The second development was the growth in support to education, carried out in cooperation with UNESCO. Support was provided to teacher training, textbook development and production, science education and to non-formal education. The greatest effort went in support of the countries most educationally deprived e.g. Sudan and Yemen; and generally to the segments of the population in all countries most deprived of educational opportunities e.g. rural children, girls; and among adults, women. The latter group benefited from support to literacy programmes.

From the sixties and through the seventies, a proliferation was observed in substantive fields of activities as well as in methods and approaches favored by UNICEF as strategies most favorable to the welfare of children in the Region. Support to new fields was particularly evident in relation to water supply and sanitation, where the emphasis was placed on assisting countries in the development of low-cost technologies for drilling of wells and for gravity-fed schemes, always with active participation of the beneficiary population. A prominent example in this field was the Sudan.

Another field of interest was that of the "Urban Child". The Egyptian capital, Cairo, became the ground for experimentation on the most appropriate community development approaches, the object of which was the creation of a better environment in which children can survive and develop. Women's programmes received particular attention from UNICEF in the Middle East/ North Africa Region where a vast majority of women are held back from development efforts because of tradition and poor educational levels. Included were literacy programmes, training in economic activities for out-of-school girls and research and studies. Particular attention in this effort was paid to the countries of the Gulf, and the two Yemens.

A programming approach favored during this period was the support to Basic Services provided in a mutually supporting manner, preferably at a sub-national level. This was applied to integrated programmes in Egypt, in

the newly reclaimed lands that could at the time benefit from irrigation capabilities created after the construction of the High Dam at Aswan. Similar procedures were successfully followed in Syria in connection with the Euphrates Dam development.

The region includes countries that are extremely poor, and several that are rich and prosperous. UNICEF cooperated with all these countries, depending on their needs. The oil-rich countries who were in great need of assistance for the development of their health, education and social welfare services, called upon UNICEF for assistance and for advice. The resulting UNICEF-assisted activities were largely paid for directly or indirectly by the beneficiary countries themselves.

The civil war that began in Lebanon in 1975 was, and continues at the time of writing, to have a terrible impact on the children and women in that beleaguered country. The situation was aggravated further as a result of the 1982 Israeli invasion. Throughout this period UNICEF responded to one emergency situation after another. Besides the 'normal' country programme which continued in Lebanon, UNICEF carried out a major rehabilitation project especially in South Lebanon. This involved reconstruction or rehabilitation of hundreds of water supply systems, schools, health services units and social welfare facilities. This special operation, representing an unusual role for UNICEF, was headquartered in the town of Quana and cost over $40 million. And while UNICEF's regional operations were moved from Beirut to Amman, Jordan in 1984, the Lebanon country office remained in place performing valuable services.

The decade of the eighties dawned with the situation in Lebanon still unsettled; a hot war was raging in the Gulf between Iran and Iraq; and a quiet insurgency war in the Sudan kept the Southern part of that country in turmoil. UNICEF's newly appointed Executive Director proposed new measures that could dramatically reduce infant and child mortality and morbidity rates, and these were being vigorously pursued in the Middle East/North Africa Region as in every other region. He considered these to be on cutting edge of an eventually extensive primary health care system in the developing countries. The key measures were the promotion of breast feeding; expanded immunization efforts; wider use of oral rehydration therapy (ORT) as a counter measure the deadly dehydration resulting from diarrheal disorders in infants and children; and growth monitoring to help parents detect any faltering in the growth of their children. These and other supporting measures combined were given the name of Child Survival and Development Revolution or CSDR. In every UNICEF office in the Region, and in cooperation with the respective countries, the CSDR programmes were given top priority status aided and abetted by vigorous social mobilization techniques.

* * *

INTRODUCTION

:UNICEF beginnings

In November 1943, at a time when the term "United Nations" was used to describe the alliance between the United States, the U.S.S.R. and Great Britain, the United Nations Relief and Rehabilitation Administration -- UNRRA -- was set up, with a membership of over forty countries and dominions, to provide relief and rehabilitation immediately war hostilities ended. Its operations preserved the lives of hundreds of millions of people on all continents.[1]

In August 1946, a decision was taken to liquidate this organization. But before its demise, UNRRA had recommented to the United Nations that a Children's Fund be created to be financed initially from the residual assets of UNRRA. The United Nations International Children's Emergency Fund (UNICEF) was created by a resolution of the United Nations General Assembly on 11 December 1946.[2] The resolution established certain priorities for the aid to be provided by this new organization: a) for children and adolescents of countries which were victims of aggression; b) for the benefit of children and adolescents of countries at the time receiving assistance from UNRRA; and c) for child health purposes generally, giving priority to children of countries victims of aggression.

In accordance with the third priority for use of the Fund's resources for child health in general, this mandate was gradually expanded as the Fund's resources increased and the urgent post-war needs in Europe were met. In the early period, emphasis was on providing assistance to children in Europe. At the peak of this operation, some six million children were receiving a daily supplementary meal, and some five million children received clothing and shoes made from materials provided by UNICEF.[3] Aid was given for health and BCG anti-tubercular vaccination campaigns, and a little later, for milk conservation projects.

Gradually, both the geographic scope and the variety of UNICEF's aid was enlarged outside Europe. In 1949, it commenced operations in China and other Asian countries; in that same year it provided emergency relief for Palestine refugee mothers and children (see following chapter for details); and the following year, other countries in the Eastern Mediterranean and North Africa Region were to benefit from UNICEF in such programmes as BCG campaigns and maternal child welfare (MCW). Aid to Latin America and to Africa was to start in 1949 and 1950 respectively.

:The Eastern Mediterranean and North Africa Region

The Region designated by UNICEF as the Eastern Mediterranean and North Africa covers a large group of countries in western Asia and northern Africa that represent a wide variety of political, economic and cultural situations. Some had long standing status as independent countries; others were still struggling to free themselves from British or French dependence; and one

country (Libya) was a United Nations Trusteeship territory. The vast majority of these countries, however, share common cultural elements: the Islamic religion, the Arabic language and a common history that dates back to the seventh century.

The region extends from Iran in the east to Morocco in the west and from Turkey in the north to the Sudan in the South. It generally encompasses the countries covered by the frequently used term of Middle East.

:An administrative note

The administration of UNICEF cooperation with the Governments of this region varied in structure from time to time. In the early days Paris was the site of a Regional Office, within which Beirut functioned as an Area Office. An Area Office for North Africa was established in Algiers in 1963. Both Turkey and Ethiopia were served by the Beirut Area Office. In the latter part of the sixties Beirut became the location for the Regional Office for the Middle East, known as Eastern Mediterranean Regional Office, or EMRO. Later on the Office would also cover North Africa and became known as MENA (Middle East/North Africa). In 1984, the Office was relocated to Amman, Jordan due to the war in Lebanon.

* * *

AN EMERGENCY IN PALESTINE

:Request to UNICEF for aid

UNICEF's entry into the Middle East Region was brought about by the dramatic events which took place in Palestine in 1948 as a result of the resolutions taken by the UN General Assembly calling for the partition of that territory and following the establishment of the State of Israel. When the resulting hostilities broke out in the Region, hundreds of thousands of Palestinian refugees throughout the area found themselves in dire straits with makeshift shelter, uncertain food and water supplies, and with no medical facilities to speak of.

On 27 April 1948 the United Nations Palestine Commission transmitted a communication it had received from the Women's International League for Peace and Freedom requesting that UNICEF be approached for an allocation of food and drugs for needy children in Palestine to be distributed through the good offices of the International Committee of the Red Cross. When UNICEF's Executive Director, Mr. Maurice Pate, received this request, he wrote the Chairman of the Palestine Commission informing him that under UNICEF's mandate from the UN General Assembly[4], the Fund should carry out its activities "in agreement with the governments concerned", and stipulated further that, "The Fund shall not engage in activity in any country except in consultation with, and with the consent of, the Government concerned." The Executive Director suggested that this issue be cleared as a prelude to UNICEF receiving a formal request for assistance, and he informed the UNICEF Executive Board's Programme Committee of his actions on 3 July 1948. As it happened, the UN General Assembly in May 1948 had relieved the Palestine Commission from the further exercise of its responsibilities, at the same time creating the office of Mediator for Palestine, which was filled by the late Count Folke Bernadotte of Sweden.

An emergency meeting of the UNICEF Programme Committee was convened in Geneva on 14 August, 1948 to consider the urgent request of the United Nations Mediator for Palestine for immediate assistance from UNICEF for mothers and children among refugees from combat areas.[5] The issue of a "government request" was resolved, UNICEF accepting the Mediator for Palestine as the legitimate spokesman for the humanitarian needs of the Palestinian Children and mothers. The Committee had before it, in fact, a request with regard to "assistance for refugee Arab and Jewish children, nursing and pregnant women". These proposals were put forward by the Mediator for Palestine whose representative, Sir Raphael Cilento, was present at the Committee meeting. The Committee became convinced that an emergency situation existed in which UNICEF could be of assistance and that such assistance was within its competence.

The request as submitted provided information based on a survey to determine the composition of the population to be assisted and to ascertain the condition of the refugees. Of an estimated 247,000 Palestine refugee children and women, 50,000 were in Lebanon, 60,000 in Syria, 125,000 in Transjordan, including the Nablus, Tulkarm and Ramallah areas of Arab Palestine, and 12,000 in Egypt. A breakdown by age group of children was provided: 41,250 under 2 years, 55,000 between 2 and 5 years and 115,000 between 5 and 18 years. There were, in addition, 12,500 pregnant women and 24,000 nursing mothers.[6]

The assistance requested was for food estimated to cost $786,563 plus shipping costs. The food list included wheat flour, rice, meat, fish, cheese, margarine, sugar, salt, fruit, and whole milk powder. The Committee recommended that assistance be provided to 270,000 children, and nursing and pregnant mothers, under an allocation of $411,000 (apart from shipping costs) to cover the foods listed above (with the exception of wheat flour since the Committee considered that cereals were not the type of protective food that UNICEF regarded as appropriate for inclusion in its programmes). The Mediator's representative indicated that he expected to receive cereals from other sources.

:Helping children on both sides

At the same time a letter was sent by the Representative of the Provisional Government of Israel to the Executive Board saying that the relief measures contemplated "...may be extended to apply to children and mothers within the territory of Israel and the territories occupied by its military forces. The children and mothers concerned are both Jewish and Arab."[7] The letter gave an estimate of the numbers involved: 12,000 children and 8,000 women.

Thus the way was cleared for UNICEF to provide assistance to children and mothers in need on both sides of the conflict that was then raging in the Region. The Programme Committee recommended that authority to approve the plan of operations be given to the Chairman of the Executive Board, the Chairman of the Programme Committee and to the Executive Director.

Prompt steps were taken for implementation. The first two shipments of food of approximately 110 tons each, sailed from New York on the 24th of August and the 1st of September 1948. The first shipment arrived in Beirut on the 15th of September 1948, less than one month after the Board action. Other shipments were to follow quickly to Beirut and Haifa. Feeding operations began in all Lebanese refugee camps on the 1st of October and supplies were sent the following week to Transjordan, Syria, and Northern Palestine. Because of the complexity of the situation and the rapidly changing conditions, special arrangements for delivery and distribution of supplies had to be made. These were to be received by the UN Supply Officer in Beirut, then reshipped to Syria and Transjordan where the governments were responsible, together with UN officials, for the distribution to the refugee camps. In Arab Palestine, however, where no government existed, a representative of the Palestine Refugee Committee carried out this responsibility together with United Nations Officials.

A UNICEF Mission in the Middle East was established in Beirut consisting of a Chief of Mission, Dr. Pierre Decoeudres, assisted by a Supply Officer, a Field Observer and an Administrative Officer. This staff was already in place in Beirut on 21 September 1948. The Mission was to work closely with the Director of the UN Disaster Relief Project, Sir Raphael Cilento, and his staff. An exchange of information was maintained with the voluntary organizations providing aid in the Region, including the International Red Cross, League of Red Cross Societies, various national Red Cross and Red Cresent Societies and the World Council of Churches. To provide a legal basis for the United Nations and UNICEF's relief work, formal agreements were concluded between the Mediator for Palestine and the Governments of Egypt, Lebanon, Syria and Transjordan. These were soon followed by exchanges of letters between UNICEF, these governments and the Transitional Government in Israel, and preliminary Plans of Operation were developed.

It was estimated at the time that a maximum of 270,000 refugee children and mothers were receiving direct assistance in the Arab States and 45,500 refugees in the State of Israel, both Jews and Arabs.

:A worsening situation

By October 1948 the situation in the Middle East had deteriorated further due to escalation in the conflict and the influx of a greater number of refugees. A wave of pessimism pervaded the international community in the aftermath of the tragic assassination of the Mediator for Palestine Count Folke Bernadotte. On 19 October UNICEF's Board Chairman received a letter from Dr. Ralph Bunche, United Nations Acting Mediator for Palestine, pointing to the "extreme gravity of the situation" and outlining the minimum measures which he believed to be required "if a disaster is to be averted."[8] He had proposed to the UN General Assembly measures including the provision of a considerable amount of relief supplies over a period of a "minimum of nine months from 1 December." He invited UNICEF to play an important role in the operation envisaged and he referred to the fact that the Central Committee of UNRAA had recently transferred to UNICEF its residual assets amounting to about $12,000,000 and strongly recommended that at least half of these funds be used for the "development of a relief programme for Arab and Jewish refugees eligible for UNICEF assistance within the framework of a general relief programme coordinated by the Mediator".

The Programme Committee was convened on 23 October, 1948 to deal with this request and to formulate recommendations for action by the Executive Board on 2 November, 1948. The request by the Mediator presented UNICEF with one of its earliest policy challenges as evidenced by a statement of its Executive Director, Maurice Pate and included in his recommendation to the Programme Committee in which he expressed deep concern "that we should not be diverted from our fundamental task of supplementary aid."[9] He felt that UNICEF should not be drawn into long term commitments of an exceptional nature. The Fund had established the practice in its European post-war relief programmes "to do no more than provide a food supplement of under 300 calories to less

than 6 percent of the children in recipient countries".[10] UNICEF was looking forward to a future, not as a full-time relief agency, but as an organization which was to aid governments in need in the improvement of the health and well-being of its children and mothers, without excluding the provision, on a short-term basis, of relief in emergency situations. The Executive Director's recommendation was to provide aid to 250,000 Palestinian refugee children and mothers in the amount of $2,200,000 to include shelter, medical supplies and food to meet the needs "through the winter months", for a period of about four months when the United Nations overall plan for the Middle East refugees will have been developed. The recommendation was debated at length and differing views were expressed.

The two resolutions submitted to the Committee differed only on the sum of money to be allocated at the current session. A joint resolution of the United Kingdom and United States called for an allocation of $6,000,000. The resolution submitted by China called for approval of the Executive Director's recommendation for an allocation of $2,200,000, and that further allocations be considered by the Programme Committee and the Executive Board at their next session. The Committee adopted the latter resolution.

A dramatic reversal took place a few days later, however, when the full Executive Board met and voted in favor of the joint UK-USA resolution for the allocation of $6,000,000. It, however, approved as a first practical step the allocation of $2,200,000. The plan, it was understood, would be subject to modification on the basis of availabilities and the nature of supplies provided from other sources. No time limit was set on the expenditure of this initial amount.[11]

Expeditiousness continued to characterize implementation of the new commitment. By 15 January 1949 a large proportion of the $2,200,000 supply programme was en route or completed. This occurred despite a shipping strike in the United States during this period. UNICEF was able to divert its shipments which were destined for other receiving countries and rushed them to the Middle East.

At the end of 1948 the UN Disaster Relief Project formally came to an end and a new organization to handle overall relief for Palestine refugees, the United Nations Relief for Palestine Refugees, came into existence. UNICEF aid to Palestine refugees was from that time on to be coordinated with this new UN body and with three major non-governmental organizations: the International Committee of the Red Cross, the League of Red Cross Societies, and the American Friends Service Committee. Agreements between UNICEF and these four entities were negotiated. During this period the number of refugees had grown from 500,000 to 800,000 and the UNICEF beneficiaries had increased to 350,000, compared to an estimate of 250,000 in October 1948.

An important development at the time was the participation of the World Health Organization WHO in the Palestine relief programme. An agreement was reached between WHO, the UN Relief for Palestine Refugees, and the three voluntary agencies for the assignment of a number of WHO staff to coordinate

the public health and epidemic prevention aspects of the health activities in the area of operations. Dr. G.D. Cottrell of New Zealand was assigned to this task and was accepted by UNICEF as its Medical Advisor for any projects that would be financed by UNICEF.[12] It is of interest to note that this programme of aid to Palestinian Refugees by WHO continues to this day in cooperation with UNRWA.

In March 1949 Dr. Cottrell proposed a "Middle East Programme on Health Protection of and Medical Services to Refugees" which requested equipment and supplies for use in preventive measures, an anti-malaria campaign, smallpox and diphtheria vaccines, and drugs for treatment of intestinal, skin and eye diseases for children. The programme would cost $2,250,000 until the end of 1949, and UNICEF agreed to provide $450,000 towards it in the form of supplies and equipment.[13]

In May 1949 the Programme Committee was informed by the Executive Director that 500,000 refugees, beneficiaries of UNICEF, were receiving assistance, and the Executive Board had already approved a commitment of $4 million, and a recommendation for committing the remaining balance of $2,000,000 was presented. The cautious optimism expressed earlier that the prospects for a political settlement had improved, had all but disappeared. Further funds were committed to keep the programme going until the end of 1949 when it was hoped that the United Nations, then scheduled to discuss the problem of the Palestine refugees, would come up with a long-term solution.

:The health situation

In spite of the difficult situation prevailing in mid-1949 and the "exposed situation of the refugees", no serious health problems had arisen and this was attributed to the adequacy of medical supplies provided by various organizations and UNICEF, the competent management of health and sanitation measures, and "good fortune in the absence of epidemics".[14] The use of DDT was reported to have had noteworthy results on the control of malaria. The major health problem was apparently tuberculosis. Therefore, approval was given to conduct a Joint Enterprise (UNICEF jointly with the Danish Red Cross and its Scandinavian affiliates) BCG campaign, among refugee children in Lebanon, Syria, North Palestine, Transjordan and Southern Palestine.

:Israel aided

In October 1949 approval was given for an allocation of $250,000 to Israel for a six month programme for the first half of 1950. The feeding programme was to include infants age zero to one year in infant welfare centres, whereas whole milk was provided to pre-school age children in nurseries and for school lunches. The first of these programmes was favored because it assisted the Israeli government in expanding its network of infant welfare centres for both Jewish immigrants and Arab children. The school lunch programme was supported because it was to be especially helpful to Arab and North African Jewish immigrant children who were subject to compulsory school attendance for the first time that year. Additionally, $30,000 was to be utilized for medical supplies for the purpose of anti-epidemic campaigns.

An interesting request pertaining to this programme appears in a note by the Israeli government indicating its "preference to receive cows for the equivalent dollar value of the milk supply requirements".[15] The government offered, in this case, to provide the necessary transport of these cows to Israel without additional cost to UNICEF. If approved, the government promised to provide the equivalent quantity of milk as provided for in the programme. The Executive Director favored this approach and recommended it to the Programme Committee since "it would not only serve to provide for the immediate emergency needs, but would aid the government in its longer range efforts to improve the milk supplies for priority groups of children and pregnant and nursing mothers".[16] For practical reasons this was never carried out. However, Israel was later aided in its milk conservation projects.

An additional allocation of $119,500 was recommended to continue the feeding programme for infants and school children, for woolen materials and leather to be made into winter clothing and shoes for children, and for medical supplies to prevent epidemics. The new programme was to cover the needs into the winter of 1950-1951. By the end of 1950, UNICEF aid to Israel amounted to $405,000. Requests for larger amounts of aid could not be considered due to the financial strictures UNICEF was then facing.

:UNRWA established: UNICEF cooperation

Late in 1949, while awaiting a decision by the UN General Assembly aimed at providing more systematic aid to the Palestinian refugees, UNICEF's governing body decided to make provisions to meet the needs of its refugee population, i.e., children, pregnant and lactating mothers for "at least a 3-month period beyond the first of the year in order to permit supplies to be in place for continued uninterrupted feeding operations after the first of the year".[17] An allocation of $1,000,000 was, therefore, approved for this purpose. By November 1949 UNICEF allocations for the Palestine Refugee programme had totalled $9,361,000.

The anticipated action by the General Assembly finally materialized on 8 December 1949, when it established the United Nations Relief and Works Agency for Palestine Refugees in the Near East, to become known as UNRWA. An overlap period with United Nations Relief for Palestine Refugees was provided until 1 April 1950. The resolution creating this new body had also commended UNICEF for the important contribution it had made towards the United Nations programme of assistance. At that time UNICEF aid had reached a high of 547,000 beneficiaries.

Arrangements were made by UNICEF with the three voluntary agencies it had been cooperating with until then to cover the distribution responsibilities allotted to them until their expected withdrawal around 1 April 1950. The International Committee of the Red Cross had covered Northern and Central Arab-held and Jewish-held Palestine; the League of Red Cross Societies[18] was responsible for the adjacent Arab States of Lebanon, Syria and Jordan; and the American Friends Service Committee was responsible for the Arab-held areas of Southern Palestine (Gaza) adjacent to the Egyptian border.

In May 1950 an agreement was reached between UNICEF and UNRWA stating the conditions under which the latter would assume responsibility for the distribution of the supplies to be provided by UNICEF to refugee children and mothers.

An important achievement before the end of 1949 was the completion of a BCG campaign among the refugees: of 85,263 tested, 9,712 were found to be positive cases of TB, and 62,908 were vaccinated.

Aid to Palestinian children and mothers was to be continued to the end of 1950 in the form of food rations for 40,000 infants, 400,000 children aged 1-15, and pregnant and nursing mothers. The food supplies, except for milk, were to be pooled with UNRWA's own supplies. This aid package also included $400,000 for cotton textiles intended to relieve the desperate clothing situation which confronted the refugees. UNRWA was to provide the raw cotton, which was to be processed into about 1,200,000 metres of textiles in Czechoslovakia at the expense of the Czech contribution to UNICEF. It was finally the refugees themselves who were to make the garments out of goods as "work relief" projects. Towards the end of 1950 UNICEF assistance to Palestine refugees amounted to $10,583,000 which was expected to meet the programme's needs until June 1951.

Once more the Executive Board was requested to extend UNICEF assistance to Palestinian refugees to cover basic needs until July 1951. It was stated that the need of the refugees for relief continued virtually undiminished. The plan for integration and works projects have not been underway for a sufficient length of time to make refugees self-supporting. An allocation of $195,000 was approved. This was to be further extended to the end of 1951 at an estimated cost of $700,000, by which time the number of aided refugees was about 320,000. This number was based upon field estimates of continuing need and discussions with UNRWA. Total aid since November 1948 totaled $11,478,000.

:New immigrants to Israel

Immigration to Israel was continuing at an average rate of 15,000 per month, and a sudden increase in the prospect of Jewish immigrants from Iraq was expected to add another 25,000 between April and July 1951, thus putting a severe strain on available food resources of Israel. In the May 1951 session of the Executive Board an allocation of $100,000 was approved for emergency supplementary feeding of infants and school-children for the period ending December 1951. The assistance approved was for 4,000 infants and 50,000 school children.

:Jordan - Dilemma of the border villages

The problem of "economic refugees" came to light in early 1952 when Jordan requested aid for some 35,000 mothers and children who were living in destitute situations on the borders of Jordan and Israel in the neighborhood of Nablus, Ramallah, Hebron and Bethlehem.[19] The populations concerned, while not obliged to move from their villages, had lost their cultivable lands to the other side of the armistice boundaries and thus had lost their means of livelihood. Not considered as refugees, they did not qualify for UNRWA's assistance. After four years of such existence the vast majority of these

"border village" inhabitants had exhausted all means of support and had no opportunity for working to create a livelihood. To alleviate their situation an emergency feeding programme was approved for the period February to May 1952 using a combination of government facilities and personnel and the UNRWA distribution system. The programme cost $60,000 and was to be reviewed by the Board towards the end of the aid period, when it was hoped that bilateral aid would come to the rescue of this unfortunate group.

About this time it became clear that no diminution in the number of refugees was taking place and that hardly any change in the nature of the problem had occurred. UNRWA was supporting 875,000 refugees, including 410,000 mothers and children, and the "reintegration" projects called for in the UN resolution to enable refugees to become self supporting were still largely in the planning stages. Since 1948, UNICEF had allocated some $12,000,000 for assistance to Palestinian refugee mothers and children, and in 1952 was obliged to allocate an additional $1,560,000 for continued assistance until 30 November 1952. Most of the aid offered consisted of food supplies, with smaller amounts for emergency medical supplies and shelter material such as blankets and clothing. At the Board session in April 1952 approval was given to the provision of prefabricated buildings for use by UNRWA in child health and welfare-related activities. These were initially intended for a programme in Korea and had an estimated cost of $765,000.

The unease felt by the Executive Board because of the relatively heavy drain on UNICEF resources due to continuity of this programme was reflected in the language of resolutions passed in the April 1952 session to the effect that these last allocations were made with the understanding that UNRWA would recommend to the next session of the UN General Assembly the assumption by UNRWA of the total feeding budget beginning 1 December 1952. While the Board did not close the door completely against further assistance, it was applying strong pressure on UNRWA and the UN to assume fuller responsibility for aid to the Palestinian refugees. UNICEF, however, had indicated repeatedly that it was willing to cooperate with countries hosting the refugees in easing the burdens imposed on the governments of those countries. This aid would be part and parcel of UNICEF cooperation with the countries concerned.

Recourse to contributions-in-kind and to restricted currencies was utilized throughout this period in an effective way to ship various commodities in aid of the Palestinian refugees. "In this way, by November 1952 UNICEF will have shipped to the Eastern Mediterranean region 300 tons of rice from Thailand, 1,298 tons of sugar from Peru, 222 tons of dates from Iraq, 1,485 tons of margarine from Australia and the Philippines, 100 tons of rye and 10 tons of sugar from Poland, clothes from Czechoslovakia, and pre-fabricated houses from Yugoslavia."

In June 1953, 840,000 Palestinian refugees were receiving rations from UNRWA; and approximately 360,000 mothers and children were benefiting from UNICEF supplies in spite of the fact that some development projects had been started and some rehabilitation had been effected. An allocation of $200,000 from the UNICEF emergency situation fund was recommended for 1954. This represented goods available to UNICEF in surplus or from contributions in kind or restricted currencies.

By 1954, with UNRWA assuming fuller responsibility for feeding programmes for the refugees, UNICEF support was limited to the border village population in Jordan, the so-called "economic" refugees in Gaza, and to 47,400 mothers and children among the Palestinian refugees, a total of 98,000.

During the period January to June 1954 UNICEF shipped to Egypt, for emergency feeding in Gaza, 20,000 pounds of skim milk, 329,000 pounds of tea and 176,000 pounds of dried fruits. For Jordan's border village aid: 682,000 pounds of skim milk, 328,000 pounds of rice, and 265,000 pounds of dried fruits. For Palestinian refugees, 3,960,000 fish oil capsules and 258,000 pounds of coconut oil.

UNICEF aid to Jordan's border villages, continued until the next round of hostilities erupted in the region in 1967, once more changing the map of human needs, especially for the children and the women.

:A new conflict

Once more, peace in the Middle East was shattered in June 1967 when armed conflict erupted resulting in the occupation by Israel of the territories of the West Bank of Jordan, of Gaza, the Golan Heights of Syria, and of the Sinai Peninsula of Egypt. Further tragic disruption to the lives of Palestinians ensued, to refugees and non-refugees alike, the latter were then considered "displaced persons". Vast movements took place in the direction of The East Bank of Jordan, into Syria and Lebanon and, to a lesser extent, Egypt. Across the Jordan river in East Jordan, some 75,000 UNRWA-registered refugees fled the fighting and about 100,000 others sought refuge as well. They were sheltered in schools, mosques and churches, or with friends and relatives in Amman and other towns as well as in three camps hurriedly set up in a radius of 40 kilometers from the capital.[20]

Three months later, with the approach of the school year, the school buildings had to be vacated. At the same time unrelenting sandstorms, followed by the approaching winter with its heavy rain and cold winds, made living conditions in the camps impossible, necessitating their transfer to the warmer climate of the Jordan Valley where seven camps were established, capable of accommodating 60,000 persons.[21] The displaced persons were violently disturbed once more in February 1968 when military incidents occurred, affecting not only the refugees and displaced persons, but also some 50,000 permanent dwellers of the Jordan valley who were obliged to move to neighboring areas. By April 1968, it was estimated that 323,000 displaced persons were living in Jordan. About the same time Syria was host to about 100,000 displaced persons and some 16,700 UNRWA-registered Palestinian refugees.

In Egypt, by 1968, some 15,000 mothers and children, refugees from Gaza and the Sinai Peninsula were being accommodated in the Tahrir and Minya land reclamation areas. In addition, about 300,000 Egyptian evacuees from the Suez and Ismailia towns were transferred inland. Immediately after the outbreak of war in June 1967, UNICEF's Executive Director, Harry Labouisse, allocated $500,000 from the Executive Director's Emergency Reserve to be used for urgent relief to mothers and children. By mail poll he asked the Executive Board to approve an additional $500,000 for supplies of penicillin and other drugs and blankets and these were air-lifted to Beirut from where they were dispatched to Syria and Jordan.

* * *

INTO THE DECADE OF THE FIFTIES

To combat disease

:BCG campaigns

In spite of UNICEF's preoccupation with the emergency situation in Palestine and the neighbouring countries from 1948 onward, it directed some attention to the major communicable diseases affecting the lives of the populations in the Eastern Mediterranean Region, and especially those that affected children and mothers. Reliable information about the health status of the countries concerned was woefully inadequate. UNICEF itself did not carry out any investigations as to the needs of children, but information by UNICEF personnel in the field and from WHO was conveyed to the Executive Board.[22] It was believed that the development of health and welfare services for children was the only effective means to counter tuberculosis, given the financial, technical, and staffing resources available at that time.

One of the earliest BCG campaigns in the Middle East was carried out by the Joint Enterprise, at the behest of UNICEF, in 1949 among Palestinian Refugee children, which eventually covered some 250,000 children in Lebanon, Syria, Transjordan and in North and South Palestine. In November of 1949, a similar campaign was conducted in Israel which managed, by the following year, to test 184,000 children and vaccinate about 100,000.[23] In Lebanon, the BCG campaign, which was limited to Beirut and its suburbs, tested 45,000 children and youths aged 1 to 18, and some 28,000 were vaccinated. The campaign in Egypt started late in 1949 as a one-year demonstration. By May 1950, 128,00 had been tested and 37,000 vaccinated. In Algeria, the campaign was initiated in November 1949 in agreement with the French government, with plans to test over 2 million children and youths. Six months later it was reported that 400,000 tests were carried out and 140,000 vaccinations completed. The successful campaign was completed by the end of 1951. Two other North African countries, Morocco and Tunisia, and the territory of Tangiers, benefited similarly from BCG vaccination campaigns in the same period.

In Jordan, beginning in 1954 the monthly average of children tested for TB reached 25,000 and 13,000 for those receiving BCG vaccination. By 1955 nearly all of the child population was covered. In the same year two permanent TB Control Centres were established in Amman and Jerusalem. TB vaccination became an integral part of the public health services.

1955 was a year of transition for UNICEF's anti-TB efforts, together with WHO, its key partner in this enterprise. Since its inception and until 1954, UNICEF assisted eleven countries in the region with BCG vaccination campaigns.[24] The cumulative number of children and youths tested by mid-1955 had reached 14 million, and 5.7 million had been vaccinated. Almost one-half of the total allocations for long-range mass health programmes were used for BCG vaccination campaigns.

In some countries, notably in Iraq, Jordan, and Lybia, it was felt that the time had come for the integration of BCG work with the existing public health services, and hence the technical assistance provided by WHO specifically for BCG campaigns was concluded. In Iran and Turkey and Tunisia, however, mass campaigns were to be continued for several years to come -- in this latter country until the early sixties.

The UNICEF/WHO Joint Committee on Health Policy (JCHP) was reviewing the progress of BCG campaigns at frequent intervals, examining problems related to the technical and administrative aspects. These included the quality of vaccines,[25] and the techniques used by field staff for testing and vaccinating. One of these reviews resulted in the creation of "assessment teams" in the Eastern Mediterranean region, which became active in obtaining "data on pre-vaccination tubercilii sensitivity" in villages and in the study of the allergic effects of different vaccine batches among school children.[26] When questions were raised in Iran and the Sudan during 1954 and 1955 about the value of the mass campaigns, WHO analyzed the findings of the assessment teams and confirmed the desirability of protecting the general child population in both countries through BCG immunization and recommended the development of mass campaigns. The advice was heeded and UNICEF provided the required assistance.[27] In Iran this necessitated a ten-fold increase in the number of immunization field teams from 8 to 80, where it was expected that some 12 million persons in rural and urban areas were to be tested in the course of five years.

The campaigns, however, did not proceed without difficulty. While they were generally well received by the population, certain factors worked against a fully efficient mass campaign. Typical of these, in the case in Iraq, were climatic conditions, the constant mobility of the nomadic population, and the prejudices and fears by some segments of the population. Material and financial difficulties intervened as well, as in the case of Turkey, when in 1956 severe gasoline shortages caused the reduction of field teams from 68 to 60. Later on, when fuel restrictions were lifted, UNICEF provided twelve jeeps and spare parts to replace worn-out transport, and by 1957 the number of field teams was restored to its original strength.[28]

:Other weapons against TB

While UNICEF aid against TB primarily emphasized mass BCG vaccinations, it supported other approaches. On the advice of the WHO Expert Committee on Tuberculosis it provided support to TB demonstration and training centres. These included facilities for diagnosis by X-ray (including mobile units) and by laboratory analysis. Each centre instituted a treatment programme in its immediate periphery. An additional weapon came increasingly into use when, in 1954-1955, inexpensive and effective anti-TB drugs came into use, among them Isoniazid (INH). On the advice of JCHP, UNICEF broadened its support to TB projects through the provision of drugs to TB centres for home treatment, whenever this could be provided under adequate domiciliary supervision of patients. But, as a result of studies carried out by WHO, the UNICEF Executive Board finally decided in 1959 against support to mass application of chemotherapy. The main reason for this change in policy was the growing conviction within UNICEF and WHO that TB control and other disease control

programmes should be dealt with as an integral part of basic public health policy in developing countries. This was the period when UNICEF was becoming more interested in supporting development of basic health networks, especially those for maternal and child welfare (MCW).

:Malaria -- control and eradication

In the mid-fifties, malaria was the most widespread disease in the world, striking some 350 million human beings. Malaria was endemic in a wide equatorial, tropical and semi-tropical belt surrounding the globe, but other regions were not immune from it. The widespread morbidity it caused had far-reaching negative economic effects on productivity and, in some areas, was capable of depopulation.[29]

Malaria's agent of transmission is the anopheles mosquito, which injects the parasites vivax and falciparum into the bloodstream of its victims. In modern times, efforts to control the disease were aimed at the mass elimination of mosquitoes. A powerful weapon came into wide use in the early forties in the form of an insecticide known as DDT. It was used in post-war Europe to control a variety of insect-borne diseases with some success. UNICEF's first assistance to countries trying to bring malaria under control took place in Greece, Hungary, Poland, and Yugoslavia. UNICEF's experience with the value of DDT residual spraying was soon to be applied in the countries of the Middle East and North Africa, a region seriously affected by malaria. During the desert campaigns of World War II, Egypt suffered a severe blow when Anopheles gambia, a virulent malaria-carrying mosquito appeared from the Sudan and resulted in the death of 180,000 people, mostly in the southern part of the country.

In 1954, over two million people in the Region were protected by DDT spraying. Of the total UNICEF allocation for mass disease control, over one-third was utilized for malaria control programmes. Assistance consisted of supplies of DDT, spraying equipment and transport and, in one case (Egypt), for a DDT production plant. In his progress report to the Executive Board in 1955, UNICEF's Executive Director reported that, despite the considerable efforts made in the past to control malaria, much work still remained to be done and substantial financial allocations would be required before eradication could be achieved. He added that eradication would probably be attempted first in Iran, Iraq, Israel, Jordan, Lebanon, Syria and Turkey, a group of countries with some 55 million inhabitants.[30]

Up until that time, the strategy used in combatting malaria was described as one of "control". Residual spraying was concentrated in parts of a country that were more highly infested. The main object was the reduction of malaria cases. For the first time, in 1955, the theory of "eradication" of malaria, strongly advocated by the WHO, was put before the Board. The object, it was proposed, should be the elimination of the disease through the total interruption of transmission. Malaria was one of the main causes of infant death, and where it was chronic, it severely undermined the health of mothers and children. With some hesitation, the Board agreed to join WHO in an effort to transform control programmes into eradication campaigns. In the following year, the Board set a global ceiling of $10 million a year for UNICEF's aid to malaria programmes. The UNICEF effort was to be concentrated in Latin America, with a comparatively smaller regional approach in the Eastern

Mediterranean Region.[31] Since its inception and up until 1956, of UNICEF's allocations of $2.8 million for mass disease programmes, $1.3 million was for malaria. By 1957, the figures went up to $6.1 million and $4.3 million respectively. Aid to malaria programmes was absorbing 37 per cent of UNICEF's total expenditure in the Region.[32] In Iran in 1956, epidemiological and entymological surveys carried out by WHO and national experts were continued in preparation for an eradication campaign to start in 1957, and plans were made for the protection of a population of 6.5 million persons in some 24,000 villages. Improved maintenance facilities for the fleet of vehicles to be used in the eradication campaign were made available by the country, and the training of field technicians was proceeding in the Malaria Institute in Teheran and in the field. UNICEF's aid to this programme up to that point totalled about $4 million.[33]

In Egypt, the DDT plant equipped by UNICEF began production in 1957 and reached its capacity in the following year, and the country was considering the conversion of its control operations to eradication. In 1957, in seven countries in the region, the number of inhabitants covered by anti-malaria operations reached about twenty million. A setback to the programme affecting Iran and Iraq occurred when it was established that the malaria vector A stephensi in the Gulf Area was resistant to DDT, affecting 2.3 million people in both countries. On technical advice from WHO, another insecticide, Dieldrin, was substituted for DDT in this area. A similar problem was soon to appear in southern Turkey. Besides technical problems, administrative, organizational and financial difficulties arose. This was not surprising, given the scale of operations, the large numbers of personnel that had to be employed seasonally, the complexity of the logistics involved, including transport, and the financial constraints faced by these developing countries.

A different type of problem, which in the long run proved difficult to deal with, was nomadism. Although the actual number of nomads was relatively small, their migratory habits made it difficult for spraying teams to locate them. The nomads' way of life naturally precluded living in substantial housing, preferring instead shelter in tents or grass huts. Neither type of shelter lent itself to residual spraying. The constant movement of the nomads also precluded the use of anti-malaria drugs -- chemoprophylaxis -- as an alternative measure.[34]

By the end of the decade and in cooperation with WHO, the largest proportion of UNICEF's allocations in the Eastern Mediterranean were expended on the eradication of malaria. Out of seven countries assisted, six contiguous territories were fully engaged in eradication campaigns. In spite of the difficulties and setbacks referred to above in the Eastern Mediterranean as well as in other regions, a major assessment carried out by WHO in 1959 asserted that the goal of eradication of malaria was attainable, that the strategy was sound and the principles upon which it was based remained intact[35]. However, as technical and logistic difficulties against eradication became increasingly manifest, including problems of insect resistance to insecticides, UNICEF, in reassessing the situation, concluded that the ultimate goal -- eradication -- was going to require much greater expense over a much longer period of time than originally thought. With many other problems facing children of the developing countries, the Executive Board decided in 1959 that no new malaria projects would be assisted except in very exceptional circumstances; and that renewal of aid to existing programmes

would depend on evidence of soundness from technical and financial points of view, and on whether the prospect of eradication was promising. By 1961, UNICEF's global expenditure on malaria projects had declined to $5.5 million from the previous high of $9.5 million. In 1964, UNICEF criteria for continuing support to malaria became even more stringent, and support to new projects all but ceased.

The decline in UNICEF support for malaria control and eradication did not result solely from disenchantment with or lack of confidence in the concept of eradication. UNICEF's own evolution at this time favored a broader approach to aiding children and mothers which was more in line with the United Nations "First Development Decade" that was to coincide with the decade of the sixties. Both in the Board and in the Secretariat, there was growing concern that a disproportionate amount of the organization's resources were being utilized for disease control, and especially malaria, to the detriment of other areas of work that could be of more immediate benefit to children and mothers. Until the late sixties support, on a diminishing basis, was still being provided to malaria projects in the Eastern Mediterranean countries, but for all intents and purposes, the era of UNICEF support to malaria and to mass disease control generally had come to an end.

It can be an error, however, to conclude from the above statements that the malaria programmes were unproductive. It is true that malaria was not eradicated, but in the Middle East Region several million people were spared the scourge of endemic malaria in countries such as Syria, Lebanon and Iraq, which had reached the "consolidation" stage.[36] As a result, infant mortality rates dropped and life expectancy improved. In some countries the anti-malaria drive was responsible for underlining the importance of developing a basic and permanent health services network. One of the key lessons learned was that without such a structure the gains of disease control campaigns could not be consolidated. In Iran, Iraq, Turkey, Syria and other countries where eradication was attempted, the large numbers of auxiliary medical personnel involved were retrained to become an important element in the development of health services, which were to dramatically grow in the decade of the seventies.

:Trachoma and other eye diseases

Trachoma and conjunctivitis were known as serious afflictions affecting the lives of millions of children in the arid and semi-arid regions around the world. These painful diseases threatened eyesight and led to blindness. In spite of the paucity of the epidemiological information then available about trachoma and associated eye diseases, it was estimated that, globally, some 500 million persons, mainly infants and children, were victimized by these diseases. It was commonly accepted that the Eastern Mediterranean Region had its large share of this epidemiology.

In 1952, when WHO and UNICEF entered the field of trachoma control, though not without misgivings, there were questions about the feasibility of large-scale approaches to treatment. It was generally established that frequent application of certain wide-spectrum antibiotics three to four times daily over a period of three to four months was required before a cure could be

effected. Moreover, the control of trachoma had to be directed not only against the disease itself but also against other associated eye diseases such as conjunctivitis. To be successful, a campaign had to include case finding, treatment, mass health education, control of vector agents (e.g., flies) and environmental sanitation measures.[37]

The early interventions by WHO and UNICEF took the form of pilot projects, including trials of mass treatment. In Egypt, in 1953 to 1954, a modest beginning was made when, with UNICEF assistance, some 5,000 pre-school children received sulphanamide prophylactic treatment against seasonal conjunctivitis, and 2,000 children were treated against trachoma with aureomycin ointment. Schoolteachers were trained to carry out the treatment under supervision. The effort was considered a great success.[38]

The following year, the project was expanded to cover one of the country's administrative districts. The Qaliub demonstration area, as it was described, provided for the treatment of school children, health education, sanitation measures and continued prophylaxis of pre-school children. Sixteen villages were involved in the demonstration project. The cost to UNICEF in 1956 was a modest $19,000 but high hopes were set upon it because of the research and evaluation work being carried out simultaneously. In that same year, WHO was helping the governments of Iraq, Jordan, Lebanon, Syria and Turkey to conduct surveys with a view to extending trachoma control measures in those countries. In the Maghreb countries of North Africa -- Algeria, Morocco and Tunisia -- full-fledged campaigns were already in progress.

The UNICEF Executive Board reviewed the progress made in this field in 1956 and again in 1959, on the basis of recommendations made by the UNICEF/WHO Joint Committee on Health Policy, Several types of strategies were being used: treatment of school children, assembling the whole population at given places, systematic house-to-house visits, mass case finding and selective treatment, tracing contacts, and self-treatment on a family basis.

A new strategy called for "intermittent" rather than continuous treatment. This stimulated the application of ointment twice daily on three to six consecutive days each month for six months. The object here was to simplify organizational arrangements, an important consideration in all mass disease control, and to effect economies in medications and staff time requirements. The "intermittent" approach was used in the pilot projects in Egypt and Turkey. In the latter country, UNICEF delivered antibiotics, transport and equipment for a project to be carried out in the new school year of 1957, with the initial objective of treating 7,000 school children. Eventually, the Turkish health authorities broadened the initial pilot phase into an intensified control programme in seven provinces.

:Trachoma in North Africa

By far UNICEF's largest involvement with campaigns against trachoma was in North Africa. On a continent which at the time was generally characterized by poorly developed health services infrastructures, Algeria, Morocco and Tunisia had relatively well-organized basic health services with a network of

stationary facilities such as clinics and health posts. The value of this was demonstrated in 1952, when BCG anti-TB campaigns were successfully carried out, which augured well for the outcome of the campaigns against trachoma and conjunctivitis.

The programme in Tunisia started in 1953 and concentrated on school children, and was pursued in a vigorous manner for several years. Seven years later, it would be reported that 400,000 new children were included in the campaign, of whom 250,000 needed treatment. In 1960, only the first graders in the schools needed to be subjected to "selective treatment" by then the only important reservoir of infection remaining in schools.[39] The campaign was extended gradually to cover all districts in the country. Of the total country population of about 4,000,000 about 2,460,000 persons were protected.

Unlike the strategy used in Tunisia, the anti-trachoma effort in Morocco called for the treatment of all school children without resort to screening, due to the shortage of medical staff. In 1960, the school campaign encompassed the whole country, and it was reported that 400,000 children were treated. Outside the schools, in the mass campaign which relied on "supervised self-treatment", 1,600,000 people were treated or protected with UNICEF assistance. Antibiotic opthalmic ointment was sold in widespread "Tabacs" shops all over the country.

In Algeria and its Sahara region, systematic screening and treatment of primary school children had been proceeding quite well. In 1960, half a million children were covered. The general community screening and treatment programme was extended around the urban and rural social centres operated by the Ministry of Education. In 1962, however, the campaign was interrupted; the school campaign was reactivated in 1963 but with reduced intensity. With hundreds of thousands of new school entrants and a dearth of teaching personnel, and with the school health staff down to a quarter of its previous strength, it was only possible to apply "blanket" treatment to 100,000 first-grade pupils in the main towns. The armed conflict and civil strife then raging in the country was taking its toll on health services as on every other aspects of community life.[40]

UNICEF commitment to the projects in Morocco and Tunisia came to a halt by the end of 1963, following a decade of uninterrupted cooperation with the two governments and WHO, in the course of which UNICEF had invested three-quarters of a million US dollars. The phasing out of UNICEF aid was a gradual process, during which the governments took over financial and other obligations of the projects as they reached the consolidation stage.

Despite the efforts deployed over the past years, trachoma continued to be a problem in North Africa and in the Eastern Mediterranean Region generally, particularly among very young children. But some of the worst pathological and social consequences of trachoma, such as blindness, had been greatly alleviated. Methods of control were pioneered, tested and proven and, as was to be shown in later years, governments were able to expand and consolidate the health services to a point where it became possible to keep the problem under control.

:Other diseases

In this era of UNICEF involvement with and support to the control of mass diseases in the Eastern Mediterranean and the rest of the world, the main culprits were malaria, TB, yaws, leprosy[41] and trachoma. But there were other infectious diseases that affected the lives of children and mothers in specific countries and areas of the Middle East and North Africa. Among these were bejel/syphilis, a non-venereal infectious disease that congenitally affects infants and children. The disease was amenable to treatment by antibiotics, especially penicillin, substances that were coming into wide use as the "miracle drugs" since the mid-forties. And while the technologies of mass control of this disease were not well understood or developed, WHO and UNICEF considered the disease important enough and responded to governments' appeals for help. Syria, for instance, benefited from a first UNICEF allocation of $50,000 in 1952. The funds were used for surveys in parts of the country and for a programme of examinations and treatment with antibiotics. By 1955, it was reported that some 23,000 persons were examined and some 9,000 were treated. 1956 was to be the final year of the attack on the disease with UNICEF support, when it was planned that 350,000 persons would be examined. Eventually over 100,000 were treated. Soon after, the disease was to be controlled by public health authorities as part of their general function, and not in separate mass campaigns. Iraq and Iran were the other countries to benefit from WHO and UNICEF assistance in their mass campaign efforts against bejel/syphillis.

UNICEF history in relation to mass disease in this period would not be complete without a mention of mycosis, a disease known commonly as ringworm. It affected infants and school-age children. Treating the disease was complex, requiring clinical and microscopic examinations and those affected had to be treated with X-ray, which was altogether a complex and costly operation. Syria, Iraq, and Israel were the chief beneficiaries of control programmes against mycosis. Aid to Syria was first provided in 1953, in the form of laboratory equipment and mobile X-ray units as well as technical advice and support from WHO. The numbers of beneficiaries involved, however, were not large. In Syria in 1956, it was reported that 35,000 were examined, while 4,000 required X-ray treatment.

The North African countries of Morocco and Tunisia received WHO/UNICEF assistance in their efforts to counter venereal diseases. Support was limited to mass treatment amongst populations with high incidence of the disease. The programmes began in 1954 and came to an end in 1962. In 1961, it was estimated that 700,000 persons were treated in mass campaigns in Morocco alone. Since the inception of the programme, about three million people had been treated. From that time on, diagnosis and treatment were carried out by rural public health teams as part of their multi-purpose campaigns. In urban areas special venereal disease dispensaries were to be responsible for examination and treatment.[42]

The JCHP recommended to the 1959 session of the Executive Board that assistance be provided on a pilot basis for control of bilharziasis, a disease, it was claimed, that afflicted some 150 million people in Africa, the Eastern Mediterranean Region and Latin America. The disease is caused by a

parasite in the bloodstream and is acquired through water infected with snails that act as intermediary hosts to the parasite. The resulting disease is highly debilitating to the bodies of its victims, who are usually peasants dependent on irrigation, fishermen and others. It is particularly damaging to the physical and mental capacities of children. Efforts to control the disease involved treatment, snail control and environmental sanitation.

In 1960, the Board approved an allocation for a bilharziosis control project in Egypt with technical assistance from WHO. The pilot project in the Province of Beheira was to last five years. The incidence of infection among the population was estimated at 40 per cent. Egypt's decade of experience in this difficult field was analyzed, and the lessons learned were to be utilized in the new pilot project. Experimental, comparison and operational zones were set up for the first two years to discover significant factors in the control of the disease. Professional and auxiliary personnel were trained and various methods of control were to be tried, including the use of molluscides.[43] UNICEF aid included laboratory equipment, molluscides, transport and training grants.

In spite of the great efforts expended in Egypt, as in other bilharzia-plagued countries, the control of the disease proved extremely difficult and costly. If anything, with the expansion of irrigated areas in Egypt, the disease had spread to areas previously free of it. The fight against bilharziasis continues to this day with new weapons, including chemotherapy and ecological techniques, but the greatest advance against the disease has been found to result from improvements in public health measures, such as improved water supplies and sanitation, and from rise in educational levels and standards of living.

:Summing up

Aside from UNICEF's expenditures in the Palestine refugee emergency assistance, the Fund, since its inception and up to 1958, had expended $16.3 million on various programmes in the Eastern Mediterranean region, of which $9.5 million was allocated to disease control, or 56 per cent. The malaria campaigns and DDT production took the lion's share at $7.3 million, or 44 per cent, followed by BCG and the TB campaigns which cost $1.5 million, or about 9 per cent of the total for disease control.

It is interesting to note that aid to maternal and child welfare services (MCW) had only received an allocation of $2.2 million during the same period, a mere 13 per cent of the total allocation. The relatively low level of support to MCW did not result, however, from a lack of interest by UNICEF in the development of a basic infrastructure for maternal and child welfare in the countries of the Eastern Mediterranean Region, and to the North African countries. There was a strong belief at that time that the most prevalent of the mass diseases had been brought under control before the basic public health services, then in their early stages of development, could devote their attention effectively to the more personalized services of pre-and post-natal care, well-baby clinics, the improvement of nutritional understanding among mothers, and general preventive work and health education.[44]

* * *

MATERNAL AND CHILD HEALTH

:Early efforts

While progress in building up maternal-child welfare (MCW) services in the decade of the fifties was slow, the period was marked by interesting experiments in various countries and by a great deal of thought given to the appropriate strategies to be pursued with respect to the nature of the services, the type of personnel required and the costs involved.

When the World Health Organization (WHO) came into being in 1948, maternal and child health (MCH) became one of its top four priority areas. A WHO Expert Committee on Maternal and Child Health held its first session early in 1949, when it recommended that UNICEF provide support to a wide range of services, including maternal, infant, pre-school, school health and immunization, as well as services for handicapped children, premature babies, child guidance clinics and for the training of personnel.[45] Furthermore, it recommended that aid be provided to maternity and children's hospitals and clinics. But while these recommendations were subsequently approved by the UNICEF/WHO Joint Committee on Health Policy (JCHP) and the UNICEF Executive Board, the exhaustive list of items proposed by the Expert Group was to undergo modifications both in terms of policy and application.

Among the factors that gave shape to the policies that finally emerged were the practical ones of budget limitations, both of UNICEF and the governments of the developing countries concerned, and the acute shortages of personnel. This was certainly the case in the Eastern Mediterranean Region. The immediate interest was in the extension, as rapidly as possible, of simple and practical measures, which in practice meant an emphasis on work in rural areas, where the vast majority of children and mothers lived. The first assistance went to the improvement of existing MCH centres, the training of traditional birth attendants, known in the Middle East as "Dayas", and for auxiliary health workers. This was followed by assistance to governments in the expansion of the networks of simple MCH services. Another approach, favored by WHO and supported by UNICEF, was the establishment in selected areas of demonstration and training projects.[46]

As government interest grew in the development of MCH services, UNICEF responded by increasing its allocations to this field. As early as 1953, at the height of the mass disease campaigns, UNICEF aid to MCH grew globally to 30 per cent of its resources, compared to only 12 per cent two years earlier. In that year, seven countries in the Eastern Mediterranean and three North African countries were receiving aid to MCH. With accumulating experience, the criteria for aid became gradually established and standardized. MCH centres were classified according to the level of services and staffing provided. Those with less qualified staff received simpler types of equipment than those staffed by doctors and trained nurses. For birth attendants, midwifery kits were graded in three standards and were issued according to their qualifications, the simplest being provided to trained traditional birth

attendants (Dayas). Besides equipment, another feature of aid to MCH centres was the provision of standardized sets of drugs and dietary supplements. These were meant to supplement governments' own provisions, not to replace them. Included were such items as powdered skim milk, vitamins, minerals and simple drugs. In practice these provisions became an increasingly important factor in the work of nurses and midwives, who could now offer concrete assistance to mothers and thus encourage their regular attendance at MCH centres. UNICEF was reluctant to provide aid to hospitals and institutions. It felt that they constituted a heavy drain on the countries' financial resources and would largely provide curative services to the privileged few at the expense of the preventive health needs of the vast majority of the population. Therefore, aid to children's services in general and to maternity hospitals was provided only where these institutions carried out important demonstration and training activities relevant to national MCH objectives.

:MCH projects aided

In 1954, UNICEF aid to MCH was reported in Egypt, Iraq, Iran, Israel, Jordan, Lebanon, Libya, Syria, Turkey, Algeria, Morocco and Tunisia. Over 1,500 MCH centres were being assisted by the provision of basic equipment and by supplies of drugs and dietary supplements (DDS). However, training activities in general were developing slowly and were facing many difficulties.

In Egypt, where UNICEF assistance was provided to hundreds of MCH centres, the important development in 1955 was the government's creation of a Permanent Council for Social Welfare to coordinate public and voluntary health and welfare services. A five-year plan was established, involving the development of a nation-wide comprehensive system of services to include the existing centres and the establishment of 600 new centres to cover unserved areas. UNICEF and WHO aid was requested for this extensive effort. In the meantime, large-scale refresher training courses were completed.[47]

Another large-scale programme of MCH was being assisted in Iran. Between 1952 and 1955, UNICEF allocation amounted to $208,500 which was used for equipment and supplies to MCH centres, but the strongest emphasis was placed on training activities. In 1956, the Executive Board was informed that training activities for doctors, health officers, nurses and midwives at the MCH demonstration centre in Teheran were making good progress, and that in five provinces (ostans) training of MCH personnel was continuing. One year of post-graduate training had been concluded for ten nurses at the midwifery school in Teheran in 1957. Earlier, UNICEF equipment was delivered to this school. At the same time, 25 rural midwifery students were undergoing training at the Shiraz rural midwifery school.[48]

Assistance to MCH development in Syria started as early as 1951 with a relatively modest allocation from UNICEF, amounting to $23,000 in support of the MCH training centre in Damascus. In 1955, five provincial MCH centres were in operation, providing services to children and mothers and carrying out training activities for health auxiliaries at the local level, a programme that proved to be successful in view of the scarcity of fully qualified nurses in the country. Rapid expansion in the number of MCH centres had, in fact,

led to staffing difficulties and to the closing of some centres, though, interestingly enough, the number of visits by women for pre-natal care was increasing rapidly throughout the country.

Israel benefited from early UNICEF assistance in building up its maternal and child health network. By 1954, some 32 MCH centres were equipped with UNICEF aid, in addition to the installation of a Premature Infant Unit in Tel-Aviv, a first for UNICEF. Training activities at various levels also received strong support. It was not until 1955 that aid to MCH was provided in the Sudan and took the form of teaching and training equipment for four training institutions, which permitted them to start courses the following year. A new nursing school in Khartoum was also established in 1956 to train fully qualified nurses in a three-year programme. WHO provided three nurse-educators to the faculty of the school. However, it proved difficult to recruit women students, and only six enrolled in the first year.

This was a problem faced by most countries of the region, and was attributed to two reasons: on the one hand, to a long-standing tradition of conservatism relating to the role of women in society, which prevented them from entering public service in general and certain professions, including nursing, in particular; on the other hand, educational levels for girls were quite low, making it difficult to recruit the requisite numbers even at minimal educational requirements. It would be a decade or two before this situation could change in a positive direction.

In the latter part of the decade of the fifties, other MCH developments of interest included the training of 30 MCH auxiliaries in Aden Protectorate, while 28 nurses and midwives completed their training. In Egypt, the training efforts to staff the new Combined Social Centres included the training of assistant midwives, who would gradually replace the traditional birth attendants. And in Libya in 1957, 11 community midwives graduated from the MCH training centre in Suk-el-Juma, and 12 trainees were recruited. A second MCH training centre was opened in Benghazi, as well as a school for health assistants and sanitarians.

:MCH in North Africa

Public health and nursing training, which was begun in 1956/1957 in Morocco, resulted in 180 auxiliary nurses completing their training the following year. By 1959, the number of trained auxiliaries exceeded 300. UNICEF assistance, which was offered in the form of scholarship grants, made it possible for the government to increase the number of nurses and auxiliary nurses to be trained, thus helping the health authorities to reduce the gap in health manpower needs that faced their growing MCH system.

In Tunisia, up until 1956, the year in which the country gained its independence, only minimal public facilities for the care of mothers and children were in existence. There were four maternity wards in major hospitals with a total of 255 beds. Major steps to correct this situation were begun in 1958 with decentralization of maternity services to major population centres in Tunis, Sousse, Bizerte and Beja. The number of maternity beds increased to over 900. In addition, several rural maternities

(comprising 10 to 15 beds each) were established with encouragement and support from WHO and UNICEF. But more significantly, beginning in 1958, a programme with preventive objectives was commenced with the construction and operation of Centres de Protection Maternelle et Infantile (PMI). By the end of the decade, over 40 of the MCH centres were under way for a major expansion of these basic services throughout the country. This decisive move in the direction of a system of basic maternal and child health services, and away from the more costly, curatively-oriented maternities, was strongly encouraged and promoted by WHO and UNICEF, which provided substantial technical and material support.[49] These developments were capped by the inauguration in 1960 of the Maternal and Child Health Demonstration and Training Centre near Tunis.

Assistance to Algeria's health services, including MCH, which was hindered during the years of strife and armed conflict that had raged in the country until the advent of independence in July 1962, could now be resumed. But a large international emergency relief programme had to be mounted at first. For UNICEF this meant moving $670,000 of emergency supplies to five Algerian ports.

Once satisfactory distribution arrangements were ensured, UNICEF turned its attention to a medium-term programme of cooperation with the Algerian ministries concerned. The two top priorities were the re-establishment of a basic health structure and a programme of accelerated teacher-training for primary education. The health services project emphasized staff training, for which UNICEF provided 1,000 stipends in 1963, and the establishment of a mobile health team in each of 15 départements (provinces) in the country, and the reopening of maternal child health services (MCH) in the towns. In these efforts a major role was played by WHO advisors.[50]

:Obstacles to growth of MCH -- budgets and traditions

Although much progress was reported by the end of the fifties in the build-up and extension of MCH services throughout the Eastern Mediterranean Region and in North Africa, progress was considered slow relative to the enormous needs in this health field. Budgetary, administrative and cultural factors were blamed for this situation. In many countries of the Region, budgets were hard-pressed to meet competing claims for development activities. In some cases preference was given to expenditure for tangible and prestigious items such as new buildings, rather than for the less tangible but more crucial activities such as training.

Political development certainly played a role: armed conflicts such as those that erupted in Palestine in 1948, the Suez war of 1956, and the Algerian conflict which lasted for six years ending in 1962, as well as the revolutions and coup d'états that took place during the decade, all resulted in administrative upheavals, "reforms" and restructuring of the systems.

Prevalent cultural attitudes in the Region were also to blame, such as those that restricted the role of women in society, and particularly their entry into public service and certain professions such as nursing. However,

distinct signs of change were being noticed in several countries, resulting from the public's growing demand for services concerned directly with the health and well-being of mothers and children. In Aden, Libya and the Sudan, a greater ease in the recruitment of women as health trainees was observed. In Turkey and Egypt, women were more readily accepting nursing and other health and social service careers but were not eager to work outside of the large urban centres. Even those recruited from rural areas were often not easily pursuaded to return to their villages for service, once they completed their training. In 1959 in Egypt, attempts to staff 50 of the newly established "combined rural centres" had to be delayed since it was only possible to recruit enough staff to open eight centres. This was the case in spite of the large pool of trainees then available.

Aid to MCH was to continue as one of the mainstays of UNICEF cooperation with countries of the Eastern Mediterranean and North Africa in the following decade, though with shifting emphases and modalities, as will be discussed later.

* * *

NUTRITION

:An early concern

When, in 1951, UNICEF shifted its main emphasis to assisting the developing countries, it had behind it several years of experience in assistance to children and mothers in the field of food and nutrition gained in post-war Europe and Asia. The key elements in these early programmes were milk distribution for supplementary feeding and assisting countries with their own milk production, the latter coming under the heading of milk conservation.

Early surveys in the developing countries, first in Central America and Asia and later on in the Middle East and Africa, revealed the extent and serious consequences of malnutrition, which bore heavily on infants, young children, and pregnant and lactating mothers. Malnutrition contributed heavily as a factor leading to the high infantile mortality rates prevalent in these regions. The numbers of children and women in developing countries in need of nutritional supplementation were staggeringly high. From UNICEF's point of view, there was no question of mass distribution of milk: the Fund's resources simply could not afford it. Neither did the governments concerned have the resources or the distribution facilities required for such a large programme. Mass distribution programmes such as those carried out in Europe were, therefore, not practical.

:Milk as medicine

The Executive Board, however, agreed to provide milk for some demonstration feeding programmes in some countries in Asia, Central America and the Middle East, in the hope that the results obtained might lead to workable programmes in the future. Huge supplies of surplus skim milk, largely from the United States, became available to UNICEF at no cost, except for that of shipping to recipient countries. But priorities still had to be established for milk distribution, and the highest priority was assigned to supplementary feeding schemes for the post-weaning and pre-school age children and to pregnant and nursing mothers. Maternal/child health centres became the logical channels for distribution, where milk powder was given as "medicine" to treat individual cases. With the further refinement of these criteria, it became the practice to offer whole milk to infants under one year of age who could not be adequately breast-fed, while skim milk was given to children and to pregnant and nursing mothers.

Milk as part of school feeding was supported for a while, later to be either abandoned or restricted to situations where sufficient local resources were made available to sustain them after UNICEF aid was concluded.

:Feeding programmes

The policies on long-range feeding described above were largely applied in the Middle East, except in emergency situations, such as the Palestinian

programmes mentioned earlier. In 1954, five such programmes were in an active phase in Egypt, Iran, Iraq, Libya and Turkey, where some 53,000 children and mothers were benefiting from milk distribution, combined often with other dietary supplements such as vitamins and minerals. In Egypt, skim and whole milk were distributed through MCH centres on the basis of a doctor's prescription. By 1955, the number of beneficiary children and mothers in the five countries was nearly 250,000. In Iran, it was reported that only 39,000 individuals were receiving reconstituted milk through 80 health centres. The numbers had not increased as rapidly as planned due to the cautious allocation of milk and its restriction to those centres deemed to have adequate supervision facilities.[51]

In Iraq, a country which was able to sustain such a programme, a school feeding programme scheme was being implemented which included a substantial daily meal consisting of vegetables, fruits, eggs and imported milk and vitamins. In 1955, over 60,000 primary school pupils were enjoying the benefits of this programme. UNICEF assistance was sought to increase the number of beneficiaries by an additional 40,000 and was requested to supply skim milk powder and fish-oil capsules.

Schools were also the channel used in Libya to introduce nutrition activities. In 1955, in the provinces of Tripolitania, Cyrenaica and Fezzan, some 200 schools were participating in the feeding programme that reached some 40,000 children. By 1956, over 350 schools were involved and 60,000 pupils were receiving food supplements. An interesting feature of the Libyan programme was the experimental organization of school gardening in ten schools. School gardening was to become a feature of "applied nutrition" schemes to be supported by FAO and UNICEF in the years to follow.

In Turkey, a one-year school feeding programme was supported by UNICEF for the school year 1956/1957 through supplies of skim milk powder, fish-liver oil capsules, milk-mixing utensils, and vehicles. Illustrating the costs involved in such programmes, the records show that 1,400,000 pounds of milk powder were delivered (provided cost-free from U.S. surpluses), and an allocation of $79,000 was made by UNICEF to cover the cost of shipping, vehicles and necessary utensils. Some initial difficulties were encountered in the reconstitution of milk and in its distribution due to inexperience, difficulties which were soon to be overcome through the cooperation of the local authorities and the Parents' and Teachers' Associations.[52]

The use of milk in long-term feeding programmes was distinct from its use as component in the maternal child health programmes discussed in the previous section. While the feeding programmes were gradually phased out, food and dietary supplements continued for some time as a component of UNICEF's assistance to MCH country programmes. At the peak year in the child-feeding programmes, 1957, over 9 million pounds of U.S. powdered milk were shipped by UNICEF to the Region for use in that programme, as well as for MCH, for the benefit of an annual average of 675,000 children and mothers.

:Milk conservation

One of UNICEF's earliest interests was assisting countries in Europe, and

later in Asia, Latin America, the Middle East and Africa in rebuilding and/or developing their own dairy industries. The rationale for this interest was the creation of self-sufficiency in the countries concerned in the production of milk, a food considered vital for the well-being of children. Its value was already proved in UNICEF's own mass feeding campaigns in post-World War II Europe. But this was largely possible at the time because of the availability of large quantities of surplus milk, mostly from the United States. The key objective of UNICEF's efforts in milk conservation was, therefore, to ensure the local production of milk and milk products for the benefit of children, and to obviate or to reduce the necessity of importing milk powder from abroad. The availability of the imported milk supplies fluctuated sharply from one year to another, making it difficult to plan infant and child feeding programmes.

An important partner in the field of milk conservation was FAO, acting as a technical advisor. UNICEF's own secretariat was strengthened by the addition of a small number of technically qualified and experienced food engineers and dairy specialists.

UNICEF's aid for milk conservation to the European countries was provided on condition that the countries concerned develop sound milk policies and that the main objective be the distribution of milk to children, and to pregnant and nursing mothers. When the Fund turned its attention to aiding the developing countries in this field, additional criteria were added to those described above. Plans of operation for such projects had to spell out clearly the child welfare objectives, and the assumption by recipient countries of local financing, administration and further development of the projects. UNICEF contributions were provided for the international components, such as imported machinery and equipment and for technical expertise.

In the beginning, the prospects of adapting the European experience to the situation prevailing in the developing countries, located mostly in tropical areas, did not seem bright. However, due to the conviction that milk conservation would encourage better use of local resources to counter the problems of child malnutrition and that the expected economic side-effects would be favourable, the Board agreed to go ahead, and in 1950 it approved the first allocation to a milk conservation project (MCP) in Latin America and followed suit in 1951 for a project in Israel, the first such project to be supported in the Middle East.

In the Middle East, where the countries had little experience with milk conservation projects (MCP), a considerable amount of lead time was required between the approval of a project and actual milk production. So, while the first project was approved in 1951, it was not until 1954 that one of the three Israeli dairies equipped by UNICEF began production. The Tenue-Noga plant had a daily output of 15,000 bottles of sterilized milk in March of that year. The two other plants were in various stages of construction and installation of equipment.

In 1955, about 18 per cent of UNICEF country allocations in the Region were committed to milk conservation in five countries: Egypt, Iran, Israel and Turkey. For most of these projects, the year was one of construction, equipment installation and personnel training. In Egypt the Production Council approved expenditure of funds for construction of a milk-drying plant at Sakha, for which UNICEF agreed to provide machinery and equipment, and FAO technical support.

In Iraq, after some delay, the sites for the plant and cattle compound were finally approved, and towards the end of 1955 construction had started on full scale. In Turkey, the new pasteurization plant at the Ataturk Farm near Ankara was nearing completion; UNICEF-supplied equipment was received and was being installed. At the same time, preliminary surveys and specialized studies were being carried out to develop a national milk policy. This was an important condition for UNICEF support to MCP in all countries. A UNICEF allocation of $445,000 for MCP in Iran was approved by the Board in 1952. But progress on the installation of UNICEF-provided equipment at the Meherabad plant near Teheran was not reported until 1956, and the establishment of a bottle-making plant suffered some delay. However, three Iranians sent on fellowships to study abroad in connection with MCP projects returned to Iran early that year to assume their duties with the project.

In Turkey, considerable progress was reported on the first phase of the country's MCP, and discussions were under way for a second phase of a national milk development programme. The new plants were to be established in rural north-eastern Turkey, and it was planned that 50 per cent of the initial output would go to free distribution programmes to children under the ministries of health and education.

:Obstacles to MCP

By 1958, milk production had started in the UNICEF-assisted plants in Iran and Turkey and were gradually to develop to full capacity. The plant in Sakha, Egypt, started production late that year.

All these projects experienced delays due to administrative problems on such matters as the constitution of their management boards, their degree of financial and administrative autonomy, the provision of necessary operating capital and their relations to relevant ministries such as agriculture, which was required to provide extension services. Other difficulties were of a material and logistical nature, such as supplying utility services of water and electricity, and delays in construction due to shortages of building materials and skilled labor. To counter these problems, UNICEF, together with FAO, resolved to supplement and enhance their technical and advisory services with the aim of bringing the assisted plants into full operation.

These extra efforts by the two agencies paid off. By 1959 progress was evidently being made; for instance, the plant in Teheran was processing 40,000 litres of milk per day, and the Ankara plant had an average out put of 12,500 litres daily, with peaks up to 16,000 litres. By 1960, the plant in Baghdad was producing 16,000 litres per day. In Israel all five plants assisted by

UNICEF/FAO in Tel Aviv and Haifa were in full or near full production. Syria was in the process of building two milk-processing plants in Damascus and Aleppo and was seeking assistance from UNICEF and FAO.

There were also some setbacks. The project in Egypt experienced various difficulties, and the milk-drying plant did not resume processing until early 1961.

It should be recalled that UNICEF's motive for assisting milk conservation projects was not milk production per se, but rather increasing the availability of milk as a component of supplementary feeding of children, pregnant and nursing mothers, especially for the low-income groups in the population. What were the results achieved? All assisted countries had committed themselves to this principle and signed plans of operation including this important proviso. But distribution programmes, carried out through the existing networks of health centres and schools, had their ups and downs and, with the exception of very few cases, met with difficulties, the most common being the inability to consistently finance the subsidies necessary to a social welfare system of milk distribution. For example, by 1957 the Teheran plant had distributed 3.5 million litres of free milk since it went into operation, representing $660,000 worth of milk. But this was far less than the full 15 per cent of the processed milk to which the government had originally committed itself.

To master the complexities of modern industrial and agricultural production in countries still relatively new to industrialization, a great deal of time and effort is required. Developing a successful dairy industry proved to be no exception. It was not surprising, therefore, that many of the newly established dairy industries ran into economic difficulties. To enhance the economic viability of milk processing, some plants, such as the one in Baghdad, resorted to the production of high-value products such as cheese, yoghurt and ice cream from surplus milk. The profits from these products made it possible to stabilize the price of milk at a level affordable to most urban populations.

UNICEF continued to assist the countries of the Middle East Region in MCP in various degrees up to the mid-sixties. A great deal of experience was gained by the participating countries, and a nucleus of trained manpower was created that was later to result in the further development of this agro-industry. Most of the plants assisted by UNICEF and FAO in that early period continue to function today on a much larger scale. And in a few countries, the practice of free or subsidized milk distribution to children has become a key component of their social welfare services, together with other nutritional services.

:A widening approach in nutrition

While UNICEF support to long-range feeding programmes, emergency feeding and milk conservation projects was continuing, a new approach to nutrition was being advocated by UNICEF and in 1957 was approved by the Board under the heading of aid to nutrition education and related activities. Reflecting a widening approach to tackling the widespread problems of malnutrition, the new

effort was described as "...an attempt to educate villagers in simple, practical measures directed at nutritional practices most in need of change, and to give them an opportunity, through such activities as gardening, fish culture, and small animal and poultry-raising, to put into practice what they are learning from nutrition education."[53]

Before the end of the decade of the fifties, this new policy direction was to be translated into a variety of projects, including national nutrition surveys, applied nutrition programmes and training activities for workers in school gardening activities. In 1960, expanded nutrition activities were commenced in Egypt where, in cooperation with FAO and WHO, a survey was launched covering the health and nutritional status and food habits of different population groups.

Ntutrition education became an important corollary to school feeding programmes in Tunisia. In 1960, a team from that country was trained both locally and in France in modern concepts of nutrition and nutrition education. Upon their return to Tunisia, they developed new teaching aids and educational methods which they introduced to 18 pilot schools.

In Libya in the same year, consideration was given to ways and means of improving school garden projects and to finding other supplementary foods for school feeding programmes. This effort was further motivated by a global dwindling of surplus skim milk supplies. Further, to improve nutritional education in the schools, an FAO consultant, with encouragment and support by UNICEF, produced a booklet in Arabic for use in schools and health centres. While the booklet was principally concerned with the teaching of health and nutrition education, it also covered school gardening issues.

Similarly, in 1960, plans were under way in Turkey to broaden the school feeding programme into an expanded nutrition project that included elements of school gardening and home economics teaching.

In the early sixties, it was evident that much was learned by the participating countries, UNICEF, FAO, WHO and other collaborators from the experiences gained from the school feeding activities. These projects stimulated new nutrition activities and directed attention to the need for making better known the basic elements of good nutrition. One of the interesting outcomes was an increased effort to develop local food resources for child feeding. The Nutrition Institute in Iraq carried out an experiment involving the use of cottonseed and planned to test its potential as a children's food of high nutritional value. At the same time, the government was training schoolteachers in preparation for a pilot school garden project. Many intitiatives along this line were taking place in other countries of the region.

:Uneven progress

A variety of methods to expand nutrition education was the order of the day in the early and mid-sixties, with one country after another introducing nutrition education to teachers, nurses and social workers at professional and

auxiliary levels. But progress in these programmes was uneven, as indicated by a report on UNICEF-assisted nutrition programmes presented to the Board in 1965. In one country, Iraq, it was stated that nutrition training was good but was too academic and research-oriented, and up to that time the field studies had not resulted in applied nutrition programmes. The training project in another country, Libya, was progressing well. Up to the end of 1964, a total of 345 men and women teachers had received one-month training couses; another group of teachers had the benefit of seven-day refresher courses, and about 100 headmasters and headmistresses participated in three-day seminars on nutrition education. The curriculum of all teacher training institutions included the subject of nutrition. At the same time, the school garden component of the projects was not progressing in a satifactory manner. The project in Jordan had just started, having suffered various delays. In Egypt, it was reported that home economics training was doing well and the national nutrition survey was expected to start in 1965.[54/]

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AN ERA OF PLANNING

:Assessing progress of UNICEF support

By the end of 1964, UNICEF had been active in assisting 12 countries in the Eastern Mediterranean region. In the previous 14 years, government projects assisted by UNICEF in the various fields called for an expenditure of $238 million, of which $180 million were contributed by the governments themselves, $34 million were provided by UNICEF, and $15 million represented the contribution of the specialized agencies, particularly FAO and WHO. The number of children in the region was estimated at 47 million.[55]

In the health field, aid to mass disease control was on a downward trend while maternal and child health and environmental sanitation were growing in importance. In nutrition the emphasis in most countries was increasingly shifting from long-term feeding and milk conservation programmes towards applied nutrition activities, including nutrition surveys, training of personnel, and school gardens: and interest was growing in the development of low-cost weaning foods. In 1965, In Iran, five training centres for MCH personnel were receiving UNICEF assistance, as well as a training school for sanitation aids. However, the development of activities in several hundred health centres was not as rapid as had been hoped for, due in part to problems of coordination by the various participating national organizations and partly to administrative difficulties.

In Cyprus, which had commenced a very successful MCH training programme a few years earlier, a troubled political situation brought these activities to a standstill. In Yemen, similar activities had just begun on a limited basis but looked promising. Iraq reported some good results in its school sanitation programmes and in the training of sanitarians but was less satisfied with the training of nurses, midwives and auxiliary personnel.

The assisted health services in Libya had suffered some early setbacks caused by the lack of qualified personnel and administrative and financial difficulties. The latter were soon resolved by increasing revenues from petroleum resources. The improved financial situation permitted the development of a five-year national health plan which foresaw a large expansion in MCH and related services. UNICEF assistance to training activities and to MCH in the Sudan continued to give limited but satisfactory results.

In spite of difficulties, Egypt's ambitious plan to establish 400 rural health units per year was moving ahead, and great improvements in the country's health services were noted. The newly built units were being promptly staffed and UNICEF assistance was being put to good use. Nurses' training was proceeding well, and a newly instituted school health project was being expanded to provide more health education. In Jordan, due to financial stringency, assisted health activities were progressing slowly, and the vaccine production plant suffered delays in the arrival of UNICEF supplied materials.

As mentioned earlier, prevalent cultural attitudes in the region were also to blame, such as those that restricted the role of women in society, and particularly their entry into public service and certain professions such as nursing. However, distinct signs of change were being noticed in several countries. In Saudi Arabia, UNICEF's emphasis on training activities was helping in the expansion of the network of health services units. In Turkey, advances were reported in the training of physicians at the School of Public Health, paramedical personnel in the high institutes for nurses (153 were graduated in 1964), and auxiliary midwives. At the same time, disappointment was expressed at the delay in establishing a broad based health programme due to lack of funds.

:How assessments were made

The above discussion on UNICEF's cooperation with the governments of the Region in the fields of nutrition and health reflects an attempt by all the parties concerned to assess the results and outcome of this cooperation. The question may arise as to how these assessments were made, and on what basis.

Information on programmes and projects came from a variety of sources. The Executive Board periodically requested that assessments be presented to it covering a broad field of UNICEF-supported activities such as mass disease control, MCH and MCP. The Executive Director typically presented these assessments based on field studies carried out in cooperation with the govenments and the relevant specialized agency. These progress reports constituted important agenda items for Board sessions. The outcome of the ensuing discussions often resulted in new guidelines for UNICEF cooperation in a particular field. It should be added that these formal assessments were global in character, and not specific to one particular region.

There were, however, other sources of information on the progress of UNICEF-supported activities. Among these were government reports, field reports by UNICEF's own staff and by those of the specialized agencies. UNICEF Regional Directors often made presentations to Executive Board sessions analyzing trends in UNICEF cooperation in their particular region.

:A decade of planning for development

The decade of the sixties was designated by the United Nations as the "United Nations Development Decade", a reflection of the growing interest manifested by the developing countries in the deliberate planning of their development efforts as a means of overcoming their economic and social underdevelopment. Many of these countries had recently gained their independence and were under pressure created by the rising expectations of their populations, thus providing a strong impetus for planned development efforts.

The countries of the Eastern Mediterranean Region were no exception to this trend. In practically all of them, governmental organs of various types were established, such as ministries of planning or planning commissions. These varied in their level of authority and in their function. Some were seen as advisory bodies with no executive powers while others, such as those of Egypt, Syria, and Iraq, were given full policy-making and administrative powers to implement the development plans.

The key instruments used in all cases were the periodic "national development plans", typically a succession of five-year development plans, and while the plans invariably purported to aim at the achievement of economic, social and cultural objectives, the strongest emphasis was invariably placed on economic development. The priority accorded economic growth was backed by a strong belief among political leaders and economists alike that a nation's economy must be developed in the first instance, and that the resulting economic growth would then permit, at a sufficient scale, the financing of social development programmes such as health, education, social welfare, housing etc. These latter benefits were seen, under this theory, as forms of consumption that could only be accommodated through the steady growth of the gross national product. Opposing views were expressed as well, advocating that social development outlays were essentially an investment in the development of human resources, without which it would be difficult to achieve any development whatsoever. To the proponents of this view, a balanced economic and social development is the ideal goal.

The significance of this debate for UNICEF and for all those concerned with the welfare of children in the context of international cooperation was obvious. For it is in the area of planning for social development on a national level that determinations affecting the health and welfare of children would be made. Not surprisingly, therefore, UNICEF at the time advocated planning for the needs of children as an integral part of the processes of national development planning. The results of this advocacy, both in words and actions, though not dramatic, were gradual in coming. As will be seen, they influenced in important ways UNICEF's methods of cooperation with the countries concerned and the types of assistance it provided.

:Country programming

A new approach to cooperation which came to be known as "country programming" was approved as early as 1961 and was confirmed in successive Board sessions. In essence, it was felt that UNICEF's cooperation would be most productive and beneficial to a country when it fit into a well-conceived and coordinated plan for social development.[56] It also meant that the limited amount of assistance that the Fund could provide would be applied in areas of high priority, as determined by the governments' own national planning processes. UNICEF staff in the field worked hard to see to it that the needs of children were adequately considered in national development plans.

This "country approach" by UNICEF was more than just a good tool for programming; it also proved to be a useful means of advocacy on behalf of the needs of children. It drew attention of policy-makers, planners and financial authorities to the importance of the younger generation as future agents of development. This approach also encouraged governments to make periodic assessments of the situation and needs of children. Where this is done, cost-effective use of resources can be considered, and more external resources can be mobilized for support of childrens' services.

UNICEF's earlier approach was to prepare, for each country, several short term sectoral recommendations with a duration of one to two years. These had to

receive Executive Board approval in two-yearly sessions. The wider acceptance of country programming resulted in a change in the direction of multi-year packages of integrated programme activities per country.

Development planning, however, proved to be no panacea. The processes involved included estimation of national needs in future periods of time, the ordering of these into priority areas and translating them into programmes and projects, and finally, estimating the costs and resources required to carry them out. The latter included national resources, international borrowing and overseas aid, both from bilateral and multilateral sources. In many cases the financing of the plans was largely dependent on external resources which were either overestimated or, for various reasons, did not materialize. When this happened and projects had to be reduced, postponed, or eliminated, the first to suffer were the social development programmes, including those of most benefit to the younger generation. Even the national resources were hard to forecast; consisting mainly of raw materials, they were subject to sharp price fluctuations in the international markets.

That is not to say, however, that the national planning efforts were not useful. In the process, the careful analyses of future needs, the establishing of hierarchies of priorities, and development of specific programmes served as guidelines for decision-makers in the countries concerned, and became subjects of popular debate and mass education of incalculable value.

:The situation of children and their needs

In 1962, UNICEF embarked on a global study, the object of which was to ascertain the situation of children and their needs. The study was carried out in selected countries in every region through the efforts of national experts aided by international specialists and supported by UNICEF staff and funding. In the Eastern Mediterranean Region, two such studies were inaugurated in Egypt and in Iran in 1964. These studies were to be a continuing effort, some of them taking several years. The information they provided proved to be of great value to the combined efforts of governments and UNICEF in planning for the needs of children, and for the elaboration of UNICEF's "country programmes". The latter, at this time, represented a new approach by UNICEF in its efforts to assist governments in giving adequate consideration to the needs of children in the context of their national development plans. In addition this approach called for the coordination of UNICEF assistance with that provided from other sources, or at least taking account of it in planning its own cooperation.

Gradual in its implementation, country programming replaced the earlier methods of negotiating one sectoral project of cooperation at a time by developing, for each country, a package of activities to be supported by UNICEF. Ideally the "package" was to include mutually supporting activities, for instance, in MCH, nutrition, education or social services, depending on the priorities declared by the cooperating countries as part of their national development plans.

While it did not prove possible to pursue this ideal in all instances, the principles of country programming were to guide UNICEF-country cooperation from the mid-sixties onwards. Before the end of the decade, a "country programme", usually under the heading "selected services for children", covering a period of two to five years, was presented to the Executive Board for approval for each cooperating country.

:Homogeneity and diversity

While many of the countries of the Region shared a common culture represented by the Islamic religion, the Arabic language, and deep-rooted history and traditions, they, at the same time, reflected a great diversity of climatic and ecological conditions, size and demographic characteristics, as well as economic and technological levels of development. Data gathered from UN, UNICEF and government sources around 1964 showed, for instance, country population figures as small as 140,000 (Bahrain in 1960), 325,000 (Kuwait in 1962), to middle-size populations such as 5.2 million for Syria (1962), 7 million for Iraq (1963), to more heavily populated countries such as Egypt with over 27 million (1962), and Iran with 22 million (1963).

GNP per capita ranged widely from under $100 to over $1000. Health indicators also reflected a wide gap, as indicated by infant mortality rates from 30 per 1000 to figures over 150 per 1000, with the vast majority nearer the high figure. Educational levels, as reflected by primary school enrollment figures, exposed a wide range of achievement: as low as 10 per cent for children of primary school age (7-14), and as high as 80 per cent.

As can be imagined, the needs of children living under such a wide range of economic and social conditions varied greatly from country to country, as well as within countries. UNICEF's response to governments' requests for assistance had to take account of these conditions.

The widening in the range of activities supported by UNICEF, that was sanctioned by Executive Board decisions in 1962, became evident in the latter part of the sixties. While the earlier emphasis on health services continued, but with more stress on basic health structures and on nutrition, support to new fields such as social welfare, community development, urban children, education and social planning was growing. Of these, the latter two areas were to play an important role in UNICEF cooperation with the countries of the Eastern Mediterranean Region.

Education

:Expansion and reform

It was after some hesitation that UNICEF entered the field of aid to education. A report prepared for the Executive Board, in consultation with UNESCO, was discussed in March 1959. The report recommended tht aid be extended to primary education at the request of governments and that such aid be utilized for the training of teachers, especially in relation to health and nutrition education.[57] Modest allocations were approved for such programmes in the beginning, but soon UNICEF's concern with education was to encompass such areas as pre-service and in-service training of teachers, training of home economics instructors, aid to teacher-training institutions, production of educational materials including textbooks, curriculum development and pre-vocational training.

In the Eastern Mediterranean - North Africa Region, one of the most striking changes in the sixties was the rapid growth of education at all levels and in nearly all countries. The number of children attending primary schools had more than doubled in a two-year period in several countries, creating demands for expansion in intermediate and secondary education.[58] The first two projects for aid to teacher-training were approved by the Board in 1962. By 1966, ten countries were receiving assistance to their education programmes, and more requests were being received.

Typical of this phenomenal interest by governments in expanding primary education was the situation of Morocco and Tunisia which, in the early sixties, had declared the goal of universal primary education by the end of that decade, with full knowledge of the cost and effort involved in such an ambitious undertaking. And even though this goal was not fully reached by 1970, much was accomplished during that period. A side effect was that the governments had to relegate some educational activities they had previously undertaken, namely, pre-school education and day-care, to the background, or simply discontinue them.[59]

The Yemen Arab Republic, a country much delayed in its overall development, and especially in education, showed eagerness to catch up with trends in the Arab world. Soon after the internal revolt of 1962 interest in education became manifest. The presence of Egyptian troops stationed in the country at that time (they departed in June 1967) brought with it a considerable number of teachers and educators. These made a valuable contribution to expansion of public education for the benefit of the children of Yemen. UNICEF cooperation with the country was considerably expanded and diversified from 1965 onwards. In 1970 an approved UNICEF commitment to Yemen provided for the in-service training of 500 teachers, hastily recruited at low levels of qualification in order to move on in this vital field. Additionally, 150 girls were to be trained in commercial skills and home economics. This was significant as it was being done for the first time. Textbooks were to be developed and published. A major project of the World Food Programme (WFP) at the time focused on school feeding. Yemen's neighbor to the south, the People's Democratic Republic of Yemen (PDRY), was equally seized with interest in expanding education. A teacher-training college was established with technical cooperation from UNESCO and material support from UNICEF.

Since education became an important element in UNICEF's support to national development starting with assisting in teacher-training and the provision of supplies and equipment (most of which were based on western or developed country models), UNICEF and UNESCO went on to pioneer new teaching and learning methods in the field of science, better adapted to the needs of children in developing countries.[60] The ability to provide inexpensive and environmentally relevant science-teaching equipment made it possible to extend the teaching of science to a wider range of grades, going down to the early primary years and stimulating greater pupil participation.[61]

An extensive project in support of science education unfolded in the Sudan from 1965 to 1970 under a UNICEF allocation of about $700,000. It involved the training of over 2,000 science teachers, the provision of well-equipped and well-adapted science teaching labs and the production of teachers' manuals and pupil textbooks.[62]

Some important changes in UNICEF's policies towards the field of education were soon to take place. Up until now, the policy was guided by the 1968 "Joint UNICEF/UNESCO Guidelines". In the 1971 and 1972 Executive Board sessions, debates on the subject took place resulting in new directions and emphases. Based on a 1972 assessment report by a UNICEF consultant, it recommended phasing out UNICEF assistance to secondary education and increasing aid to primary education, "especially to basic education, formal and non-formal, for educationally deprived children."[63] The Board was motivated by assessment of the results of the First Development Decade then coming to light, indicating that while notable economic growth had taken place during the decade, progress did not extend downwards to reduce mass poverty.

This failure was reflected in education, where growth in primary education and the reduction of drop-out rates lagged far behind that of secondary and higher education. In fact, the absolute number of illiterates had increased with population growth although the literacy ratio had risen slightly. These assessments most certainly applied to the Eastern Mediterranean Region, but in varying degrees, from one country to another.

The new policies emphasized aid for education of children deprived of educational opportunities, particularly those found in rural and remote areas, including nomads, and in urban slums and shantytowns. UNICEF aid would be provided to educational planning geared to these new policies, to out-of-school education, to girls and women, and to innovative approaches aimed at reaching the deprived groups.

These new policies were soon reflected in UNICEF assistance to education, particularly to the countries most deprived in this field. Yemen, which until 1961-1962 had no school system to speak of, was, under the new guidelines, one of the most deserving. Throughout the seventies, assistance to primary education was expanded, with stress on the training of personnel, particularly teachers and principals. From no schools at all in 1962, by 1973 there were 750 primary schools in Yemen with about 50,000 pupils (7,000 were girls). There were over 1,600 teachers in the primary cycle alone.

Meanwhile, in the three Maghreb countries of North Africa, great strides were being taken in expanding educational opportunities to all children at the primary level. In the early part of the decade important experiments in what was described as "pre-vocational" training were taking place, particularly in Tunisia. Given the reality that for the majority of children schooling will not exceed the primary phase, curricula were modified to include skills in manual training and orientation to the earning of a livelihood. The International Labor Organization (ILO) provided the technical advisory services required in the development of pre-vocational training. To meet the growing demand for teachers, provincial teacher-training institutions were strengthened. In 1970/1971, they were able to train 1,600 new teachers. But the efforts extended also to training the under-qualified teachers already in service. For this purpose ten in-service training centres were established and in that same period qualified over 500 teachers. An innovative idea for that time was the use of correspondence courses to encourage under-qualified teachers to improve their knowledge and skills. In 1970/1971, it was reported that some 2,000 teachers benefited from these courses.[64]

A particular problem facing educational developments in Morocco, as well as in Algeria and Tunisia, needs to be underlined: during colonial times, the French language was strongly promoted at the expense of the people's own mother-tongue, the Arabic language. The redress of this serious cultural imbalance was attained after independence, when these three countries mounted an extraordinary effort to introduce school children to a serious study of their mother tongue, though education continued on a bilingual basis (French-Arabic). Technical assistance from other Arab countries, especially from Egypt, greatly facilitated this task.

In Algeria, educational expansion was even more dramatic. The rapid growth in enrollment from 500,000 in 1962/1963 to 2 million pupils in 1971/1972 and 2.5 million in the following year put a severe strain on the government, especially in relation to meeting the demand on teachers. In the 1970/1971 academic year, there were 61,000 teachers, of when about 5,000 foreign teachers were recruited from Arabic-speaking countries to provide Arabic language instruction. Since independence in 1962, the Arabic language replaced French as the country's official language. UNICEF was called upon to assist the government in expediting the process of "nationalizing" education. UNICEF support started in 1962 and by 1970 amounted to $1.5 million. From 1971 to 1974, $2.25 million were provided by UNICEF in support of teacher-training, educational supplies and textbook production. Algeria's educational efforts in that period included providing school meals to some 80,000 children. It is reported that in 1970/1971 alone, this included the distribution to school children of some 9 million litres of milk.[65]

Tunisia was no less eager to expand educational opportunities for children, judging by the growth in the enrollment rate of 21 per cent in 1953 to 77 per cent in 1967. From 5,125 teachers in 1955 the number grew dramatically to 17,800 by 1970.[66]

Throughout the Eastern Mediterranean and North Africa Region, concern with education was high on the governments'agendas. One common concern was to change school structures and curricula so as to make them more attuned to the social, economic and cultural environment in which the majority of the pupils was likely to spend their future years.

:Non-formal and non-conventional approaches

In 1973, when the Executive Board discussed a report by the International Council of Educational Development (ICED) on "non-formal education"[67] and gave it a favorable response it opened the way for UNICEF support to educational polices and practices that would supplement the formal classroom based on traditional forms of education. In the Eastern Mediterranean and North Africa there was good receptivity, if not great enthusiasm, for these new approaches. In many instances UNICEF was requested to provide material and technical support to activities related to women's literacy and adult education generally, to agricultural youth clubs, and to school canteens and gardens as well as cooperatives.

But even in relation to "formal" education UNICEF assistance took many non-conventional forms. Examples include in Morocco the support to training of school administrators and principals and not only teachers; and the use of radio in education and teacher training in Yemen. The latter formed only a part of a unique experience known at the time (mid-seventies onward) as the "Multi-media in-service training of teachers and other educational personnel"[68] The model was established by the UNRWA/UNESCO Institute of Education (based in Beirut, Lebanon) and was successfully used in Iraq, Jordan, Sudan, Syria and Yemen. During that period of growth the need for qualified teachers was far greater than the capacity of teacher training facilities in most countries. This either limited the number of children who could have gone to school, or put unqualified teachers in schools. In some countries the teachers were not unqualified but rather under-qualified.

The multimedia approach offered the possibility of giving a much greater number of unqualified and under-qualified teachers the opportunity of doing substantive on-the-job training leading to certification. This was done using a number of techniques including programmed instruction, intensive summer training and demonstration, action school/community research -- followed through by field tutors who observed trainees in action in their schools and conducted special sessions periodically on weekends. Because of the numerous mediating techniques, the approach was labeled multimedia.[69]

An indication of the extent of UNICEF assistance to education in the Region was that up to 1970 over 13,000 schools and educational institutions were aided with equipment, supplies and other forms of cooperation. The cost to UNICEF up to 1980 amounted to $20 million for formal education and $8.9 million for non-formal programmes of education.[70]

A Return to Nutrition

:Training

Towards the end of the decade of the sixties, progress in the field of nutrition was slow. It is true that the milk conservation projects (see earlier section) in Iran, Iraq, Syria and Turkey were progressing well and school feeding schemes in several countries were by now well established. But it was clear that much more needed to be done to counter the widespread nutritional problems. About this time a stirring of interest among governments was taking place.

In 1968, the FAO Conference for the Near East, held in Baghdad, called for the establishment of a Regional Nutrition Commission. UNICEF began discussions with the World Food Programme (WFP) and the UN Development Programme (UNDP) about joint future projects in Iraq, Lebanon, and Syria. One outcome of these negotiations was the setting up of a joint FAO/WHO/UNICEF nutrition training scheme, which included provision of training courses in nutrition within the faculties of Medicine, Agriculture and Sciences of the American University of Beirut. Participants were selected from among key government personnel who, upon completion of the course, returned to their countries to promote national nutrition programmes.[71]

:Weaning food

A hallmark of that period, however, was the widespread interest in the development of an industrially produced, low-cost, high-protein supplementary weaning food. It was widely believed that, if successful, such a product could go a long way to reducing the prevalent malnutrition problems. Lack of adequate amounts of protein in the diets was blamed for these nutritional deficiencies.

Typical of these projects was the one initiated in Egypt as far back as 1966 with discussions on acceptability and marketing tests lasting until 1968. The earliest of these products in fact was developed in Algeria and called "Superamine". A plan of operations between UNICEF and the Egyptian government, with participation by WHO and FAO, was signed in 1969. UNICEF's first allocation to the project for 1970 amounted to $445,000. WHO and FAO were to provide technical expertise and advice. Another important participant in this initial stage was the World Food Programme (WFP), which offered to provide $1 million worth of raw materials, namely, wheat flour and skim milk. The formula consisted of wheat flour, chick peas, lentil powder, milk, sugar and a mineral/vitamin mixture. The plan called for the production by 1973 of 1,000 tons per year of a low-cost, protein-rich weaning food to be named "Superamine", named after the "successful"Algerian product. Production would go up to 2,000 tons by 1975. The government committed itself to purchase part of the product for "social distribution", either free or at a subsidized price, through MCH facilities and social centres. This was to cost the government some $700,000 in two years. The balance was to be sold through pharmacies and groceries. The package contained 300 grams and was to be sold for Pt. 10 (approximately $0.25 at the time).

March 17, 1973 was a day to be remembered as the Minister of Public Health unveiled the Superamine plant and inaugurated production of the new product. UNICEF's contribution helped pay for the machinery and equipment for the production lines, for transport equipment, personnel training and the initial hard-to-come-by supplies of enzymes, vitamins and flavoring.

Projects along similar lines with slight variations in formulas were launched, some earlier, some later in Turkey (the product there was named "Sekmama"), in Algeria, Morocco (Superamine), and in Tunisia under the name "Suha".

These weaning food production projects were to have many ups and downs. Technical problems of various kinds were encountered. Raw materials were not always forthcoming from local sources (low-crop years), and therefore import requirements had to be increased, adding greatly to the costs. There were problems and shortages related to packaging materials as well. The products, though well received, proved for the most part to be beyond the means of the poorer families, and government budgets could not consistently support the social distribution components of the project.

Undoubtedly a large number of children benefited from these products in spite of the difficulties outlined above. And a larger population was reached with nutrition education messages through radio and other forms of advertising carried out by the producers of the weaning foods.

As will be seen later, the experience gained from these and earlier nutrition approaches was to produce a shift in strategy towards encouraging breast-feeding, the household production of weaning food relying on locally available foodstuffs and active popular participation in seeking solutions.

* * *

HOW TO AID THE BETTER-OFF COUNTRIES

Traditionally, UNICEF relied on certain criteria in the allocation of its relatively modest resources among the developing countries with which it cooperates. These included such factors as child population and the per capita gross national product (GNP). Relatively higher levels of resources are allocated to developing countries with higher population and lower GNP/per capita.

The growing number of oil-rich countries in the Eastern Mediterranean Region put before UNICEF the dilemma of how to aid these better-off countries. The agency's experience in cooperation with such countries as Saudi Arabia, Kuwait, Algeria and others made it clear that national wealth does not automatically solve the problems of high infant and child mortality rates and widespread malnutrition. But here is a situation where the sharing of international experiences could aid these countries in building up, over time, the necessary infrastructure for health, education and social services to meet the needs of their children.

After some hesitation and debate on the best means of cooperation with the better-off countries, and in consultation with the countries concerned, various modes of assistance were developed, such as demonstration projects, advisory and consultative services, technical assistance and personnel training. These services were often provided at no cost to UNICEF, with UNICEF-supported activities being funded directly, or indirectly through the general contributions of the countries concerned to UNICEF.

As it developed over a period of time, UNICEF dealt with three levels of assistance:

1) Aid to the least developed countries (LDC's), e.g., the Sudan and the two Yemens;

2) Normal level of aid to countries with intermediate levels of GNP; and

3) Aid to the better-off countries, where normally no financial aid from UNICEF was required.

In 1966, the government of Israel informed UNICEF's Executive Board that the country's services for children had reached sufficiently high standards that it no longer required UNICEF's financial aid. In the same communication it thanked UNICEF for the past assistance rendered since the establishment of the State of Israel in 1948.

In Saudi Arabia UNICEF cooperated in community development projects as early as 1962 but later concentrated on girls'education, a sphere of development that reflected one of the government's high priorities in the social field. This was done in cooperation with UNESCO. Methods of procurement of educational and health supplies and equipment via UNICEF's well-developed supply procurement services was another area of cooperation.

In Iraq, another country with above-average national income, UNICEF cooperation revolved around supporting research for the development of industrialized infant food; the evaluation of pre-school education leading to policy development; studies on the possibility of primary health care (PHC) in Iraq's rural areas and reimbursable procurement by UNICEF of relevant supplies and equipment.

Similar activities were carried out by UNICEF in its cooperation with other better-off countries such as Bahrain, Iran, Kuwait, Qatar and the United Arab Emirates.

New approaches to programming

The adoption of the methodology of country programming opened the way to a great variety in approaches and to a virtual proliferation of programme areas. Among these, and worth noting throughout the sixties and the seventies, were: a)regional projects; b) integrated development; c) services to urban children; d) water supply and sanitation; and various means of advocacy on behalf of children's needs. This partly resulted, in the words of James McDougall, Regional Director for the Eastern Mediterranean Region, addressing the Executive Board in 1969, from "UNICEF, feeling more confident of its contribution to international development efforts, feeling that its programmes were placed firmly in the mainstream of development plans."[72]

:Regional programmes

Reference was made earlier to the homogeneity among the countries of the Eastern Mediterranean with respect to language and other cultural factors. This made it possible for UNICEF to support programmes organized on a region-wide basis. One of the most successful was initiated in 1968 and continued into the mid-seventies in cooperation with WHO's Regional Office (based in Alexandria, Egypt). This was the Regional Child Health and Midwifery Training project, in which practically every country in the Region participated. Institutions providing the regional training were nursing and medical colleges in Lebanon and Egypt. An important feature of the programme was that it encouraged the production of teaching materials in Arabic.

Another regional project in the same period of time involved UNICEF cooperation with the Food and Agricultural Organization in the Regional Nutrition Project. Workshops, seminars and other forms of information exchange were utilized to train teachers, home economists and medical personnel at various levels in the various aspects of food and nutrition.[73]

In a different category was the Regional Women's Project initiated in 1970/1971. It resulted from the growing feeling in the Region that for social development programmes to succeed in the Eastern Mediterranean Region, an enhanced status of and participation by women must be achieved. The long-standing and strong traditions in the Region against active participation by women had to be dealt with effectively but at the same time with sensitivity. A regional adviser on women's programmes was engaged by UNICEF's Regional Office in Beirut. The project was initiated by a survey on the status and needs of women in Egypt, Lebanon and Yemen. Each of these

countries had its distinct characteristics in terms of women's traditional roles, levels of education, and economic and social activity. The survey, in which women's organizations and governmental bodies took active part, produced very valuable information, most of which became available for the first time, and proved of great value to governments and the international agencies concerned.

In several countries programmes were developed specifically with the object of enhancing women's participation in community life, and these took various forms, such as training women in income-generating activities and encouraging them to participate in literacy courses.

As a part of UNICEF's participation in International Women's Year, 1975, the Executive Board allocated $100,000 for a regional project to promote the development of women's programmes. Soon thereafter a Centre for Studies on Women and Development was established at Al-Azhar University in Cairo, Egypt. One of its early accomplishments was the development of courses and field studies oriented to women studying medicine, the humanities and social development.[74] In Jordan UNICEF assistance was provided in the planning of a community centre for women in Dheiban. Its activities included non-formal education and vocational training for out-of-school girls. In Saudi Arabia a training seminar for the staff of the Bureau of Women's Activities of the Ministry of Social Affairs was organized with the technical advice of the UNICEF adviser on women's services from the Regional Office in Beirut. The national Women's Union of Syria sought and received UNICEF and WHO help in organizing a regional seminar in August 1975 on the subject of "nutrition programmes" as developmental activity. The outcome of this meeting was a nutrition education programme that served as a model to be used in the different countries of the Middle East for implementation by governmental and non-governmental organizations alike.[75] In Oman a two-village study on child rearing practices had an important bearing on the status of rural women and the welfare of children in that country.[76]

:Integrated development

Services to children are most efficient when provided in an integrated, mutually supportive manner. This "formula" was most widely accepted and strongly promoted by UNICEF since the 1960's. The Eastern Mediterranean was one of the regions where this approach was taken up and implemented with great vigour. The idea originated when Egypt asked for UNICEF assistance in connection with the urgent necessity to resettle some 90,000 Nubians whose homes and lands were to become inundated as a result of the construction of the High Dam at Aswan. New villages were being built on higher ground at Kom Ombo to house the new settlers, and all kinds of services were needed in their support. UNICEF's idea was originally to provide aid to pre-school services, but as a result of a survey conducted among the affected population, and upon further reflection, the UNICEF Representative suggested a "Comprehensive Services for Children" project, based on the needs of the "whole child".[77] The idea was endorsed enthusiastically, though the title was changed to "Integrated Services".

In 1969 activities to reclaim land in the Delta and the adjoing desert with the help of water from the "stabilized" Nile, acquired great importance. And

again we had a situation where villages were being built from scratch - "another opportunity to look at the whole child"[78] The result in the following few years were projects of assistance to child related services provided on an integrated basis to many of these new villages.

In Iran, attempts were made to create models in social development of field services for children which could be used in demonstration and training for developing countries. Support under this concept was provided to Regional Development, in Kerman Province, to nutritional programmes for pre-school children and to primary health care. Syria's ambitious Euphrates Dam development project was to be the basis for several projects of an "integrated" character.

The best documented, however, was the project in Egypt where, in the aftermath of the construction of the High Dam at Aswan, opportunities were created in the Aswan zone itself at the southernmost part of the country and in the reclaimed lands in the North Delta to demonstrate the possibility of integrated services at an affordable cost. In this latter zone a population of some 90,000 people was being settled in new villages. The components of the integrated package included MCH services, homecraft, mothercraft, day care, pre-vocational training and youth clubs.[79]

UNICEF support began in 1970 on an experimental basis. By 1973, an allocation of about $1,000,000 was made available to cover the requirements of an integrated basic services project for children in the ten zones of the overall land reclamation project. Equipment relevant to these activities and training grants were provided to 282 villages and 8 small towns. By 1975, assistance was provided to 46 health units, 166 health clinics, 10 maternity and paediatric wards; daycare centres, over 100 youth centres, and to basic education.

Did the government and UNICEF overextend themselves in these efforts? Were resources spread too thin to be effective? Much, in fact, was learned from the experience of supporting social development in newly reclaimed lands (similarly in the Euphrates Dam development in Syria), or in backward territories. The question was frequently raised as to whether, in a situation of meager resources, priority in investment should be given to economic activities of potentially higher yield? While no clear or decisive answers resulted from such debates, there was no question about the necessity of at least minimum investments in human resources development, i.e., in basic services, whether in areas of short or long-term potential (such as in the case of reclaimed land).

:Children of the cities

In some countries of the Region, urbanization was growing by leaps and bounds, with the unfortunate consequence of the growth in slums and shantytowns. And while the UNICEF-supported programmes in these countries covered rural as well as urban children, the bias was generally in favour of the rural areas. Studies carried out in the early seventies, besides outlining the nature of problems faced by children in these unfavorable urban situations, also suggested certain lines of action to help redress the worse aspects of the problem. However, the countries concerned had meager resources to devote to their solution, and hence they emphasized the necessity for self-reliance.

Based on a study presented to the Executive Board in 1971 guidelines were established for UNICEF action in relation to urban children. The application of these new policies manifested themselves more in the regions of Asia and Latin America, which have the highest urbanization rates. But one instance in the Eastern Mediterranean Region is worth noting, namely, a project in the Boulaq district of Greater Cairo, in Egypt. A neighborhood with newly developing industries, it had a population of some 66,000 in 1972, the majority being new "migrants" from rural areas and other Cairo neighborhoods. Over 40,000 were children up to 14 years of age. Adult literacy was 64 per cent for males and 30 per cent for women. In cooperation with the Cairo municipal government, UNICEF developed an experimental project using the community development approach as its main instrument. Through active participation of the local inhabitants a programme of priority actions was outlined, covering the areas of sanitation and garbage disposal, health education, expanding MCH activities and women's literacy. The project developed a great deal of enthusiasm, which stimulated government and industry to contribute to community facilities. A new primary school for 800 children was added, industries supported a new youth centre and 24 literacy classes were operating by 1973. The municipality improved sewage facilities and water supply. UNICEF's contribution included supplies and equipment for all the above-mentioned activities as well as training grants for community development and health workers. From a UNICEF point of view, one of the main objects of the project was the development of a model of a replicable urban development in which government and citizens' efforts are concerted to meet the basic needs of children in deprived urban communities. Enough success was achieved in Boulaq to encourage the Board in 1973 to agree to extend the experiment to new urban areas. A highly populated part of Cairo known as Shubra Khema, a newly industrialized neighborhood, and an ancient residential area known as Darb El Ahmar, were added to the project. The lessons learned earlier in Boulak were usefully applied here especially in relation to citizen participation and social mobilization. The programmes stressed improvements in water and sanitation, youth and women's activities and the construction of simple day care centres for children of working mothers.[80]

Towards the end of the decade of the seventies further projects referring to urban children took place outside the capital Cairo. Through the Ministries of Planning and Local Government projects were developed in three regions which were selected for "concentration" of UNICEF cooperation and inputs. The purpose was to gradually develop multi-sectoral integrated delivery of services for children. Seventeen districts at various degrees of urbanization (13 peri urban, 4 urban) were included. Programmes were always preceeded by a study of community needs and resources. To promote community support and participation a one-week workshop was organized in Alexandria in which some 200 participants took part. Included were provincial and district officials, local council members and community representations (NGO's). The purpose was to discuss planning procedures, programme development,etc. Eventually the project resulted in the development of 17 health units, 30 day care centres as well as training activities for over 1000 nurses, educators, social workers and supervisors.[81] Urban projects were also initiated in Jordan, Syria and Lebanon.

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ADVOCACY FOR CHILDREN

UNICEF had recognized for a long time that, while its aid and assistance to developing countries was recognized by them as valuable, its material aid was, and will always be, limited, given the large dimensions of the problems being faced. Hence UNICEF considered that the process through which its aid was given provided important opportunities for dialogue with governments about the needs of children and how best to meet them. The processes included demonstration of innovative, low-cost approaches to solving problems, studies, surveys and research to develop reliable information on the basis of which to argue and, hopefully, to convince governments to pursue alternative approaches. 'Advocacy' was the term increasingly used from the seventies onward to describe these processes.

In the Eastern Mediterranean Region, with its mix of least developed, better-off and in-between countries, the tools of advocacy proved to be of great value in enhancing children's services and their welfare. In 1969, the Maurice Pate Award was bestowed by the UNICEF Board on Al-Azhar University of Cairo[82] to institute a Chair in Family Planning at the university's Faculty of Medicine. The high prestige of this famous university, especially known throughout the Islamic world, would help attract attention to the importance of family planning in the context of maternal and child health.

An important landmark in advocacy for the needs of children was the convening of the Arab States' Conference of Children and Youth in National Planning. It was held in Beirut, Lebanon, from 23 to 28 February 1970. After a year-long period of preparation, pre-conference workshops were held in various Arab capitals on the main agenda items of the conference: rural children, urban children and youth, pre-school children, out-of-school children and planning and research. The Arab countries were represented at a high level in the Beirut Conference. Also represented were the League of Arab States, United Nations bodies and specialized Agencies.

Close cooperation was maintained with the United Nations Economic and Social Office in Beirut (UNESOB) in the conduct of essential research, surveys and evaluations. More intensive cooperation was sustained with the Social Development Department of the League of Arab States. Meetings were held informally from time to time to coordinate the two organizations' efforts in areas of mutual concern. Some of the outcomes of this cooperation, for example, were the translation into Arabic of key UNICEF studies on children and women and their wide distribution by the League at its expense.

UNICEF in the Gulf

Reference was made earlier to UNICEF cooperation with the better-off countries of the Eastern Mediterranean region, mostly located in the area of the Gulf. It was in 1974 that the Executive Director proposed to the Executive Board a new policy approach to UNICEF cooperation with the "enlarged group of countries with GNP per inhabitant above US $400 (at 1970 prices)".[83] These

included the major petroleum exporting countries such as those located in the Gulf Area of the Eastern Mediterranean. The Executive Director explained that while such countries may have more adequate financial resources, they at the same time have "underdeveloped basic services for children and a shortage of professional and administrative personnel to staff them."[84]

He suggested the following actions:

1) The provision to these countries of advisory services by regular UNICEF staff;

2) The expanded use of "Country Programming and Project Preparation Fund", known as CPPPF, [85];

3) Cost sharing of "regular" assistance projects; and

4) Reimbursable procurement of supplies and services.

In the field the responsibility for implementing this policy became the responsibility of the UNICEF Abu Dhabi Area Office, which opened in 1972 and covered UNICEF cooperation with Bahrain, Kuwait, Qatar, the Democratic Republic of Yemen, the Sultanate of Oman, the United Arab Emirates and the Yemen Arab Republic. This combination of high-income and poor countries confronted this office with the problem of developing approaches appropriate to their differing situations.

In Bahrain, a country small in area and population (some 300,000 in 1975), and a relatively high GNP per capita income, UNICEF assistance was in the early seventies requested in relation to child health problems, to education and social services. A 1971 Board commitment of $156,000 made it possible for UNICEF to aid in the in-service training of over 200 primary teachers; to assist the newly organized College of Health Services in providing MCH training for nurses; and in the provision of advisory services for day care programmes. In the latter part of the decade UNICEF cooperation with Bahrain was funded by modest allocations from IFPP as part of a sub-regional plan of action for children's programmes in the Gulf Area.[86] The project included research and data collection, advisory services and the training and development of manpower in the social development field.

Oman, another of the Gulf countries new to UNICEF cooperation, had lived for centuries isolated from the rest of the world until 1970, when a new regime came to power and opened the gates of the country to the outside world, putting it on the road to modernization and development. Oman's population in 1975 was estimated to be about 766,000 and was counted among the better off countries of the Gulf, but purely on economic terms. Socially the country faced severe problems: children in large numbers suffered from malnutrition, gastro-enteritis and acute respiratory infections. There was a lack of clean potable water for the majority of the population which suffered from an unhealthy diet. Educational levels were extremely low.[87] And in spite of the great efforts by the new government to expand primary education, in 1978 nearly 90 per cent of the adult population was illiterate. Primary school

enrolement grew from 900 male students in 1970 to 76,000 in 1978, 37% of whom were girls.[88] UNICEF's first programme of cooperation was approved in 1972 for a multiple year committment amounting to $186,000.

So little was known about the country in general and conditions of children and women in particular. In cooperation with the Ford Foundation a survey was carried out among Omani women about practices and beliefs related to health, nutrition and child rearing. The report findings were discussed at a national seminar, in which a large number of government officials participated. One of the early outcomes of this exercise was the initiation of two pilot projects for the provision of basic services using community development techniques. The success of these efforts led to their extension to new areas in the country's interior, but with stronger emphasis on primary health care (PHC). From 1979 onward UNICEF support to activities in Oman was funded through IFPP.

In the United Arab Emirates (UAE) UNICEF's role was primarily the provision of technical assistance and advisory services. In 1977 the Ministry of Information was assisted in producing 14 educational films for use in child care centres and mobile cultural units. The cost of producing these films wase covered by the Government. Another example of this relatively new form of cooperation was the assistance provided by UNICEF in planning for the establishment of four community service centres which were eventually established: two in Abu Dhabi, one in Ajman and one in Sharjah. These are multi-purpose centres providing health, education and social services, staffed by health and social workers who were trained for their tasks with UNICEF help.[89]

A unique activity of that period in UAE was the convening in 1977 of a seminar for women leaders and trainees from all over the Gulf area, which produced a nucleus of trained social development workers dedicated to the promotion of rural basic services.[90]

It should be noted that most of the technical/advisory services were provided by UNICEF personnel, but where necessary UNICEF recruited advisers in specialized subjects to work with the governments concerned. Such consultants, for example, were provided to Qatar in relation to the development of pre-school curricula, equipment and building design; the production of audio-visual aids in education; and to carry out a survey on the situation and needs of children.

In 1978 two training courses were organized in cooperation with UNICEF in Kuwait, one for pre-school and kindergarden personnel and the other for youth leaders interested in social services. Among sub-regional activities of special interest was the "Regional Conference on the Arab Child Health" which was convened in Kuwait from 5 to 11 December 1979. Participants were specialists and scientists from Bahrain, Iraq, Kuwait, Qatar, Oman, UAE, Saudi Arabia, Democratic Yemen, Yemen Arab Republic, Somalia and Sudan. Sponsors, besides UNICEF, included the International Children's Centre (ICC), based in Paris, and WHO. Technical participants included the American University of Beirut (AUB), Institute of Child Health of London, Dublin University, Yale

University and other academic and scientific institutions.[91] The conference came out with a set of practical recommendations and project proposals, covering a wide range of issues, e.g. promotion of breast feeding and improved nutritional practices, immunization, and child disabilities. As is customary in connection with UNICEF-supported and/ or sponsored conferences, arrangements were made for follow up actions on the resulting recommendations.

:Saudi Arabia

UNICEF cooperation with Saudi Arabia started back in the early sixties, when, in cooperation with the government and in collaboration with UNDP and the United Nations Office in Beirut (UNESOB), a Community Development Training Center, the first of its kind in the Kingdom, was established in Dereya. More active cooperation, however, materialized in the early seventies. In 1972, when the government declared its intention to extend education to girls and established the Presidency of Girls' Education (PGE), UNICEF offered its full cooperation by providing technical assistance and training. PGE launched an ambitious programme which included not only school age girls, but also literacy for adult women, going as far as declaring the goal of eradicating illiteracy by 1992. Throughout the period and into the eighties UNICEF continued to offer its technical assistance through the provision of consultants, training and staff support, not only to education, but to MCH and other basic health and social welfare services.

In 1987 UNICEF responsibilities for cooperation with the Gulf countries were transferred from Abu Dhabi, UAE, to Riyadh, Saudi Arabia.[92] The "two Yemens" had their separate country offices.

:Gulf states as donors

In discussing the better-off countries of the Gulf in the context of external aid, reference should be made to their role as "donor" countries, a role that grew during the seventies. This generous aid was provided both bilaterally and through the United Nations organizations. An example was the emergence of such bodies as the Kuwait Fund for Economic and Social Development which in 1974 was capitalized at us $500 millions. These funds were utilized to provide soft loans to worthy development projects in Africa and Asia. Another example, more closely linked to UNICEF concerns, was the Arab Gulf Programme for United Nations Development Organizations, known as AGFUND, which will be referred to in some detail in the pages to follow.

:Expanding aid to poor countries

Reference was made earlier to UNICEF cooperation in the Yemen Arab Republic, one of the poorest countries in the Region. With a population of 6,668,000 inhabitants in 1975, it had an estimated GNP per capita of $300. UNICEF assistance was first provided in 1962. Between 1973 and 1977 UNICEF expenditures on its programmes of cooperation amounted to $3,828,000. This included assistance to the Health Manpower Institute, where about 50 health workers of various categories and levels were trained annually. An important project for the development of rural water supply was carried out with special financial contributions from the Federal Republic of Germany and later from the United Nations Capital Development Fund (UNCDF)[93] The funds were used to provide villages with piped water networks, many of which were installed

through self-help schemes. Assistance to water supply continued after 1977 with emphasis shifting to strengthening the capacity of the government's Rural Water Supply Department. Assistance to programmes of education proved also to be of great importance to Yemen. This included the upgrading facilities of basic education schools, and extending the coverage of non-formal education units, improving educational supervision, and the technical capacity of personnel operating the printing press for text book production. During 1978 ten kindergarden serving 1700 children, 40 primary schools and the country's first day care centre received UNICEF equipment and technical support. For the People's Democratic Yemen (Democratic Yemen), at the 1979 Executive Board, the Executive Director recommended a commitment of $1,100,000.00 from General resources and a "noting" in the amount of US $4 million, subject to availability of funds, in support of UNICEF cooperation in the period 1979-1980. These amounts were to cover requirements of assistance to health, nutrition, water supply, education and rural development.[94] Much smaller in population compared to its neighbor to the north, (Democratic Yemen had a 1975 population of 1,660,000), but a similarly low GNP per capita, a high infantile mortality rate (152 per 1000), but a relatively high school enrolement of 78 per cent (for first level ages 7-12 for both sexes; the female rate was 48%). UNICEF cooperation started, in 1951 when it was still under colonial rule. In more recent times e.g. the period 1973-1977 the stress was on manpower training in the health sector. In that period alone 3000 such workers were trained at the Health Manpower Institute in Aden. By 1977 a substantial network of health services was operating fairly adequately. It included 26 hospitals, 15 health centres, 25 MCH centres, six mobile health units and 263 simple rural health posts. UNICEF was instrumental in the provision of supplies and equipment to this network over a period of years. Aid to education figured prominently as well during this period. In the academic year 1976-1977 UNICEF provided science laboratory equipment for twenty primary and preparatory schools. In the same period UNICEF provided support in the pre-service training of 1500 teachers and nine-week in-service training courses for about 3000 teachers.[95]

:Aid in the Sudan

The largest country in Africa, the Sudan, together with Egypt and the other North African countries, forms a geographic and historic link to the Middle East and the rest of Asia. Relative to its large area, it makes for a low population density. (Area over 2 million sq. km.; population in 1975: 18,268,000). Its poor economic situation is indicated by its GNP per capita of $272 in 1976. A survey on the needs of young children which was carried out by the Development Studies and Research Centre of the University of Khartoum was completed in 1979. In general it revealed the situation of children in terms of health, nutrition and education as precarious, particularly so in rural areas. Reference was made earlier to UNICEF cooperation with and assistance to Sudan, a relationship which goes back to 1948. But in the era of country programming the programme approved by the Board for the period 1973-1977 was the first substantial multi-year programme adopted for that country. Its cost to UNICEF amounted to $4,938,000. It covered important support to child health and nutrition activities and introduced innovative means in the training of primary school teachers. One of its memorable achievements was in the rural water supply field. In the Wau area of Bahr el Ghazal province, UNICEF assisted in developing a successful rural water programme. Thanks to new well-drilling techniques introduced it was possible to drill more than 100 boreholes and to fit them with hand pumps

in a short period of time. The following year, 1978, was also a year of intense programme cooperation at a cost in that year alone of $3.8 million. A system of primary health care was taking shape with the ambitious goal of extending it throughout the country. The emphasis was placed on immunization, nutritional counselling and improved sanitation and hygiene.[96] The government's ambitious goal of achieving universal primary education by the year 1990 prompted it to appeal to UNICEF for continuing support in the field of education. In the two year period since 1977 over 2,200 teachers had graduated from the Teacher Training Institute (ISETI). Besides assisting this endeavor, UNICEF provided teaching aids for primary schools, short-term study tours for educational supervisors, paper stocks for printing text books and manuals and support to school feeding activities. Related to education but closer to the area of social services was the technical and material support to 94 kindergardens including training courses for at least 60 day-care supervisors. And although the social services aspect of the programme, including women's training in appropriate technologies fell short of the planned targets, it helped establish parameters and standards for pursuit of these activities in future years. Implementing these programmes in the Sudan faced tremendous challenges. The size of the country, served with a poor infrastructure of seasonal roads and poor transportation and communication facilities, required special provisions on the part of UNICEF. Its tradition of organizational flexibility enabled the UNICEF Country Office to cope with this challenge.[97] UNICEF support to programme developments of relevance to the welfare of children and women in the Sudan continued with vigour into the decade of the eighties.

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A TRAGEDY IN LEBANON

:The war breaks out

A civil war broke out in Lebanon on 13 April 1975 and in a real sense the issues and problems that brought it about were yet to be resolved at the time of this writing. The capital, Beirut, and its suburbs were affected as were the Tripoli, Balabeck, and Zahle areas. Losses in human lives were considerable and most of the country's institutions were functioning at a very low level when they were not entirely paralyzed.[98] In that first year of the conflict the prevailing view was of hopeful optimism that the conflict was to end soon. When the Executive Director authorized the use of $ 140,000 for relief assistance in response to a government request it was hoped that the strife would soon end. In fact plans for rehabilitation and reconstruction were being discussed and the Executive Board approved a committment of $200,000 for that purpose. Sadly the war was to prove intractable and of long-term disastrous effect and, as is always the case in such tragedies, particularly so for children and women.

The early clashes took place in the so-called "Poverty Belt" surrounding Beirut, resulting in the displacement of thousands of persons seeking refuge in the Southern suburbs of Beirut. The emergency funds referred to above were used to aid in this situation using food and medical supplies stored at UNRWA's warehouses.[99] In the years that followed "similar calamities became a recurring syndrome hitting, one after the other most of the coastal areas, mountains and plains, as well as all Palestinian refugee camps without exception."[100] UNICEF's prompt response to the immediate and urgent needs was forthcoming on a regular basis for relief of suffering, but also for such activities as the vaccination of young children. Between April 1975 and September 1976 more than one million displaced persons benefited from the emergency relief provided.

A special unit, within the UNICEF Regional Office, was established in 1976 to deal with the emergency. It was first located in Cyprus (Beirut harbor and airports were closed). Supplies from the Cypriot ports of Larnaka and Limasol were onforwarded on small cargo vessels, operated by the International Committee of the Red Cross (ICRC), which would call on secondary ports of the Lebanese coast. From there, supplies were distributed to areas of need in the country. In 1977 the new Emergency Unit was moved to Beirut. However for years to come resort to the use of Cypriot Ports becme a frequent necessity. The first supplies ordered by the Emergency Unit arrived in May and June 1977 and were used to replace on a "country-wide basis" the losses incurred by public schools, social centres and health facilities of various level.

:The conflict continues[101]

With no end in sight of the conflict, aid to the country's children continued to be provided on a large scale. This made it possible in late 1979 for more

than 200,000 children to return to their schools. A governmental body named the "Higher Relief committee" was established and was headed by the Minister of Social Affairs with responsibility for coordinating all emergency assistance activities in Lebanon. In this period the restoration of water systems in various part of the country, damaged by the war, became an urgent necessity particularly in the South. UNICEF cooperated with the Ministry of Hydraulic and Electrical Resources in the procurement and installation of pumping units, storage tanks, chlorination equipment and pipelines. These activities made it possible to reactivate these facilities with a capacity of 110 million litres per day. The difficult mountainous terrain in many locations made it extremely difficult to achieve successful results, but much ingenuity was exercised in facing these challenges, aided by help from such sources as the United Nations Interim Force in Lebanon (UNIFIL) who in various instances helped ferry equipment by helicopters. In other instances mule transport proved the only practical means down steep ravines.

For the period 1975-1980 these emergency/rehabilitation activities required an expenditure of US 21.5 million, partly from UNICEF's regular resources and from special funds contributed for the purpose. Of these amounts $10.8 million were expended on the water projects alone.

:The "Regular Programme" continues

In spite of the preoccupation with emergency actions, the so called "regular" programme of UNICEF in the country never closed. A network of twelve "Basic Services Units" continued to function. Each provided a comprehensive range of services with active community participation in the poorer sectors of Beirut and in the northern parts of the country, the Beqaa Valley and in the South. In the early eighties new programme initiatives were undertaken, including the introduction on a pilot basis of a "basic life skills" component into the curriculum of public primary and secondary schools. The skills included carpentry, sewing, typing, book-binding, as well as gardening in rural schools. Kindergarden supervisors were trained in cooperation with the Ministry of Education. UNICEF also supported the printing and distribution of two textbooks on health education. Another undertaking, designed to help alleviate the psychological effects of the war on children aged 2 to 11, was the establishment of "Children's Peace Playgrounds" within the spaces available to schools that have been rehabilitated with UNICEF's support.

Within the "regular" programme was a special component which provided assistance to the large number of Palestinian mothers and children living in Lebanon. These were refugees who for one reason or another were not registered with UNRWA as refugees. The projects covered the fields of health, water supply, sanitation, child care and health education, and were funded through the Executive Director's Emergency Reserve, regular budget resources and special-purpose contributions. Between 1977 and 1985 a total of $1,754,000 was expended on these activities.

:An unusual role for UNICEF[102/]

Early in 1977 a National Council for Development and Reconstruction (known by the acronym CDR) was established within the Presidency of the Republic. Its

main function was considered to be the reconstruction of the ravaged areas in the country. UNICEF worked closely with the new body, a relationship which was formalized in October 1982 by the signing of an agreement by which the government authorized UNICEF to undertake a major reconstruction and rehabilitation effort in the South. To this effect it put at the disposal of UNICEF the amount of 150 million Lebanese Pounds (at the time equal in value to US $41 million). It is of interest to note that this amount was part of a us $417 million contribution apportioned to Lebanon by the 10th Arab Summit Conference held in Tunis in November 1979.

UNICEF was already functioning at an "operational" level beyond its normally accepted role of an international aid-giving organization. But the circumstances in Lebanon were far from normal, and hence UNICEF was now, under the new agreement, even more "operationally" involved. Implementation of the joint programme effectively started in 1981 under the leadership of the special unit referred to earlier, and became known as "Reconstruction of South Lebanon" or RSL. This latter set up its headquarters in the village of Qana, where UNIFIL also had its headquarters. From there RSL commenced a vigorous programme of reconstruction and rehabilitation in the South. Later, when as a result of a special appeal made by the UNICEF Executive Director in 1982, $34.3 millions were made available, RSL was able to extend its work to other parts of the country including the Beirut area, Shouf and west Bekaa areas, which were sadly affected by renewed fighting. It however took until 1985 before the full programmes, including 317 projects, were implemented. It must be noted that much of this work was carried out in close collaboration with and active participation of the communities concerned.

:The hot summer of 1982

The situation was dramatically changed for the worst when in June 1982 Israel invaded Lebanon. The UN Secretary General ordered the evacuation of all United Nations Agencies, their international personnel and dependents: UNICEF Office, however, remained open and operational under the severest possible circumstances, under the leadership of a senior UNICEF official of Lebanese nationality[103] and a small staff of dedicated workers. They managed to initiate emergency relief operations for the waves of displaced persons who were fleeing in all directions to evade the dangers from the invading forces. In swift response the UNICEF supply warehouse in Copenhagen, Denmark, dispached, in succession, five cargo planes loaded with 159 tons of relief supplies. These were unloaded in Damascus, Syria, and from there supplies found their way by trucks to various destinations in Lebanon including Beirut in spite of the great difficulties encountered (On 13 June the invading forces had reached the Damascus-Beirut road).

At this point Beirut was under siege, water and electricity were cut off, and food commodities were not allowed to enter some parts of the city. It was an urgent priority to solve the water supply problem which prompted UNICEF to launch "Operation Water Jug" (30 June). In the first stage clusters of five 1000-litre tanks in 5 areas of West Beirut were erected. Water tankers went around filling these tanks three times a day.[104] A total of 25 old wells within the area were rehabilitated, while 21 diesel-generators mounted on small trucks moved around the various thirsty areas to pump water from the

underground reservoirs of apartment buildings to the upper floors. A key figure in these energetic efforts was a staff member of UNICEF, an engineer by profession.[105] A similar effort was maintained to supply hospitals and health centres with water.

When, James Grant, UNICEF's Executive Director, arrived in Lebanon, having traveled by road from Damascus, West Beirut was still under siege "with probably more than thousand shells falling yesterday, intermittent light and water supply and virtually no food supply currently permitted."[106] During the visit he reviewed with government officials and the UNICEF and other agency personnel the progress of the activities being undertaken both in relation to relief and reconstruction activities.

Fighting and severe tensions reached a peak in February 1984 when a decision was taken to relocate the Regional Office, an action which proved both delicate and dangerous. After some false starts the convoy carrying the regional staff finally got under way on 18 February, moving under the UN flag via Tripoli and into Damascus, and a day later to Amman, Jordan, where UNICEF's Regional Office for Eastern Mediterranean and North Africa (MENA) has been located ever since. It should be noted that this "displacement" did not apply to the UNICEF staff in charge of Lebanon's country programme or the RSL staff who continued to carry out their duties out of Beirut, Qana and Baabda. Wide international support to UNICEF's efforts is manifested by the fact that between 1982 and 1985 an amount of US $76 million were contributed by governments (over $66 million by some 35 countries), UNICEF National Committees ($2.7 million), by non-governmental organizations ($2.2 million) and by United Nations agencies (over $3.8 million).

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COMING TO THE AID OF WORLD CHILDREN: A PRINCE FROM THE GULF

On a day in April 1980 His Royal Highness Prince Talal Bin Abdul Aziz Al Saud, of Saudi Arabia, was appointed Special Envoy for the United Nations Children's Fund, (UNICEF). This was announced after Prince Talal had arrived in New York for two days of meetings with the UN Secretary General and with UNICEF's Executive Director, James Grant who stated that the Prince, in his new capacity, would undertake actions aimed at raising in a significant manner the level of services for children in the developing countries and to the extent possible, increase the resources available for these services. The UN Secretary General on the other hand pointed out that Prince Talal's work on behalf of children would help maintain the momentum that was generated during the International Year of the Child.[107] Prince Talal's own background suited him most admirably for this task.

An experienced administrator and diplomat, he has contributed to his country's development through projects in education, health and social welfare. He held the positions of Minister of Finance and National Economy, was vice chairman of the Planning Council and was earlier a Minister of Communications. In the period to follow, Prince Talal undertook an active programme of visits to developing countries in Asia, Africa, the Middle East and Latin America, as well as numerous European and Arab countries, meeting with heads of state and government, briefing them on his findings about the situation of children and women in the Third World.

Through these initiatives Prince Talal conceived the idea of a funding organization representing the various countries of the Gulf in support of the developmental and humanitarian work of the United Nations Organizations. As a result of extensive consultations with the governments concerned a "statement of principles" was signed in April 1981 by Bahrain, Iraq, Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates on the establishment of what has subsequently become known as the Arab Gulf Programme for United Nations Development Organizations; and briefly as AGFUND.

The most immediate beneficiaries were to be UNICEF and UNDP, but eventually other UN agencies as well. In its first year AGFUND channelled assistance to development projects in 46 countries. During its first bienium, it reached out to 77 countries with grants totaling more than $81 million.[108] Of this amount UNICEF received $25 million in 1981/1982 for projects in 19 countries representing all the world's regions. In the following bienium 1982/1983 AGFUND's contribution amounted to $21,900,000 for UNICEF activities in 40 countries in Asia, Africa and Latin America.

For nearly five years, since his appointment as special Envoy, Prince Talal travelled extensively in Africa, Asia, Latin America, Europe and the United States to advocate the cause of children. In April 1985 the UNICEF Executive

Board passed a resolution expressing deep gratitude for his remarkable efforts and generous assistance as "one of the world's most dedicated champions of children", and as an "eloquent spokesman and strong advocate for the cause of children". On 19 December 1984, Prince Talal resigned as UNICEF Special Envoy in order to devote more time time to AGFUND, at the same time reconfirming his continuing commitment to the children whom UNICEF serves.[109]

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THE EIGHTIES - STEPS TOWARDS CHILD SURVIVAL AND DEVELOPMENT

When the decade of the eighties dawned on the Middle East and North Africa, the situation in the Region could have been viewed by some with pessimism, by others with cautious optimism. Some old intractable problems remained without solution, for instance the situation of the Palestinians in the occupied territories of the West Bank and Gaza, and elsewhere in the region. The situation in Lebanon remained tense and hoplessly tangled as far as a political solution is concerned, and the Iran-Iraq war broke out and continued in spite of valiant efforts by the United Nations to bring about peace. In the Sudan, a quiet war in the South continued to flare up intermittently. All of these situations had far reaching and tragic repercussions on the countries concerned and on the Region in general, but particularly for the children and women.

For UNICEF globally the new decade brought with it a reassessment of its objectives, priorities and means for achieving its goals. For, in spite of the great strides made in the previous decade by UNICEF, the governments and other partners in actions favoring the welfare of children, many serious and basic problems remained. Infant and child mortality rates in most developing countries remained unacceptably high, as were morbidity rates. This was certainly true for the Middle East/North Africa countries, both the poor and the rich.

The challenge facing policy-makers both in governments and the development aid agencies, especially UNICEF, was to come up with measures that could dramatically reduce this waste of lives, that could at the same time be affordable. It was against this background that UNICEF, under the direction of its new Executive Director, James P. Grant, vigorously promoted the search for solutions and new strategies. There was mounting evidence that high infant and child death rates could be sharply reduced in low income countries if simple and well proven technologies were widely utilized. Four of these seemed particularly appropriate: immunization against six of the most common childhood diseases; control of dehydration due to the widespread diarrhoeal diseases; the promotion of breast-feeding proven again and again as the healthiest and safest food for infants; and regular growth monitoring which, if practiced with regularity, would help parents detect their children's faltering growth long before serious malnutrition sets in and helping them to deal with it.[110] In the following years of the decade these measures were to be promoted with vigour, and were considered a spearhead for accelerating primary health care. By 1983, this programme became known as the Child Survival and Development Revolution or CSDR. The four measures mention above remained central to the "package", but other techniques were incorporated in particular countries such as the control of acute respiratory infections, concern with perinatal mortality, low birth weight and parasitic diseases.

These new approaches combined together with more vigorous social mobilization were to have an impact on the types of programmes carried out by UNICEF in cooperation with the governments in the MENA Region thoughout the decade. And

while these changes did not totally displace the broader approach to child survival and development issues that characterized UNICEF programmes in the region, top priority was clearly accorded to programmes and activities considered to have a favorable impact on child survival, with the greatest attention being given to expanded immunization efforts. From Iran and Turkey in the East to Morocco in the West and in Sudan and the Yemens in the Southern perimeter of the MENA Region UNICEF support was provided to the countries to enhance the above programmes both in the traditional forms of supplies, equipment and training grants, as well as through the more modern uses of social communication and mobilization, supported by effective monitoring, research and evaluation. These actions were further strengthened through UNICEF cooperation with the League of Arab States and with other regional organizations.

The goal of reducing by half infantile mortality rates (IMR) in the region during the decade 1980-1990 has been politically accepted and was spinning action for child health beyond immunization.[111]

In connection with this, new methodologies to measure changes in IMR were being developed, including "rapid survey" techniques.

By the middle of the decade of the eighties most Middle Eastern and North African countries had given high priority to child immunization efforts in anticipation of the goal set for universal child immunization (UCI) by 1990. This required a tremendous effort in social mobilization, improving the statistical data bases to permit more accurate monitoring of progress and in such physical requirements as the 'cold-chain' and transport. In 1987, the Arab Health Ministers adopted the goal of reducing infantile mortality rates (IMR) at least by 50 per cent by the year 1990, compared to the rates which prevailed in 1980. It is worthy of note that this goal has already been reached by Iraq and Jordan.

The mid-decade was also a period of great economic hardship to the vast majority of developing countries resulting from a combination of factors, including depressed prices for these countries' primary commodities and mounting of external debts. UNICEF was commended for its ability to stimulate thought on the issues of development cooperation, as it drew attention to the particularly heavy burden on vulnerable groups (children and women) resulting from the vigorously promoted economic adjustment measures. The object of UNICEF advocacy in this realm is that adjustment should be attained through a balance between economic growth, equity and social welfare of the most vulnerable groups. In other words an "adjustment with a human face".[112]

In the MENA Region the effects of adjustment efforts have been particularly noted in those countries at the lower income levels such as Sudan, the two Yemens, and those at the somewhat higher national income levels including Algeria, Egypt, Syria, Morocco and Tunisia. As the decade drew to a close much progress in immunization and the expanded use of oral rehydration therapy was reported. "Sustainability remained the overriding concern; but there was less uneasiness as the campaign-launched countries -Algeria, Iraq, the Syrian Arab Republic and Turkey - reach maturity."[113] All of these countries have

maintained or exceeded 65 per cent coverage for combined diptheria, pertussis and tetanus (DPT) and oral polio vaccines and were gradually learning to consolidate their gains.[114/]

Generally speaking, throughout the region gains appear to be made in the battle for child survival, and in several countries those concerned were begining to turn more attention to child development issues including those of early stimulation of infants and pre-school children; concern with prevention, treatment and rehabilitation of child disabilities; and the broader field of basic education, especially for girls and women.

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ANNEX I: FOOTNOTES

1/ John Charnow and Margaret Gaan, "History of UNICEF", 1965, unpublished.

2/ General Assembly Resolution 57 (1)

3/ Final Report of the First Executive Board, UNICEF. 11 December 1946 - 31 December 1950. E/ICEF 160. January 1951.

4/ Charnow and Gaan, Op. Cit.

5/ UN General Assembly Resolution 57 in accordance with Article 55 of the Charter of the United Nations (11 Dec. 1964)

6/ Report of the 57the meeting of the Programme Committee, meeting held at Geneva on 14 August 1948. Document E/ICEF/74

7/ Ibid.

8/ Letter Addressed to the Executive Board of UNICEF by Dr. M. Kahany, Representative of the Provisional Government of Israel on 13 August 1948. UNICEF document E/ICF/74 Annex 2

9/ Letter addressed on 19 October 1984 to Dr. Ludwik Rajchman, Chairman, Executive Board, International Emergency Children's Fund by Ralph Bunche, United Nations Acting Mediator for Palestine. UNICEF document E/ICEF/80 Annex IV

10/ Recommendation of the Executive Director for Relief to Refugee Children and Mothers in the Middle East. UNICEF document E/ICEF/81 Annex IIIA. October 1948

11/ Ibid.

12/ Report of Programme Committee on its 59the - 62and meeting held at European Headquarters of UNICEF, Paris, 23 through 26 October 1948.

13/ Report of the Executive Board on its 40th - 42nd Meetings held at the Palais de Chaillot, Paris 28th and 29th October 1948. E/ICEF/82, 20 November 1948.

14/ Programme Committee. Report on Progress of Middle East Operations, January 1949. E/ICEF/93

15/ Report of Sub-Committee on Medical Projects, 5 March 1949, Paris. E/ICEF/111.

16/ Report of Executive Director to 93rd meeting of Programme Committee, 20 October 1949. E/ICEF/129.

17/ Programme Committee. Recommendation by the Executive Director on Additional Allocations. E/ICEF/W.85. 28 October 1949.

18/ UNICEF Programme Committee, Executive Director's Recommendation on Additional Allocations. E/ICEF/W.85. 28 October 1949.

19/ These included Jericho, Ramallah, Nablus, Jerusalem, Bethlehem and Hebron.

20/ Statement to the Executive Board, by Gurdial S. Dillon, Director, Eastern Mediterranean Region. 3 E/ICEF/CRP/68-38. 18 June 1968.

21/ Ibid.

22/ The Executive Board then consisted of 25 member states of the UN, later joined by Switzerland.

23/ UNICEF Compendium, June 1950, New York.

24/ Including Ethiopia which at the time came under UNICEF's Regional office for the Middle East.

25/ A highly perishable liquid vaccine then in current use. It was not until 1962 that the more reliable freeze-dried BCG vaccine was to come into wide use.

26/ General progress report of Executive Director, 1956 E/ICEF/309/Add.4.

27/ UNICEF General Progress Report of the Executive Director, 1957. E/ICEF/336/Add.5

28/ Maggie Black, "The Children and the Nations". UNICEF 1986.

29/ Progress Report of the Executive Director, E/ICEF/300/Add.4, 1955

30/ Charnow and Gaan. OP. cit.

31/ Including Ethiopia and British Somaliland, at the time included in UNICEF Eastern Mediterranean Region.

32/ Progress Report of the Executive Director, E/ICEF/336/Add. 5, March 1957.

33/ General Progress Report of the Executive Director, E/ICEF/376/Add. 4, February 1959.

34/ Maggie Black, "The Children and the Nations". Op. cit.

35/ Op. cit.

36/ "Consolidation" was the phase that followed a 3 to 4 year period of residual spraying, after which a shift occurs to surveillance, case finding, respraying of "core" areas, and the use of chemotherapy.

37/ Charnow and Gaan. Op. cit.

38/ Progress Report of the EXecutive Director, E/ICEF/300/Add. 3, 1955.

39/ General Progress Report of the Executive Director E/ICEF/409/Add. 2 May 1961.

40/ Progress Report of the Executive Director, E/ICEF/480/Add. 3, October 1963.

41/ Yaws and leprosy were not rampant diseases in the Eastern Mediterranean Region.

42/ General Progress Report of the Executive Director, E/ICEF/409/Add. 2, May 1961.

43/ UNICEF Recommendation of the Executive Director for an Allocation. United Arab Republic (Egypt). Bilharziosis Control Pilot Project. E/ICEF/R.870, February 1960.

44/ General progress report of the Executive Director, Part V; E/ICEF/376/Add.4, February 1959.

45/ Official records of the World Health Organization, No. 19, Geneva 1949.

46/ Charnow and Gaan, Op. cit.

47/ Progress Report of the Executive Director E/ICEF/309/Add.4, 1956

48/ Progress Report of the Executive Director E/ICEF/336/Add.5. 1957

49/ "L'Enfant D'age Prescolaire en Tunisie" a report presented by the Tunisian government to UNICEF's Executive Board, ICEF/CRP/Pages 65-32.

50/ Op. Cit., General Progress Report of the Executive Director, Oct. 1963.

51/ Progress Report of the Executive Director, E/ICEF/300/Add 4, 1955

52/ Progress Report of the Executive Director, E/ICEF/336/Add. 5, 1957.

53/ Report of the Executive Board, Supplement No. 2A, UNICEF, March 1960, New York.

54/ Report of UNICEF-Assisted Programmes on Nutrition to Executive Board, E/ICEF/CRP/1965

55/ Warner G. Middleman, Statement to the Executive Board, CRP/1964 - A/28, January 1964.

56/ Report to the Executive Board by G. Dillon, Resident Director, Eastern Mediterranean Region, E/ICEF/CRP/66-30, 23 May 1966.

57/ Ibid.

58/ General Progress Report of the Executive Director: Programme Developments in Africa, E/ICEF/447/Add.2, 1 May 1962.

59/ "Regional Programme for the Eradication of Illiteracy in Africa", UNESCO Regional Office for Education in Africa, Dadar 1986.

60/ H.M. Phillips, "UNICEF in Education: A Historical Perspective", UNICEF History Series, Monograph VIII, May 1987.

61/ Ibid.

62/ Progress Report, Cairo Area Office, UNICEF, 1970.

63/ "UNICEF Aid to Education, Review of Policy", UNICEF document E/ICEF/L.1279/Add.1, 1972.

64/ Ibid.

65/ Rapport Annual, 1971. UNICEF Bureau pour L'Afrique du Nord. Alger.

66/ Rapport Annual, 1973. UNICEF Bureau pour L'Afrique du Nord. Alger.

67/ Non-formal Education for Rural Development: strengthening learning Opportunities for Children and Youth. E/ICEF L.1284. February 1973.

68/ According to Habib Hamman; letter to John Charnow, 2 December 1987. SEE also E/ICEF/P/L.1677. March 1977.

69/ Ibid.

70/ H.M. Phillips, "UNICEF in Education - A Historical Perspective". UNICEF History series, Monograph IX. 1987.

71/ Ibid.

72/ Statement by James McDougall, Director for Eastern Mediterranean to the Executive Board, 23 May 1969 in Santiago, Chile, E/ICEF/CRP/69-21.

73/ Ibid.

74/ "Commitments and Notings", UNICEF Programme Committee, E/ICEF/P/L. 1634/Rev.1. April 1976

75/ General Progress Report, E/ICEF 642, 1976

76/ General Progress Report of the Executive Director, E/ICEF/637. 1975.

77/ This information is derived from a letter by Mr. Ralph Eckert, dated 8 December 1987. Mr. Eckert was UNICEF Representative in the Cairo Area Office

78/ Ibid.

79/ P/L 1935 United Arab Republic, 10 Feb. 1971

80/ "Urban Component in Country Programmes. 1980". E/ICEF/681 (Part II)Add.4.

81/ Ibid.

82/ Op. cit.

83/ UNICEF, General Progress Report of the Executive Director, New York 1974. E/ICEF/632

84/ Ibid.

85/ CPPPF are funds provided on a regional basis to be used for project development, related studies, surveys and evaluations.

86/ Country Programme Profiles, Bahrain; E/ICEF/P/L. 1851, April 1979.

87/ UNICEF, Gulf Area Office, Abu Dhabi; Annual Report 1978.

88/ Ibid.

89/ Fuad Hassan, UNICEF Senior Programme Assistant; 1977 Annual Report, Abu Dhabi. October 1977.

90/ A.G. Berouti, UNICEF Representative, introduction to 1977 Annual Report, Oct. 1977.

91/ UNICEF Gulf Area Office, Annual Report 1980, December 1980.

92/ UNICEF Gulf Area Office, Annual Report 1987. Riyadh, Saudi Arabia.

93/ UNICEF, Country Programme Profile, Yemen. E/ICEF/P.L.1859. April 1979.

94/ UNICEF, Country Programme Profile, Democratic Yemen E/ICEF/P/L.1852(REC).

95/ Ibid.

96/ UNICEF, Country Programme Profile, Sudan. E/ICEF/P/L. 1857(REC), April 1979

97/ Ibid.

98/ UNICEF Executive Board, 1976 Session. "Programme Development in the Eastern Mediterranean Region" E/ICEF/L.1352 Rev.1, March 1976.

99/ This information and that contained in the following pages is indebted to a memoir by Rachid A.Koleilat, Deputy Regional Director of UNICEF for most the period of the events described. The memoir is entitled "UNICEF AND The Long War in Lebanon 1975-1986". HIST/54/, April 1986, CF/HIST/IC/86-04.

100/ Ibid.

101/ Op. cit.

102/ UNICEF, Press Release, 30 June 1982. R/82/9.

103/ R. Koleilat, then Deputy Regional Director.

104/ From a telexed report of the Executive Director, James Grant, on his visit to Lebanon 7-11 July 1982. Unpublished.

105/ Engineer Raymond Naimy, UNICEF staff member.

106/ From a telexed message by UNICEF Executive Director.

107/ UNICEF Information; Press Release "UNICEF Appoints Saudi Prince as Special Envoy" PR/80/4. 11 April 1980. PR/9/85

108/ AGFUND, Arab Gulf Programme For United Nations Development Organizations.

109/ UNICEF Information, Press Release "UNICEF Executive Board Pays Tribute to H.R.H. Prince Talal Bin Abdul Aziz Al Saud" 26 April 1985

110/ M. Iskander, UNICEF in Africa South of the Sahara, A Historical Perspective. UNICEF History Series. Monograph VI, March 1987.

111/ According to Richard Reid, UNICEF Regional Director, Regional Office for the Middle East and North Africa, September 1988.

112/ UNICEF. Report of the Executive Board, 1987. E/ICEF/1987/11. For more information see "The Impact of World Recession on Children". A study prepared for UNICEF. Edited by Richard Jolly and Giovanni Cornia. Pergamon Press. 1987

113/ UNICEF. Programme Developments in the Middle East and North Africa. E/ICEF/1988/10. February 1988.

114/ Ibid.

ANNEX II: STATISTICAL TABLES

A. UNICEF expenditures for Middle East and North Africa by countries from inception through 1985 cumulative total with a breakdown by decades

(in thousands of US dollars)

	1947-1959	1960-1969	1970-1979	1980-1985	Total through 198
Algeria	13	4 108	4 459	1 096	9 676
Bahrain	--	--	262	1 365	1 627
Cyprus	--	189	372	--	561
Democratic Yemen[a/]	80	583	5 310	4 660	10 633
Egypt	1 830	3 141	20 587	22 929	48 487
Iran	5 621	10 776	2 104	163	18 664
Iraq	1 538	3 879	1 944	--	7 361
Israel	1 316	529	--	--	1 845
Jordan	1 851	2 532	2 916	2 442	9 741
Lebanon	127	313	16 975	73 175	90 590
Lybia	440	392	3	--	835
Morocco	1 184	3 230	8 753	8 180	21 347
Oman	--	--	510	1 570	2 080
Saudi Arabia	--	175	537	--	712
Sudan	301	1 100	14 463	43 185	59 049
Syria	1 009	2 036	3 862	2 429	9 336
Tunisia	823	3 723	6 949	1 951	13 446
Turkey	4 425	7 070	3 426	1 515	16 436
Yemen	--	879	6 932	11 271	19 082
Palestinians	16 335	--	--	3 117	19 452
Regional	59	668	1 565	919	3 211
Total	36 952	45 323	101 929	179 968	364 172

a/ UNICEF assistance prior to independence was given to Aden.

B. UNICEF expenditures for Middle East and North Africa from inception through 1985 by main categories of programme activities

(in US dollars)

	1947-1959	1960-1969	1970-1979	1980-1985	Total through 1985
Child health	14 396	27 169	38 126	41 964	121 655
Water and sanitation	a/	a/	16 237	58 086	74 323
Child nutrition	3 321	4 770	6 584	1 637	16 312
Social welfare services	a/	1 769	12 052	8 350	22 171
Formal education	--	5 442	16 149	33 899	55 490
Non-formal education	--	1 442	6 964	3 162	11 568
Emergency relief	19 235	4 731	1 941	14 180	40 087
General	--	--	3 876	18 690	22 566
Total programme aid	36 952	45 323	101 929	179 968	364 172

a/ Separate information not available.

C. UNICEF expenditures for Middle East and North Africa from inception through 1985 by main categories of programme activities

(in percentages)

	1947-1959	1960-1969	1970-1979	1980-1985	Total through 1985
Child health	39	60	37	23	34
Water and sanitation	a/	a/	16	32	20
Child nutrition	9	11	6	1	5
Social welfare services	a/	4	12	5	6
Formal education	--	12	16	19	15
Non-formal education	--	3	7	2	3
Emergency relief	52	10	2	8	11
General	--	--	4	10	6
Total programme aid	100	100	100	100	100
Total as a per cent of programme expenditure all regions	15	16	11	12	13

a/ Separate information not available.

D. Number of institutions, centres and installations which have received UNICEF equipment and supplies in Middle East and North Africa through 1985

	Through 1959	1960-1969	1970-1979	1980-1985	Total through 1985
Child health[a/]					
District and referral hospitals	66	210	667	631	1 574
Urban health centres and institutions	136	431	2013	2 123	4 703
Rural health centres	836	2 133	4 232	6 613	13 814
Sub-centres, village MCH centres	110	2 497	4 081	15 883	22 571
Total child health	1 148	5 271	10 993	25 250	42 662
Water systems[b/]					
Open/dug wells and handpump installations	--	--	983	2 477	3 460
Engine driven pump installations	--	--	248	345	593
Piped and reticulated systems	--	--	113	195	308
Other[c/]	--	--	1	265	266
Total water systems	--	--	1 345	3 282	4 627
Child nutrition[d/]					
Demonstration centres[e/]	--	1 896	4 236	1 278	7 410
Support centres[f/]	--	128	173	76	377
Training centres	--	43	367	190	600
Total child nutrition	--	2 067	4 776	1 544	8 387
Family and child welfare					
Child welfare centres	--	373	1 754	1 325	3 452
Women's institutions[g/]	--	267	1 110	441	1 818
Centres for adolescents and youth	--	439	1 148	24	1 611
Training institutions	--	258	242	21	521
Total family and child welfare	--	1 337	4 254	1 811	7 402
Formal education					
Schools	--	13 121	6 898	6 841	26 860
Teacher training institutions	--	306	887	387	1 580
Other institutions	--	50	261	667	978
Total formal education	--	13 477	8 046	7 895	29 418
Pre-vocational training	--	545	687	415	1 647
Total	1 148	22 697	30 101	40 197	94 143

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

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

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

d/ Excluding milk and food conservation

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

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

g/ Including community centres, co-operatives, etc.

E. Number of national personnel receiving training stipends in countries with which UNICEF cooperates in Middle East and North Africa

	Through 1969	1970-1979	1980-1985	Total Through 1985
Health				
Doctors	1 214	2 183	1 186	4 583
Nurses and midwives (including auxiliaries)	2 372	7 653	1 729	11 754
Traditional birth attendants	19	282	1 070	1 371
Other health and sanitation personnel	1 908	9 660	9 623	21 191
Total health personnel	5 513	19 778	13 608	38 899
Nutrition				
Village volunteers	18	870	304	1 192
Technical and administrative personnel	3 785	726	530	5 041
Total nutrition personnel	3 803	1 596	834	6 233
Family and child welfare				
Women's education and training	572	5 162	1 904	7 638
Other welfare personnel	5 363	16 671	4 921	26 955
Total family and child welfare personnel	5 935	21 833	6 825	34 593
Education				
Teachers	20 770	57 931	38 051	116 752
Other education personnel	--	7 984	13 324	21 308
Total education personnel	20 770	65 915	51 375	138 060
Pre-vocational training	271	1 593	1 337	3 201
Other				
Planning personnel	1	2 041	463	2 505
Statisticians	--	170	40	210
Transport personnel	--	81	--	81
Toral other personnel	1	2 292	503	2 796
Total	36 293	113 007	74 482	223 782

Number of children benefiting from mass disease campaigns assisted by UNICEF prior to 1970[a] in Middle East and North Africa

(all figures in thousands)

BCG vaccinations against tuberculosis

Cumulative through 1959		1960-1969		Total through 1969	
Tests	Vaccinations	Tests	Vaccination	Tests	Vaccination
37 608	15 573	35 845	20 143	73 453	35 716

Trachoma

Cumulative through 1959		1960-1969		Total through 1969	
Examinations	Treatments	Examinations	Treatments	Examinations	Treatments
1 930	1 604	18 759	8 135	20 689	9 739

Conjunctivitis

Cumulative through 1959	1960-1969	Total through 1969
2 658	7 032	9 690

a/ UNICEF assistance for disease control activities were consolidated with the assistance to basic child health services during 1970's.

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