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Address from Mr. James P. Grant
Executive Director of the United Nations Children's Fund (UNICEF)
to the
XIV World Conference on Health Education

"Health Education: Historic Windows of Opportunity"

Helsinki, Finland
17 June 1991

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"Health Education: Historic Windows of Opportunity"

I am very pleased and honored to be here today, back after three years with my friends and colleagues of the International Union for Health Education. At no other time in your organization's long and distinguished history -- a history closely inter-twined with UNICEF's own -- has the 3-year interval between your world conferences witnessed so many far-reaching changes on the world scene and in the field of health. The basic thrust or cumulative effect of those changes is very much in line with the theme you have chosen for this conference: "Health -- a United Effort". Never before have we believers in health education had greater opportunities than we do now. The question we must ask ourselves (and I include myself as a health educator) is: how can we -- will we -- take advantage of these windows of opportunity before they pass? Do we do business as usual or do we take major new initiatives? That is a central challenge facing us as we meet here in Helsinki.

A new international climate -- and new opportunities

United efforts have indeed moved the world in a healthier direction in these past three years. In particular, the end of the Cold War between East and West has created a new international climate. It is possible, for the first time, to mount truly united efforts to solve global problems and to mobilize global co-operation in support of national solutions. Despite the recent Gulf war, the easing of international tensions will lead to significant cuts in military spending -- in both the industrialized and developing worlds -- and one major challenge before the likes of us is how to help make leaders and politicians realize that it is "good politics" and good national security, too, to use a significant portion of the savings derived from these reductions to revitalize health and education systems, create jobs and alleviate poverty.

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Also contributing to this improved international atmosphere are the bold strides being taken toward democracy in large parts of the world -- not only in Central and Eastern Europe but in virtually all of Latin America and in many countries of Africa as well. Democracy is good for people and universal health education can be good for competing leaders in a democracy. Wherever truly competitive democracy has been in place for a generation or more, e.g. Sri Lanka and Costa Rica, the health and education of the poor is far better than in the majority of traditional authoritarian regimes. In short, in a true democracy, the poor have a vote and that vote has to be taken into account or those in power will not long remain so. Democracy should be a boon to health education, particularly if we health educators can help political leaders recognize the significant contribution health education can make to their success in politics.

We have started this last decade of the 20th century with a growing international consensus -- in theory if still far from full practice -- in favour of human-centered development. The United Nations Development Programme's new annual Human Development Report and the focus on poverty of the World Bank's World Development Report 1990 reflect this trend. Development is increasingly measured not by economic growth alone or even fundamentally, but by greater equity, empowerment of individuals and communities, the improved health of women and children, the democratic participation and expanded life choices open to ordinary people. There is a growing consensus that this is not only good morality and good politics, but also can be the best economics. Another major challenge before us here today is how do we believers in health education -- the lowest cost means of bringing health to people -- help convert this growing intellectual consensus into widespread practice.

What are the new building-blocks?

Over the past few years, there have been remarkable breakthroughs in health and medicine, advances in public awareness of healthy lifestyles, of the relationship between individual health and that of the planet, and extraordinary progress in the legal, ethical and practical aspects of society's treatment of children. Many of these developments are, to a great extent, the fruits of your efforts, and I am convinced that they give our united efforts for health far better chances for success than ever before, even though many of these advances are incipient and fragile, or have not yet reached those most in need.

As a reminder of how far we have come in so short a time, I recall citing, in my address in Houston three years ago, the joint communique that had just been issued in Moscow by then U.S. President Reagan and USSR General-Secretary Gorbachev, in which the leaders of the two super-powers made but one reference to development issues, namely, support for the WHO-UNICEF goal of reducing the scale of preventable childhood deaths. This was unquestionably a sign of progress in capturing political attention to human needs, and it gave us hope that the advances that were then taking place in the field of international security could be translated into advances in the social and humanitarian fields.

The World Summit for Children

Only two years later we were in a position to measure progress not by a brief statement of support for child survival from the leaders of two nations, but by the comprehensive and specific commitments made by 71 world leaders plus senior representatives from 88 other countries who participated in the World Summit for Children. Talk about united efforts! That first global summit of leaders from East and West and North and South marked a critical turning point in the history of humanity's treatment of the young and a major step toward a human-centered approach to development.

Three years ago in Houston, Dr. Nakajima spoke of the "potential for a virtual revolution -- globally -- in health in the remaining years of this century, particularly with regard to children". For many years, we had been saying that political will was the essential missing ingredient for this revolution to take place. Subsequent events, culminating in the World Summit, tell us that we now have that political will -- not as much as we would want, perhaps, but to a far greater extent than ever before. Now, far more than ever, it is up to us to take advantage of that new political will to accelerate human progress -- particularly in those areas where the principal obstacles are not financial but involve changing attitudes and practices. That is where we can make the greatest difference at the least cost.

UCI 1990 -- a health education success story

Health educators -- and other "agents for change" working across the entire gamut of health and development disciplines -- played a crucial role in creating this new political will. Universal child immunization (UCI) provides the best example, although many others could be cited. You will recall that when we met in Houston, optimism regarding the possibility of reaching the 1990 UCI goal for the Expanded Programme on Immunization (EPI) was tempered by the harsh realities of slow-down and retrogression in development efforts in much of the Third World during the 1980s. On October 8th, Dr. Nakajima and I expect to be able to announce that this largest peacetime collaboration in history has, in fact, been successful.

How was it possible for the world to achieve universal -- that is, over 80 per cent -- child immunization by the end of 1990, quadrupling coverage from the 20 per cent level of only a decade ago? How was it possible -- especially during such hard times -- to reach over 100 million infants last year with vaccines four or five times during their first year of life -- a total of over 500 million contacts every year between children and organized delivery systems extending, often, to remote villages and settlements unreached by even the postal service?

Clearly, this effort, which has saved more than 12 million lives since the campaign began -- and three million last year alone -- is far more than a medical or scientific success story. It is a health education success story in the broadest sense, a story of societies organizing, communicating and mobilizing to apply knowledge -- the knowledge that the major child-killing and child-crippling diseases can be prevented, at low cost, through immunization.

The same can be said of the remarkable expansion in the use of oral rehydration therapy against life-draining diarrhoeas, now used by more than one-third of all mothers, now saving the lives of more than one million children annually.

Effectively communicated to mothers, families and communities through the most diverse of modern media and traditional channels, this knowledge is transformed not only into acceptance of these interventions and techniques -- acceptance implying changed behaviour at the individual level -- but into demand at the social level. A critical threshold of empowerment and participation is crossed when individuals seeking to improve their lives move beyond the family sphere to demand action -- and take action themselves -- in the public sphere. In this era of democratization, in particular, politicians and government officials -- including those responsible for health systems -- ignore such civic demands at their peril.

To a large extent, it was the impending success of the immunization effort to which health educators have contributed so much that gave the international community the confidence to set a much broader range of goals and pursue them using many of the structures and strategies established for EPI/UCI as a model and platform for building sustainable service delivery systems. Over a period of two years, during 1989 and 1990, members of the health and development community from around the world worked to articulate an agenda for child survival, development and protection in the 1990s that was later endorsed by the presidents, prime ministers and monarchs who attended the World Summit.

The 1990s' agenda

It is an ambitious but "do-able" agenda with 27 specific targets [attached]. Seven of the major, over-arching goals are:

1. Between 1990 and the year 2000, reduction of the infant and under-five child mortality rate in all countries by one-third or to 50 and 70 per 1000 live births, respectively, whichever is less. This would save the lives of 50 million children during the 1990s and slow population growth as well.

2. Between 1990 and the year 2000, reduction of the maternal mortality rate by half. This would save the lives of 1.5 million women during the 1990s.

3. Between 1990 and the year 2000, reduction of severe and moderate malnutrition among under-five children by half.

4. Universal access to safe drinking water and to sanitary means of excreta disposal. This, if achieved, would bring water to the present 1.2 billion people without it -- a large number even without taking into account the billion to be added to world population over the decade. But need, even though large, is not totally out of scale in relation to the 1.3 billion people who gained access to safe water during the 1980s.

5. By the year 2000, universal access to basic education and achievement of a primary education level of knowledge by at least 80 per cent of primary school age children. At present, more than 100 million school-age children are not in primary school -- two-thirds of them girls.

6. Reduction of the adult illiteracy rate to at least half its 1990 level, with emphasis on female literacy. Today, some one billion adults are illiterate, of whom two-thirds are women.

7. Improved protection of children in especially difficult circumstances, tackling the root causes leading to such situations.

The health goals adopted at the World Summit are the most specific (and measurable) of all, including:

* an increase in immunization coverage of under one-year-olds from 80 per cent to 90 per cent;

* global eradication of polio and guinea-worm disease by the year 2000;

* neo-natal tetanus elimination and 90 and 95 per cent reductions in measles incidence and deaths, respectively, by mid-decade;

* reductions of diarrhoea-related deaths by one-half and of deaths due to acute respiratory infections by one-third in children under five; and

* virtual elimination of iodine and vitamin A deficiency disorders, among others, by decade's end.

The role of health educators

Health educators -- all those involved in health and development activities -- must play a key -- an indespensible -- role if these targets are to be met. The World Summit Plan of Action states:

> "The experience of the 1980s shows that it is only through the mobilization of all sectors of society, including those that traditionally did not consider child survival, protection and development as their major focus, that significant progress can be achieved in these areas. All forms of social mobilization, including the effective use of the great potential of the new information and communication capacity of the world, should be marshalled to convey to all families the knowledge and skills required for dramatically improving the situation of children."

This is the global, top level political endorsement of health education and social mobilization strategy so many of us have been seeking. For too long, policy-makers have not sufficiently appreciated the importance of building health education components into overall development plans: Your

efforts have been underfunded and, all too often, you have found yourselves administratively isolated within the overall health system. How can we make the most of this political endorsement to augment the impact and scope of our work?

How to make a difference

Permit me to recapitulate for a moment. We now have a generally favourable international climate to work in; democratization is paving the way for accelerating progress in scores of countries; our action agenda for child health for the 1990s is clearly established and is based on techniques and know-how that have already proven themselves do-able and affordable; the missing ingredient -- political will -- is now more solidly in place than ever before, and health education has, finally, received a top-level political green light.

This is the opening, the window of opportunity, we have before us. Again, we must ask ourselves: how can health educators best seize this opportunity? Where can concerted effort in health education make the most difference, given the multiplicity of problems we are being asked to tackle in a single decade?

The communications challenge

Our experience over the past few years with the Facts for Life initiative (which we previewed at your last conference in Houston in 1988) helps us begin to answer these questions. It is the health educator's guide to achieving most of the World Summit's health goals. Its success should make us feel optimistic about our ability to translate modern medical knowledge into basic health messages that empower families and communities to save and improve the lives of their children. Facts for Life -- published by WHO, UNICEF and UNESCO in partnership with more than 100 of the world's best-known agencies working for children and health -- has become a key tool for health education. It has ten basic clusters of messages -- beginning with timing of births and breastfeeding and concluding with AIDS. Two years after its launching in July 1989, Facts for Life is in use in over 80 countries, with approximately three million copies circulating in more than 100 languages. In scores of countries, Facts for Life has been incorporated into national health programmes, with some degree of budgetary support. Over 125 international NGOs -- including the International Union for Health Education -- and several thousand local NGOs, have formally allied themselves with the initiative. It is being used in thousands of ways today.

Thanks to the creativity and ingenuity of health educators and others, the messages of Facts for Life are finding their way into street theatre, rural radio programmes, comics and soap operas. The are seen on supermarket bags, milk cartons, T-shirts, calendars, billboards and bumper stickers and made the subject of newspaper supplements and puppet performances. Our informal surveys indicate that:

* Facts for Life is being incorporated into the national educational curriculum and/or national literacy programmes in at least 30 countries.

* Facts for Life is now being used, in different ways, by the health services in most developing countries.

* Also in most countries, the mass media have responded to the challenge with TV and radio "spots", regular articles, serializations, quizzes and competitions, documentaries and interviews.

* In many countries, religious and spiritual leaders are among the most influential communicators of Facts for Life.

* Many heads of state and government ministers have been personally involved in promoting the Facts for Life message.

* We are hearing that Facts for Life and its companion booklet for health communicators, All for Health, are quickly becoming the standard plain-language reference material for officals, health practitioners, educators and volunteer organizations concerned with protecting the health and nutrition of children and families.

Clearly, the key to the success of the Facts for Life initiative has been its flexibility in sending common messages. While the standard international edition of the book contains universally applicable messages regarding child health, and is relevant in all countries, national authorities -- with the help of educators and communicators such as yourselves -- have opted, in the vast majority of cases, to publish national, regional and even local adaptations of the international text, taking into account prevailing conditions, beliefs and traditions.

The experience we have gained with Facts for Life only confirms the need to obtain thorough knowledge of the needs, conditions, customs and particularities of target populations. Ultimately, it is at the level of the individual, the family and the community that health messages have their effect. For that reason, communication planning must draw on detailed data about people's attitudes and conditions and needs to be as decentralized as possible and involve the target populations at every stage of the campaign.

Healthy lifestyles

Attention is increasingly focused on the impact of individual behaviour on health. At a time when both the industrialized and developing worlds are searching for ways to finance health systems, increased emphasis is being placed on prevention of ill-health through changes in values, standards and lifestyles...changes that cost nothing but which can have an enormous influence on individual and community well-being.

I remember that Bill Foege, when he headed the U.S. Centers for Disease Control in the early 1980s, used to point out that medical interventions needed to add a single year to the life expectancy of the average adult American male would cost more than $10 billion annually. He said you could add eleven years -- today, it would be somewhat less -- if you would do four

cost-free things: stop smoking, moderate your alcohol intake, watch the quality and quantity of food intake, and do a moderate amount of exercise.

The progress we have witnessed in these areas in recent years has been due, largely, to massive public education campaigns hammering away at ingrained habits over at least two decades. These lead -- especially in the richer countries -- to an enhanced sense of individual responsibility for and control over one's own state of health and even to a new culture of personal well-being and fitness.

We all know, however, how difficult it is to change our habits and lifestyles, especially when they are long established and continually being reinforced by the social environment. Faced with the immensity of the costs to society of treating the consequences of prolonged unhealthy and risky behaviours, policy-makers are gradually coming to see that prevention through health education is the only practical, affordable, long-term solution. This, in turn, will require health educators to take the Facts for Life approach in new directions and apply it to new problems, based on an ever more sophisticated understanding of what motivates people and communities to take charge, insofar as it is possible, of their own health and lives.

Focus on adolescents

One of the lessons of public health campaigns in recent years is that teenagers need to be a key target population for health education programmes. This is due to the fact that most behavioural patterns are consolidated during adolescence and because youth are being exposed today to new risks to health and longevity. These include sexual risk-taking leading to adolescent pregnancy or childbirth prior to marriage; attitudes toward breastfeeding; unsafe abortions; sexually-transmitted diseases, sometimes leading to infertility and/or infection with HIV; accidental or intentional injury associated with alcohol or drug use, among others.

UNICEF and WHO have begun working together in Healthy Lifestyles for Youth, a public education programme aimed specifically at adolescents and youth. Understanding how best to reach, motivate and empower them with health knowledge during this crucial period of their lives -- before it is too late and the cost to society becomes unbearable -- this is one of our central challenges in the decade ahead.

The AIDS challenge

The AIDS pandemic, which has taken an increasingly devastating toll worldwide over the past ten years, has highlighted the need for carefully-designed, massive public education campaigns co-ordinated with community-based public health action focused on the prevention of unsafe sexual practices and HIV transmission risks associated with IV drug abuse. Such campaigns have met with significant success in a number of countries, leading to modified behaviours among the general population and sub-sectors of the population. In recent years, for example, the rate of new HIV infections has declined by more than half among gay men in the United States as many have changed their sexual practices to avoid transmission of the AIDS virus.

But this progress could find itself threatened by what some experts are calling the "second AIDS epidemic". A number of recent studies suggest that AIDS is continuing to spread among gay teenagers and young men who, for a variety of reasons, have not embraced or sustained the behaviour adaptations now largely accepted by the older generation which has so painfully experienced the horror of AIDS. Evidently, they have not internalized the message developed and taken to heart by large numbers of older gays that safe sex is the only real protection against AIDS.

There is an important health education lesson and challenge here. Prevention messages must connect realistically with the actual circumstances faced by those whose behaviour you seek to influence -- in this case, adolescents. Generic messages, while scientifically accurate, simply do not address their specific needs.

Baby Friendly Hospitals

It is clear that, in order to reach the year 2000 goals for children, the "lifestyles" of institutions -- not just individuals -- need to be changed. Breastfeeding affords a good example of why our work must focus on both. I do not need to enumerate here the reasons why breastfeeding is good for infants, good for mothers (although I did want to mention, in passing, the growing body of evidence that exclusive breastfeeding for six months significantly reduces the risk of breast and ovarian cancer in mothers). You are all well aware of the many benefits of breastfeeding and dangers of bottle-feeding. Between three and four thousand babies die every day -- more than a million each year -- merely because mothers are not effectively empowered with the knowledge, are not adequately motivated and not adequately supported to breastfeed. These lives can be saved -- at essentially no cost.

Breastfeeding is overall on the decline in the world. Recent modest gains in reversing this trend in industrialized countries are being offset by increased bottle-feeding in developing countries. As in the case of smoking, the trend toward bottle-feeding may indicate that the South is acquiring another harmful habit of the industrialized countries just when the North -- mindful of the immense social and individual costs involved -- is beginning to shake it off. It is a wasteful and unnecessary cycle that must be broken.

Over the past two years, efforts to promote breastfeeding have intensified. There are signs of progress. In response to a call issued by WHO and UNICEF in 1989 -- and most assuredly as a result of your efforts and those of NGOs promoting breastfeeding -- it now appears probable that the leading manufacturers and distributors of breast-milk substitutes will put an end to free and low-cost supplies to maternity wards and hospitals by December 1992.

Generally speaking, the great majority of hospitals do not promote or support breastfeeding. With the best of intentions toward both mother and newborn, their routine practices and the way they are organized wind up discouraging breastfeeding. Babies are, to use the words of a leading Mexican paediatrian, "kidnapped" from their mothers at birth.·· This needs to be turned

around, and soon, now that it looks like the flow of free formula to the hospitals will be cut off within 18 months or less. Unfortunately, hospitals, our "temples" in the field of health medicine, remain centres of cure and not centres for education. Hospitals can and must be converted into lighthouses of knowledge giving off strong impulses of health education, beginning with birth itself, beginning with empowering mothers with the ability to breastfeed and knowledge of the benefits of breastfeeding. And why not, before your next World Conference on Health Education?

WHO and UNICEF are currently planning for a worldwide campaign to get maternity services to implement the "Ten Steps to Successful Breastfeeding" (attached) endorsed by our two agencies. The "Baby Friendly Hospital" campaign will accord a "Baby Friendly" designation - a plaque or certificate - to hospitals and other maternity services which practice the Ten Steps and, ultimately, go beyond to include other baby friendly practices such as oral rehydration therapy, growth monitoring and immunization. And where deliveries are done at home, why not similarly designate "baby friendly" villages as well? Although bringing about such reforms won't be easy -- there will always be forces resisting change -- this campaign will be greatly assisted by the fact that hospitals -- already financially-strapped -- will save money by becoming "baby friendly", by educating and supporting mothers to care for their infants.

Just as the United Nations, on its 40th anniversary, decided to reach universal child immunization by its 45th as a concrete symbol of global co-operation, might the International Union of Health Educators undertake a commitment, here this week, on its 40th anniversary, that when you meet again three years from now, we will have brought about a structural transformation in world attitudes toward breastfeeding -- with the cutting-edge being the conversion of the majority of hospitals and maternity services into truly "baby friendly" institutions? Every health educator in this room, whether linked to a hospital or not, can be influential on both a professional and personal level. You can initiate training programmes in institutions seeking "baby friendly" certification. You can work with the community to create demand for "baby friendly" maternity services. The challenge, in short, is for each of you to become part of the process of transforming hospitals into genuine centres of education and prevention, as part of the effort to meet the year 2000 health goals for women and children.

A child friendly world

A number of recent developments have combined to make the decade of the 1990s an extraordinary window of opportunity. In the new atmosphere resulting from the end of the Cold War, the Convention on the Rights of the Child entered into force last year as international law and the world's leaders promised -- at the World Summit for Children -- to elevate children's needs to the highest rank of society's priorities and concerns...to give them a "first call" on society's resources, in bad as well as in good times, in peacetime and even amidst war. They matched this remarkable legal/ethical breakthrough with commitments to meet a comprehensive set of realistic goals to improve young people's lives, inviting the world and their publics to

sharpen their scrutiny and measure progress at the one, five and ten year points. The dramatic success of the worldwide immunization effort culminating in 1990 gives us confidence that the broader set of targets facing us can be reached.

But the mere existence of the opportunities afforded us by these welcome developments do not mean success is somehow guaranteed. Continuing to do what we have been doing will not be enough. Political will at the leadership level needs to be matched by a movement for children, for health and education...a movement from "below". We need a powerful, peaceful movement demanding that society invest in human development and that democracy extend, effectively, beyond the political to the economic and social spheres...a movement to ensure that the promises made to children at the World Summit are kept and the year 2000 goals are met. This worldwide movement for children will find natural allies in the movements for democracy, peace, the environment, women's equality and racial justice that are shaping this last decade of the 20th century -- and in the movements for decent health care and education now gathering strength in many countries.

Will we -- will health educators -- be at the forefront of this new movement? In order to do so, we now must go beyond communicating information to advocating changes in the way societies view and provide for children and youth, women and mothers. We can help incline the balance in favour of long-term investment in human development, poverty alleviation and the narrowing of gaps between rich and poor within and between countries. The challenge we face is to accompany every well-targeted health message with a message of grassroots participation and empowerment, a message that links personal with civic action for individual, institutional, community and -- yes -- global change. That is where the momentum will be generated for building a baby friendly...a child friendly...a people friendly world.