

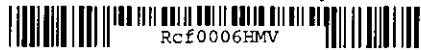
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Executive Director of the United Nations Children's Fund (UNICEF)
to the
Thirteenth Assembly of the
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(IFPMA)

Montreux, Switzerland
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I appreciate this opportunity to address the International Federation of Pharmaceutical Manufacturers' Association. I only regret that a meeting of the Secretary-General with heads of all the agencies in the United Nations family - such as UNICEF, and the specialized agencies such as WHO, and the World Bank and the IMF - has prevented my personal participation, but I know that David Halliday [Director, UNICEF Supply Division] will represent me well. I look forward to a future opportunity for special dialogue with you.

You are meeting at an unusual time for the children of the world - in terms of their health, and for health care in general. On the one hand, it is a time of continuing severe global economic difficulties, which not only slow economic growth in many parts of the world but which are also leading to massive retrenchment in public services in those most seriously affected countries - including reduced supplies of essential drugs to many hospitals and clinics in many countries. Progress in preserving the lives of our children is now slowing in many countries after four decades of historically unprecedented improvement which witnessed more progress for children as a whole than the preceding 2,000 years. In country after country, there is evidence of rising levels of malnutrition, in some cases of rising infant mortality, and many indications of a decline in other indicators of child welfare, particularly among the poor and vulnerable.

On the other hand, the coming together of two sets of developments holds out the prospect that the next 10 years could see great advancements in the health and mortality status of children. Any realistic attempt to realize these historic possibilities will necessarily involve the major participation of the pharmaceutical industry. The pace of progress will be affected by pharmaceutical innovations of the decade ahead, and it is only reasonable to foresee that the pharmaceutical industry will in turn be affected by these

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significant efforts on behalf of the survival and well-being of hundreds of millions of children. New pharmaceutical frontiers will be opened in the years ahead, and major possibilities for building the image of the industry will be presented as natural ramifications of your responsibility for providing life-saving products and innovations.

The years 1950 through 1980 witnessed a halving of the infant and child mortality rate. In 1950 the death toll of under-5 children amounted to nearly 70,000 daily. By the mid 1980s, despite a far greater number of births, it is down to 40,000, and today we see the prospects for again halving current child death rates over the next 10-15 years.

How is this possible at a time of economic difficulties in so many countries? It is the combination of new, improved, and rediscovered low-cost technologies which are relevant to the great majority, with a new capacity to communicate with the heretofore largely unreached - particularly those with low incomes in the rural and urban slum areas of developing countries - that allow these historic possibilities to emerge. The convergence of these two factors has produced the potential for a virtual revolution in children's ability to survive through primary health care. We refer to this as the "Child Survival and Development Revolution". This potential was first outlined in UNICEF's annual publication, The State of the World's Children for 1983; the summary of the 1986 Report is available at this Assembly.

The low-cost mass-application technologies include oral rehydration therapy (ORT), vaccines, breastfeeding, growth monitoring with simple weight charts, addition of food supplements such as vitamin A to diets, and the promotion of female literacy and family spacing. Their effective use could more than halve the tragic loss of child lives today.

Use made of medical knowledge depends, of course, on social organization, and until recently the great majority of the world's children were not benefiting significantly from these advances. In recent years, and particularly since the WHO-UNICEF sponsored conference at Alma Ata on health for all through Primary Health Care by the year 2000, we have seen major progress in the outreach of health clinics, pharmacies and health auxiliaries. The principal challenge increasingly is how to involve and empower parents to a far greater extent since it is in their hands that these practices will actually make the life-or-death difference. Parents need to know the importance of bringing in their children three times for immunization even if, as often happens, the children run a fever from the vaccinations. Parents need to know how to do oral rehydration therapy at home to combat the dehydration from diarrhoea that takes the lives of more than 10,000 children daily. They often don't understand the importance of these methods; this is where the new ability to communicate with the world's poor becomes so important. This new capacity is evidenced, as your marketing people know, by the ubiquitous radio, television, and so forth. Until very recently, that radio was rarely if ever used to talk about the biggest killer of children - diarrhoea - or about the nearly 4 million children who died from lack of immunization. We have television, with at least one now in many villages in

most countries. Today about 50 per cent of the mothers in the developing countries in the 20-30 age bracket are literate. And there is now a school in virtually every village. Also, importantly, there has been a revamping of traditional systems of communication. One can turn to religious groups (whether Christian or Islamic or Buddhist) and have a whole new capacity to communicate, to spread ideas that they did not discuss 20, 15, or even 10 years ago.

Just a week ago I was in Turkey, a country which has, in a single year, made dramatic strides in implementing these low-cost/high-impact techniques through massive social mobilization efforts. Both the President and the Prime Minister of Turkey provided the critical leadership to launch a child survival revolution a year ago with the first of three national immunization weeks for 5 million children under 5 years old. That original campaign - in which both leaders personally immunized children - focused on the six diseases which in 1984 took the lives of more than 30,000 Turkish children, and crippled tens of thousands more. With more than 50,000 Moslem imams taking the lead in each mosque (just as Colombian priests had in their churches when that country pioneered this national immunization campaign approach in 1984), and with the active participation of 95,000 village teachers (who returned from summer vacation two weeks early for the purpose), and with the local leadership of all 67 provincial governors, some 85 per cent of all young Turks were fully immunized against these dread diseases by winter snowfall. No country with a population comparable to Turkey's 50 million had ever accomplished so much for children in such a short period of time. Since this spring, this broad-based approach has extended to encompass a massive promotion of oral rehydration therapy, means for coping with acute respiratory infections, and family planning.

Turkey is just one example. Similar techniques are evolving in country after country, with each nation tailoring the approach to fit the particular structures and cultures of its people. The list of success stories is becoming impressively long.

As a result, the United Nations goal of Universal Child Immunization by 1990, first established by the World Health Assembly in 1977 but considered wishful thinking by most only 24 months ago, is now a viable possibility. One indicator of progress is that UNICEF's procurement of one-half billion doses of vaccines last year reflects a 200 per cent increase between 1983 and 1985, and we expect that amount to double again by 1990. Another indicator is the estimate that more than 800,000 child deaths were averted last year as a direct result of the Expanded Immunization Programme. Similarly, in 1980 UNICEF distributed 23 million ORS packets of a global 33 million; last year UNICEF's total was 80 million of a global 290 million. Half a million lives were saved last year as a result of this simple cure.

The potential for this industry's collaborations in these Child Survival measures is only beginning to emerge. For instance, the giants of the vaccine industry, UNICEF and many others could work in close cooperation to make realistic the goals of Universal Child Immunization by 1990 and of keeping all

children immunized from that point on. The children now being immunized represent a new target population for vaccination. While newborns in developing countries have always been there, conventional systems were ineffective in reaching them. New primary health care approaches and strategies have been necessary not only to make the vaccines more readily available, but also to convince people that they must want - demand - immunization for their children.

The same is true for other essential pharmaceuticals. A huge mass of people is effectively without drugs on a regular basis. The need is to extend the accessibility of the most necessary drugs to those populations whose basic health needs are not being met by the existing supply system.

The provision of essential drugs need not be expensive, and, if effectively handled as part of national policy, essential drugs can be provided for the great majority at a cost which can almost certainly be afforded by their societies.

An innovative programme piloted in Tanzania provides an example. This programme, started in 1983 with the support of the Danish Government (through DANIDA) and in collaboration with WHO and UNICEF, was designed to provide a regular supply of 32-36 essential drugs to all 3,000 clinics and dispensaries in the rural areas of the country, covering roughly 20 million rural Tanzanians and, in practice, reaching an estimated 75 per cent of them.

Under the Tanzanian scheme, generic drugs are supplied each month in a pre-packaged box, with standardized contents matched to the broad health needs of the region of the country. The boxes are taken to sub-regional centres by the Ministry of Health, but from there to the village health clinics the local community is responsible for collection and transportation. This reduces costs to the central government and also introduces the invaluable element of participation by service recipients. Through community involvement and monitoring, members of the community know of the box's arrival and thus that supplies should be available for the next month. They also begin to learn what is possible in terms of effective treatments for indigenous sicknesses - and how to obtain it.

To help improve efficiency in the use of drugs, a crash training programme was held during the first year for some 5,000 basic health workers, providing refresher courses in diagnosis, prescription, and use of essential drugs in relation to the most common illnesses and needs.

Several lessons from the Tanzanian programme are worth studying, and the project will be discussed in some depth in UNICEF's soon-to-be-published book, Adjustment with a Human Face: Protecting the Vulnerable and Promoting Growth. From the viewpoint of meeting the needs of those previously unreached populations of the world's poorest and most vulnerable, it is particularly notable that for under US 50 cents per person per year, essential drugs are provided in their generic form through the basic rural health services covering 20 million people. This cost includes the medicines themselves plus related transport and training.

What are the implications to the pharmaceutical industry of this restructuring of health services for the poor to reach the heretofore largely unreached? I will only suggest some.

For you, the drug manufacturing companies of the world, there will be an ~~expanded market if these~~ programmes reach a significant portion of the estimated 1.5 billion people in dire need. And while this enormous new market will of course generate some profit, special pricing and packaging structures will be required. I would suggest that of potentially far greater impact to your industry is the long-term confidence and respect of the world public that will ensue. Because drugs are playing an increasingly beneficial and visible role in improving the well-being of the world's poor majority, those who discover, produce and provide these life-saving tools at a cost which can be afforded by the poor majority merit a place of esteem in the public eye.

A major opportunity presents itself uniquely to this group to facilitate the marketing aspect of making essential drugs available and known to the world's poor. As marketing organizations, you represent possibly the best marketing and education talent in the world, and because of the relevance of your field, much of your problem-solving experience is directly applicable. However, this is precisely where the pharmaceutical industry is sometimes seen to be part of the problem rather than the solution. Thus, the immediate problem in the control of diarrhoea is how to bridge the gap between modern knowledge that is available and its use in the setting of a community. A dramatic example of this lag is the more than 4 million needless deaths from diarrhoeal dehydration when there is a largely effective and inexpensive new oral rehydration therapy (described by "Lancet" as "potentially the most important medical advance of this century") - and much diarrhoea could be avoided in the first place through convincing education as to simple household health practices like hand-washing and the use of latrines. Unfortunately, mothers all-too-often turn first to widely promoted, expensive and largely ineffective drugs. Hospital after hospital is demonstrating that with primary reliance on oral rehydration therapy there can be sharp reductions both in diarrhoeal deaths and in drug expenditures.

In Nairobi last November and in other forums, we have seen encouraging progress toward ensuring the rational use of drugs, and I am confident of continuing progress on this front as we each seek means to effectively reach the currently unreached.

Also of significance to this industry is the fact that, at this juncture, a major opportunity exists to participate in saving the lives of millions of young children annually by facilitating the Child Survival and Development Revolution through technological research. An example of striking need in this area is the search for more heat-stable vaccines. The newest vaccine in the Expanded Immunization Programme is 20 years old. The most troublesome, Pertussis vaccine, is over 50 years old. We can buy all the vaccine a child needs for some 50 US cents per child. Yet it costs anywhere from 10 to 30 times that much (US\$5-15) to actually immunize that child. Why? Much of these costs of course are due to the fact that EPI programmes require trained

manpower. But a major cost factor is that existing vaccines require special handling in refrigeration, as well as injection.

As you are all aware, smallpox was declared eradicated in 1979. The vaccine was invented in 1790. Why did it take nearly 200 years? What finally made the difference and created the possibility of finishing that job? I would propose to you that what took so long were the same hurdles we face today in regard to measles. The keys to the smallpox eradication success were the changed character of the new freeze-dried vaccine which was not dependent on a cold chain; the bifurcated needle, which could be used by low-skilled vaccinators, and a new organizational approach emphasizing vaccinations in outbreak areas.

What has stopped us from overcoming measles? Last year 2 million children died from this disease, even though a low-cost vaccine exists. The recently developed more heat-stable freeze-dried vaccines will help, as will the new social marketing techniques described earlier to create demand. But we need better disposable syringes, and it would be better still if we could use no syringes at all.

In fact, in relation to this specific point, I would like to pose a very serious challenge to you: Who in this audience, the drug companies of the world, can find a way to make measles vaccine which does not need injection and does not need a cold chain? The company that does will surely receive a hero's welcome from the families of the world.

The fruit of your laboratories represent the future of medicine. I understand that your annual research and development expenditures exceed US\$2 billion. What portion of the fruit from that research will significantly aid in reducing today's daily death toll of 40,000 young children?

We also urge you to join the UCI-1990 campaign. Your skill in creating demand has tremendous potential in these efforts. The children of the world will benefit from your participation, and your visible and active collaboration will reflect highly on the industry as well. Likewise we urge you to promote breastfeeding and vigorously insist, among all companies, on compliance with the international marketing code for infant formula, to protect the health and nutrition of young children and, parochially, to assure fair competition among all companies in the market.

Some of these steps will undoubtedly, in the short run, involve less use of some products, while the demand for others increases. Again, the investment you will be making in good-will toward your company name and industry reputation penetrate to a realm that can't be reached by marketing expenditures and techniques.

The assembly in this room represents an extremely important industry that wields formidable power in the world health arena. I would like to present to you a challenge: Consider how the IFPMA might provide all-out support to the Child Survival and Development Revolution over the next ten years. Because of

the status you enjoy in the world health community, your leadership role in this effort has the potential for sweeping impact far beyond your direct contributions. And because of the potent relevance of the varied fruits of your industry - in terms of research, essential drugs themselves and your influence in marketing - your foresighted decision to seize this challenge will bolster the credibility that these possibilities can become reality. Indeed, because of the pragmatic necessity of your work, with your commitment they truly do come closer to reality.

* * *

As the chief executive officer of the world community's agency created exclusively for advancing the well-being of the world's children, I personally look forward to the opportunity to explore this further with the chief executive officers of the companies which manufacture one of our most essential tools.