File Sub: CF/EXD/SP/1990-0037

Address by Mr. James P. Grant
Executive Director of the United Nations Children's Fund (UNICEF)
to the 59th Annual Meeting of the
American Academy of Paediatrics
upon receipt of the
E.H. Christopherson Lectureship Award on International Child Health

Boston, Massachusetts
9 October 1990

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I am honoured to address the American Academy of Paediatrics (AAP) as the recipient of the E.H. Christopherson Lectureship Award on International Child Health. Dr. Christopherson brought to his years as Executive Director of the American Academy of Paediatrics great insight into the international linkages in child health issues from his years of public health work in Brazil with the Office of Inter-American Affairs. It is a topic of timely concern today.

This 59th meeting of the AAP occurs at a time when we might well be experiencing a sea-change world-wide in the attention that is given to the needs and rights of children. Did we not see evidence of this at the global level nine days ago at the World Summit for Children, where 71 Heads of State and Government and representatives from another 60 countries, from North, South, East and West came together in the largest gathering of world leaders in history to take decisions on an agenda devoted solely to issues related to children? The Declaration and Plan of Action adopted by that World Summit of more than 130 countries received perhaps the broadest rhetorical concensus at the highest level of any agreement in history. Among the principles that received this rare endorsement was one that might be called children's right to "a first call" on the resources and concerns of society for the essentials of their survival, protection and development. The Plan of Action from the World Summit states:

> "There is no cause which merits a higher priority than the protection and development of children, on whom the survival, stability and advancement of all nations - and, indeed, of human civilization - depends."

A new voice is sounding out for children. Increasingly, everybody is agreeing...and it is becoming undeniable...that children are not receiving the priority they deserve. In this country we have seen major media turn to this issue in recent weeks. Two weeks ago "Time" magazine's international edition cover story on the plight of the world's children - 40,000 of whom die daily,

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two thirds from such readily preventable causes as lack of vaccination, diarrhoeal dehydration and inadequate breastfeeding - posed the question: "Does anyone care?" Last week "Time's" U. S. edition blast the confronting question across its cover: "Do we (Americans) care about our kids?"

Surely one would be quite right in saying that the level of health and medical care in this country for children who walk into paediatricians' offices is second to none in the world. Why is it, then, that the child mortality rating of this country has slipped to 26th in the world, with countries and areas such as Singapore, Hong Kong and Taiwan now doing better, in national average, than we? And why is it that countries as diverse as Sweden and Japan, whose child mortality rates were double those of the United States 4 decades ago, now have child mortality rates half those of the United States?

"Time" magazine's cover article stated that:

> "There will be no real progress, no genuine hope for America's children until the sense of urgency forces a reconsideration of values in every home, up to and including the White House.
>
> "When adults lament the absence of 'values', it is worth recalling that children are an honest conscience, the perfect mirror of a society's priorities and principles."

The new voice for children has sounded from other corners. One month ago today the "New York Times Magazine" ran a probing cover story by one of your long-time members - Prof. Berry Brazelton, well-known in this city and throughout the country as a paediatrician at the Harvard Medical School and Children's Hospital Center.

Among Dr. Brazelton's devastatingly honest observations was that, in this country, a family does not receive help in providing health care for its children unless they are willing to truly label themselves among the poorest of the poor. He states:

> "Only for the group of desperate families willing to label themselves hopeless - unwed, unemployed, homeless - do we have handouts, like Aid to Families with Dependent Children. To qualify for help, a family must first identify itself as a failure. The labels stick. Treated as such, people will feel and act like failures. Despite the huge amounts spent on welfare, the efforts are generally counterproductive, offering money without real support."

The article goes on to note that:

> "By 9 months of age, the babies who show signs that they expect to fail for the rest of their lives can be identified by various tests."

To those of us who are concerned with the health and well-being of children, the blaring prominence in the press of these dismal conditions is actually a most encouraging and welcome development. May we not be at the

beginning of a new era, when people can now be so frank? It forces the great question: where do we go next? What can be done about these disturbing conditions - globally and at home?

It is a sign of great hope that more and more people are asking these questions. People of this country, and indeed, people throughout the world look to you, as physicians to the children of the United States, for guidance and leadership in issues of child health and well-being. What do you reply, when people ask what can be done?

Given the opportunity that is opening up to us today through this new insistence on improving the health of the world's children, if an organization such as the AAP did not act, would that not diminish the role and status of paediatricians everywhere? People look to you as leaders on these issues. If you do not assume the mantle of leadership in finding and implementing solutions, who will step out front and seize the lead?

The young children whose lives are counted in the grim statistics of worsening conditions in this country are, by overwhelming majority, not those who visit you as patients. Similarly, the children who suffer so throughout the world - the 40,000 who die daily, the majority from preventable causes - are those who remain largely unreached by basic health services.

How do you help to extend the benefits of your knowledge and skills to children who are currently unreached, including those who live half-way around the world as well as those in America's growing deprived areas? How might you ensure that this knowledge is effective in reaching the millions and millions of children - in fact, the majority of the world's children - who will not only never walk into your office, but who will rarely if ever see the inside of any doctor's office or hospital?

The key to the next steps, I am convinced, are already before us. They lie in a now-classic source: the guiding principles behind primary health care, codified more than 10 years ago at Alma Ata. I can remember my own father, Dr. John B. Grant, discussing these principles more than a half of a century ago, and I believe that three of those principles could still make the critical difference today.

The first of those principles is that the use made of medical knowledge and techniques for health protection depends on social organization. A problem of the highest priority wherever children remain unreached by primary health care services is how to overtake the vast lag between existing knowledge and its use in the community setting. By the early 1980s the gap between readily available low-cost knowledge, such as immunization against measles, tetanus, and whooping cough; oral rehydration; the merits of breast feeding, and growth monitoring, and their widespread use had never been larger. Attempts to close that gap sparked the world-wide child survival revolution now in process, and they became the principal cause of the recent World Summit.

A second basic principle is that a vertical medical system cannot be truly effective, or even stand by itself, unless it is integrated in other activities in society in a concerted attack on problems of health, development

and social reconstruction. Health programmes must be synergistically integrated into other social services.

A third principle is that successful organization implies reliance upon economically practical strategies for serving the entire population rather than just the relatively well-off majority, and that this necessarily means, in low-income societies and communities, the major participation of the communities and families themselves in the health system.

It is these basic principles, articulated in Alma Ata in 1978 and adapted into the "child survival and development revolution" (CSDR) in the mid 1980s, which lay the foundation for the tremendous success in improving child health during the 1980s, currently saving the lives of nearly 4 million children annually, and allowing countries such as China and Sri Lanka to have the relatively low child mortality rates of the United States of the 1950s, while still at the income levels of the United States of two centuries ago.

While the expertise of physicians such as yourselves, and of research and teaching institutions such as those you represent is desperately needed to accelerate international child-health efforts, there is also much to be learned in industrialized countries from the successes won by countries in extremely constrained circumstances.

Thus it has been the coupling of readily available low-cost/high-impact health knowledge and technologies with delivery systems that involve and reach whole populations, which have made the dramatic difference in saving the lives and improving the health of vast numbers of children, where sufficient numbers of doctors simply do not exist to meet the health needs of all children.

In our increasingly interdependent world, lessons must be drawn from both industrialized and developing countries to truly meet the health needs of children in either. While countries such as the United States are rich in sophisticated medical health knowledge and technology, we have not been adept at ensuring that this knowledge is made available to difficult-to-reach populations. We have much to learn from the community participation and nation-wide social mobilization efforts in an increasing number of Third World countries during the 1980s which placed strong emphasis on restructuring health budgets to meet the needs of all of a nation's people with basic services, rather than, for example, providing expensive and sophisticated medical treatments for the relative few who could afford them. Take for example Pakistan, which financed a full multi-year round of immunization for the youth of the entire nation by postponing the construction of a single urban children's hospital. Or look at Bangladesh, ranked among the least developed countries of the world. Six years ago, fewer than 3 per cent of Bangladeshi children were immunized against the main child-killing diseases. Today there is every indication that before the turn of the year, Bangladesh will have come close to achieving the goal of protecting 80 per cent of its under-ones through this extremely low-cost preventive health measure, a higher level, incidentally, than we in the U. S. achieve for under-twos.

Something major is afoot throughout the world which has resulted in an increase in immunization levels from some 10 per cent globally at the opening of the 1980s to an anticipated 80 per cent by the end of this year.

How did such vast proportions of the world's population, with such meager means, with so few facilities and clearly inadequate infrastructure, use what they had to make the dramatic progress for their children which was achieved in the 1980s? They did it by applying the principles of primary health care; by empowering people with basic health knowledge and technologies using every available means - through the media, ratio, TV and the press; through teachers and their schools; through priests and imans at the village level; through commercial channels; and through mass participation in health services at the community level. And there are lessons to be gleaned from their successes.

The health knowledge and technologies themselves have been developed largely in the industrialized world, and there is now an increasing need for improving those technologies and simplifying their delivery. This is your bailiwick; the world community looks to you for advances, leadership and guidance. In my few moments with you this morning, I would like to highlight some of the specific low-cost health measures which, having been very broadly applied through innovative social mobilization efforts, have been responsible for major progress in child health. With your help at this crucial phase, they hold still greater potential.

First of all, immunization, long seen as the essential preventative tool of paediatrics, has indeed been the driving force of the child survival miracle. More than 2 1/2 million child lives are currently being saved annually as a result of universal child immunization efforts of recent years. Remarkably, levels of immunization for under-ones in developing countries as a whole now exceed levels of immunization for under-twos in the United States. But more than 2 million children still are dying annually from measles, tetanus, and whooping cough in those still unreached child populations where disease incidence is the highest because of poverty and inaccessibility.

In Third World countries, some different concerns must be faced regarding immunization than those which confront paediatricians in this country. Due to the high burden of disease in developing countries it is critical that mothers get their children protected at the earliest possible age and that they follow a schedule of immunizations which reaches children at younger ages than the ideals followed in the United States. A vaccine missed for even a week or two may mean the child contracts a fatal disease and, although we recognize that immunity may be enhanced by waiting for a later age, the urgency of providing protection must take precedence. Surely, in your practice when a child presents with a minor illness fever, cold or diarrhoea it is not unreasonable to spare the child further discomfort of a shot, asking the mother to return a week later with the high certainty that she will come. In the developing world, not only is it possible that the mother will be faced with unsurmountable obstacles to returning, but also chances are considerable that the child could contract a life-threatening illness even in this brief interval. It is vital that health practitioners realize that under those circumstances there are no real contra-indications to immunization. Your support - in your teachings, writing, etc. - of the World Health Organization's (WHO) immunization schedule and policy, i.e., no contra-indication to vaccination, would do muchto enhance the early and timely coverage of immunization programmes.

As many of you may be aware, efforts are underway in this country to make

some major contributions on the immunization front through a children's vaccine initiative. Over the next 10 years, scientists in this and other countries will bend their efforts to significantly improving children's vaccines using the most modern techniques of molecular biology and genetic engineering. They will attempt to incorporate multiple antigens into single-carrier vaccines which can be administered in a single dose, orally, and early in life. Hopefully it will even be heat-stable to avoid the need for refrigeration to preserve this new miracle multi-valent Children's Vaccine. Many of you may participate in the development of this modern miracle that will save lives and assure that even one contact soon after birth may protect a child from virtually all immunizable diseases.

A second area in which major improvement is possible for low cost is in the control of diarrhoeal diseases. Still, diarrhoea remains the largest single killer of children in the world, claiming 3.5 million young lives each year - more than half of which are due to dehydration alone. Studies in this country as well as abroad have proven beyond any question the efficacy, safety and appropriateness of oral rehydration therapy, the amazing mixture of salts and sugar, which when ministered in a timely way - fully protect from dehydration and can save lives - more lives, than any other single technology of our times. The advantages of oral rehydration therapy over intravenous and other remedies were updated most lucidly in the "New England Journal of Medicine" last month by Drs. Mary Ellen Avery and John D. Snyder, who concluded, among other findings, that:

> "Not only is appropriate oral therapy effective, but it is less painful, much safer - since the child's thirst protects against overhydration - and far less constly than intravenous hydration."

A more active lead by America's paediatricians in using and promoting oral rehydration therapy and in pointing out the inappropriateness of pharmaco-therapy for diarrhoea would make a great contribution to effective treatment in the Third World...you are, after all, the role models in teaching and practice for much of the developing world.

There is probably not a paediatrician present who would not recommend breast-feeding as the ideal form of nurturing the young infant. However, in this and many other industrialized countries, the majority of mothers whose families live above the poverty line can make a choice to do otherwise without condemning their children to almost certain illness and increased risk of dying. That choice to not breastfeed, made in the developing world, increases the risk of death 10-to-15 times in the first 3-to-4 months of life and even 3-to-5 times simply by adding other foods or bottle-feeds to ongoing breast-feeding. The often close interaction of infant formula companies with professional paediatric societies is seen throughout the world as a tacit endorsement by those societies and their members of infant formula. In many developing countries paediatric societies have recently taken the bold step of weaning themselves from financial dependency on the resources made available from these companies, in order to make a more forceful statement in favor of exclusive breast-feeding. These brave professionals believe it is more important to be seen, to be independent of, and distant from the promotional activities of infant formula, than it is to receive their generous support for meetings and other activities. How far can you and the AAP go to provide

leadership in this brave fashion?

A global meeting on Breastfeeding in the 1990s, which gathered high-level health policymakers from governments, bilateral and U.N. agencies, met in August in Florence at the Spedale degli Innocenti Center. The Innocenti Declaration issued by that meeting stated in no uncertain terms that:

> "Attainment of the goal (of empowerment of all women to exclusively breast-feed for four to six months and to continue breast-feeding with complementary food well into the second year) demands in many countries reinforcement of a breastfeeding culture and vigorously defending it against incursions of a bottle-feeding culture. This requires commitment and advocacy for social mobilization, utilizing to the full the prestige and authority of acknowledged leaders of society in all walks of life."

Are you willing to use your personal status and that of the AAP and other professional organizations to which you belong to make a stand on this issue?

Every paediatrician - perhaps especially in the U.S. - keeps a careful record of the growth of each child. Indeed, the child's growth record is as much a tool of paediatrics as is the stethoscope to a cardiologist. In this city, Professor Charles Janeway of Harvard's Children's Hospital Medical Center always taught that the best measure of child health was his or her regular gain in weight. His students have recounted to me in their later professional years how Professor Haneway himself would carry a child to the weighing scale and carefully plot the weight before he would consider a case in consultation. In an attempt to emulate this profoundly snsitive and yet simple means of assessing child health and growth, UNICEF has encouraged growth monitoring as a basic tool of early detection and action not only in clinics but also in far flung villages in the remote areas of the developing world. We have found that a mother herself can accurately weigh a child even in the most remote village and that paramedical workers can detect at an early stage faltering growth as an indication of ill health, inappropirate feeding, psycho-social deprivation and other problems of the young child.

Unfortunately, often not even Third World doctors appreciate the power of this tool - being more attracted by modern laboratory tests and complicate machines. A tremendous gap in knowledge esiste between yourselves and the rest of the medical community around the world regarding the improtance of growth monitoring. How might you help bridge that gap? This tool, which you take for granted and use as a cornerstone of your daily practice, is not yet appreciated and not yet seen to be scientific and sound. Were you to conduct research and publish on the sensitivity and value of regular monitoring of growth, in the detection of th4e underlying problems in the child's environment, on the use of weight gain as a measure of recovery from illness as a tool to counsel mothers in taking necessary action at home - this would greatly enhance programme efforts throughout the world aimed at providing this sensitive diagnostic technique to each and every child. You could, for example, at international meetings you attend, call for a meeting on growth monitoring and its importance for triggering the diagnostic search, and for detection of subtle abnormalities early in the course of illness. If health practitioners elsewhere realized how highly you respect and use this growth

chart, they would adopt and use it, thus enabling the ealry detection and treatment of malnutrition, the underlying cause of most deaths and disabilities, long before it is otherwise evident.

These are but a few very specialized examples, within your field, of the need for a cross-pollination between the strengths of maternal and child health care in industrialized and developing countries. There are countless more.

The World Summit for Children grouped the "do-ables" - feasible measures of the highest priority - for children into a set of goals for children and development in the 1990s which were adopted as an annex to the Plan of Action, and I attach a summary of those goals to the distribution copy of my comments this morning [ATTACHED]. They include such ambitious yet feasible objectives for the 1990s as reducing child mortality by a third, reduction of severe malnutrition among young children by half, reduction of maternal mortality by at least half, and some select and specific goals on the reduction or elimination of childhood diseases. I commend them to you.

It is most interesting to note that many of these quantitative goals have been accepted and adopted to the United States by the U.S. Department of Health and Human Services in its report released in September by Dr. Louis W. Sullivan, Healthy People 2000. We see, in this report, a brilliant assessment of current health conditions, used to determine feasible U.S. goals for the decade ahead. Many of the objectives are identical with the goals signed at the World Summit: reductions in infant and maternal mortality, low-birth weight, and accidental child deaths; increased use of ante-natal care, breast-feeding, and immunization, including the elimination of measles from this country. These form an integral part of the global effort to improve the world for children.

I muut mention that the most important of universally applicable messages regarding child health have been collected into a book called Facts for Life - a book which has the force of a global initiative behind it. These messages received the joint endorsement of WHO, UNICEF and UNESCO before they were published under the co-sponsorship of more than a hundred non-governmental organization partners. The initiative behind Facts for Life is one of empowering families with the basic knowledge which could, in their hands, make the life of death difference for their children. The messages are equally relevant in every country, and they are messages which every family has a right to know.

Consider for a moment, that if today's child death rates were to continue, we would witness the tragic loss of some 150 million children during the decade. Fortunately, progress is already in motion toward saving 25 million of those young lives. If, however, the goals to which governments, including the United States, committed themselves at the World Summit are realized, the lives of some 50 million young children will be saved before the turn of the century, and comparable numbers will be spared lives of crippling disabilities. Paradoxically, the same efforts that save children's lives will slow population growth rates as target rates are reached and parents choose to have smaller families as they gain confidence that the children they have will survive.

Along with such new capacity to improve the health and well-being of massive numbers of children, however, comes a new responsibility. If 40,000 children were dying each day without our knowledge and from causes which we could do little to prevent, it would be tragic, indeed. But for 40,000 children to die each day from largely preventable causes with our full congnizance is not only tragic, it is obscene The great writer Primo Levi observed that, "Once we know how to reduce torment and do not do it, we become the tormenters". Are we to be judged with the hindsight of history as having joined, by de fault, the tormentors?

We are living, I believe, at a great turning point...a moment at which new attention to children's issues, including that issuing from the World Summit, has brought a dark secret of our current civilization into the light, and we can no longer in good conscience ignore the plight of children. Whether or not we successfully take the new direction offered by the turning point is up to you...to us.

We may truly be on the brink of becoming a civilization that gives a first call on its resources to children, in bad times and in good, for the essentials of their survival, protection and development. We are at the threshold of a world in which this "first call" principle endorsed by the World Summit is accepted as the order of the day ... but we have not yet crossed into the new world.

What advance can individual paediatricians and the AAP make toward the crucial steps through that door; what role can you fulfill in ceasing the daily harvest of our youngest and most vulnerable from the streets of Harlem to Bombay? A leading role, I am convinced. The world looks to you, and rightfully so, for guidance and leadership in child-health issue. The "Time" magazine article I mentioned earlier closes with the question:

> "Where is the leader who will seize the opportunity to do what is both smart and worthy, and begin retuning policy to focus on children and intercept trouble before it breeds?"

There will perhaps never again in our life-times be the opportunity that exists at this moment to make major advances in your area of expertise. Can we turn the tide on massive preventable child death? For the children - and the future - of our world - working together - I think we can. Will you take a still more active lead for America's and the world's children?

Thank you.