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Remarks by Mr. James P. Grant
Executive Director of the United Nations Children's Fund (UNICEF)
at the closing of the
Third meeting of the Task Force for Child Survival

"Protecting the World's Children – An Agenda for the 1990s"

Talloires, France
12 March 1988

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As we gather in our closing minutes, I am reminded of a passage from Shakespeare that I quoted at the closing in Cartegena: "...there is a tide in the affairs of men which taken at the flood leads on to fortune". I went on to say then that I believed we all shared the sense, as that Cartegena meeting closed, that such a flood tide was close at hand with respect to the world's ability to control the great infectious diseases of children. It seems to me these comments are even more apt as we close this session today.

I believe it is worth viewing our session here in the context of several monumental developments which have occurred since we met at Cartagena - some negative and some positive. On the negative side, first we have seen the expenditures on the arms race continue to soar to such an extent that even the two superpowers today face major economic problems as a consequence. Second, we have seen the global economic crisis lock in for much of the Third World, particularly Latin America and Africa, to a degree that really only the most pessimistic of us anticipated two and a half years ago. And this crisis has particularly affected the poorer countries and the poorer people in all countries.

On the other hand, there are important positive influences in which we are working. Some would highlight, first and foremost, the dawn of the end of the nuclear arms race, and, possibly, a significant lowering of East/West tensions. We can see hope in Central America. We can see hope in places such as Afghanistan. Among the most hopeful of developments which have occurred since we last met are precisely the positive manifestations discussed in this forum during the last two and a half days - i.e., that there really is a very special willingness to work together for children on a massive basis, if only those of us toiling in the vineyard will come up with do-able cost-effective approaches that the leaders of our countries can act upon. And it seems to me that this extraordinary progress to which Margaret Catley-Carlson referred has

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occurred because so many of you have come forward with do-able propositions for the societies of your own countries - but also because those proposals have been do-able beyond your own borders, and have fostered global cooperation. In this context, I would like to give special thanks to those who have given us their presentations of problems and opportunities. And I would like to focus my remarks this morning, as have others, especially on the presentations which have been made here. To name just a few, I will begin with the insights and experiences shared by the Minister of Health of Columbia, who gave an encouraging description of the forward momentum that is continuing despite massive disasters in his country that followed our Cartagena meeting. You will remember that the Expanded Programme of Immunization (EPI) began the month after the volcanic eruption in which 20,000 were buried in mud, and during the period of an attack on the Supreme Court. The Government was trying to fight a terrible set of drug problems. Despite that, we witnessed the Government persist. And they have persisted through a change of Government, including a change of party. Yet throughout this, we have seen the momentum sustained; we have seen it broadened; we have seen it encompass other vital interventions such as oral rehydration therapy, acute respiratory infections, and others. And in one very encouraging aspect we saw it spread into a revamping of the education system, involving all parts of society. Most importantly, we see immunization and other child survival activities continuing on a sustainable basis.

We must give our thanks to the Minister from China. He represents the largest country in the world that this year is achieving 85 per cent coverage in the country as a whole. And, hopefully, that 85 per cent level will be reached in every province before the end of this year.

We owe unique thanks to the Special Secretary of Health from India. India today has 20 per cent more children - almost 25 per cent more small children - than China. They have the most difficult problem of any country in achieving universal child immunization as an entry point to a health revolution. It was most encouraging to hear the Secretary's statement that he expects that they will achieve the goal of 80 per cent by the end of 1990, even though there will be, obviously, major pockets in the country where there will be lesser coverage.

The Minister of Health from Morocco gave a special indication of what can happen in a short time. The decision was taken, I believe, in early 1987 to move toward universal child immunization. By the end of that year, they have gone from less than 50 per cent coverage to virtually universal child immunization levels - a remarkable accomplishment.

From our Minister from Uganda we have a demonstration of what can come out of determination. Those of us who have seen him struggling in the field have been particularly struck by the power of this quality. I have had the privilege of traveling with him - focusing not only on immunization but on all of the problems, including, probably more forthrightly than any other developing country, the problem of AIDS. He has consistently projected that sense that he is determined, but has also acknowledged that the outside world must help: it must help not just on immunization and related health measures, but to some extent on the total environment in which the country exists - including some interaction on civil disturbances.

Dr. Leimena, from Indonesia, gave us perhaps the most compelling story. He told of the tremendous acceleration of UCI and of that effort's serving as a catalyst for a near doubling of the "posyandus", or maternal and child health care centres. As of this March, posyandus reached approximately 85 per cent of the population - a doubling since we met at Cartagena - and a remarkable accomplishment. This is an excellent example of the interaction that can come from these moves.

We have heard from Dr. Kumate Rodriguez of the progress in Mexico on all these fronts. We had a remarkable candour from the Minister from Peru. An important indicator of progress can be seen in the fact that five of the six countries with the largest population of children in the world are represented here, and we have heard from these five that they do expect to achieve their UCI-1990 goals within the time frame. None were prepared to make that statement at the time that we met in Bellagio. That is yet another manifestation of change, and it is a major one, considering the fact that 65 per cent of the world's children live in these countries.

This has been a very pragmatic discussion. I think we have all welcomed the central emphasis on the sustainability question and on how to expand universal child immunization (UCI) and oral rehydration therapy (ORT) to a broader range. It is clear that in almost all cases, at the start of accelerated efforts there is some slippage after the national days and weeks of a campaign. But it is equally clear that with the right awareness and commitment, one can turn these campaigns into a new tool of political mobilization in the country. It is clear from our discussions that there is a significant advantage to holding campaigns in a country with a strong existing infrastructure, even if that infrastructure has not been delivering services to children. Really, what a campaign does in a situation like that is like hitting the existing structure over the head with a baseball bat to command their attention - to focus efforts toward children and related priority problems. A good example of what can be gained by mobilizing a sturdy infrastructure can be seen in Turkey. I was reading just last night the report on Turkey's accelerated programme. The effective economic cost to immunize a child in Turkey, at the present near 80 per cent level, is US$17.00 per child. But the out-of-pocket expenditure cost is US$2.50 - with the other US$14.50 as the value of the donated or contributed television time, radio time, school teachers' time, the health system's time, Rotarians' time, the Prime Minister's time, etc.

The fact that a country can put up that US$14.50 does indicate that there is a big existing infrastructure. And it is obvious that if a country does not have that much infrastructure established, yet is still committed to success, then the expenditure side must be larger. But it is also very clear that countries which have pursued their campaigns - even the least developed countries - have found it to be an effective tool. One illustration of this of which many of you are aware has occurred in Burkina Faso. They did move into a campaign before there was an infrastructure, but the attention on primary health and the experience of success in achieving one aspect of it led to the massive buildup of one of the most rapidly laid foundations of a village health infrastructure we have seen in any country.

We have heard the needs of special situations. We have been sensitized to Latin American problems by Peru, and we are aware that there are clearly other countries like Bolivia and Haiti in which special attention must be given to those problems from the points of view of the international agencies and from the donors, as well as, obviously, from the countries that adjoin and have so much to contribute. We have heard many references to the problems of the poor countries of Africa. And, clearly, something exceptional does need to be done in response. This applies to education; it applies to many other fields as well, and it is the classic example that you cannot, in the long run, separate health from economic development and progress.

We have heard special emphasis in these discussions on the new capacity for social marketing and communications. And at the next Bellagio, this might really be a topic for much more extended discussion, because it is quite clear that it is this new capacity for social mobilization and communication that is the key to replicability of the successes we have seen to date in child survival efforts. There is a communications revolution in the great majority of developing countries which enables us to use these new technologies that we have available and which, ultimately, has the capacity to fuel comparable revolutions, to answer the question we shared yesterday with Barber Conable regarding education, health, and other fields.

We have participated, at this Bellagio III meeting, in the first serious discussion of the importance of cost recovery. This discussion was opened by the Minister of Health from China on the start of a new cost recovery system in China. And it is very appropriate that it was the Health Ministers of Africa who, in their "Bamako Initiative" said that at least half of the solution to health structure problems could be addressed by greater mobilization of domestic resources, and they proposed a new form of alliance with the potential donors. It is my hope that the donors return home with a serious intent to help these African countries that have come up with a self-help approach that really is an initiative on their part.

While we have been meeting here, there has been a very welcome indirect impact of our child survival efforts. The Drafting Committee on The Convention on the Rights of the Child completed its session and presented its work to the Commission on Human Rights, which endorsed the progress being made in drafting the new Convention. And it is noteworthy that when one asks "How has this moved so fast ?" - one of the reasons is that this emerging common international spirit in support of child survival has contributed to a context in which people are prepared to look at the whole child rights convention much more seriously. It is noteworthy that in the January meeting of the Drafting Committee, with the draft Convention virtually completed, agreement was reached to have one major reopening, and that reopening was to include as a new right the right of a child to survive. It was added with a whole new amplification of a section saying that where cost-effective new technologies become available for the health and well being of children, there is an obligation by society to ensure that these reach children and mothers. This, in effect, said that there is a morality that marches right behind the increase in capacity.

Before I conclude, let me mention that Dr. Mahler will address some forward-looking issues, particularly regarding vaccines, and that I give strong endorsement to his views. And it was in 1985 that President Sarnay, the first democratic president of Brazil after a long period of military rule, maintained as one of his major themes, that the time had come for a new law of emancipation to free those children born into the slavery of instant death; that it was just as unconscionable as slavery, as colonialism, as apartheid, to allow these tens of thousands of children to die every day and tens of thousands to be crippled every day. This was really another way of articulating the comment which we have heard several times from the floor here today, that the time has come to end the "disease" of childhood. We want to ensure that 40 to 50 per cent of the deaths in a country do not occur in the first 2 or 3 years of life. It is fitting at the close of this conference that we recall then-President Betancur's opening words to us at Cartagena, when he said that the Child Survival and Development Revolution is helping us to find opportunities where others have only found problems. We are finding ways to use these means to build competence in multilateral action and in the ordering of nations. We are witnessing it, I believe, right here in our common effort to work together. Finally, he said that success in this will give back to the world faith and confidence in life and development. And somehow we do need to rekindle faith that we <u>really</u> <u>can</u> make a great difference to the world.

As I looked at the Draft Declaration of this conference that was being circulated at lunch, I was reminded that we have measures in hand which would not only save about 100 million children from death and disablement between now and the end of the next decade if the goals we are talking about are achieved - and it is basically do-able if we want - but also we know that now, even more importantly, by the end of this millennium, should we meet this challenge we would have brought an end to the mass death of children for the first time in history. And if we can do this - we all know how much encouragement smallpox eradication gave us - then perhaps many previously undreamed possibilities for progress will be revealed as feasible. Several USAID administrators have sighted this phenomenon. Similarly, we have seen favorable repercussions in terms of competence in what was done in the grain revolution to increase grain production in Asia. But, if we can achieve the goals of this conference's draft declaration in the next decade, I think it will give us a faith to start the next century with a new yet proven sense of who we are as a civilization, and what we can accomplish. And, when you look at it, who are the master craftsmen of this effort? So many of you in this room. Thank you very much.

DECLARATION OF TALLOIRES

12 March 1988 - Talloires, France

PROTECTING THE WORLD'S CHILDREN: AN AGENDA FOR THE 1990's

Remarkable health progress has been achieved during the past decade. Global recognition that healthy children and healthy families are essential for human and national development is steadily increasing. Consensus has been reached on the strategy for providing essential community primary health programmes. The international community has become engaged in partnership with national governments in the creation of successful global programmes, ensuring the availability financial support and appropriate technologies. These include:

- immunization programmes, which now protect more than 50% of infants in developing countries with polio or DPT vaccines, preventing some 200,000 children from becoming paralyzed with polio and over a million children from dying each year from measles, whooping cough, or neonatal tetanus;

- diarrhoeal diseases control programmes which now make life-saving fluids (particularly oral rehydration salts) available for 60% of the developing world population, the use of which may be preventing as many as 1 million deaths annually from diarrhoea;

- initiatives to control respiratory infections which hold promise in the years ahead of averting many of the 3 million childhood deaths from acute respiratory infections each year in developing countries not prevented currently by immunization;

- safe motherhood and family planning programmes which are so important in protecting the well-being of families.

Progress to date demonstrates that resources can be mobilized and that rapid and effective action can be taken to combat dangerous threats to the health of children and mothers, particularly in developing countries.

This progress is the result of:

- enthusiastic world-wide agreement for the development of health strategies based on primary health care;

- the commitment of national governments, multi- and bilateral development agencies, non-governmental organizations, private and voluntary groups and people in all walks of life to give priority to these programmes;

- co-ordinated action by the sponsors of the Task Force for Child Survival: UNICEF, the World Bank, UNDP, WHO and the Rockefeller Foundation.

We, The Task Force For Child Survival, conveners of the meeting "Protecting the World's Children - An Agenda for the 1990s" in Talloires, France on 10-12 March 1988:

1. **EXPRESS** appreciation and admiration for the efforts made by the developing countries to reduce infant and child deaths through primary health care and child survival actions.

2. **COMMIT OURSELVES** to pursue and expand these initiatives in the 1990s.

3. **URGE** national governments, multi- and bilateral development agencies, United Nations agencies, non-governmental organizations and private and voluntary groups to commit themselves to:

- increase national resources from both developing and industrialized countries devoted to health in the context of overall development and self-reliance;

- improve women's health and education, recognizing the importance for women themselves, recognizing women's contribution to national development and recognizing that mothers are by far the most important primary health care workers;

- accelerate progress to achieve Universal Childhood Immunization by 1990 and to sustain it thereafter;

- accelerate progress to eliminate or markedly reduce as public health problems the other main preventable causes of child and maternal mortality and morbidity, striving to reach sustained universal coverage of children and mothers by the year 2000;

- assure the development of new vaccines and technologies and their application, particularly in developing countries, as they become appropriate for public health use;

- promote expanded coverage of water supply and sanitation;

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The Task Force For
Child Survival

- pursue research and development, including technology transfer, in support of the above actions.

4. **SUGGEST** that the following be considered by national and international bodies as targets to be achieved by the year 2000:

- the global eradication of polio;
- the virtual elimination of neonatal tetanus deaths;
- a 90% reduction of measles cases and a 95% reduction in measles deaths compared to pre-immunization levels;
- a 70% reduction in the 7.4 million annual deaths due to diarrhoea in children under the age of 5 years which would occur in the year 2000 in the absence of oral rehydration therapy, and a 25% reduction in the diarrhoea incidence rate;
- a 25% reduction in case/fatality rates associated with acute respiratory infection in children under 5 years;
- reduction of infant and under five child mortality rates in all countries by at least half (1980-2000), or to 50 and 70 respectively per 1000 live births, whichever achieves the greater reduction;
- a 50% reduction in current maternal mortality rates.

Achievement of these targets would result in the avoidance of tens of millions of child deaths and disabilities by the year 2000, as well as a balanced population growth as parents become more confident their children will survive and develop. The eradication of poliomyelitis would, with the eradication of smallpox, represent a fitting gift from the 20th to the 21st centuries.

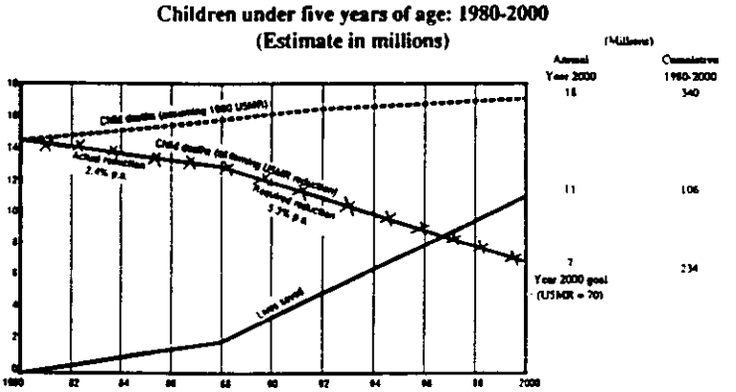
5. **DRAW** world attention to the potential for enlarging upon the successes outlined above to encompass low cost, effective initiatives to:

- improve the quality and coverage of educational services to obtain universal primary education and 80% female literacy, and
- virtual elimination of severe malnutrition of under five children while also significantly reducing moderate and mild malnutrition in each country.

6. **WELCOME** the progress being made in drafting the Convention on Rights of the Child and join the United Nations General Assembly in urging completion of the Convention in 1989, the 10th anniversary of the International Year of the Child.

We are convinced that vigorous pursuit of these initiatives aimed at protecting the world's children will ensure that children and mothers - indeed whole families - will benefit from the best of available health technologies, making an essential contribution to human and national development and to the attainment of Health For All By The Year 2000.

Alternative Global Projections of Child Deaths and Lives Saved
Children under five years of age: 1980-2000
(Estimate in millions)



Projection A deaths
The 1980 under-five mortality rates remain constant to the year 2000.

Projection B deaths
Up to 1987 the under-five mortality rates are as estimated by the United Nations Population Division. From 1987, countries make sufficient progress to reach their CSDR targets by the year 2000 i.e. either an under-five mortality rate of 70 or half their 1980 rate whichever is lower.

Projection C lives saved
The difference between projection A deaths and projection B deaths