Subj Chron: CF/EXD/SP/1987-0007

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
Hawaii Conference on Health Leadership Development and Child Survival

Honolulu
2 February 1987

"Leadership in Mobilizing All for Health for All"

cover + 11pp + 0b

unicef

United Nations Children's Fund Fonds des Nations Unies pour l'enfance Fondo de las Naciones Unidas para la Infancia
Детскому фонду Объединенных Наций 联合国儿童基金会 لليونيسيف الأمم المتحدة منظمة

Chron Subj: CF/EXD/SP/1987-0007

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
Hawaii Conference on Health Leadership Development and Child Survival

Honolulu - 2 February 1987

"Leadership in Mobilizing All for Health for All"

Thank you for inviting me here; I am deeply honored to have the opportunity to deliver the Dr. Ira Hiscock lecture. As Executive Director of the United Nations Children's Fund I have a special appreciation for the work of Dr. Hiscock. His academic work at Yale and his untiring contributions to the health field in Hawaii, including his instrumental role in establishing the University of Hawaii School of Public Health, place him among major figures in the lineage of public health innovators. This background, combined with the 24 year tradition of concern for public policy issues that the Hiscock Lectureship has shown, is an approach shared by UNICEF.

I am especially pleased to be here with you in Honolulu today to address the Asia-Pacific Academic Consortium for Public Health because the theme you have chosen seizes upon today's major frontier for child health and international public health.

This 1987 Hawaii Conference on Health Leadership Development and Child Survival comes at an important time for those of us committed to the improved health and survival of the world's children. It is an important moment for two mutually-opposing reasons - reasons of deepening problems but, simultaneously, reasons of heightened opportunities. I will endeavor to describe to you both the problems and the opportunities.

But, beyond this description, my real purpose is to explore with you the very provocative theme you have set for your meeting, and to issue to you, and to those involved in child health everywhere, and to my colleagues in UNICEF and WHO, a challenge: how do we develop and direct the leadership among

cover + 11 pp + Ø6

individuals, institutions and organizations in the Asia-Pacific region and all around the world to sustain the progress of these past four decades by creating and advancing health breakthroughs for the world's children that are so major that they constitute a veritable revolution in the prospects for children's health and survival? Far from being a slogan or abstraction, we of UNICEF believe that this child survival and development revolution is a quite achievable goal if enough of us are determined to make it a reality. Such a commitment can offer new hope in these dark times for the health of hundreds of millions of children born into poor familiies in low-income countries. But this is a goal which can be achieved only with the help of those in this hall.

We meet today at a time of continuing severe global economic difficulties, which not only stunt economic growth in many parts of the world and particularly in the least developed countries, but which are also leading to massive retrenchment in many countries on public expenditures for health, education and other services vital to well-being. As the seventh straight year of global economic decline, 1986 saw family incomes decrease and food prices rise, aggravating the nutritional status of children in the poorest households. As is too often the case during times of economic recession, a disproportionate share of suffering was born by those least equipped to combat the effects of poverty - the most vulnerable of the poor, including children and women. Progress in preserving the lives of our children is now slowing after four decades of historically unprecedented improvement during which we witnessed more progress for children as a whole than during the preceding 2,000 years. Between the end of World War II and 1980, for example, child death rates in the developing countries were reduced by half and literacy rates increased multi-fold.

The post-War era has been the first in human history in which it has been possible to think seriously in terms of bringing the basic essentials of health and nutrition to all humanity. Given the continuing trends of economic distress, will the 1980s mark the moment that that opportunity was lost, at least for this century? Or will current difficulties serve rather as a spur to new levels of creativity in advancing toward the United Nations goal of Health for All by the year 2000 through Primary Health Care? And will these new levels of creativity for health in developing countries also have special meaning for the industrial countries, including the United States, Canada, Japan, Australia and New Zealand?

Unfortunately, trends have been moving towards the loss of this historic opportunity - and this was so even before the global recession deepened. But there is new hope if these dark times generate new creativity and new initiatives, similar to those we saw in the United States with the New Deal, in Canada with the Mackenzie King recovery plan, and later in the world community with the United Nations, the Bretton Woods institutions and the Marshall Plan arising from the ashes of World War II.

Health begins with people

For those of us preoccupied with public health and nutrition, this creativity must begin with principles of health care and public health

services which we have known in theory for years but which we have been slow to apply in practice. We have the know-how for families to take a vastly greater role, often using readily available resources, in their own nutrition and health - including saving each others' lives - yet these practices are underutilized, while ill health and high death rates continue. I remember my father, one of the original pioneers of primary health care, articulating the principles of such a people-empowering approach when he was in China in the 1930s. Most countries are still slow in fully applying them today.

The first of these principles is that social organization is the key to efficient use of medical knowledge and health protection. The immediate social problem is to overtake the lag between modern knowledge and its use in the community setting. Two dramatic examples of this lag between knowledge and use are the leading single cause of premature death in North America - tobacco - and the leading single cause of premature death in the developing world - diarrhoea. Nearly 400,000 North Americans (more than 1,000 daily) die prematurely each year because of smoking. In the developing world we are still faced with more than 4 million needless deaths (12-14,000 daily) from diarrhoeal dehydration while there is a largely effective home remedy, not to mention that much diarrhoea could be avoided in the first instance by such relatively simple measures as washing hands and drinking clean water. Indeed, in a suprisingly large number of cases, life-saving cures are available for almost nothing more than the simple price of <u>training</u> those who need it, and - this is the difficult part, as we know from the smoking example - <u>by society</u> taking the lead to make the training available and to help the individual psychologically to apply this knowledge.

A second basic principle is that a vertical medical system cannot be truly effective, or even stand by itself, unless it is integrated in other activities in society in a concerted attack on the problems of development and social reconstruction. Health is not simply a "sector," a responsibility of the Health Ministry alone; it must be an explicit goal to be achieved through all sectors with mass citizen participation - through education, better nutrition, communication channels and the media, and through national and local community leadership. The academic community has a critical role to fill in this regard, both because of its multifaceted leadership stance institutionally and because of the direction and example for which people look to prominent individuals within a university.

A third principle is that successful organization implies reliance upon economically practical strategies for serving the entire population rather than just the relatively well-off. There are all-too-many examples of major hospitals established or expanded in the poorest of countries where the drain of operational costs has led to the curtailment of health clinics and preventive services. We are also well aware of the needless competition of hospitals in industrialized nations which each feels that it must have tremendously expensive diagnostic equipment. The rationality of a converse approach was recently demonstrated in Pakistan with the decision taken in 1982 simply to postpone building a major hospital centre in the capital city of Islamabad in order to finance a 3-year national programme of immunization,

promotion of awareness of oral rehydration therapy, and training of tens of thousands of traditional birth attendants. The need for a re-ordering of priorities is perhaps best illustrated in a statement made by Pakistan's then-Minister for Finance, Planning and Economic Affairs, Dr. Mahbub-ul-Haq, at the Annual Meetings of the World Bank and IMF in Seoul (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."

Reflecting these three principles for Public Health, the Alma Ata Conference in 1978 of the world's health professionals, sponsored by the World Health Organization and UNICEF, formulated the concept of Primary Health Care. By seeking to apply those basic principles of health care which my father and his contemporaries articulated a half century ago, we can transform the health of peoples even at low income levels. A limited number of places as different as China, South Korea, Sri Lanka, Kerala, and Taiwan demonstrated in the 1960s - with a modest increase in financial resources but most importantly a directed and sustained strong political will - how to reach the many rather than just the largely urban, relatively better-off minority and how to do so when their real per capita incomes were comparable to those of a major industrialized nation of two centuries ago and to achieve infant and child survival rates reached by the U.S. only in the middle of this century.

While many countries have recently paid more than just lip service to promoting primary health care (e.g., millions of village health workers have been trained), the majority of health resources are still not directed toward achieving it, and there is clearly a need for leadership in shifting this focus. Those charged with health care have, rather, tended to remain isolated in the so-called health sector, and they have been reluctant to aggressively seek the involvement of other sectors in health promotion, or to shift health knowledge from the traditionally conservative health professional to the general public. This continues, although we know that health care knowledge is far more cost-efficient, and often more effective, when it is in the hands of those who need it most. In the great majority of countries - industrialized as well as developing - far too much emphasis remains, first, on cure rather than prevention, and second, on excessive reliance on medical facilities for improving health to the neglect of schools, radio, television and other communication facilities which can transfer much of health prevention and care to the family. Even within the curative sector and despite the growing emphasis of recent decades on reaching the poorer majority, the more affluent minority still benefit disproportionately. Regretfully, in many countries the global recession has even further exacerbated this situation.

A climate for revolution

In such an environment - with economic deterioration intensifying the reticence of the health structure to address the needs of the poor and the

most vulnerable - is there any possibility of recapturing the past modest momentum in developing countries - and industrial countries - toward improved health and nutrition?

The answer is yes. Or at least, "yes, if".

The possibilities exist today in the developing countries because of one central new development of recent years - largely a by-product of the development progress of the past decades - that now holds forth the potential for truly major breakthroughs even in these lean times. Vigorous use of this new development over the past four years is already saving the lives of significantly more than one million small children each year; truly vigorous support could mean annually saving the lives of 5 million small children - more than 10,000 each day - by 1990, and improving the health of more than 100 million more while also decreasing population growth and dramatically improving the well-being of women.

What is this new development? It is the new capacity - the major new potential - to communicate with the poor majority in developing countries. Indeed, we have seen a revolution in social communications and organization, and its use for social benefit is only beginning to emerge. As a result of general development progress, a literal transformation has taken place in virtually every country, no matter how poor or under-developed, in the capacity to communicate with the poor majority.

There are training programmes, and virtually every village now has a school, to the point that most young mothers in their 20s and 30s can now read and write. With increased incomes, the ubiquitous radio is now in a majority of the world's homes. In most countries there is at least a television or two in every village, and frequently in many homes, with the result that people throughout a country can know what is going on and how to do things. Religious structures - whether Christian, Islamic or Buddhist - have a whole new capacity to communicate. And, perhaps to the surprise of those in the "developed" world, it now seems that people in such less-developed areas as Africa, South Asia and north-east Brazil - while they still have per capita incomes lower than those of Europeans or North Americans of two centuries ago - now have a capacity to communicate not achieved in the industrialized world until just one or two generations ago. The expansion of this capacity and its purposeful use is vital to the process of accelerating PHC programmes in the face of difficult or deteriorating economic conditions.

Children are the first frontier

With precious little in material supplies added to the know-how potentially shared through these newly expanding channels, dramatic improvements in the condition of life for the masses are being achieved. The revolutionary possibilities of these advances come to our attention in the field of child health (but the potential is hardly limited to this sphere). The newly evolved capacity to communicate in low-income communities has coincided with the realization that major, grossly underutilized technological

advances of recent years could bring about revolutionary improvement in the well-being of children - a Child Survival and Development Revolution - at extremely low cost...a cost so low that virtually all countries could afford them with a modicum of international cooperation, if only they are combined with the new capacity to communicate with the poor who are most in need of these technological advances. Country after country in Asia, Africa and Latin America could so improve the health of their children over the next 5 to 10 years as to cut the infant and child death rates in half.

What are the actual mechanisms through which people can take charge of their own health care? A number of these new, improved, rediscovered or newly appreciated technologies, which are detailed in UNICEF's current annual report, The State of the World's Children, 1987, include:

-- The recently discovered oral rehydration therapy consisting of a remarkable yet simple treatment composed of salts, potassium and glucose in water - and costing only a few cents - which can be applied by parents at home for a child suffering from diarrhoeal dehydration, the number one child-killer that claims nearly 5 million lives annually. No wonder Britain's Lancet described this as "potentially the most important medical advance of this century".

-- Recent advances in vaccines, now costing only fifty cents to immunize a child for life against tetanus, measles, polio, whooping cough, diptheria and tuberculosis which cripple and kill several millions of children every year.

-- The recent swing back to an appreciation of the nutritional merits and medical advantages of breastfeeding and improved weaning practices.

-- Growth monitoring through frequent charting (usually monthly) of weights that enables the mother to detect early signs of malnutrition and, in a surprising majority of cases, to deal with it through means within the parents' own control.

-- Better family spacing of children, which alone could reduce the infant toll by half among low income families in developing countries.

-- Increased female literacy, so that mothers can better apply the knowledge now available.

-- Food supplementation, when necessary, to stem the permanently disabling effects of malnutrition.

To be effective, however, all of these measures require that parents be aware of and use them, whether it is to mix oral rehydration formulas at home, or to bring a child the three or four times necessary for full immunization against six killer diseases. We all know how difficult it is to have people adopt new practices - (how many in this audience of distinguished health authorities are still smoking?) - and this is particularly true of families

from low-income and often illiterate backgrounds who may be reluctant to bring their children for vaccination. In many cases the family has not been made aware of the common side-effects of vaccination, such as fever and other symptoms associated with illness, and the experience of these immediately following a first and second vaccination heightens their reluctance.

This, of course, is where the new capacity to communicate with parents is so important, using all channels intensively to reach the parents and local communities. Empowering parents, and particularly mothers, with present knowledge and technologies is the key to unlocking the potential for a revolution in child health. But, and I stress the but, the responsibility for turning that key rests with the whole of society, for the mother cannot act alone. Again, the continuing prevalence of smoking even in the most well-educated and informed countries stands as a grim reminder of the societal support and encouragement required.

...and lives are being saved

It has been exhilarating to see how fast the potential for a Child Survival and Development Revolution has advanced in the four years since first articulated with respect to primary health care.

Among the developing nations, Colombia, for example, has been a pathbreaker in demonstrating the viability of these approaches and their combined effect in support of Primary Health Care. Beginning in 1984, Colombia started a major initiative to raise the percentage of their children immunized from a minority to near universal coverage. The key was leadership from then-President Betancur and active participation by the media (the press, the radio and television stations) and by groups such as the Church and the Red Cross, the Rotarians, the Lions, the Scouts, schoolteachers, businessmen, and all of the government ministries.

Another exemplary effort in this region comes from El Salvador where these efforts became politically relevant as well as socially. Child immunization has become sufficiently good politics that in 1985 in El Salvador all the feuding factions were persuaded to lay down their arms (for the Sundays of February 3rd, March 3rd, and April 23rd) and pick up their children...and immunize them. When Salvadorians realized that more children died in that war-torn country from not being immunized than all the people who had been killed in all the fighting the year before, they understood the magnitude of the tragedy. And they were willing to co-operate - or, at least, to not shoot at each other - to allow a National Immunization Campaign to go forward. And so the government, and the guerrillas, and dozens of private groups (including notably the Catholic Church and the Red Cross) all set out to protect children, rather than see them caught in the crossfire. A second round of this accelerated programme was successfully completed last year, and it has now become incorporated, in its expanded form which serves all of the children, into the annual calendar of the PHC structure. In fact, that's where I spent my weekend - as El Salvador began its third annual campaign, again with a "National Day of Tranquility" on Sunday.

Another example is Turkey, which launched its child survival revolution just last September with a national immunization week for 5 million children under 5 years old. The campaign 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), and with the active participation of 95,000 village teachers (who returned from summer vacation two weeks early for the purpose), some 85 per cent of all young Turks were fully immunized against these dread diseases. This spring, this social mobilization approach was extended to encompass oral rehydration therapy, means for coping with acute respiratory infections, and family planning.

These success stories are not alone. They are being joined by others - in Burkina Faso, China, the Dominican Republic, Ecuador, India, Nigeria, Pakistan, Peru, Egypt and many others.

On a regional level, a major and historic series of events within the last six months has gathered forces in South Asia to accelerate activities on behalf of children and women despite economically difficult circumstances. In an exemplary process, the seven countries of the South Asian Association for Regional Co-operation (SAARC) cooperated in a masterful and innovative approach to regional prioritizing of activities related to child health and well-being. Thirty-four million children are born each year om South Asia, four million of whom do not survive their first birthday and another two million die before they reach the age of five; the mentally and physically disabling after-effects of childhood disease are rampant. A groundbreaking South Asian Parliamentarian Symposia in Colombo recognized the potential and importance of the CSDR and the need for a public ethic placing needs of children first. This was followed shortly by a Conference on South Asian Children held in New Delhi in which representatives of the SAARC countries - - laid a foundation for durable solutions by focusing causes of similar origin which are conducive to maximizing efforts of mutual support.

The conclusions of that conference, adopted by the SAARC Summit meeting at Bangalore in November, offer an exemplary framework on which to build a regional plan for the future through strengthening the coming generation. "The Bangalore Declaration" states in part:

> "The Heads of State or Government recognized that the meeting of the needs of all children was the principal means of human resources development. Children should therefore be given the highest priority in national development planning. ... They subscribed to the goals of universal immunisation by 1990, universal primary education, maternal and child nutrition, provision of safe drinking water and adequate shelter before 2000."

The Summit leaders also called for an annual report on progress, bringing a forceful element of accountability into the process of accomplishing these goals. UNICEF looks forward to working with SAARC and its Member States as they build on this promising foundation.

Achievement of our revolutionary goals for child survival and development, of course, is of monumental importance. But perhaps of even greater importance, in the long run of history, will be the means by which we are achieving these goals: the mobilization of whole societies - not by fear or regimentation or at great expense, but by hope, participation and communication.

The role of universities

Now as to my direct and specific challenge to you: I wish to urge you - as individual professors, academicians and health authorities and as members of your institutions, to join with us and others in creating and sustaining the Child Survival and Development Revolution (CSDR) so as to eliminate mass ill-health from these readily preventable causes - in the Asia-Pacific region and all over the world - during the next decade. We call on you to join in partnership in this "revolution".

What does this mean?

New modes of progress present a new set of problems, and as society's great "think tank", the academic community has a crucial function in responding to change. The roles that universities uniquely play, and which are vital to the success of the CSDR, fall into two main areas: first of all we look to universities for development of effective solutions and, secondly, to inform and lead society toward enacting those solutions.

In the first role of developing solutions, the formidable resource to a society that the research capacities of its universities offers is a powerful tool, and we call upon you to choose for your own work and to promote amongst colleagues research topics that support CSDR approaches. I might add that the strategy paper on "Roles and Strategies for Asia-Pacific Universities in Child Survival and Development", which was prepared for the conference, offers some excellent insights on the many forms of work that offer opportunities in this regard as well as several specific aspects of the CSDR currently in need of further research. Especially notable among the forms suggested are the prospect of using sabbatical opportunities to support relevant advances, and the possibility of offering masters and doctoral-level candidates in various health sciences a concentration of course work in Child Survival and Development. Short term intensive trainings in Child Survival and Leadership Development for multi-sector professionals such as physicians, attorneys, engineers, managers and economists were also suggested.

A few of many areas that call for immediate study include:

-- Social mobilizations practices and strategies. Both theoretical and immediately applicable expansion of our knowledge in the fields of information, education and communication are needed to seize the opportunities presented by this rapidly advancing field.

— Situation analysis. Join with us when we do these in your own countries. This could have a dramatic impact on the quality of information available for programme formulation.

— Monitoring and evaluation of programmes. Advancements in methodologies to keep up with the changing nature of programmes as we accelerate and go-to-scale is a continuing need. This very essential element of effective programming would also benefit tremendously from systematic collaborations in gathering and analysing information.

— Planning and management of accelerated programmes. One must know the national policy on communication and relevant legislation in order to design programmes. Many professionals who approach a development programme are unaware of policies in existence in the country in which they are working. Universities could organize to make such information available, and would provide a tremendous service by mobilizing to help in this way.

— Advancing medical technology itself. There is still a dire need, even within the measures of the CSDR, of such improvements as a more heat stable measles vaccine that does not need skilled injection.

These are, of course, but a few of the direct research areas where progress is urgently needed. It is also necessary that relevant research be focused into readily applicable form, where traditionally universities might be inclined to pursue a more theoretic approach.

In the area of developing leadership in public and child health, universities have a tremendous potential for directing all levels of professional, political and popular will toward the life-saving activities of the CSDR. Individually, members of the academic community set a potent example within a society. Personal example, as well as expressed personal interest in the activities of one's own community, both have profound effects on the behaviour of others. Thus, if members of the academic community breastfeed their children, or insist upon using ORT when the occasion arises, people notice and follow the example. Similarly, if a respected professor inquires informally of community leaders how many children in the community have been immunized, the question will be noticed. You command a tremendous respect in your locale: Are you willing to use your position to further the goals of the CSDR?

There are other more institutional roles of leadership for which we look to universities, as well. Among the many organized sectors of a society whose collaboration and participation are vital to the CSDR, the academic community's role in the social order is quite naturally one of leadership. Here again, the strategy paper prepared for this conference presents many innovative ideas on how universities might increase the potency of their input to this "revolution" through one of the measures which the CSDR approach advocates - social mobilization. That is, universities could form new mechanisms for collaboration, pooling relevant information and resources, thus multiplying the capacity to assist far beyond that of any one university.

A pressing need exists in several countries to expand the concept of public health beyond the health sector and engage all sections of a society in the task of improving health. Universities can:

— Create and participate in leadership groups, and host relevant conferences and gatherings among special interest as well as multi-sector groups.

— Participate in the social mobilization of accelerated CSDR programmes, using both physical facilities and human resources.

— Promote exchange of information. For example, those who deal primarily with relevant theoretical issues and those who deal primarily with operational activities might benefit tremendously from an occasional "exchange programme", if you will. A professor who spends a year consulting on a field-based operation may return to academia with renewed insight, and certainly the programme in which he or she becomes involved stands to benefit from the professional expertise.

Again, these are but a few of the means by which the academic community can participate in the activities presented here. We call upon universities to expand the strength of their interrelation with society in order to share the rich cross-fertilization usually reserved for the extended academic community. And we call upon you to mobilize - to use the networks amongst your institutions - to join in this alliance.

The potential of this experiment goes far beyond the tasks of child survival. With the proper leadership and guidance, it may, indeed, be a key to the ascendency of people - of popular will, popular rights, and popular power - in the full range of social concerns. Let us seize this historic opportunity and take full responsibility for the success of this hopeful and peaceful revolution.