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Address by Mr. James P. Grant
Executive Director of the United Nations Children's Fund (UNICEF)
to the
Asia-Pacific Academic Consortium for Public Health
Third International Symposium on Public Health in the Asia and Pacific Region

"Teaching Health Professionals to Teach"

Jakarta, Indonesia
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I am honoured to address this symposium. I see among you many distinguished veterans of successful struggles to improve the health and well-being of children from throughout Asia and the Pacific region.

I am especially pleased to speak to a gathering of this importance which has taken as its theme one so close to the heart of UNICEF's work - that of reaching the unreached. Rather than speak about the significance of the topic, I will take it as a point of departure that we are, at this stage, working toward common goals in this area, and today I will pose what I believe are difficult but key questions on how to go about achieving those goals.

More than 50 years ago, my father, Dr. John B. Grant, a life-long medical educator with the Rockefeller Foundation who took the lead in establishing the first public health training institutions in China and India and in pioneering primary health care in Asia, warned his colleagues that the most urgent problems facing the health community was the lag between modern knowledge and its use in the setting of a community - our topic at this symposium. He noted then that the two outstanding related causes of this lag in the health field were the lack of scientific investigation of methods to apply the results of the growing body of scientific knowledge to society, and the lack of training of health personnel to apply these methods. He went on to say that universities were the principal instruments for generation, utilization and application of new knowledge. He claimed that these institutions, and particularly medical and health education schools, bore the primary responsibility for the development of effective and scientifically based community health care.

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Over half a century later, our failure to adequately overtake that lag between knowledge and its use is vividly demonstrated by the approximately 50,000 people - two thirds of them children under 5 years of age - who will die prematurely today, tomorrow, and every other day, from causes which are now readily preventable at low financial and political cost. The inadequacies of the medical education system of today bear a substantial responsibility for that lag.

Responsibility to the community

If we seriously aim to bridge the gap between available medical technology and its actual use by a population, one key question emerges for medical educators: what is the responsibility of the medical and public health communities to the community at-large? Is the health education system primarily responsible only for the quality of care to the individual patients a health professional attends? If so, does this profession effectively abandon to others those who fall beyond their immediate reach? Ultimately, it is the medical and public health schools which decide who shall benefit from the knowledge which you in the health field have accumulated. The schools decide on what is taught, and on how it is taught.

Today, for example, in most medical schools, aside from schools of public health, less than 1 per cent of medical education is devoted to topics such as community health and broadscale health education. Virtually all doctors are required to have service in a teaching hospital as part of their training. Few, on the other hand, have a comparable requirement for training in a community setting. Has the corporate medical community decided by its action - voting with its feet - that medical education does not include health education and health of the community as significant concerns? Are the patients who make office visits or are admitted to hospitals the overwhelming concern of the medical community and the doctors it teaches? Are you in the schools of public health forever to be the exceptions that prove an unfortunate rule that there is no major role for the majority of the medical profession - for the doctors it teaches, and the standards it sets - in the next great frontier of health progress - the frontier of health for all the world's people?

Reaching the unreached

What is the role of the public health school as the custodian of knowledge that is needed, but that much of the community does not get? How, for example, can that knowledge be used to save and improve the lives of those hundreds of millions who will never visit a doctor's office and will never see the inside of a hospital?

We have known for a long time that the use made of medical knowledge and efficiency of health protection depend chiefly upon social organization. This was among the conclusions of the landmark report of the Bhore Committee in India in 1946, and is among the main principles of primary health care codified 10 years ago in the Declaration of Alma Ata, in which the

international health community declared itself committed to the goal of "Health For All by the Year 2000". Yet we have been slow in applying the principles of social organization to society as a whole, and, in particular, to the curriculum of medical education institutions.

The increasing communications and development revolution of recent decades - the ubiquitous radio, TV, schools in virtually every village, the explosion of modern marketing, the rapid increase in non-governmental organizations - have created new low-cost patterns for social organization. This, combined with advances in low-cost health technology, offers a vast, new capacity to extend health care far beyond the very limited domain of one-to-one, doctor-to-patient relationships. Indeed, the whole world is now within our reach for the first time.

The new potential arises from one of the most basic, and still least acted-upon, facts about human health in our times. That is that the majority of the serious threats to human life and physical well-being are, at this point, more susceptible to informed actions by individuals than they are to further medical breakthroughs or even increased professional services, important as these may be.

As the new Director-General of the World Health Organization, Dr. Hiroshi Nakajima, told 1,500 health educators three months ago:

> "We must recognize that most of the world's major health problems and premature deaths are preventable through changes in human behaviour and at low cost. We have the know-how and technology but they have to be transformed into effective action at the community level. Parents and families, properly supported, could save two-thirds of the 14 million children who die every year - if only they were properly informed and motivated. Immunization alone could save 3 million lives - and another 3 million deaths a year could be prevented by oral rehydration, a simple and cheap technology. A recent report by the U.S. Surgeon General indicated that diet and food habits are implicated in two-thirds of all deaths in the United States. A study just completed in India has shown that about 600,000 Indians die from tobacco-related diseases a year; the worldwide total, as estimated by WHO, is 2.5 million deaths per year.
>
> "We know conclusively that no-smoking, careful driving, appropriate dietary habits, low salt and fat intake, no more than moderate alcohol consumption and physical exercise, will have a profound impact on the health of every individual, including the elderly. An apt slogan, 'AIDS - don't die from ignorance', can be applied to practically every other health problem." (emphasis added)

A dramatic illustration of the new potential for widescale application of readily available low-cost health knowledge and technology exists in the field of child health. As a result of accelerated low-cost child survival activities in the 1980's, such as growth monitoring, oral rehydration therapy,

promotion of breast-feeding, immunization, family planning, female literacy and food supplementation (sometimes referred to as the GOBI-FFF actions) the lives of millions of children - reaching 2.5 million in the last 12 months alone - have been saved, and the cripplings of millions more prevented, by people and nations which have mobilized to put today's low-cost solutions at the disposal of the majority of families in the context of primary health care. This is thanks in no small part to a growing "Grand Alliance for Children" comprised of a vast array of groups including, notably, the International Paediatrics Association; non-governmental organizations; community and religious institutions; organizations of government leaders - including the South Asian Association for Regional Co-operation (SAARC), which was a pioneer in resolving, at Summit level, to act on behalf of children; the ASEAN Summit last year; and this summer, the Organization of African Unity (OAU) Summit, with 31 Heads of State participating, and the Moscow Summit of General-Secretary Gorbachev and President Reagan; and many, many others which are acting on behalf of children. This Grand Alliance would happily welcome the positive leadership of the medical education community as a whole. But, all too often, it has had to act without - or even in spite of - the medical education system, with the notable exception of the dedicated efforts of schools of public health and of many gifted individuals within it as we see at the APAC Symposium this week.

The fact that considerable progress has been made in this remarkable revolution for children - and the potential for further major advances - was confirmed in mid-March at a meeting in Talloires, France, convened by the international Task Force on Child Survival (often referred to as the "Bellagio Group"). The Talloires meeting consisted of a dozen health ministers and health secretaries from most major developing countries of the world (Brazil, China, Colombia, India, Mexico, Nigeria, Pakistan); heads of major international organizations such as Barber Conable of the World Bank, Halfdan Mahler of WHO, and myself; plus major bilateral aid agency administrators such as Margaret Catley-Carlson of CIDA (Canada), Carl Tham of SIDA (Sweden), and Alan Woods of USAID; and private leadership from the Rockefeller Foundation and Rotary International. Out of this review of the world immunization/child survival effort came the exciting conclusion that, with a modest additional amount of political will, major advances <u>are</u> possible. It was decided there that it is possible - by the end of this century - twelve years from now - to reduce the 1980 child death rate of each country by more than <u>half</u>, or an under-five child death rate of 70, whichever is less, saving from death or disability in this process well over <u>one-hundred million children</u>. Such historic progress will be possible, however, <u>only if</u> - armed with the new low-cost/high-impact health tools, and our new ability to communicate with the world's poor - we <u>double</u> average child mortality reduction rates of the first half of the 1980s - and of the past 35 years.

The "Declaration of Talloires" [attached] begins with the statement:

> "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 of financial support and appropriate technologies."

The Declaration of Talloires proposes Year 2000 health goals for each country which received consensus approval of participants at Talloires. Of these goals, a useful "short-list" of do-able Year 2000 goals could be capsulized to include:

1) halving 1980 under-5 mortality rates, or reducing them to 70 per 1,000 live births, whichever is less;

2) elimination of polio (endorsed by The World Health Assembly this May);

3) achieving universal primary education (to which I would add 80 per cent literacy among women of child-bearing age);

4) achieving less than 1 per cent severe malnutrition; and

5) promoting expanded coverage of water supply and sanitation.

Much has been accomplished in the pioneering effort to reach the unreached which we in UNICEF call the potential for a "Child Survival and Development Revolution" (CSDR). Yet the grim reality of 23,000 children still dying each day in Asia alone and 40,000 world-wide - and the daily crippling of a comparable number, remind us that much remains to be done. We must now ask: What are the next steps?

Planning the survival and development of children

As you map the next steps of this effort, I urge you to consider the goal set by the United Nations in 1980 (originally in terms of infant mortality, and now translated into under-five child mortality), and reaffirmed at Talloires to halve the 1980 child mortality rates by the year 2000 in every country, or to reduce them to 70 per 1,000 births, whichever is smaller. In the countries of Asia and the Pacific, what will it take to achieve this goal which requires the reduction of child mortality rates by an average of some 3.5 per cent annually?

Progress has been varied, so far. With two decades to achieve this unprecedented goal, yearly progress for the first five years was only about half the rate necessary in such countries as Bangladesh, India, Nepal and Pakistan. Thus, in India for example, where the target under-five child mortality rate (U5MR) by 2000 is 70, the mortality rate decreased by an average of 2.39 per cent between 1980 and 1987 instead of the approximately 3.5 per cent average required. In order to meet its year-2000 U5MR goal of 70, India will have to achieve an annual reduction rate of 4.79 per cent until the end of the century. The Philippines, for example, has achieved a reduction rate that is only half the rate they must attain to reach the Year-2000 goal. With a target U5MR of 43, between 1980 and 1987 the annual rate decreased by approximately 2 per cent. For the rest of the century the Philippines must achieve an annual reduction rate of approximately 4 per cent in order to meet the goal. This clearly will require redoubled efforts.

On the other hand, Asia also holds some outstanding examples of infant and child mortality reduction which have been ahead of or close to target rate of 3.5 per cent annual reduction, and which serve as models in the prioritizing of health care despite limited resources. For example, Hong Kong, Indonesia, Singapore, Taiwan and Thailand have been ahead of schedule during 1980-1987, as was Sri Lanka, until events of this year.

Fortunately, most Asian countries have been accelerating their child survival efforts in the primary health care context since the mid-1980s and dramatic improvements are in prospect in most Asian countries as is well-illustrated in Indonesia, our host country.

Indonesia is undergoing a process of restructuring its health sector in order to accomplish a broader impact on the health and well-being of the populous in return for limited resources. Despite falling oil prices which cause severe financial constraints resulting in cut backs to the overall health budget, President Soeharto announced in November 1986 in Jogyakarta, the sharp acceleration of the expanded programme on immunization and of the village-level "Posyandu" system. This had been made possible in part by the reduction of hospital construction throughout Indonesia. This approach mobilizes participation by calling upon the already existing service organizations (such as women's association and local village groups) to support self-help preventative health measures such as those through the Posyandus that integrate family spacing methods, prenatal care, oral rehydration therapy, immunization and growth monitoring. This village-level structure then interfaces with the health centres (Puskesmas) which serve a much larger population and a number of villages.

In 1986, there were 133,786 Posyandus organized by the PKK (Family Welfare Organization of Women) in 40,435 villages out of a total of more than 68,000 villages in Indonesia. By mid-1988, the number had increased to more than 200,000 Posyandus in nearly 50,000 villages, achieving the 1991 target of providing one Posyandu for every 100 children under five years of age three years ahead of schedule in at least the ten most populated provinces, which represent 85 per cent of Indonesia's population. These centres cover about 10 million mothers and 20 million children under five years of age. President Soeharto has taken active leadership of this accelerated child health and survival effort which is supported actively by the educators, television, radio, provincial administrative apparatuses, and a wide range of non-governmental structures, including religious organizations, at little direct additional cost to the government. President Soeharto's role is symbolized in many ways.

The beneficial impact of this acceleration is illustrated in the rapid increase toward universal child immunization which has increased from a level of 1 per cent for DPT3, and OPV3 in 1981 to approximately 65 per cent in 1987. Use of packaged ORS has increased more than three fold from 1985 to 1988. Achievement of an infant mortality rate of 50 (equivalent to an associated under 5 mortality rate of 70) has been advanced to no later than 1994.

The foresighted adjustment policies of Indonesia reflect the political commitment of the Government to programmes for child survival and development. Adjustment of policy in the health sector began in fiscal year 1983-84, and since that time the percentage of the development budget allocated for hospitals has declined from 19.2 to 5 per cent for 1987-88. During the same period, the percentage of the development budget allocated for rural health centres actually increased from 42.2 to 71.6 per cent. The 1988-89 budget provides for significant increases in health (35 per cent) and in social welfare and women affairs (48 per cent), both well above the 15 per cent increase in spending projected for development overall for 1988/89.

In the past ten days while on a visit to Iran and Iraq, I have witnessed two other dramatic examples of the present great potential for overcoming the lag between medical knowledge and its use in a community setting. Both Iran and Iraq, in the early to mid-1980s, adopted accelerated child survival programmes with many similarities to the Indonesian model, including notably, first, an interface mechanism at the village level between the family and the community on the one hand, and the health system on the other. And, secondly, there was widespread national mobilization including personal involvement of their Presidents, of TV, radio, and primary school teachers, religious leaders and NGOs. As a consequence, infant and child mortality have decreased by more than 40 per cent in both countries despite the war, resulting in the saving over the past 12 months in Iran of some 100,000 child lives and in Iraq, with its much smaller population, of 30,000 child lives.

I should add parenthetically here that success in achieving this goal for reduced child mortality can be expected to help reduce births by an even greater number. As we have seen recently in many countries and regions, as under 5 child mortality drops below about 100 per 1,000 live births, largely because of much greater parental involvement, the number of births drop even faster as parents gain confidence that their first children will survive.

This is illustrated in Indonesia where as compared to 1980 rates, more than 200,000 child lives - more than 500 daily - were saved in the past year. The drop in birth rates from 33.5 in 1983 to 29.2 in 1987 resulted in avoiding the much larger number of approximately 700,000 births in the past year.

Measuring real progress in child health

Preparing for the next development decade and planning such goals brings to light another glaring need which is made all the more urgent by the accelerating pace of progress for children - the need for better data. To quote Sir William Petty, "To measure is the first step to improve". There is a need for accurate recording not only of births and deaths, but of causes of death, literacy and nutrition levels, and of a number of social indicators. Where mechanisms are in place to gather this data, we must insist that they receive the resources necessary for effective, comprehensive and timely operations. Such information is extremely important for a myriad of reasons, including analysis and prediction of trends.

There is also an urgent need, particularly in developing countries - where registration of such information is not always reliable, takes several years to compile, or may not even exist - for a means to gather the same kind of information inexpensively and quickly in order to respond to the immediate needs revealed in such figures as changes in infant and child mortality rates. UNICEF acknowledges the extreme importance of developing and legitimizing the relatively new methods of collecting such data through rapid surveys. As an example of the unique value of such a method, UNICEF has this year used a new standard survey tool developed in conjunction with the London School of Hygiene and Tropical Medicine, based on the analytical techniques devised by Professor William Brass. The survey was piloted this past spring in Jordan, where significant recent efforts have been made to reduce under-five deaths (including a rapid expansion of immunization and widespread promotion of ORT). The results show that the IMR had fallen from 75 per 1,000 live births in 1980 to 35 per 1,000 in 1987 (an annual average reduction rate of 10 per cent). The U5MR was 49 - a marked contrast with the figure of 62 by which Jordan is represented in the standard, internationally comparable statistics. The survey was completed within three months of the decision to implement it, at a cost of less than $20,000. All countries need an effective programme for computing national infant mortality and birth rates annually. This should be a goal for all countries by 1990.

Convention on the Rights of the Child

I am compelled to mention another important example of the progress being made by the growing "Grand Alliance for Children" of relevance to the public health community, and that is the remarkable work done on the draft "Convention on the Rights of the Child". The Convention, which is targeted for adoption, hopefully, by the General Assembly of the United Nations during the fall of 1989 in commemoration of the 10th anniversary of the International Year of the Child, represents an opportunity to establish global norms not only to discern children's rights for survival, protection and development and how to assure them, but in the responsibilities of governments to protect those rights.

Approval of the Convention on the Rights of the Child by the General Assembly in 1989 will not occur automatically. It will require an all-out effort by all of us. And, once endorsed by the General Assembly, it will be up to people of concern in every country to secure ratification of the Convention by each national Government.

It is people working together on behalf of children that will make this long-sought advance a part of our reality.

Time to teach

In the immediate domain of the health professions, whether we are talking about the challenge of the major health threats in the industrialized world, or the greatest health problems of the developing world, or the new and universal threat of AIDS, the principal challenge, as we have seen, is one of informing and supporting people in applying what is already known.

For the doctor to become the teacher of his community would be to return the title "doctor" to its original meaning, namely, from the Latin "docere" - "one who teaches".

I was reminded recently by a wise friend, that in days of old every educated Chinese was expected also to be a doctor - to have studied the healing and medicinal arts of the day as part of his being an educated person. Today the challenge is whether every doctor and everyone involved in the healing professions can also be, at least equally, an educator - "one who teaches" ... a "doctor" in the truest sense. A principal goal after all, is as Dr. Nakajima has noted, to properly inform and motivate all individuals so that they are empowered to take better care of themselves and their children.

I am very pleased to be able to share with you today that, in the task of bringing basic health knowledge to those who need it most, a major step will be taken early next year with the joint publication by WHO, UNICEF and UNESCO of a collection of 10 major health themes broken down into 55 priority messages under the title Facts for Life. This publication contains, in message form, the most important information now available to help parents protect their children's lives and growth. That knowledge - on such topics as the timing of births, the promotion of growth, the feeding of young children, the prevention of illness (including diarrhoea and AIDS), the technique of oral rehydration, and the importance of full immunization - is knowledge on which there is world-wide scientific consensus; it is knowledge on which most parents can act; and it is knowledge which has the potential to drastically reduce child deaths and child malnutrition. It is therefore knowledge which every family, by right, should have.

Facts for Life has made a special effort to present this in information messages which can be understood by all. Although the ultimate recipients are the families who must actually use the knowledge, the more immediate target is the broad spectrum of communicators of all kinds - community workers and groups, health and medical educators, school teachers, and all those who can help to put today's knowledge at the disposal of today's parents so that it can actually be used to save the lives and improve the health of those previously unreached by such benefits of modern progress. Facts for Life is, especially, a primer which doctors and health professionals can use to teach.

The role of medical educators

How can the fundamental role of teaching health be restored to the medical - the health-professional? How can schools of public health mobilize medical schools as a whole so their graduates can be made more responsible for the health of the entire community rather than for just a selection of individuals?

In training health professionals universities must take far greater responsibility for their relationship to the community. Perhaps the single aspect of health education capable of the highest-impact on the future of public health is the settings in which students practice. The World Federation for Health Education, after four years of extensive preparatory

country and regional research worldwide, presented to its "World Conference on Health Education" in Edinburgh in August such findings as:

-- "Medical education must exploit a full range of settings for education, with the whole community and all its health service resources being employed...";

-- "Students must acquire the ability to promote health as well as deal with disease, not only in individuals but also in populations".

-- "Medical schools should revise basic curricula to achieve balanced education in the community... in accordance with the concept of primary health care"; and

-- "All medical students must be exposed to a broad range of learning environments that should range from rural health districts in the field to the urban tertiary care institutions".

I would add to this that medical and public health schools must not only place students in a variety of existing community health care environments; they must take the lead in designing, advising on, and creating health care environments which actually meet the health needs of populations whose needs are now inadequately met. It is, in fact, in community settings that the most exciting research and teaching is possible - research into the health dynamics of the community, rather than into the pathology of just the patients in a hospital ... working on solving the health problems of the community rather than discussing them in classrooms.

The historic medical breakthroughs of the coming years will occur not just in science laboratories. Just as important will be those "laboratories" in which the community - not the individual - is the patient. The skills we must foster are those of treating the whole population. In addition to looking at the temperature, heartrate and enzyme levels of a patient, we must now measure the infant and maternal mortality rates, the nutrition levels, etc. We must take health surveys, keep good records - and know how to use them. We must look at the overall environment in which ill-health occurs. A primary role of the doctor will be to teach self-health activities and to promote social change for better care and prevention.

Fortunately, pioneering work in this approach to health education is underway. Thus, there is a rapidly expanding number of schools in the "Network of Community-Oriented Educational Institutions for Health Sciences". Organized in 1979, the network now has 100 full, associate and corresponding member institutions which aim to make education for the health professions more relevant to the health needs of the communities they serve. These institutions are putting people out in the community, reaching beyond hospitals. They are giving the community/field area an emphasis that is equal to that of the teaching hospital. Just as bedside teaching provided the major revolution in medical education in the last two generations, it is community-side teaching that today gives doctors the opportunity to contribute toward the worldwide goal of equity in health care.

What is next?

Am I an optimist or a pessimist as to the capacity of health education to respond adequately to these challenges...to these new opportunities? I like to be optimistic, but I should note that history tells us that normally - not always, but normally - severe crises are required to provide the tremendous energy necessary to overcome the inertia of prevailing policies. Thus it took the Great Depression to achieve the breakthrough to the New Deal in the United States. World War II preceded the establishment of the United Nations and the Bretton Woods institutions - and the World Health Organization and UNICEF. Closer to home in your own profession, in China, only during the 1960s were the rudiments of primary health care effectively brought to the vast majority of the people, but at great societal cost - including the closing of most medical schools.

What are the consequences, you may properly ask, of medical education not becoming far more relevant to future needs? Nothing dramatic for doctors, other than a continuing loss of status as leaders in their communities and in their self-respect. The worst consequences are for the tens of hundreds of millions who will die prematurely, and for the larger numbers who will suffer needlessly. And if these are in fact reduced by intervening leadership from other sectors, the role of doctors will move more rapidly toward that of technicians, not leaders. It may be noteworthy that among the 435 members of the U.S. House of Representatives today, only one, I am informed, is a medical doctor.

Is the formal health community wise enough to make the hard choices now which would ensure its continuing leadership role in society's health in the 21st century - or will inertia compel an underserved society to take education for health in the community into other hands?

I began my remarks today stating that it has long been acknowledged that a major challenge to health professionals is to make existent techniques available to those removed from the channels of easy access. We are beginning to close that gap. The 1980s has seen major strides in meeting this age-old challenge. Can you, in your role of leadership in the health field, channel the benefits of progress and momentum now evident at the international level, into efforts in your own countries which will achieve the United Nations Year-2000 goals for child survival? Can we make the Child Survival and Development Revolution the world's most critical revolution, a revolution which will accelerate achievement of primary health care, and the goal of "Health for All by the Year 2000"? Can we not extend the benefits of some of your most critical knowledge to the great majority of the world's children? Can we reach the unreached?

It is you - the world's leaders in the field of public health - who must take a leadership role in making these possibilities realities throughout the world. I urge you to take even stronger leadership in this peaceful revolution for the health of children, and of all the world's people.

Thank you.