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Address by Mr. James P. Grant
Executive Director of the United Nations Children's Fund (UNICEF)
to the
Thirty-seventh session of the World Health Organization (WHO)
Regional Committee for Africa

Bamako
9 September 1987

"Toward Maternal and Child Health Care for All:
A Bamako Initiative"

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Your Excellency, Mr. President,
Madame Chairman,
Dr. Mahler and Dr. Monekosso,
distinguished delegates, your excellencies, colleagues and friends:

I am greatly honoured to speak to you here in Bamako. In this room is gathered a group uniquely capable of affecting the health and well-being of the people of Africa. You include the great majority of the Ministers of Health of this continent. In addition, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) have been valued colleagues in sharing the struggles of Africa. Together our institutions and our staff have pioneered, suffered setbacks, and shared satisfactions over the successes of African governments with which we have cooperated. Now we meet at a crucial moment for this continent. Africa faces great promise and progress on one hand, but on the other, economic hardships of unprecedented proportion.

A significant measure of the progress on this continent during the past quarter century, during which the great majority of Africans have enjoyed national self-rule, is the reality of improved child well-being. Child death rates have dropped by some 40 per cent since the early 1950s, when one child out of every three died before reaching age 5 and many others were crippled for life from a wide variety of causes. Basic literacy and education rates have soared relative to the 1950s. Millions of Africans have acquired highly developed skills.

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More recent developments, however, have been devastating for the countries of Sub-Saharan Africa. Per capita food production has fallen 5 per cent in the 1980s, for example. We are all aware of the impact of drought in so many countries, and while we are thankful that there has been some brief respite, it appears that drought conditions may be returning to several countries. Furthermore, it is clear that the crisis has already left many long-lasting scars.

Global economic difficulties of the 1980s have impacted most heavily on Africa, and the effects have been disastrous. Average incomes fell by 15 per cent between 1980 and 1985. The economic downturn of the past year and a half has been even more serious. In 1986, Africa's earnings from exports fell US$19 billion. The net transfer of resources leaving Africa is now greater than the inflow, with the difference measured in billions of US dollars. Even countries long cited as exemplary economic models have had to default this year on their debt payment schedules.

Many are indeed working toward improvements in this respect, as we saw at the Special Session of the General Assembly on Africa in May of 1986 - an historically unprecedented gathering. At that meeting, African governments pledged to implement national reforms. A report of the Secretary-General to be released next week will document the impressive extent to which many African governments have followed through on those pledges - as was clear from the statements made at the recent OAU meeting in Addis Ababa. The tragedy is, however, that in spite of these efforts, international donor support has been limited in fulfilling its side of agreements.

The African continent has been troubled further, along with the rest of the world, by the advent of AIDS - the impact of which is just beginning to be felt.

The Southern part of the continent has been plunged into a noxious interaction of economic issues closely linked to the disruption brought by armed conflict and, in some cases, active efforts to economically destabilize populations. The impact of this on children has been thoroughly devastating. According to a UNICEF report, "Children on the Front Line", issued last January, those southern African countries most actively affected by destabilization efforts suffered markedly disproportionate infant mortality rates and levels of malnutrition. 140,000 children died in Angola and Mozambique alone in 1986 as a consequence of these destabilizing actions.

One of the most disturbing aspects of the continent's complex crisis - exacerbated but not created by the recent drought - is that, by the end of the century, although the African population will be only about 14 per cent of the world total, demographers project that on trend lines calculated even before the AIDS crisis emerged, that Africa will account for over 40 per cent of all infant and child deaths worldwide, up from 15 per cent in 1950 and 31 per cent in 1986. Africa is the only continent in the world where the absolute number of deaths is increasing - from an estimated 3.8 million under-five deaths in 1950 to 4 million in 1970 and 4.3 million in 1980.

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Must we accept that these grim projections describe the future of this noble continent, the birthplace of mankind?

We all hope that the global economic and political climate will change. Prudence requires, however, that we who are concerned with the health of children and their mothers must assume that the climate will remain very difficult indeed.

What can be done under these circumstances? Given what we have, what is possible? Can we responsibly hope to achieve the year 1990 goals of universal immunization and virtually universal access to ORT? Can we hope to achieve the even more difficult goals for the year 2000 of reducing infant mortality in all countries to 50 or 60 per 1,000 births? I will discuss today several critical issues which, properly handled, would result in the nearly impossible becoming possible.

Adjustment with a human face

In spite of obvious conflicts of interest between creditor and debtor countries, and between those making most of the economic and political decisions and those suffering the consequences, there is some space for improving the outcome in terms of human welfare. Indeed, there is more room for manoeuvre than may often be realized, and which concerned governments and international agencies could use constructively, if they choose.

The cut-backs and economic 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 to President Nyerere 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, in many countries throughout the world, to let children die. As a consequence, many are dying each day in the mid-1980s.

Recent experience - documented in UNICEF's just-published major study entitled "Adjustment With a Human Face" - shows 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 disproportionate cut-backs, as too often has been the case. 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 higher priorities on those programmes which result in the most benefit to the most vulnerable.

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Parenthetically, I should note that even in the context of warfare, which so tragically affects thousands of children and women on the continent, the concern of African parents and African governments for these most vulnerable groups in distress is apparent. Just as, in Nigeria some years ago, UNICEF helped save children on both sides of the conflict, so too, in 1985 at the height of the Ugandan conflict, did UNICEF respond to the needs of Ugandan children through a "corridor of peace" bridging the fighting lines. Both warring parties allowed UNICEF and the ICRC to provide immunization, drugs and medical supplies for children and mothers in the war zones, so that they would not fall victim to the conflict from the lack of health services. The will to do the impossible is there! It can be done.

PHC - more urgently needed and more feasible than ever

A guidepost in discerning what can be done in restructuring the health sector to alleviate human suffering despite constrained resources is found in the principles underlying Primary Health Care (PHC). Yet today, almost a decade after the milestone codification of these principles at the Alma Ata conference co-sponsored by WHO and UNICEF, and further, after ample proof of their valididity, we are still paying too much lip service to this far-sighted approach. In most countries, the overwhelming majority of health expenditures remain on curative rather than preventative measures, and on major urban facilities rather than village and community health posts capable of serving the majority.

A true implementation of PHC is far more possible today than even a decade ago, however. A major factor which has had a profound impact since Alma Ata on the direction of this work is the realization that economic and technical developments of recent years have vastly increased the capacity to communicate. There is today a rapid and continuing increase in the ability to communicate with the world's poor - through radio, press, TV, schools in every village, thousands of new farmers', women's, and business associations, and so forth - and a whole new perception in the international community of what can be done with programme communication as a powerful tool for, in the words of one of the eight points of the Alma Ata Declaration, "...education of the public concerning prevailing health problems and methods of preventing and controlling them".

This new capacity gives us the potential to take newly developed, improved or rediscovered low-cost/high-impact medical techniques and knowledge readily at our disposal and accelerate the application of PHC principles. UNICEF has called this approach the potential for a Child Survival and Development Revolution (CSDR) which can also serve as a leading edge for advancing PHC generally. The actual medical techniques are, of course, familiar to you, and include immunization against six child-killing diseases, Oral Rehydration Therapy, a return to the practice of breastfeeding with proper weaning, growth monitoring, and family spacing. Combining the new capacity to communicate with these techniques and technologies has allowed the mid-1980s to see in many countries a very sharp expansion of the immunization and ORT programmes in particular.

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I would like to mention that we are extremely enthusiastic about a nearly completed joint WHO/UNICEF publication, to be released in 1988 in celebration of the Alma Ata Declaration anniversary, entitled "Facts for Life". This book arranges basic health knowledge relevant for families, including that mentioned earlier, into ten "information packets" which, if known by all families and if their use of it is facilitated by governmental and societal support, could vastly improve the health and physical and mental growth of young children while reducing by more than half the present toll of approximately 4 million child deaths each year.

The ability of the African countries to make progress in the survival and development of their children through dramatically accelerating their expanded programmes for immunization despite extremely constrained resources has demonstrated truly quite brilliant utilizations of extremely limited resources. Indeed, congratulations are in order for this group of African Ministers of Health. It was you who declared 1986 the "Year of Immunization" during the Lusaka Conference in 1985 and encouraged external donors, including most notably the Italian Government, to respond. In the early 1980s, of the four million children born each year, more than one million were dying, and a comparable number were being crippled for life, because they were not immunized against six diseases at a cost of some US$5-15 per child. Today, Africa is clearly committed to preventing this tragic waste through achieving the goal, which you set, of Universal Child Immunization by 1990 - ensuring coverage of at least 75 per cent of Africa's under-ones.

Between 1984 and 1987, more than 40 African countries have sharply accelerated immunization programmes.

Mauritius and Seychelles had achieved the UCI goal by 1986. Among those countries which are currently seized with accelerated immunization programmes and which stand a good chance of achieving your UCI goal in 1987 are Botswana, the Cameroons, the Congo, Côte d'Ivoire, Lesotho, Morocco and Senegal. Others, such as Tanzania, and Zambia, should achieve the UCI goal in 1988. I have been privileged to personally observe and participate with heads of government and ministers of health in such accelerated efforts involving national social mobilizations in many of your countries, including the Cameroons, Chad, Ethiopia, Gambia, Mozambique, Nigeria and Senegal. These are truly remarkable accomplishments, and the efforts shine as a beacon of hope wherever children continue to lose their lives to immunizable diseases.

It is important to note the encouraging global response through external funding to these African life-saving initiatives. UNICEF has effectively programmed for 1986-1990 more than US$180 million for support of UCI in Africa, of which US$160 million is already committed from generous international sources. The global community is heartened by the Italians' strong faith in your Expanded Programme on Immunization (EPI) in Africa, evidenced in commitments of more than US$100 million. Extremely generous contributions have also been made by others, including notably Canada, the United States, and Rotary International (which has already committed US$10 million). Another example of international cooperation has been the WHO/UNICEF Technical Coordinating Committee for Africa on immunization.

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Expanding social mobilization

The successful progress of African countries toward meeting the UCI goal set two years ago by the African Ministers of Health - you in this room - has been truly inspiring. Already, as a consequence of these accelerated efforts toward UCI 1990, hundreds of thousands of children have been saved from deaths and from lives of crippling disablement from these six diseases. This success challenges us to ask what other major advancements are already within the reach of the African peoples, even given the severe conditions which grip the continent today.

Clearly there are other major applications of this concept of educating and mobilizing all for health - illustrated in accelerating EPI programmes - where health ministers have so successfully mobilized others to promote their work: heads of state, radio, TV, press, artists and intellectuals, priests and imams, traditional leaders, ministers of education and information and non-governmental organizations - as in combatting and reducing diarrhoea, in promoting weight monitoring and better weaning practices, etc. Low-cost technologies and knowledge do now exist to achieve the U.N. goals for the year 2000 of an infant mortality rate of 50 or less for all countries - if only societies will give sufficiently high priority to communicating this knowledge to families and to facilitating this use.

Another major relevant advance for the children and the future of Africa, therefore, was made at the O.A.U. Summit meeting in Addis Ababa at the end of July, when the Heads of Government (including notably the President of Mali who is with us today) passed the "Resolution on Universal Child Immunization in Africa: Objective 1990, as a Component for the Protection, Survival and Development of the African Child". This landmark resolution not only declares 1988 as the Year for the Protection, Survival and Development of the African Child, using immunization as a vehicle for achieving other wider goals, but it also calls on Member States to actively play a role in mobilizing communities with a view to creating more awareness of the need for resources aimed at achieving the goals of Child Survival and Development in general, and in particular the 1990 UCI target. The resolution further urges Member States to ensure that issues relating to Child Survival and Development remain at the forefront at all national, subregional, regional and continental fora. Furthermore, it requests the UNICEF Executive Director to facilitate the implementation of the resolution through the mobilization of necessary resources and communities to complement national efforts. Mr. Chairman, UNICEF accepts as a directive this farsighted request, and we will do all in our power to redirect our efforts toward these ends.

Cost recovery and essential drugs for all

Two of the principal remaining obstacles to achieving the year 2000 goal of Health for All even when priority is given to prevention, to low-cost technologies, and to national social mobilization of all for health, involve finance, particularly during these times of continuing economic difficulty. The first is how to secure adequate amounts of essential drugs, including

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vaccines, which need to be imported. The second is how to finance locally most of the costs for the health posts and health workers.

Considering these two problems together, some of us have a vision - a dream - of what is possible - of a bold next step toward improving the health and well-being of people throughout Africa - and I invite you to tell me whether this vision should fade, or if it should be actively explored and developed.

What is this dream? What is this vision? Imagine an expanded PHC system throughout Africa within five years, which would meet the essential drug needs of the great majority - e.g., of more than 80 per cent - and which would be largely locally financed and managed. Before we succumb to an old frame of mind which dismisses such a goal as ever-elusive, I would like to admit that as recently as 1983, even we in UNICEF, with all of our optimism, found it difficult to imagine that UCI would be do-able in Africa by 1990.

We (and I think I can include all of us in this room) are discovering that there is a key to making PHC centres work effectively, that there is one element which, when available on a dependable and affordable basis, draws families to the centres, and for which the great majority of families are actually willing and able to pay.

The component of PHC which may prove most capable of filling this catalytic role is the provision of essential drugs for all.

We are learning through more imaginative programming of essential drugs in such places as Tanzania, Kenya, and Benin not only that supplies can be provided at extremely low cost, but we are also learning, in Benin for example, that the return for the expenditure can be far greater than the provision of medicines alone - which is no minor return in itself.

In fact, the cost of providing essential drugs is usually less than many people realize and far, far less than most people already pay. In Tanzania, for example, UNICEF and WHO have for the last four years supported a programme providing a continuous supply of essential drugs for 20 million of the rural population at a cost that translates to approximately 50 US cents per person per year. This scheme is not only truly low-cost, it has been pioneering in other ways as well. Under this approach, a container truck of essential drug kits is provided to regional centres in the country each month, each kit containing 32 essential drugs matched to the needs of a typical Tanzanian rural health centre, as determined by district health personnel. The kits are delivered by the Ministry of Health to sub-centres within each region. It is then the community's responsibility to take each kit the final 5 to 20 miles to the individual health care centres. This responsibility not only establishes a measure of community contribution to transport but also involves the community as a watchdog to guard against pilfering or black-market sales. It is a measure of the success of the programme that, after four years, its approval knows no political boundary, it enjoys a virtual absence of any accusations of loss or fraud, and it is achieving at a modest cost its goal of providing the rural population with a continuous supply of essential drugs.

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UNICEF, like WHO, believes that models of essential drug provision on these lines (which also operate successfully in Kenya and Mozambique, for example), deserve to be reproduced more widely in many other countries in Africa.

An additional innovation which holds great promise is being successfully pioneered in, among other places, Benin. We know that the great majority of people are prepared and able to pay for their own drugs. This is evident wherever needed drugs are available. In Benin we are seeing that even if people pay two or three times what UNICEF pays for the drugs, quality-controlled supplies can still be provided on a dependable basis at rates which are very affordable for most. The difference of the mark-up is being used to strengthen the PHC system; it is paying the salaries of the village health workers and other local costs. Village and district management is central in this scheme. Guinea is already exploring a similar model, and Ethiopia and Burkina Faso are formulating plans to enact similar programmes.

In this vision for Africa - and as we are beginning to see in these pioneering programmes - when the local costs of the PHC system are financed in good part through the people's purchase of these essential drugs, that system provides many more health care services (particularly for maternal and child health) than merely the distribution of drugs. And when families become accustomed to using a centre regularly because they know it is a good source for medicine, soon they use it for other purposes as well. While people might not be lured in for instruction in basic sanitation practices, for example, they do come for essential drugs when they are needed - and they are willing to pay for them - especially if the supply is appropriate to local health problems, affordable and dependable. Once that fee contributes to the salary of the health care worker and finances maintenance of the centre, and once people are using the facility and listening to the health care worker, then they will be much more likely to join in efforts to immunize their children, to learn about the benefits of pre-natal care, family spacing, ORT, and monitoring the growth of their children, and to find out about prevailing health problems and the methods of preventing and controlling them.

The essential drugs programme also gives the country a chance and base to revamp treatment schedules, train health personnel, embark on a national programme on use and misuse of drugs as well as centralizing local production.

A problem still exists, of course, with regard to foreign exchange, since people using these services have only local currency available. This is where I see the potential for a major new foreign aid support programme for PHC, analagous to that successfully achieved for UCI 1990. An initial 5-year programme rising to US$100 million yearly to complement foreign exchange allocations by African governments should be sufficient to provide not only the essential drugs for most of those currently unreached, but through their sale to the participants in primary health care, would provide a major thrust toward achieving local financing for a PHC system that could encompass virtually all of Sub-Saharan Africa during the 1990s. External assistance for essential drug supply could be provided through provision of financial support and through drugs in-kind.

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The prospects for sustained world-wide public support would be greatly enhanced if participation in this internationally supported programme was based: first, on agreed programmes, as with the country programmes for UCI/1990, which provide assurance of meeting the essential drug needs of the great majority - including particularly the children and mothers who are the most vulnerable - by a not-too-distant foreseeable date of perhaps 5 years; and, second, on using the surplus resulting from the sale of these drugs on a marked-up basis (except for vaccines and the small minority of recipients completely unable to pay for essential drugs) to greatly strengthen local financing and management of PHC, at the village and district level. The cost recovery received at the national level would then be used either for further reimbursable procurement or, where the essential drugs are financed through external assistance, to support promotion of primary health care through the Ministry of Health, Ministry of Education and other appropriate channels.

Your Excellencies, the Health Minsters of Africa, I ask you: is this a dream which should fade rapidly with the advent of the reality of daybreak, or should we seriously explore it further together? Is it an appropriate follow-up to the decision at the OAU summit in July?

Should a group of countries choose to take advantage of this new possibility to ensure the provision of essential drugs to the great majority of their populace while simultaneously enhancing local finance and district management of PHC, I pledge here that UNICEF is ready to work with those governments, in conjuction with WHO, to actively explore both the establishment of comprehensive essential drug programmes, and methods for overcoming financial, political, and logistical barriers. We would actively assist in bringing this issue to the international donor community to enlist their necessary support.

Africa's success in making significant progress toward achieving the UCI goal proves to a skeptical world that the African health community can accomplish the seemingly impossible when it works together.

A new initiative on essential drugs along the lines I have just described has the potential to fill a number of missing elements of the PHC system. Perhaps most noteworthy among these, it could attract the external finances necessary during the next 5 to 15 financially difficult years which lie ahead, particularly for the least developed countries, to secure adequate amounts of essential drugs, including vaccines, and to initiate the local financing of a PHC system responsive to the needs of the vast majority.

A locally self-supporting PHC system for all of Africa by the year 2000 - with children immunized, parents empowered with knowledge to promote and protect the health of their children, and essential drugs for all - may seem impossible. But in our vision it is not. African countries, with a modest increase of effective international support by the year 2000, can so improve the health of African children and women as to reduce by half the level of more than 4 million child deaths and 100 thousand maternal deaths which was suffered annually in the early 1980s. We are learning throughout the world,

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including in the United States as evidenced by the [attached] editorial in this past Sunday's New York Times, that there are no more important and no more cost effective investments than in such programmes for mothers and children. We see the dependable and affordable provision of essential drugs, and particularly those most relevant for women and children, as a key to such a formidable accomplishment. We therefore pledge UNICEF's fullest support in helping to explore and develop such a programme.