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Address by Mr. James P. Grant
Executive Director of the United Nations Children's Fund (UNICEF)
to the
South Asian Association for Regional Cooperation (SAARC)
Parliamentary Symposium on:
Child Survival, Population and Development

Colombo, Sri Lanka
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Mr. President, Honorable Parliamentarians, Colleagues and Guests.

There is a very justified cause for excitement as this distinguished gathering meets here today. We are meeting at a unique moment in South Asian history. It is unique in the sense that, thanks to the development progress in South Asia of recent years and of recent technological advances, the possibility now exists to save the lives of millions of young South Asian children annually while simultaneously lowering birth rates, greatly improving the health and productivity of tens of millions of children, adding to the general well being of more than 100 million families and contributing significantly, in the process, to the developmental goals of each of the SAARC countries individually, and to those of the region as a whole if, and this is the challenge, if the SAARC countries will work together in intensifying and accelerating widespread efforts already underway.

The need for accelerated progress is very real indeed. Of the 34 million children born in 1984 in the seven countries of SAARC, more than 3.5 million children died before their first birthdays and, in the absence of the new innovations we are discussing this week, another 7 million will have died or been crippled for life by their fifth birthday. The small child of a very low income family in South Asia is sick on an average of 160 days per year!

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Shocking as these figures may be, even they reflect the tremendous progress that has been made over the last 25 years. For example, if the child death rates of 1960 were applied to the population of 1984, the toll would have been more than 10 million per year instead of 5 to 6 million.

Progress during the past 25 years despite economic hardship is admirably exemplified in our host country, where child death rates are a third of those in the region as a whole and where birth rates are substantially below the regional average - enough so that if Sri Lanka's death rates and birth rates were to prevail for the whole SAARC region, there would have been nearly four million fewer child deaths; more than 7 million fewer births, and population growth would be reduced by 20 per cent, or by 3.8 million per year.

But we all know that progress in Sri Lanka and in other, more localized areas such as Kerala in India is the process of many years and of many social investments difficult to replicate at this time of economic hardship.

What is it that gives us hope to progress even faster with the health of South Asian children in these difficult times? What are the new dimensions that at this juncture could produce, in a single decade, the kind of change it has taken 20 to 30 years to accomplish in the past?

The vastly improved communications capacity and social structure of virtually every country - the product of the monumental development progress of the past four decades - creates new means for reaching, teaching, and supporting parents and families in protecting their children. This capacity combines with newly discovered, low-cost/high-impact techniques and technologies (some of which were introduced in South Asia, such as Oral Rehydration Therapy, developed in Bangladesh and first applied on a large scale in India) which address the leading killers of children in the world today: malnutrition and malnutrition-related diseases. Together, the capacity to communicate and the techniques to communicate about give us the possibility of saving millions of young children's lives each year while reducing birth rates and population growth, and greatly improving the "survivors'" prospects for a healthy life.

In 1984, more than 4,000 South Asian children died <u>each day</u> from the consequences of diarrhoea. As we all know, a great many of these deaths could have been prevented if all parents were knowledgeable about Oral Rehydration Salts - and in fact much of the diarrhoea would not have been contracted in the first place if parents knew such basic hygenic practices as boiling water, washing hands, and the use of latrines. Another 4,000 were dying each day from not being immunized even though widespread immunization facilities exist. Today vaccination against the six major child-killing diseases is available at costs so low that virtually every country can afford to immunize its young children - <u>if</u> there is the political and popular <u>will</u> to do so.

Other readily available yet grossly underutilized methods that show comparable promise include the monitoring of children's growth with simple weight charts to warn of impending malnutrition, a return to the widespread

practice of breastfeeding, addition of vitamin A, iodization and iron to diets, promotion of female literacy, and proper family spacing.

Thus we do have the knowledge which could so improve the health of children that if effectively applied could be expected to reduce death rates to one third of the current toll even by 1990, and to half by 1995.

We also know, interestingly enough, that such progress through deeply involving parents would probably be associated with a significant reduction in the absolute number of births. In fact, success with these programmes could be the biggest new factor in slowing population growth in South Asia.

As the late Prime Minister Indira Gandhi of India said:

> Parents are more likely to restrict their families if they have reasonable assurance of the healthy survival of their two children.

In 1984, the International Conference on Population, in Mexico City declared:

> "...through breast feeding, adequate nutrition, clean water, immunization programmes, oral rehydration therapy, and birth spacing, a virtual revolution on child survival could be achieved. The impact would be dramatic in humanitarian and fertility terms."

The biggest challenge we face today is not finding the cures; it is finding how to get people themselves to participate in using the knowledge we already have. It is here that the recent experience of South Asia gives us the greatest hope. In the last three years alone we have seen the most innovative pioneering, and it is here that our new ability to communicate with the populace comes into play. We have had heads of government immunizing children; we have had television in specific localities provide hundreds and thousands of television spots. We have seen many new forms of social mobilization as with the BRAC in Bangladesh, and the involvement of school teachers and parents in every village.

As parliamentarians you are certainly familiar with the new power of radio and television, of local religious and civic groups, and of what can be done through the schools. This potent tool is now being enlisted in the service of child survival, and once the networks of social organization are established they do not go away. The result is an emerging infrastructure capable of delivering the benefits of basic and modern technologies to those in whose hands it can make a life-and-death difference.

What provides such a unique opportunity today is the nature of the current challenge. We are not faced today with learning how to cure these social ills. All of these recent pioneering innovations in South Asia and elsewhere answer that.

We know that a cooperative effort begun in 1986-87, capitalizing on the valuable experience being accumulated in each of the SAARC countries, could contribute greatly to saving the lives of more than 2 million infants and small children annualy by 1990, and to halving the infant mortality rate for South Asia (from its levels of the early 1980s) by 1995. It would contribute greatly as well to the wellbeing of women, who today bear the greatest and most immediate burden of the widespread ill-health of children. And it would build on many encouraging actions already underway in countries of the region and help strengthen them through a series of activities, possibly starting with exchange of experience.

Can South Asia afford these programmes at this time of economic hardship? The wisdom of reordering financial priorities is perhaps best illustrated by a statement made by Dr. Mahbub-ul-Haq as Pakistani Minister for Finance, Planning and Economic Affairs at the Annual Meetings of the World Bank and IMF in Soeul (October 1985):

> "Must we spend a good part of our development budgets to provide facilities for the rich and privileged? I discovered from my own experience that it took only the postponement of one expensive urban hospital to finance the entire cost of an accelerated immunization and health care programme for all our children."

And we do know that the international community is prepared to provide additional financial support for these child survival programmes.

Just as South Asia pioneered the massive increase in grain production in the late 1970s known as the Green Revolution, there is now a parallel, even more historic opportunity for the SAARC countries to pioneer a child survival revolution which could have a profound impact on population growth as well.

Let me post to you now the key question: Can the Child Survival Revolution be truly mounted on a South Asia-wide basis and sustained?

It would be the greatest gift of all to the children of the world on UNICEF's 40th anniversary if, looking back five years from now, we could see that South Asia, through the initiative of SAARC and its individual member countries, launched in 1986 the initiative that had truly had such impact that South Asia served as an inspiration for other regions and the health and well-being of its youth had ensured a more secure future at the world level.