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Address by Mr. James P. Grant
Executive Director of the United Nations Children's Fund (UNICEF)
to the
International Conference on "Better Health for
Women and Children through Family Planning"

Nairobi
5 October 1987

"Few Deaths/Fewer Births: A Virtuous Circle"

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I join in the greetings as we open this important Conference in Nairobi.

As we begin the vital process of sharing ideas and formulating plans of action at this impressive gathering, I would like to take the opportunity of these few moments with you to highlight two main aspects of the relationship between better health for women and children and family planning.

First, I add my voice to those at this conference who so capably portray and document the growing awareness that *birth spacing is one of the most powerful ways of improving the health of children and their mothers, noting also that when family planning is effectively included with other low-cost measures to improve the health of children and mothers, a survival revolution can be expected in most developing countries.* The global effort to inform and enable families to practice family planning, waged under the accomplished leadership of the United Nations Fund for Population Activities, the World Health Organization, and others represented here, has made a major contribution—including the significant improvement to the health and well-being of mothers and children attributable to this effort; it parallels and enhances other child survival and Primary Health Care activities.

It is now clear, for example, that if parents worldwide knew the importance of timing births and had access to, and used—as a part of a primary health care system—effective methods of family planning to avoid births that are too early or too late, too close or too many, up to a third of all infant deaths in the world—and approximately 200,000 deaths of mothers in childbirth—could be prevented through these measures alone. Furthermore, in the process, the prospects for a healthy life would greatly increase for those who survive—both mothers and children.

A principal problem is, as we are all aware, that the gap between modern medical knowledge, such as

family planning techniques, and its actual use in the community by those persons for whom it will make the vital difference, has historically been a formidable chasm. As we meet here in Nairobi in the 1980s, however, among the tools at our disposal for solving the human dilemmas addressed by this conference, is an unprecedented potential to close that crucial gap. Our newfound ability to *communicate* with low income families through the mobilization of existing structures (radio, television, teachers and schools, farmers' associations, women's organizations, religious groups, non-governmental organizations, and so forth) has made it possible for the first time in history for national leadership with modest amounts of political will to reach and involve, on a broad scale, those who have traditionally been bypassed by many of the advantages of modern and relatively low-cost knowledge.

The convergence of this new capacity to communicate with recently developed or newly appreciated low-cost/high-impact medical technologies, have together created the unprecedented potential for a virtual revolution in child survival and development—that which we now call the Child Survival and Development Revolution (CSDR). Together, and if applied globally, these low-cost measures have the potential, before the end of this millenium, to *save the lives of more than 7 million children*—more than half of the 14 million under-fives—who are now dying each year.

The actual medical technologies are, I am sure, familiar to you. Besides family spacing they include: immunization against the six main child-killing diseases, oral rehydration therapy, a return to the widespread practice of breastfeeding with proper weaning, growth monitoring, female literacy, and food supplementation.

My *second* point is that at the heart of all of these low-cost programmes is the essential ingredient of *changing people's attitudes* and that success with these child health programmes which are dependent on family participation—such as immunization, control of diarrhoea diseases, and growth monitoring—will have a very significant impact on clarifying attitudes toward both the number of births *desired* and family planning. A common feature between specific family planning techniques and the full range of CSDR activities that makes widespread adoption of all of these measures possible is this truly revolutionary capacity to communicate, which gives rise to the equally powerful new potential for social mobilization, and an end result of both is the changing of attitudes and behaviour. Furthermore, in the same process wherein people become empowered with the knowledge of low-cost self-health measures capable of making a life-and-death difference for themselves and their families, they also gain access to the community and governmental support necessary to *use* that knowledge.

Indeed, it is the synergistic relationship between specific family planning programmes and other mother and child health measures, based on this shared attribute of changing people's attitudes, which opens the door to perhaps the most important element of the correlation between death and birth rates as it relates to the CSDR approach. It provides the key to the most often asked question about this CSDR: "won't it lead, of course, to even greater population growth?" The answer, paradoxical as it may seem at first glance, is 'no'. On the contrary, a sharp reduction in child deaths through this approach now can be expected to support and encourage other changes which will also lead to *less* population growth—to population stabilization at lower levels and earlier—than if historic patterns continued.

The links between death rates and birth rates are many and complex. But the bottom line is that there has never been a significant and sustained fall in birth rates which has not been preceded by a significant and sustained fall in child death rates, and today we see an acceleration of that pattern. As President of The Population Council, George Zeidenstein, stated at a conference in India last year:

"There is no example in contemporary societies

where fertility decline has preceded declines in infant and child mortality. Thus, among high mortality societies, an emphasis on infant and child survival should be an important element of population-related policies, as well as a goal to be pursued for its own sake."

Historically, when overall death rates make that first-stage steep fall from around 40 deaths per 1,000 as a result of governmental measures not requiring personal involvement of the families, such as eliminating famines, epidemics and reducing malaria—measures in which the families themselves were not particularly involved—the decline in birth rates follows a long way behind. The result is rapid population growth. Fortunately, history has also shown, in the era since World War II, that after overall death rates have fallen to around 12-15 per 1,000 people, then each further fall of one point in the death rate has usually been accompanied by the reverse, i.e. by an even larger fall in the birth rate than in the death rate. The linkage between falling child death rates and falling birth rates is particularly close when the fall in the death rate has been as a result of family involvement in programmes such as the family planning and child survival measures we are discussing today, which require the deep personal involvement of families on a mass basis to succeed and which increase the confidence in millions of families that they can protect the survival of their own children, and which in turn give them the confidence and will to have better families through fewer births.

The U.S. Academy of Sciences published a similar conclusion, stating:

"Policies and programmes aimed at reducing infant and child mortality considerably below present levels may be an essential underpinning of government programmes for fertility control ... as death rates are brought below 10-15 per thousand in present high-fertility, high-mortality countries, birth rates should be correspondingly reduced."

The acceleration in fertility decline that accompanies mortality reductions achieved through methods of strong family involvement is quite understandable. When parents become more confident that their children will survive, for instance, it is logical that they tend to have only the number of children they actually want, rather than compensating for likely deaths by extra births, and this is exactly what occurs. Furthermore, the parents of a child who dies in infancy tend to have another child sooner than they would otherwise have done—again increasing the birth rate. This point is substantiated in the background paper prepared for this conference by Cynthia Lloyd, "The Effects of Improved Child Survival on Family Planning Practice and Fertility".

This consistency between child death and birth rates which occur under the circumstance of direct family involvement, deliver to those of us concerned with family planning and maternal and child health, a major challenge—for there is no point in this birth-rate/death-rate circle at which we can sit back and simply expect good results to follow: we must actively encourage these low-cost/high-impact practices which we know to be effective. Knowledge and use of birth spacing requires active policies and participation by the government and the populace, and once adopted, the practice is an effective way of reducing the number of births as well as deaths. Similarly, *empowering women*—for example, through literacy or informal education programmes—will help to both lower death rates and lower birth rates. And perhaps the greatest example is *breast-feeding*—one of the most effective low-cost ways of increasing the survival chances of infants in poor communities, it is at the same time one of the most effective contraceptives in the developing world. Breastfeeding, although not totally dependable from an individual mother's point of view, still prevents more conceptions in developing countries than family planning programmes.

A major aspect of the synergistic return on the interrelatedness of family planning practices and more specific maternal and child health programmes

can be concretely illustrated in Indonesia. The initial impetus behind the very creative village-based maternal and child health care, or "posyandu", system was the desire to enhance family planning. It soon became evident that the inducements of highly desirable health services, such as growth monitoring, oral rehydration and food supplementations, sustained and moved forward the family planning initiatives. Today the principal accelerating factor in the proliferation of posyandus—from 115,000 in late 1986 to some 200,000 expected in early 1988—is the political decision to accelerate the provision of child survival services, notably immunization, and these in turn are vastly bolstering the availability and actual usage of pre-natal and family planning services. This same virtuous circle is evidenced elsewhere in the developing world in the evolution of low-cost health services and supportive village hamlet retail outlets.

The allure of low-cost medical technologies capable of saving children's lives and greatly improving the health of women and children draws widespread public support—and families—toward using programmes. The empowering of mothers with today's knowledge about ways and means of improving their children's health can generate the confidence—the feeling of having control over their own lives—which is at the heart of the population and fertility questions, and it is behind the acceptance of family planning. In this sense life-saving techniques involving parental action—such as oral rehydration therapy and ensuring a full course of immunizations—can be linked directly to attitudes more conducive to smaller families.

This was expressed 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, when she stated:

"Parents are more likely to restrict their families if they have reasonable assurance of the healthy survival of their two children. The prevention and cure of childhood disease thus acquires special importance: nutrition and immunization need special attention. Diarrhoea (the biggest single killer of children) is easily cured."

The effect is to create a sense of empowerment in which parents *want* to have fewer children, *and* have the means to accomplish this. It is when this changing of attitudes converges with the knowledge and availability of the means for fulfillment, that the very sharp drops in birth rates accompany improving mortality rates.

In conclusion, allow me to draw attention to the dramatic evidence of those countries which can be said to have already brought about a "child survival revolution" while still at low levels of income. Countries such as Sri Lanka, China, Costa Rica, the Republic of Korea, and Thailand, for example, reduced child deaths to historically unprecedented rates for countries while at such low levels of per capita income. Their achievements contributed to the start of a significant downturn in birth rates in the 1960s which has been further accelerated by effective national family planning programmes. It is noteworthy that if all developing countries were to achieve the same child death rates and the same birth rates as the average for these five countries, then there would have been 9 million fewer deaths in the world last year—and nearly 22 million fewer births.

The unique gathering of this formidable group in Nairobi is an auspicious event. We are faced with enormously challenging and urgent problems—with greater capacity to effect solutions than has ever existed in history—and with an excellent start already underway. The rapidly growing use of child survival measures in the 1980s has already improved the health and nutrition of hundreds of millions of children, brought greater well-being and happiness to scores of millions of families, and, *in the past year alone*, saved the lives of more than 2 million. These benefits could be doubled over the next three years. Let us seize the opportunity to further accelerate our efforts in tackling the problems together—greater than the sum of our parts—for the mothers and children—and for the future—of the world.