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Address by Mr. James P. Grant
Executive Director of the United Nations Children's Fund (UNICEF)
to the
Symposium for Parliamentarians of Countries in the
Association of South East Asia Nations (ASEAN)
on Child Survival, Population and Development

Jakarta
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Child Survival, Population and Development

Jakarta - 9 June 1987

This symposium occurs at a time of great promise for South East Asia. While economic hardships persist in the region, rapid social progress in many of the countries of the Association of South East Asian Nations (ASEAN), in no small part a result of two decades of regional activities by ASEAN, provide encouraging examples to neighbors.

My most urgent concern, as Executive Director of the United Nations Children's Fund, is improving the survival and wellbeing of children. My proposition to you today is that ensuring the improved health and the survival of children in Asean Countries can be achieved far more readily than we anticipated five years ago...and constitute a major contribution to population stabilization as well. This is so not only because parents are more likely to have fewer children if they feel more secure in the survival of the children they do have, but also because the types of methods employed in achieving a

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Child Survival and Development Revolution - such as promoting breastfeeding and family spacing - also in and of themselves result in fewer and healthier children. My purpose today is to demonstrate that - despite today's economic climate - the capacity exists at this stage to not only sharply decrease the present tragic number...900,000 ... of preventable child deaths in South East Asia, but in the process, to contribute to building a foundation for a broad range of social and economic advances...and slow the growth of population as well.

The correlation between death and birth rates was recently described by the president of The Population Council, George Zeidenstein, when he stated:

> "There is no example in contemporary societies where fertility decline has preceded declines in infant and child mortality."

Even more relevant for the Asean countries is the fact that all have reached the stage where further decline in death rates, particularly among children, can be expected to be accompanied by a larger, often much larger, reduction in birth rates and a consequent slowing of population growth. The reduction in birth rates can be further accelerated by effective programmes promoting the concept of family planning.

We know that the survival and health of children are intimately interrelated with population growth rates. Sharply improved child survival, health and nutrition can help to significantly increase the desire for fewer births, especially when these goals are addressed through means under parental control, such as oral rehydration therapy (ORT) to combat the lethal effect of diarrhoeal dehydration through low cost and readily available means. And slowed population growth (particularly through timely child spacing with its great beneficial impact on the health of mothers and the birth weight of babies), can significantly improve child health and nutrition, contributing to a virtuous circle of improved health and slowed population growth. A principal means of achieving these and related goals is training women and including them in the planning process, and of course increasing literacy levels among women.

That improving children's chances of survival can, in fact, lead to stabilized population was stressed by the late Indian Prime Minister, Indira Gandhi, at the South Asian Meeting of Parliamentarians on Population and Development shortly before her death in 1984. She stated :

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

ASEAN experience attests to this, and we can detect the consistency of this relationship in the pattern that forms between death and birth rates. In country after country, as the crude death rate is first reduced, the birth rates fall much more slowly and population growth accelerates. Once the death rate is reduced to 12 to 15 per thousand population, however, a stage now reached by all ASEAN countries, in the great majority of countries each

additional significant drop in the death rate is accompanied by a larger drop in the birth rates. This is illustrated by experience in the Philippines. Between 1960, when the death rate had reached the crucial level, at 16, and 1985, the rate dropped 8 points to 8 per thousand. During the same period the birthrate plunged 14 points from 46 to 32. Thailand has also recently demonstrated the same principle. Between 1960 and 1985 the crude death rate dropped from 16 to 8, and that 8-point reduction coincided with a birthrate reduction by 18 points from 44 to 26.

A further illustration of the correlation between low death rates and low birth rates can be seen in Singapore, where the lowest death rate of the ASEAN countries, 5 per thousand in 1985, is accompanied by the lowest birth rate of of 17. Thus the 3 point reduction in death rates from 8 to 5 between 1960 and 1985 was accompanied by a 21 point drop in birth rates, from 38 to 17. If all of the ASEAN countries had the crude death rates and birth rates of Singapore, there would be 1.45 million fewer deaths and 2.45 million fewer births, for a 1 million reduction in annual population growth i.e. a 17% reduction in present population growth.

Please see table in Annex.

One of the lessons learned by countries going through this developmental phase is that when death rates go down that important step from 15 to 7 or 8, the improvement which that reflects can only be accomplished by education and empowerment of the populace. A people must be increasingly capable of fulfilling its own basic human needs in order for this more dramatic and disproportionate shift for the better to occur. By contrast, a country can reduce its death rates to the 15 range through measures that require relatively little family pacticipation e.g. through avoiding famines and epidemics and through malaria spraying.

It is well known that at a certain point, when death rates reach the level that Indonesia is just achieving, as a general rule, this is accompanied by a steep drop in birth rates. Confidence in anticipating rapid progress for donesia is bolstered because the

approach being taken quite actively by Indonesia's health sector is toward empowering families and communities to take a far greater role in their own health care - precisely the direction needed to accelerate progress at this stage.

Within Indonesia, the province of Jogjakarta shows impressive results for the direction they have taken in responding to health needs. Jogjakarta enjoys the lowest infant mortality rate (IMR) in the country, which was 35 in 1985. If all of Indonesia had achieved this level, the lives of more than a quarter of a million (231,000) Indonesian infants would have been saved that year. And if all of Indonesia had the birth rates of Jogjakarta, the annual population increase would be substantially less for the country as a whole.

The possibilities for dramatic advances in child survival exist today 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 prospect for major breakthroughs, even in these lean times, when combined with recent technological advances. Vigorous use of this new development in the past several years is already saving the lives of close to one and one half million young children each year in developing countries worldwide; truly vigorous support could mean by 1990 annually saving the lives of 5 million small children worldwide - and improving the health of several million more while also contributing to decreasing population growth.

Revolutionary potential in communications

What is this new development? It is the new, and still rapidly growing, capacity - the major new potential - to communicate with the poor majority in developing countries. Indeed, it is the revolution in social communications and organization which has occurred in recent times. The techniques have long been known to politicians seeking to secure support for their election and to businessmen seeking to sell their manufactured products, but it is only now that these means are beginning to be used intensively for promotion of social benefit in such fields as health and education.

A major transformation has taken place in virtually every country with respect to the capacity to communicate, no matter how poor or under-developed, as a result of general development progress. The ubiquitous radio is everywhere in the rural countryside, and not only televisions, but VCRs can now be found in many villages. Almost every village now has a school; women's organizations, farmer's associations and commercial retail outlets in villages have vastly increased in numbers. A growing proportion of young mothers in their 20s can now read and write.

Religious structures - whether Muslim, Christian,Hindu or Buddhist - have major new capacities to communicate. And, perhaps to the surprise of those in the "developed" world, people in least-developed areas of Africa, Asia and Latin America - 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 it neared the mid 20th century - just two generations ago.

Children's health as a revolutionary frontier

The revolutionary potential of these advances in social communication and mobilization on the condition of life for the masses, first pioneered in promoting the Green Revolution (which was researched and tested in the Philippines) in the production of wheat and rice in Asia and then with respect to family planning, is now being most dramatically demonstrated in the field of child health. The evolution in the capacity to communicate in low-income communities coincides with the growing realization that major, grossly

underutilized technological advances of recent years could bring about revolutionary improvement in the well-being of children - what we have come to call the potential for a Child Survival and Development Revolution (CSDR) - 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 majority who are most in need of these technological advances.

What are the actual mechanisms which could so effect the survival of young children worldwide? These new, improved, rediscovered or newly appreciated technologies are detailed in UNICEF's current annual report, The State of the World's Children, 1987. They include:

-- The recently discovered oral rehydration therapy consisting of a remarkable yet simple treatment composed of salts, potassium and glucose (sugar) 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 immunization, now costing only fifty cents for all the vaccines required to immunize a child for life against tetanus, measles, polio, whooping cough, diptheria and tuberculosis which cripple and kill five to six million 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 for poor families through selective, relatively low cost measures to increase their food supply.

Programmes can be flexible enough to meet the priority needs of each country, thus including programmes on acute respiratory infections, maternal nutrition, micro-nutrient deficiencies like vitamin A and iodine deficiency disorders where relevant, and support for systems of essential drugs supply.

To be effective, all of these measures require that parents be aware of and use them, whether it is to mix oral rehydration formulas at home, to bring

a child the three or four times necessary for full immunization against six killer diseases (even though the child may run a fever after each immunization), or to maintain and promote breastfeeding and improve weaning practices. We all know how difficult it is to have people adopt new practices, and this is

particularly true of parents from low income and often illiterate families who may be reluctant to bring their children the several times necessary for full immunization, a process which the parents probably do not understand in the first place and which is particularly confusing after the child runs a fever following each vaccination visit, as is often the case. The experience of Malaysia, where the government is making a sustained effort to involve the media in bringing health messages to the population is significant. The recent decline in Malaysia's IMR has been largely achieved by bringing a comprehensive range of preventive and curative services to children and mothers, in particular an accelerated programme of immunization, supported by a wide range of communications activities.

This, of course, is where the new capacity to communicate with parents is so important, using all channels intensively and generating new creative means 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 the responsibility for turning that key rests with the whole of society, for the mother cannot act alone. Experience shows that it can be done - if we can get the help of the village health worker, the village imam or priest, the local radio and television, the village school teacher, the local non-governmental organizations and others who have influence in their communities. This help is easier to get with the encouragement of national leadership - Presidents, Prime Ministers, and parliamentarians.

These examples show that social mobilization can have a tremendous impact on children's ability to survive. But the effects do not stop there, even within the specific application of social mobilization to the field of children's and women's health. This people-empowering approach can also extend to another profound level where the beneficiary's very sense of self and role in society is enhanced. The principal reason for this, as I mentioned this morning, is that the Child Survival and Development Revolution rests upon one central foundation embodied in the concept of Primary Health Care: that people can and ought to be enabled to take far greater care of themselves. A new respect for the capacity of the individual and the importance of governments fostering and encouraging use of that capacity emerges. Consistent with this, these technologies offer a new relevance to the family - enabling people to take action - compared with the days when health care was only available through minimally accessible large institutions reliant exclusively on experts in "white coats" intervening.

Adjustment with a human face

The cut-backs and adjustments which many countries are undertaking reflect in part the severe constraints imposed by the international economic system and in part on the way countries have re-formulated their policies in response to these pressures. It is the summation of these factors which brought forth the anguished plea from President Nyerere of Tanzania when he stated, "Must we starve our children to pay our debts?"

Our response must be an emphatic "No" - Children shouldn't be required to die to pay a country's debts. Unfortunately, actual practice is all too often, still, to reduce disproportionately health, education and social services for the weakest and most vulnerable, and many are dying each day as a consequence in the mid 1980s.

Our experience is that there must be a two-pronged response to this situation. First, we must vigorously defend the importance of social investment to the overall future of a country so that the social sectors do not carry disporportionate cut-backs, as too often has been the case. I have recently visited a country which has reduced its health expenditure by 90 per cent in the past 2 years. In view of this, we welcomed with enthusiasm the remarks of Jacques de Larosière, the recently-retired Managing Director of the IMF - who, in his address to the United Nations Economic and Social Council (ECOSOC) in Geneva last summer, stated:

> "Adjustment that pays attention to the health, nutritional and educational requirements of the most vulnerable groups is going to protect the human condition better than adjustment that ignores them. This means, in turn, that the authorities have to be concerned not only with whether they close the fiscal deficit but also with how they do so."

The challenge now is to convert a growing rhetorical consensus with Jacques de Larosière's statement into actual practice. Second, and of equal if not greater importance - for those of us gathered here - because the power to act lies substantially with those of us in the health and other social sectors is that the social sectors themselves must produce internal restructuring to put priorities on those programmes which result in the most benefit to the most vulnerable.

The opportunity for a re-ordering of priorities within the health sector is perhaps best illustrated by a statement made by Dr. Mahbub-ul-Haq, then Pakistani Minister for Finance, Planning and Economic Affairs 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."

The challenge now lies in moving from a consensus on principles for better adjustment practices to concrete actions. The adjustment process must be broadened so as to include a minimum floor for basic human needs; the health, education and social sectors must be restructured so as to meet these needs; and, in the broader scope, the economy must be restructured so as to emphasize employment policies and action which provide both increased output and more income for the disadvantaged.

Our host country offers another noteworthy example of putting these principles into action. Indonesia is undergoing a process of restructuring

the health sector in order to accomplish a broader impact on the health and well being of the populace in return for limited resources. Despite falling oil prices which caused severe financial constraints resulting in cut-backs to the overall health budget, President Soeharto announced in November 1986 in Jogjakarta the sharp acceleration of the expanded programme on immunization and of the village-level "posyandus" system. This has 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 associations and local village groups) to support self-help preventative health measures that integrate family planning methods, prenatal care, oral rehydration therapy, immunization and growth monitoring.

In 1986, there were 133,786 posyandus in 40,435 out of a total of more than 68,000 villages in Indonesia. By March 1988, the number will be increased to nearly 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 centers will cover about 10 million mothers and 20 million children younger than 5 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 if any direct additional cost to the government.

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 per cent 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 42.4 per cent to 71.6 per cent.

The challenge for Parliamentarians

As Members of Parliament and colleagues in this Symposium, you have a role to play in assuring that the opportunities presented by the CSDR are not lost at this crucial and promising moment for the ASEAN countries, but rather that the life-saving potential of this "revolution" are fully realized in each of your countries.

What can you do? What role is there for the Parliaments of South East Asia in advancing these techniques? And for Parliamentarians as key leaders in their countries and home districts?

Most specifically, in the conclusions you draw from this symposium, consolidate a firm plan of action that is committed to the goals of the CSDR. ASEAN has a proven capacity to take action that is effective regionally and supportive at the country level, but this is a "first" in the field of child health and survival. Achieving universal coverage of essential services for children by 1990 is a goal already encompassed within ASEAN's larger ambitions. It is time to highlight that goal.

As this distinguished gathering shares the expertise available from one another's company, as well as the potential for coordination and cooperation, I urge you to develop a tangible plan of action that you can bring back to your respective countries. I urge you to devise action goals that are "doable" at national and subnational levels, and that are appropriate to any country in the region as is the case with the goal of universal child immunization by 1990.

This symposium is an opportunity to exchange ideas and come up with a pragmatic plan for action.

Fortunately, parliamentarians from other regions are likewise taking a leading role in this initiative, and we have the opportunity to learn from the pioneering work of others. For example, parliamentarians from the seven countries making up the South Asian Association for Regional Cooperation (SAARC) drew up 10 pledges for action, committing themselves to a number of priority action points that Parliamentarians can use to advocate the ethic of children first as a national priority and to promote the protection of children's interests, such as immunization, in their countries. I commend their action plan to you as an inspiration - the recommendations they singled out offered an exemplary and quite feasible plan. Similarly, the French-Speaking African countries drew up an action plan outlining six concrete recommendations they would urge Parliamentarians to take at national levels in their respective countries. These included increased demographic analysis of the situation of women and children, national level mobilization, and incorporation into the corporate planning process of integrated services on behalf of women and children. But these measures can only come alive if parliamentarians take them home and bring them to life through their own leadership and active participation.

Legislatively, as Members of Parliaments, you can propose the adoption of National Health Policies for Children in your countries. Such policies, of course, should provide for the promotion of these simple low cost techniques and their incorporation within your formal health and education systems.

As leaders of your own communities, you can publicly demonstrate your confidence in ORT and growth charts by distributing sample packets and charts to health centres, community groups, teachers, and constituents in your districts. You can urge the media to encourage their use, and insist that health workers understand them, use them, and help promote them. You can encourage other community leaders to join you in immunizing children with oral polio vaccine. You can encourage local analysis of the impact on your communities of preventable causes of serious illness such as polio, measles and diarrhoea.

Legislatively, as well, you can protect the practice of breastfeeding which is so essential not only for better health and major cost savings, but also for spacing births. WHO and UNICEF jointly engaged in intensive discussions with the international medical community, industry, governments and NGOs, over a several year period, resulting in the 1981 adoption by the World Health Assembly of the "International Code on Marketing of Breastmilk Substitutes" as a model to governments of the marketing standards they ought

to allow in their own countries and of means to promote breastfeeding. It is extremely important that national codes be enacted in every country to control the abuses of breastmilk substitute promotion where those abuses have already caused terrible damage in terms of children's lives and children's deaths, and to prevent the occurance of such abuses in other countries.

As participants in this and other fora, you can express yourselves regionally and provide for coordinated regional action. I have previously met with Parliamentarian associations in South Asia, Latin America, and Africa, as well as with the League of Red Cross Societies, the International Pediatric Association, and others. Each of those bodies has resolved in support of accelerating child survival and development and several are planning programmes of action to pursue it. I urge this Symposium to do the same. The ASEAN countries have made exemplary progress, yet much remains to be done. At this vital juncture it is you who must assume the leadership in these efforts. And I hope that you will seek the support of your colleague legislators - the members of state assemblies and other bodies throughout your countries.

Children's advocates

As Parliamentarians, you are in a unique position. In your role as legislators, you and your Governments establish the national policies and priorities which are the framework of action affecting children and their families. In your role as representatives, you have an intimate awareness of the real needs of your constituents, and can work with them in your districts in assuring their opportunities for expressing those needs and taking the many self-help measures available in most communities, particularly with a modicum of governmental assistance. You also know the capacities and limitations of the government to respond to those needs. In a very real sense, you are an essential link between people and policy-makers - between need and fulfillment.

It is you - the Parliamentarians of South East Asia - to whom we turn for partnership in ensuring that children have their chance.