File Sub: CF/EXD/SP/1991-0006

Address by Mr. James P. Grant
Executive Director of the United Nations Children's Fund (UNICEF)
"Cecil G. Sheps Visiting Scholar in Social Justice"
at
The University of North Carolina
Distinguished Lecture Series on International Health

"Reaching the Unreached: Miracle in the Making"

Chapel Hill, North Carolina
21 March 1991

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"Reaching the Unreached: Miracle in the Making"

I am very pleased to be with you on this beautiful afternoon in Chapel Hill. Before I truly extend my appreciation to Cecil Sheps and speak about the common ties that have kept us in pursuit of similar aspirations throughout our professional lives, I would like to state two propositions. In a moment I will link those propositions to the work guided by our common ties.

1990: Historic year for the world's children

My first proposition is that 1990 marks the most historic year ever in world history for children. Several milestones were reached last year. We saw the achievement of a universal child immunization effort that was seriously launched as recently as 1985 -- on the 40th anniversary of the United Nations -- to be achieved by December 1990. Its objective was to immunize at least 80 per cent of the children of the Third World younger than one year of age -- a greater percentage than the United States and Canada immunize their under two-year-olds -- against each of six killer diseases then taking the lives of five million children annually. Final tallies are still coming in, and dozens of international verification teams are out, but it looks as if this goal has been achieved. And three million children will not die next year as a result.

But its significance is far greater than that. The immunization effort is, in many parts of the world today, the single governmental service that reaches the most communities. In countries such as Indonesia, Nepal, Nigeria and Pakistan, a little package of ice with polio vaccine periodically reaches more hamlets and villages than even the postal service, which most of us think of as the "universal" government service. The number of man-days that it took

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to accomplish this has probably exceeded the number of man- and women-days that went into building the largest pyramid. Considering the cumulative activities from the high Andes and the Amazon, the Congo, the Himalayas and the jungles of Sumatra, this is the largest single collaborative peacetime effort in world history.

In five years it has accomplished virtually the impossible. Countries such as Bangladesh, in which only two per cent of under-ones were immunizied against the six antigens in January 1986, have increased that coverage to about 70 per cent today, with more than 90 per cent receiving at least one immunization -- somewhat short of the government's 1990 goal, but a remarkable achievement nevertheless. China now has immunization levels of 94 per cent for the country as a whole. Every province -- and probably even every county -- has exceeded their goal for 1990 of 85 per cent coverage of under-one-year-olds. Even amidst its civil conflict, El Salvador is likely to have achieved its goal. As I said earlier, 75 per cent coverage is what we have achieved in the United States for under-twos, yet it is now being achieved globally for under-ones. It is truly a major demonstration of what can happen when people set their minds to something.

The second milestone of 1990 was the coming into force of the Convention on the Rights of the Child. This, too, seemed highly improbable even five years before. When it was first proposed in December 1979, during the International Year of the Child, I was then the United States Representative to the Executive Board of UNICEF. I remember writing in my report, "I do not expect to see this Convention come into force in either my working or my living life time". But the Convention came into force on September 2nd, last year, having been adopted by the General Assembly of the United Nations in November 1989. No human rights convention had ever garnered in a year's time following adoption the necessary minimum of 20 ratifications to come into force. Yet within nine months that 20 had been achieved, and by the time one year had passed, 71 countries had ratified the Convention on the Rights of the Child. The United States has not yet even signed to signal that it is seriously considering ratification, but I am confident it will do so with enough public awareness. Still, ratification by 71 countries in only a year indicates that something extraordinary is happening.

The third milestone was the World Summit for Children. It was the greatest gathering of heads of state ever in world history, by a substantial margin. It was truly a global Summit, with the participation of leaders from East and West, North and South. And the subject was children. And, of course, they pronounced high principles. Children should have a high priority, or as stated in their text, children should have a "first call" on the resources of society for the essentials of their survival, protection and development. Unquestionably, these are nice words to have from such a collection of heads of state. But they went substantially further ... further than most summits are allowed to go by the "sherpas" who organize them on behalf of the principals.

First, they took the incautious action of setting a series of quantified goals, to be achieved by a certain date -- which politicians traditionally avoid. They set 27 goals to be achieved by the year 2000, including:

- reduction of infant and child mortality by one-third;
- reduction of maternal mortality by one-half;
- reduction of malnutrition by one-half;
- reduction of illiteracy by one-half;
- universal access to primary education with at least 80 per cent of primary school children able to pass a certain minimum achievement test;
- eradication of polio; and
- elimination of iodine deficiency diseases.

This is a very impressive range of concrete goals. But then they went a step further. Since the year 2000 is a long way off and is beyond the expected tenure of most of the leaders who attended the World Summit for Children, they decided to set a goal to be achieved by December 31, 1991, when most would still be in office. They all -- including President Bush -- committed themselves to have reviewed, by that date, their own national plans to see if they were on trend to achieve the goals they set for the year 2000. This was not just a set of goals for the Third World. The leaders of the industrialized countries committed themselves both to look at their own internal situations with respect to children and to review their foreign aid programmes, to ensure that they support these objectives.

One would think this was ambitious enough, but they went still further. They invited others to help in achievement of these goals: international agencies, non-governmental organizations (NGOs), municipalities, states and provinces. They acknowledged that success would be impossible without these other groups. This was especially unusual coming from several Third World countries, because NGOs usually are not given much pride of place in those countries.

Finally, in their bravest action, the leaders asked for a regular monitoring of their performance, by the United Nations, starting in 1992. Then they requested that, within the United Nations, UNICEF take a particular interest in this monitoring process. This gives us a little extra authorization to ensure that there is appropriate follow-up. Reports are to be published periodically and submitted to the General Assembly of the United Nations. In mid-decade there is to be a major global review convened by the Secretary General, its exact form yet to be determined.

It is very unusual to have such a degree of specificity of goals emanate from a summit. The designated follow-up process is unusual, too -- here, a committee will not be doing it, but rather a dedicated agency that believes in the importance of these goals ... a unique arrangement.

Of course, there was also the surrounding ambiance of 1990. The end of the Cold War; the dramatic reduction of the interventions into all the conflicts in the Horn of Africa; the dampening effect the end of the Cold War had on South Africa and its apartheid policies, and in turn, the impact on Angola and Mozambique; the easing of tensions in Central America; the dramatic advance of democracy throughout the world -- these all contributed to an environment that allowed distinct improvements for children. So that is my first proposition -- that 1990 was a truly historic year.

The 1990s: new windows of opportunity

My second proposition is that the 1990s have the potential, with reasonable help from the likes of you -- us -- to become the most historic period ever for children. Child-related issues could be elevated from their status of the past generation -- a position characterized by benign neglect -- to one of equality and even the possibity of preferential treatment. We are all accustomed to nice words about "children first"..."mothers first"...but what happens in reality, when there is an economic crisis or a war? At the bottom of the heap, bearing most of the burden, usually are children and their mothers -- the most vulnerable groups of all. It was even true in the United States when we endured the economic transition of the early to mid-1980s, and remains true today.

But now we have the potential, by the end of this decade, to liberate children from so many of the diseases that today take the lives of some 40,000 every day, more than two-thirds of them unnecessarily ... to liberate them from the very low level of education and nutrition that so many have been locked into. Does not this belie conventional wisdom, to envision the 1990s as this kind of decade?

Look around the world. We see a terrible situation in Africa, with primary products at the lowest price levels since World War II...civil wars... massive debts that remain unresolved...and AIDS. Look at Latin America -- the Latin Americans are still trapped in economic crises resulting from their debt burdens. The United States has its own situations. A look at statistics from New York shows that 13 per cent of children were living in families below the poverty line in 1969. That figure increased to 19 per cent by 1979. By the late 1980s, some 40 per cent of the children of New York City, our leading city, were living in families below the poverty line, and it must not be forgotten that the safety net is somewhat thinner now than it was 10 or 20 years ago. And, what is more, New York City now has the additional problems of AIDS and drugs.

Why is it, then, that we think it is possible in the 1990s to achieve greater progress for the children of the world than during any decade in history? I will come back to that shortly.

Guiding principles -- beacon for many generations

It is a great privilege to be the first Cecil G. Sheps Visiting Scholar in Social Justice. I like all three aspects of the distinction: Sheps...visting scholar...and social justice.

There are many common ties. Cecil Sheps and I come from very similar family heritages, with a long tradition in fields related to social justice. We have had, in particular, common linkage with an unusual man by the name of John B. Grant. My linkage is quite obvious: he was my father and mentor. When I was in my early teens he used to take me along as his junior assistant on his travels around China, and that was a very strong influence on my life. Cecil has mentioned how John Grant came into his life out of Winnipeg, early in his professional career. At the time of John Grant's death in 1962, Cecil

was the head of the American Public Health Association's Medical Care Section, and he introduced a resolution about John Grant. It reads very nicely, and except for the fact that it is written in the past tense, it would serve well to describe the man I know as Cecil Sheps:

> "Throughout his long career he has been a towering figure of vision, strength, statesmanship and leadership in the endless struggle to improve the welfare of mankind...to the provision and modernization of health services in China, India, Europe, the Americas -- indeed the whole wide world. His deep insight, boundless energy, originality of thought, universality of understanding, deep devotion to duty, his tireless spirit, and his ceaseless plotting into action will continue to spur us on in the future as this rare combination of qualities did in the past. Unheeding of the advancing years and disabilities imposed upon him, he continued to the end as the tireless fighter and wise leader in a major task of our civilization. We shall continue to be guided by his example."

I think both Cecil and I have continued in our own different ways to be guided by John Grant's example in the years since then. All three of us believe very strongly in a concept that was articulated by the historian Arnold Toynbee, who said, "Ours is the first generation in history in which it is possible to think of bringing the benefits of civilization and progress to all people".

It is true. When we look back to the United States or Western Europe of 100 years ago, we find that infant mortality rates were nearly 200 per 1,000 live births. It was not possible to think, then, of well-being for all people. It has only been in the last 50-60 years that it has been possible to realistically consider the possibility of everyone's sharing in a basically decent way of life.

John Grant believed very strongly that morality should march with changing capacity and that as capacity changes, morality should keep pace. If one lived in a world in which not much could be done about poverty, then doing little or nothing about it would not be a crime. But when it is possible to do something about poverty, or about its worst manifestations, then it is clearly immoral not to act. For example, the fact that today we have 40,000 children dying every day, two-thirds of them from readily preventable causes -- that is an obscene situation.

Both John Grant and Cecil Sheps believed it is imperative to close the gap between knowledge and its use in the community, that there is a strong obligation to put the knowledge that is available to the use of all and not just to a handful.

Finally, our common ties lie in certain shared principles that John Grant was the first to articulate, in the early 1930s. They have been refined, added to, and abetted by Cecil and others, including by myself. But by the early 1930s, John Grant had established certain principles that were to guide his work thereafter. There were many of them. Five of them, however, have been particularly key to me. As I believe they are still vital guideposts, I would like to mention them here.

First principle: the use made of medical knowledge depends on social organization. Many examples abound. Yesterday 7,000 children died of dehydration from diarrhoea because their parents did not know how to use a little six cent packet of oral rehydration salts (ORS) mixed with a litre of water, or the home brew equivalent. In 1980, only one per cent of the mothers of the world were aware of what Lancet called potentially the biggest single medical breakthrough of this century. Today, about half of the world's mothers know to use oral rehyration therapy (ORT) when the need arises. The key to this dramatic increase is obviously social organization. In the industrial countries, we see this principle in action in another way. We see it in the field of tobacco abuse. We have the knowledge: tobacco is taking the lives of 1,000 Americans a day. It is taking another 2,000-3,000 lives around the world and that number is on trend for significant increase. Still, we have not yet been able to put together the social organization -- we have not been willing to put together the social organization -- to cope with that chronic disease.

Second principle: a vertical medical system cannot be truly effective or ever stand by itself unless it is integrated into other activities of a society, in a concerted attack on the problems of health. In an economy rife with joblessness, one that has no social security and poor education -- the best medical science will make relatively little difference against the negative influences of malnutrition, of ignorance and the like. Health programmes need to be integrated with other social services: education, nutrition, and adequate employment opportunities. Is it reasonable to think of dealing with the problems of diarrhoea without also addressing the problems of clean water and adequate sanitation? Is it reasonable to think of dealing with the problems of drugs in modern society without addressing the root causes of substance abuse in society? The health system must always be multi-sectoral: this is perhaps more important to the health of the world's people than even the specific medical expertise of doctors themselves.

Third principle: successful organization implies reliance upon economically practical strategies for serving the entire population rather than just the elite or a relatively affluent minority. In low income societies and communities this means that the majority of the community and of its members must be participants in the health system. We see in the United States today a health system that serves well, in terms of results, perhaps two-thirds of the population. It is not, however, an economically practical programme for all of society. So sometime in the future we will either become an increasingly unjust society, with adequate health care for fewer and fewer people, or we will develop a new organizational pattern that will incorporate all of the population into health services. It is noteworthy that the new Convention on the Rights of the Child enumerates as one of the first rights, the right of a child to the essentials of basic health services.

Fourth principle: the education of a health professional requires not only a teaching hospital but also a demonstration health center based in the community. Dr. Abraham Flexner, the man we so admire for initiating the teaching hospital mode of practice that gave American medical education such an edge around the world, said, as long ago as 1910:

> "The physician's function is fast becoming social and preventative rather than individual and curative. Upon him society relies to ascertain and to enforce the conditions that prevent diseases and work positively for physical and moral well-being."

Although Dr. Flexner voiced this insight in 1910, there are only a relatively small proportion of medical schools in the world, still today, that have actually created a teaching district or its equivalent. The health sciences here in North Carolina are well ahead of the average in this domain; unfortunately, worldwide the normal situation continues to be medical schools that belie Dr.Flexner's statement of some 80 years ago.

Finally, John Grant always felt that a health system had to function within a regional frame. There had to be primary units that interfaced with the individual, working the way up through different referral layers to a hospital with high skills and supervisory capacity. There had to be at least a population of a quarter of a million or half a million -- a significant population -- in order to develop a total, effective health system for a community.

All of these principles remain valid today. Our failure to fully observe them and to adequately overcome the lag between health knowledge and its use is vividly demonstrated by the fact that yesterday some 50,000 people died from readily preventable causes, more than two-thirds of them children under five. Another 50,000 will die tomorrow and the day after tomorrow. Among the children, some 7,000 will die, as noted earlier, due to dehydration from diarrhoeal diseases. Another 6,000 will die from vaccine preventable causes -- well down from the 15,000 earlier in the decade but still tragically unacceptable. Six thousand to 8,000 will die from acute respiratory infections. And among adults we have a rising number now dying daily from causes related to smoking.

The PHC Breakthrough

What has happened on the positive side? During these same decades of the 20th century, there has been significant change in the health arena. The great landmark of global health, the meeting at Alma Ata in 1978 convened by the World Health Organization and UNICEF but also involving many NGOs, set out the mandate: Health for All by the Year 2000 through Primary Health Care (PHC). This was a monumental breakthrough. There is no equivalent in any other major sectoral field. The drive for Health for All by the Year 2000 through PHC received a vital impetus: it had the full commitment of the Director-General of WHO at the time -- Dr. Halfdan Mahler -- who devoted all of his discretionary time for the next four or five years to advancing the concept.

By the early 1980s, however, the momentum on PHC had slowed. The global recession set in, difficulties mounted in Africa and Asia, the trend quickened toward market economies, and economic difficulties in Western Europe and North America had repercussions throughout the world. Meanwhile, the lag between available knowledge for children and its use continued to widen. That gap began to become increasingly unconscionable, particularly as the hope of

government-financed services began to weaken and crumble around the edges. In times of such hardship, it is traditionally the most vulnerable -- especially children and women -- who suffer the greatest burden. And yet it is also out of great adversity that some of the most brillant innovations arise.

Against the background of hardships of the early 1980s, two sets of forces came together to the benefit of children in the developing world. The first was readily available low-cost/high-impact health knowledge and technology. Oral rehydration therapy had been invented in the late 1960s; measles vaccines had come to the fore earlier in that decade. A full realization of the scientific marvels of breastfeeding had emerged only recently and the concept of growth monitoring was new.

At the same time, a second set of forces -- a vast new asset -- was coming into play, and that was the revolution in communications that was taking place around the world. Thus, for example, in India every other home has a radio, and most communities today have a television set. In a country like Yemen, whose level of material progress in some ways resembles that of the 13th century, one learns of isolated valleys with no roads and no electricity, where, nonetheless, almost every home has a television set and a VCR, run by a storage battery that is periodically recharged by a villager with a generator for 10 or 12 eggs or some similiar exchange. In country after country, the religious organizations have built modern communication structures. Even in the Maldives, a very low income country, on every one of the hundreds of islands the mosques get their daily or weekly messages from the capital city. The same is true in the remote regions of Turkey. In addition to these communication capacities there are the effects of a marketing revolution that show up everywhere in the world today: in the high Himalayas and the high Andes; in the jungles of the Amazon basin, one can find the ubiquitous small radio, batteries, flashlights and matches, among other products that have managed to creep into every corner of the world.

A revolution in child survival and development

In the early 1980s, against the backdrop of slowed momentum in health and the crumbling of financial support for education and basic services everywhere, bringing together the newer technologies and the capacity to communicate produced a startling synergistic effect. When things get worse people often think more clearly. Out of just such a situation emerged the proposal which ultimately came to be known as the Child Survival and Development Revolution (CSDR).

I might add parenthetically that four times out of five, major innovations of society are born of disasters or near disasters. Thus it took the great depression to produce the New Deal. World War II gave rise to the Bretton Woods institutions and the United Nations. It took the Communist threat, "Moscow on the march", to motivate implementation of the Marshall Plan and a whole new era of economic co-operation. And similarly, out of the tragedies of the early 1980s one of the bright advances was the proposal for a Child Survival and Development Revolution.

The CSDR proposal was to halve child mortality between 1980 and the year

2000, relying on such readily "doable" technologies. The key, of course, was how to mobilize these new channels of communication to support the new technologies, and this meant, in effect, that societies had to be convinced. It was first picked up in a series of countries: Colombia, Egypt and Turkey were among the pioneers.

The Colombian example began with leadership from the top to persuade all sectors of society to participate. Faced with high child death rates due to immunizable diseases and diarrhoeal diseases, then-President Betancur decided in 1984 to mobilize the country to put to use the low-cost health knowledge and technologies of the CSDR, with immunization at the cutting edge. He mobilized the co-operation of the media, including the leading opposition press -- there were more than 10,000 radio and television public service announcements -- and he recruited the Catholic Church and the Red Cross, the Rotarians and Lions, Scouts, schoolteachers, business people, and all of his government ministries.

Since that first campaign in 1984, the great majority of Colombian children have been immunized and the use of ORT is now widespread, thereby saving the lives of some 10,000 young children each year who would otherwise have died, and preventing the crippling and wasting of many thousands more.

The challenge in such an effort, of course, is how to sustain the advances gained. In Colombia, the "campaign" approach has now given way to ongoing primary health care infrastructures which have been vastly bolstered by intensive and complementary follow-up efforts. The primary school curriculum has been revised to emphasize health education, and all high school students have to contribute at least 100 hours of "health scout" service as a precondition for receiving their diplomas. Television and radio spots and promotions now have a continuing supportive role. The Church instituted a training programme for priests, and pre-marital counseling now includes a whole cycle of issues regarding the responsibilities of the parent to the health of the child -- on immunization, ORT, etc. -- as a major component. Every parish priest devotes several homilies a year to these messages. In short, society has become involved in health in a very major way, and at the same time the basic health system has clearly been strengthened. All these measures have resulted not in higher costs for government services, but rather in the saving of many millions of dollars.

In Egypt, oral rehydration therapy was used as the big breakthrough of the Child Survival and Development Revolution. There, 200,000 Egyptians were dying annually of dehydration from diarrhoea. Those deaths have now been reduced by more than half. From the success in mobilizing to spread the use of ORT, Egypt was able expand into immunization and other areas.

Turkey succeeded in a similarly massive and effective mobilization. Turkey illustrated the capacity to accomplish these aims, when the will exists, with relatively small expenditures. Theirs is somewhat of an exaggerated example, because they decided, when they launched the national programme, to immunize children through age five, following the pattern set in the United States. In most countries, the effort is made to immunize children through age one, and not to focus efforts on the older children. But in

Turkey more than four million children through age five were immunized in that historic effort. When Turkish economists calculated the cost of that first campaign, they found that US$28.5 million was spent to fully immunize these children. The actual cash expenditure for the Ministry of Health, however, was just US$3.5 million, and even of that portion, the majority came from UNICEF and other external sources such as Rotary International and USAID. The outlay by the Turkish Ministry of Health from its budget amounted to no more than US$1.6 million, and that was largely accomplished by a transfer of previously obligated funds from other departments of the Ministry. The other US$25 million summed up the value of donations such as free television time, sports benefits, volunteer time (I believe even my own time was calculated in that!) and other benefits that accumulate when a programme "piggybacks" on an existing system. So although the value cost was US$28.5 million, the actual outlay was only a fraction of that.

A similar situation exists with many of the health problems of today. In this country, the health hazard caused by smoking is a good example. The problem is not one of big expenditures; it is a question of changing values, standards and habits. I was reminded of this in 1982 by Dr. William Foege, who was then head of the U.S. Centers for Disease Control. He said that adding one year to the life of an average adult American male -- using medical means -- would cost over US$10 billion. Yet, he explained, that man could add 11 years to his own life if he would do four things that cost nothing whatsoever -- that, if anything, save money: he could stop smoking, moderate alcohol consumption, watch the quality and quantity of food intake, and get a moderate amount of exercise. Whether in the developing world, where oral rehydration therapy can make a difference, or in the industrial world, dealing with chronic diseases, an epidemiological approach to health and well-being shows that there are tremendous reservoirs of capacity, if society can be organized to help support the needed behavioural changes. Much more than the health sector must, of course, be mobilized.

The successes of the universal child immunization (UCI) efforts in country after country were frankly a surprise to me. It was a surprise, for example, that immunization took the lead. I had expected oral rehydration therapy to be the major success: it is cheap, life-saving, and administered at home. ORT doesn't require sophisticated skills or support networks. But it turned out that two great qualities of the immunization effort worked in its favour, even though vaccine delivery requires a cold chain and an administrative structure. One of those characteristics was that immunization is quantifiable, measureable, and people could be held accountable. For example, a president could say to a governor, "I want 80 per cent of those children below age one to be immunized or I will get a new governor". Second, there was very little resistence to rapid and broadscale expansion of immunization -- the effort had very few enemies. With ORT, on the other hand, it is amazing how many frictional obstacles there are. Pharmacies do not want a shift to ORT. I defy you to go to any of the pharmacies here in this area and find a package of oral rehydration salts. Instead, you will find quarts of pedolite costing two, three or four dollars and taking up a lot of shelf space. And incidentally, it sometimes takes two or three quarts to save a child's life. How much better it is to have the small sachets of salts costing only pennies and which dissolve in water ... particularly since we

have good clean water with which to prepare the mixture. We found the degree of resistence by hospitals to be most suprising. For example, in northeast Brazil, 40 per cent of the hospital beds, at the time of my first visit, were occupied by diarrhoea patients paid for by the state. If the great majority of these cases were suddenly treated at home or on an out-patient basis, as happens in country after country as the shift to ORT is made, who would pay for all those beds? And finally, even our doctor friends sometimes stand in the way. In a country like Brazil, the first point of contact between most doctors (certainly this is true of paediatricians) and a child occurs when the child has diarrhoea. If through public education all of those families are trained to treat diarrhoea at home, doctors lose this first contact with the child. Thus, many factors surfaced that we did not anticipate, slowing down the forward movement. But even with ORT, as I indicated earlier, major progress has been made.

The most powerful unite for the most vulnerable

We discovered that one great way of getting things moving was to convince heads of state to play a role. They found it good politics to do so. And it was against this background that for the first time we began to get heads of state to act in groups. The first time this occured, interestingly, was in Central America, when the region was very much a "hot spot". Seven heads of state in Central America decided to co-operate on something -- what else but children could have galvanized them? It happened on World Health Day, April 6th, 1986. They all agreed to go on television together. There were Presidents Ortega of Nicaragua and Duarte of El Salvador and the President of Guatemala and the Prime Minister of Belize. Tensions between Nicaragua and El Salvador were then quite high and Guatemala did not even recognize Belize's right to existence -- yet they were all on television together calling for co-operative efforts on behalf of the region's children.

That experience set a precedent for other countries to follow. We were able to parley the Central American innovation a few months later to get children's issues on the agenda where the heads of state of 1.2 billion people were meeting in the second summit ever of the South Asian Association for Regional Cooperation (SAARC). And they adopted immunization goals...education goals...and to my suprise they adopted the goal of early action on the Convention on the Rights of the Child. After that, it was not difficult to persuade the Organization of African Unity, the OAU Summit, to take up these issues. The momentum began to gather such force that when President Reagan and General Secretary Gorbachev met in Moscow in May 1988 to talk about security matters, they also talked about the child health revolution. It was the only non-security matter addressed at the Moscow meeting. The most publicized photo of that Summit was one of the two leaders holding children in their arms.

Synergism takes hold

All of this high level activity created excellent momentum for rapid progress on the Convention on the Rights of the Child and then on the proposed World Summit for Children. The sequence was almost ideal. The Convention came into force offically on September 2, 1990. Then, less than four weeks

later came the World Summit, with the tools to implement, in effect, the right to education, the right to health and the other rights enshrined in the Convention. The World Summit gave meaning to these rights and set up a process to pursue them...so much so that we now see a very realistic prospect that health for all children will be achieved by the year 2000. At the heart of all this is one clear truth: you need a multi-faceted approach to health if it is going to succeed. I stressed this earlier: you need to have education...you need to have jobs and income...you need to have nutrition -- progress is needed on all of these fronts together. It is also true that if one wants advances on all of these fronts simultaneously, the way to achieve it is to establish some concrete goals around which society can organize itself. The immunization effort was something tangible. People could see it. They could strive for it. It was cost-effective. The challenge now is how to put to use the system developed in that effort and adapt the lessons to the pursuit of more complex child health goals. And in effect, that is what is happening today.

In South Asia, 90 per cent of the babies born today are registered on some form of a village register for immunization purposes. Once that baby is registered, it can be reached with other services, such as vitamin A or iodine oil capsules. The same system can be used to identify the pregnant mother. The quantification process opens an inroad to dealing with longstanding problems that have faced rural health centres throughout the Third World. For example, even where these rural health centres physically existed, they themselves were far removed from the benefits of modern health knowledge and technology, even in reference to the epidemiological solutions to their own indigenous health problems. Everything petered out with them; the health centres delivered very little in meaningful services. It was the immunization programme that began to make these outposts into the active frontline of the health system. They had to deliver vaccines, and on time -- and the linkages were made throughout the system to enable this to happen. The UCI effort infused a whole new spirit, gave impetus to a whole new approach.

Proven principles / new applications

What does this mean for us here in North Carolina today? It means several things. One is that we ought to take a fresh look at our immediate surroundings. Why is it, for example, that North Carolina ranks number 47 out of 50 states on infant mortality rates? Why is it that developing countries like Chile and Costa Rica, both of which went through terrible financial problems in the 1980s, and both of which had very high infant death rates just thirty years ago, are now at or below the level of North Carolina? We need to look at the experiences of countries like Costa Rica which, like North Carolina today, had plummeting rates of breastfeeding in the 1970s but which were able to turn this around to the extent that 90 per cent of the mothers are now breastfeeding. These two countries -- others could be cited as well -- have been able to reduce malnutrition by almost half during the 1980s in spite of great economic difficulties. So, clearly, there are techniques of social organization available that are not being adequately used in our own states -- in New York, in North Carolina. We need to consciously learn more.

Second, whatever their deficiencies may be, our universities and their

specialities, their medical schools (such as here in North Carolina), are lighthouses of the world. Basically, you are the ones who set the standards. In the Third World, when UNICEF promotes oral rehydration therapy or breastfeeding, we are always asked the question, "Isn't this a second best remedy? What are they doing at Chapel Hill? What are they doing at Johns Hopkins?" These are the questions we hear so often. I wish we could come back with a clearer answer. It is a lot clearer today than it was eight or nine years ago. Ten years ago, U.S. institutions were very slow to change. But it would be instructive to examine our institutions to determine, for example, how many hospitals in this area, including the teaching hospital, are "Baby Friendly"? WHO and UNICEF have put out a joint publication outlining Ten Steps a hospital can reasonably be expected to implement if that hospital is to effectively support a mother in breastfeeding and to get the mother and the baby off to a good start. Ten very simple steps make a hospital a "Baby Friendly" institution. These practices need to become commonplace throughout the world and, clearly, North Carolina could be a leader in this.

Third, I would say to those of you who are in health sciences that the next ten or fifteen years will be the crucial period when the chance exists to realize Dr. Flexner's vision -- a vision for the century -- that health services take on a much stronger social purpose. After all, what does the word "doctor" come from? Its root is from the Latin, "docere", which means, "one who teaches". Today the challenge is for every doctor and everyone involved in the healing professions to also become, at least equally, an educator -- "one who teaches" -- a "doctor" in the truest sense.

On the children's front, the world community is beginning to exercise, for the first time, its capacity to act on a common problem together. There could be no better cutting edge for making progress at the end of the Cold War, at the end of forty years of that conflict...as we start to focus on our world population problems...on the world's environmental problems...than to take up the cause of children, who are so close to the hearts of all peoples, and yet who suffer perhaps the greatest single obscenity in the world today. I challenge you to find a worse current obscenity than what is happening, still, to some hundreds of millions of children around the world.

What better way to end this century than to have liberated the world's children from mass diseases, mass malnutrition and hunger, and from mass ill-education? What better legacy could be given by the 20th to the 21st century? What better start for the next millenium?

Can we do it? I think that with the spirit of Cecil G. Sheps -- and by that I mean a spirit that is tireless, dedicated, and never knows when to quit -- if enough of us have that kind of spirit, I am confident that we can. I am convinced that the resulting advances for children can be the cutting edge to a much better world for all for centuries to come.