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Address by Mr. James P. Grant
Executive Director of the United Nations Children's Fund (UNICEF)
to the
Kerolinska Institute Nobel Conference on
Health Research for Development

Stockholm, Sweden
22 February 1990

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Детский Фонд Организации Объединенных Наций 联合国儿童基金会 منظمة الأمم المتحدة للطفولة

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I am very pleased to join with you in Stockholm this week and to respond to the important and most timely report of the Commission on Health Research for Development which was released this morning.

We at UNICEF agree with the essential elements of the four principal recommendations of the report, and we welcome them wholeheartedly.

They could hardly appear at a more opportune moment, for several reasons. The United Nations is this year in the process of formulating a strategy for development in the 1990s, in which I expect and hope human goals will form a prominent part. We in UNICEF with our colleagues in WHO and UNFPA have already been engaged in sustained consultations with governments and others on specific goals for health, nutrition and other areas of action crucial to human well-being.

The Commission's recommendations also arrive during preparations for the historically unprecedented World Summit for Children, which will mark not only the first time that global leaders will gather to discuss only issues related to children, but also the first-ever summit of heads of state or government from North, South, East and West. The meeting, scheduled to take place in New York on September 29-30, will offer a most unique opportunity to bring health/development issues to the attention of world leaders, and to elicit a response-for-action from them.

This report also comes just as countries are involved in procedures to ratify the Convention on the Rights of the Child, which was just adopted by the United Nations General Assembly in November. The Convention codifies the principle that it is not just a good idea to make the benefits of health science available to all children. Children - <u>all</u> children - have a <u>right</u> to health services. And the rights of children, of course, translate into obligations by families and society. The Convention will come into force for

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ratifying countries as soon as 20 nations have taken the step - and there is strong hope that that will happen by the time of the Summit, the last two days of September.

This report also comes at a time when the worldwide shift to greater use of market economy mechanisms is putting many established health delivery systems and programmes into crisis. Thus, the shift in China in the early 1980s from commune-supported primary health systems to fee-for-service put the health for the poor into turmoil from which it is only now recovering with new and modified delivery systems. This greater use of the market economy is being felt most strongly in the Marxist countries and the debt crisis countries of Latin America and Africa, but also to some degree in industrial countries such as the United States.

Finally, a brief reference to its timeliness with respect to the accelerating East-West detente which offers the prospect of a major "peace dividend" on the scale of hundreds of millions of dollars by the mid 1990s. Developing countries alone are currently spending $400 million a day for military purposes.

Delivery systems - bridge between knowledge and use

The need for the recommendations in the report is great - particularly for its early, but not fully developed, emphasis on applied systems research. The devastating consequences of the lag between readily available health knowledge and its effective use by those who need it was well illustrated by WHO Director-General Dr. Nakajima, when he told a global meeting of health educators:

> "We must recognize that most of the world's major health problems and premature deaths are preventable through changes in human behavior and at low cost. We have the know-how and technology but they have to be transformed into effective action at the community level. Parents and families, properly supported, could save two-thirds of the 14 million children who die every year - if only they were properly informed and motivated. Immunization alone could save 3 million lives - and another 3 million deaths a year could be prevented by oral rehydration, a simple and cheap technology."

The Commission's findings also enter the field of influences capable of impacting global health just as we start the 1990s, a period during which, as far as children are concerned, we are probably on the verge of undertaking the greatest effort for child health ever initiated.

If current child death rates were to prevail, 150 million children would die in the 1990s, the majority of them from causes for which we have long-since discovered low-cost cures and preventions. Fortunately, we know that we are chipping away at the problems involved. If the improvement rates of the 1980s were to continue, we could expect to reduce the number of child deaths by some 20 to 25 million during this decade.

Goals highlight the need for applied systems research

However, the set of goals now being established by the WHO, UNICEF, and associated agencies (and I've attached a list of those goals to the distribution copy of these remarks) aims to more than double the rate of improvement in child health, so that by the year 2000, instead of 40,000 children dying each day, the toll will be down to less than 20,000 - meaning that the lives of some 50 million children will have been saved over the decade. By the turn of the century, we envision, for example, that the last case of polio will have been suffered...that few will have contracted neonatal tetanus for at least five years...that gurinea worm will be a thing of the past...and that measles will be on its way to eradication early in the 21st century.

These goals have undergone an extensive review process among health experts at country, regional and international levels, and broad agreement has been reached that, while ambitious, they are feasible. The scientific know-how is available to achieve all of the goals for children for the 1990s that appear on the list before you. Further global biomedical advances in fields related to the goals will of course be desireable. We would never find an adequate answer to the dilemmas presented by AIDS or malaria without further breakthroughs in medical science. But the basic medical knowledge to improve the health and save the lives of vast numbers of people at low-cost already exists. Perhaps even more urgent than further medical discoveries, important as they are, is the need to improve our delivery systems in order to make full and better use of what is already known, and to increase the motivation for supporting the lines of research that lead to that improvement. The use made of medical knowledge depends on social organization. We will not achieve these goals without significant advance on each of the four recommendations of this report, particularly with respect to essential national health research (ENHR) and greater exchange of experience between countries. Proponents of ENHR will miss a great opportunity if they cannot use the World Summit to stimulate mini summits on research in their own countries.

Health despite hardship

In the period between 1950 and 1980 a number of countries and regions with widely different economic and political systems - including Chile, China, Costa Rica, Kerala State in India, Sri Lanka and Taiwan - demonstrated that with sufficiently strong political will it was possible to achieve dramatically improved health despite low income circumstances. In most of these countries, the annual per capita income at the time was roughly US$100 in 1960 dollars, and US$10 to 15 was spent per capita per year on nutrition, education and health services. It was largely the experiences of these countries which laid the foundation for Alma Ata in 1978, where the principles of Primary Health Care were codified. At Alma Ata, the gap between existing low-cost health knowledge and its availability to those who need it was confronted directly. Community-level participation in health care and delivery were promoted, and it was declared that:

"The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries."

Far more systems research should be conducted within and by the countries which between 1950 and 1980 experienced success in improving health despite economic constraints. South-South networks should be better used so that others may learn from their lessons. The countries I have just named, however, all demonstrated an extraordinary level of political will in achieving their gains. It would be extremely difficult to replicate that level in most countries during the 1990's. There is a need for practical and routine procedures that are part of sustainable services and do not require special mobilization of political will on a long-term basis.

Making the do-able probable

Many times I have said that, in the field of child health, what is required to transform the unprecedented potential which exists today into reality is exactly that political will. If what we needed were the political will to climb a 400 foot hill, we could generate it easily. But if we needed to come up with the political will to climb Mt. Everest, we might not be able to. On this scale, the Chinas, Costa Ricas, Taiwans and Sri Lankas have scaled a sizeable mountain! By analogy, one of the roles of research is to demonstrate how major health advances can be made in a population without being dependent on the amount of political will of the countries mentioned. The strong political will in China and Cuba was a result of the basic services emphasis common to the early stages of dynamic Marxism. The political will in Taiwan and Chile was closely associated with the desire of these authoritarian regimes to pre-empt dissatisfaction among the poor that made the poor susceptible to external revolutionary ideologies. The special political will in Sri Lanka and Costa Rica resulted from highly competitive democratic processes that led political forces to vie for the votes of the poor.

The Commission makes the point that there are two kinds of health research - global and country specific. The greatest needs in global research are for simplification of procedures and reduction of costs, rather than for further development of high-technology and high-cost systems. For example, the development of oral rehydration salts (ORS) 22 years ago was the result of high quality scientific research that was used to simplify the answer to a major medical problem. Parents can now administer the life-saving solution at home for a few cents per bout of diarrhoea - a practice which can replace expensive hospital-bound intravenous treatment. However, because of the lack of appropriate country specific delivery systems, less than one per cent of mothers were using this great medical breakthrough in 1980 against the world's greatest single killer of children. Even today, 10 years later, well under half of parents are using this remedy. In the great effort toward Health for All, we need to make the task of improving health so readily do-able that it is seen as obscene not to do it.

Empowerment through self-health - everyone's issue

The economic difficulties of the early 1980s pressed all societies to search for still lower-cost means to maintain and improve health. It was against this background that in both industrialized and developing countries we have seen a much greater emphasis on empowering people to better care for themselves. Thus, for example, increasing the life expectancy of the average American male by a single year using curative measures such as high-technology medical advances, medicines, hospital facilities and so forth would require increased expenditures of many billions of dollars annually, according to estimates by the Center for Disease Control in Atlanta. Yet the life expectancy of that same man could be increased by some 10 years through four simple self-health measures that actually consume less and save money: by not smoking, eating less with a better diet, drinking alcohol in moderation, and getting adequate exercise. But a person has to first know what to do, based on social research and experience, and secondly, he or she must actually do it. Sometimes it requires considerable support to accomplish both: to develop and share the knowledge, and to provide the support to make it happen.

Closing the gap between available health knowledge and its use by those who need it is why we in UNICEF have placed such a strong emphasis on the revolutionary new capacity to communicate among all of the peoples of the world. At the heart of UNICEF's commitment to the child survival and development revolution (CSDR) has been, first, our awareness that greater amounts of grossly underutilized vital health knowledge exist; and second, our confidence that major new mechanisms also exist today through which that knowledge could be conveyed and the motivation to use it could be stirred. Developing those mechanisms requires research on behaviour within each country.

The next steps

Now that the Commission's report has been issued, we are faced with the critical question: How do we translate it into action? How do we get on with the kinds of research recommended in the Commission's report? What are the next steps?

The Commission rightly emphasizes the importance of global health research to make additional biomedical breakthroughs. This must continue, especially to simplify procedures and lower cost. We need to develop technologies and methods that can be used in health posts and at home rather than in sophisticated hospitals, e.g., the past development of oral rehydration therapy and the future development of a single heat-stable pill to replace the present multiple vaccinations required to immunize children fully against the six main child-killing diseases, along with the necessary cold chain and highly skilled personnel which that entails.

Most important, the Commission has rightly identified the lack of country specific health research, and especially delivery systems research, as being the main obstacle to action. There could, I believe, be no better group than that assembled in this room today to take the next step: to identify very effective means of doing such research. We need to identify not only what the

obstacles are, but what the mechanisms are for overcoming them. The Commission clearly identifies country specific research as the highest priority in international health research, but notes that there is very little being done now. There is minimal capacity or support for this research. There are few people with adequate expertise in health system research. Field laboratories and population-based study sites have received little attention or support, even though we have known since the Ting Hsien experiment in China in the 1930s that this is what is needed. These laboratories are required to adapt general principles to the local circumstances and cultural constraints in each area. Appropriately adopted practices must be built into the routines of health care - both in peripheral health services and in health habits and lifestyles in the home. Is it not time that every medical school and health training institute had a teaching district designed to improve the relevance of training - and similarly to help prioritize the concerns of the institute with feedback from the actual community and its health problems?

Essential national health research must be strengthened on two fronts. In some cases, of course, projects must be funded externally. It is also extremely important that the national capacity to do such research be built up, and that networks be established and strengthened among the various institutions.

The advent of the World Summit for Children signals perhaps the most important opportunity of our generation to harness political will for global health and development issues, as these issues do, of course, have a vital impact on children. What message might you/we at this gathering prioritize as the most important message to send to the World Summit for Children? Equally important, what message might we send to countries to help them seize the opportunity of the Summit to achieve a breakthrough in ENHR?

Next week The Task Force for Child Survival will meet in Bangkok for the Bellagio IV meeting. We anticipate that they will help define what kinds of research needs should be articulated at the Summit. What inputs might Bellagio IV receive from this gathering?

One way that I would like to see this report translated into action with respect to UNICEF is to have some members of the Commission, if they would, meet once more, and after careful analysis of UNICEF's present programme, make specific recommendations to UNICEF regarding how our own research might better incorporate the findings of your study. Perhaps we could collaborate with UNICEF's team which is working on national capacity building for child survival and development at the International Child Development Center in Florence. The meeting might be held in Florence, New York, or, probably best, in a developing country such as Bangladesh where UNICEF has a major programme of support.

Gathered in this room are many of our generation's leaders in the health field. People look to you, and rightfully so, for leadership and guidance in public health issues. Are you willing to use your status to strengthen the linkages between research- and action-oriented public health groups? A new dialogue, and a new fusion is needed between the two. Are you willing to lead the way?

Finally, what better forum than this to contemplate - and hopefully to act upon - a long overdue omission in the domain of international science. Is it not time that a Nobel prize were awarded in the field of health in addition to medical science? Brilliance in developing new science breakthroughs needs to be rewarded; but so does brilliance in putting available knowledge to use!

Our moment in history, posed at the threshold of a new century, is a vibrant moment in many arenas, and especially in the sciences. Never before has the scientific community been faced with the opportunity - and the challenge - to do so much, for so many, and for so little cost - both financially and politically. Surely this is true in the field of child health, where the low-cost/high-impact health knowledge and technologies to save millions of child lives annually have been identified, and efforts have begun to make them available to all people. But it is also true throughout the health field. Life-saving knowledge and technology exist; they are being refined and expanded, and they await the means for broad-scale application.

As I said to the Convocation of Nobel Laureates two years ago in Paris in relation to the miraculous advances in child health, surely the time has come to put the mass deaths of children from immunizable diseases - from diarrhoea and from other causes preventable at low-cost - alongside slavery, colonialism, racism and apartheid on the shelf reserved for those things which are simply no longer acceptable to humankind. Low-cost/high-impact advances exist throughout the health field, and from UNICEF's point of view there is now an obscene gap between medical knowledge and its application for those who most need to know. The time - and opportunity - have come to bridge that gap in the 1990s. What more worthy gift, I ask you, could we devise from the 20th to the 21st century?

It is you, we - the world's leaders in the health sciences - who must now assume a still greater leadership role in translating today's possibilities into solid health practices for everyone. The Commission's report makes an important contribution toward stronger leadership in this transformation toward healthier societies throughout the world - and we beneficiaries of it are deeply appreciative.

GOALS FOR CHILDREN AND DEVELOPMENT IN THE 1990s

The U.N. Convention on the Rights of the Child embodies the most comprehensive listing of goals for the well-being of children. Full implementation of the Convention is the ultimate objective of programmes for children and development. The following goals, derived through a process of extensive international consultation, are essential means to achieve that ultimate objective.

I. Major Goals for Child Survival, Development and Protection

- Between 1990 and the year 2000, reduction of infant and under-5 child mortality rate in all countries by one-third or to 50 and 70 per 1000 live births respectively, whichever is less.
- Between 1990 and the year 2000, reduction of maternal mortality rate by half.
- Between 1990 and the year 2000, reduction of severe and moderate malnutrition among under-5 children by half.
- Universal access to safe drinking water and to sanitary means of excreta disposal.
- By the year 2000, universal access to basic education and completion of primary education by at least 80% of primary school age children.
- Reduction of the adult illiteracy rate (the appropriate age group to be determined in each country) to at least half its 1990 level with emphasis on female literacy.
- Improved protection of children in especially difficult circumstances.

II. Supporting/Sectoral Goals

1. *Women's Health and Education*

- Special attention to the health and nutrition of the female child, and pregnant and lactating women.
- Access by all couples to information and services to prevent pregnancies which are too early, too closely spaced, too late or too many.
- Access by all pregnant women to prenatal care, trained attendants during child birth and referral facilities for high risk pregnancies and obstetric emergencies.
- Universal access to primary education with special emphasis for girls, and accelerated literacy programmes for women.

2. *Nutrition*

- Reduction in severe as well as moderate malnutrition among under-5 children by half of 1990 levels.
- Reduction of the rate of low birth weight (2.5 kg or less) to less than 10%.
- Reduction of iron deficiency anaemia in women by one-third of 1990 levels.
- Virtual elimination of iodine deficiency disorders.
- Virtual elimination of vitamin A deficiency and its consequences, including blindness.
- Empowerment of all women to exclusively breast-feed their child for four to six months and to continue breast-feeding with complementary food well into the second year.
- Growth promotion and its regular monitoring to be institutionalised in all countries by the end of the 1990s.
- Dissemination of knowledge and supporting services to increase food production to ensure household food security.

3. *Child Health*

- Global eradication of poliomyelitis by the year 2000.
- Elimination of neonatal tetanus by 1995.
- Reduction by 95 percent in measles deaths and reduction by 90 per cent of measles cases compared to pre-immunisation levels by 1995, as a major step to the global eradication of measles in the longer run.
- Maintenance of a high level of immunisation coverage (at least 85% of children under one year of age) against diphtheria, pertussis, tetanus, measles, poliomyelitis, tuberculosis and against tetanus for women of child bearing age.
- Reduction by 50 per cent in the deaths due to diarrhoea in children under the age of five years; and 25 per cent reduction in the diarrhoea incidence rate.
- Reduction by one-third in the deaths due to acute respiratory infections in children under five years.

4. *Water and Sanitation*

- Universal access to safe drinking water.
- Universal access to sanitary means of excreta disposal.
- Elimination of guinea-worm disease (dracunculiasis) by the year 2000.

5. *Basic Education*

- Expansion of early childhood development activities including appropriate low-cost family and community based interventions.
- Universal access to basic education, and achievement of primary education by at least 80 per cent of primary school age children through formal schooling or non-formal education of comparable learning standard, with emphasis on reducing the current disparities between boys and girls.
- Reduction of the adult illiteracy rate (the appropriate age group to be determined in each country) to at least half its 1990 level, with emphasis on female literacy.
- Increased acquisition by individuals and families of the knowledge, skills and values required for better living, made available through all educational channels, including the mass media, other forms of modern and traditional communication, and social action, with effectiveness measured in terms of behavioural change.

6. *Children in Difficult Circumstances*

- Provide improved protection of children in especially difficult circumstances and tackle the root causes leading to such situations.

ESTIMATED CHILD DEATHS AND LIVES SAVED

1990 - 2000