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Address by Mr. James P. Grant
Executive Director of the United Nations Children's Fund (UNICEF)
to the
Sixth Annual Meeting of the
Japan Association for International Health

Tokyo, Japan
28 August 1991

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Executive Director of the United Nations Children's Fund (UNICEF)

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Tokyo — 24 August 1991

It is, indeed, a pleasure to be able to meet here today with prominent Japanese medical and health professionals, as well as distinguished leaders from other fields, who are all vitally interested and involved -- as we at UNICEF naturally are -- in health co-operation with developing nations. The members of the Japan Association for International Health (JAIH) provide strategic intellectual input into the shaping of government policy as well as public opinion regarding Japanese international health assistance. As Japan continues to intensify and expand its co-operation with the developing world, your organization's prestige and influence will surely grow and the impact of your thinking, of your advocacy and action, will be measured by tangible improvements in the lives of many millions around the globe. UNICEF is honoured by this invitation from JAIH and we look forward to strengthening our ties over the years of this last decade of the 20th century. Over the next half hour I would like to outline the foundation of this partnership and make some specific proposals for joint action in the months and years head.

And what a critical decade it will be for the health and well-being of peoples everywhere! Over half a century ago, the historian Arnold Toynbee noted that for the first time since the dawn of history, it had become practical to dare to believe that the benefits of civilization could be extended to the whole human race. If this was true 50-odd years ago, it is even more so today. In the 1990s, making the benefits of modern civilization available to all -- in the field of health, first and foremost -- is not only a possibility, but a practical and moral imperative.

The end of the Cold War and the dramatic advance of democracy throughout the world, among other developments, have opened an extraordinary window of opportunity for us on the threshold of the third millenium. If we do the right things -- and by now, the do's and don'ts of human development are quite clear — we can if, we have the will, accomplish in ten years what took thirty or fifty years to accomplish in earlier historical periods.

Let us recall that infant mortality in the United States at the turn of the century was approximately 125 per 1,000 births and took nearly half a

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century to fall below 50 per 1,000. In the early 1920s, when I first visited Japan, the infant mortality rate was over 145 -- equivalent to sub-Saharan Africa today. By the time of my return to Japan in 1946, IMR had fallen to approximately 100 per 1,000 live births, roughly equivalent to that of India today, but in another decade it dropped to under 40 -- all this in a total span of less than 30 years! And now Japan has an IMR of 4.5 per 1,000 births, the lowest in the world! We in UNICEF believe that your experience in Japan, widely applied, can accomplish remarkable progress in this next decade -- bringing a rapid fall in IMR to all countries of the developing world. Let me explain...

Progress toward Health for All by the Year 2000

I have been asked to focus my remarks today on progress made along the path to meeting the goal of Health for All by the year 2000. As you know, it was at the International Conference on Primary Health Care, held in Alma Ata, the Soviet Union, in 1978, that this target and the Primary Health Care (PHC) strategy for achieving it were first proposed. Shortly thereafter, both the goal and the strategy were adopted formally by the international community. The principles codified at Alma Ata continue to provide the guiding light for those determined to make the benefits of modern health sciences available to all the world's people.

UNICEF -- which, along with the World Health Organization, co-sponsored the Conference -- is applying the principles of Alma Ata to our work on behalf of children in over 120 countries throughout the developing world. Our experiences shed light on a particular corner of the overall picture of primary health care. I suggest, however, that a review of how far we have come, with regard to children, toward achieving Health for All by the Year 2000, will provide lessons with a more universal application, for adults as well as children, and for industrial as well as developing countries.

The international community quantified what is meant by Health for All for children when, at the beginning of the 1980s, it adopted the goal of halving 1980 infant and under-five child mortality rates in all countries by the year 2000, or reducing them to 50 and 70 per 1,000 live births, respectively, whichever is less. This would bring developing countries to about the level achieved in Japan in the early 1950s. Success would mean saving the lives of more than 60 million children over two decades.

Looking back at your own experience, I can see the application of many important principles relevant to many countries -- principles embodied in the Alma Ata Declaration, but applied decades earlier here in Japan. Along with improved water and sanitation and mass attention to elimination of intestinal parasites, universal education of women led to greater attention to the nutritional needs of young children and protecting them from common infections. Active self-help efforts by the communities themselves -- another key strategy of Primary Health Care -- also played an important role in improving the health of children and mothers in Japan. In many cases, people from diverse sectors of society, including school teachers, local politicans and leaders of the agricultural co-operative, joined hands with health workers

in this effort. The child health record -- your boshi techo -- became the tool in the hands of each mother to assure her baby's health. This was an early form of social mobilization for child survival and development! Even before your remarkable economic leap forward of the late 1950s and 1960s, the major battles for Japanese children had been won.

Today, 13 years after Alma Ata and nine before the year 2000, considerable progress has been made toward improving child health worldwide, particularly in the past six years. For example, as a result of two interventions alone -- immunization and oral rehydration therapy -- more than ten million child lives were saved since the early 1980s, rising to four million children annually by the end of 1990. Nearly comparable numbers are being protected by anti-polio and other vaccines from lives of crippling disability due to childhood disease. Average Third World infant mortality has dropped from 93 to 76 deaths per thousand live births and from 142 to 117 deaths in the case of under-five-year olds. But perhaps most important is that several elements, based on experience in PHC as well as the general development process, combine to give us hope -- and reason to believe -- that the stage is set for truly major advances in the next few years, and this ambitious goal for reducing child mortality can actually be achieved. What are these factors?

Principles for action; reasons for hope

For the first factor we can turn to the very content of the Declaration of Alma Ata itself, as stressed by your fellow-countryman, Dr. Hiroshi Nakajima, the distinguished Director-General of the WHO, when he told the 1988 World Conference on Health Education:

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

Doing more with less

Indeed, the role of health communication and education is perhaps even more central today than ever before, as a result of several key developments of the 1980s. First, the economic recession of the 1980s hit the developing countries, especially Africa and Latin America, the hardest, forcing drastic reductions in health expenditures. The dimension of the crisis was much greater than most realize in the industrialized countries, where the adverse impact, while significant, was much less severe. It is still widely believed, for example, that money is flowing from rich nations to poor nations to assist in the struggle against poverty. In 1980, US$50 billion a year went from the rich countries to the poor. For several years now, however, the flow has been reversed. Taking everything into account -- loans, aid, repayment of interest and capital on outstanding Third World debt -- developing countries are now transferring tens of billions of dollars to the industrial countries each

year. The net outflow reached as high as US$35.2 billion in 1988 and the World Bank estimates the figure at US$22.5 for 1990. Furthermore, in the 37 poorest nations, governmental spending per person on health was reduced by 50 per cent during the last few years of the decade. Starting from an annual level of only US$2 -US$5 per capita (or even less), you can well imagine the devastating effect this cutback has on public health programmes. Today, many governments are not paying even base salaries of their medical personnel, much less providing them with minimal essential drugs and supplies. With the burden of these changes borne disproportionately by the most vulnerable within poor societies -- especially children and women -- an urgent need emerged to restructure the health sector to do more with less.

Fortunately, the health knowledge and technologies exist to make dramatic improvements in the health and well-being of children at very low cost if only families could be adequately informed and motivated to act. The actual techniques are, of course, familiar to you, and include immunization against the six main child-killing diseases; oral rehydration therapy against life-draining diarrhoea; a return to the practice of breastfeeding with proper weaning; growth monitoring; female literacy; food supplementation with vitamin A, iron, iodization, etc.; and family planning. These interventions alone, if practiced universally, could accomplish the goals of mortality reduction set out in 1990.

The Child Survival and Development Revolution

During the 1980s it was realized that combining these existing low-cost/high-impact health knowledge and technologies with our new capacity to communicate among peoples of the world could create the potential for a virtual revolution in child survival and development -- a "Child Survival and Development Revolution" (CSDR). Such an approach could serve as a leading edge for advancing PHC generally. But these revolutionary possibilities could become realities if, and only if, the popular and political will emerged to make them happen -- the will to inform, to motivate and to provide the necessary support systems such as those required to promote immunization and breastfeeding.

Guided by the principles set forth at Alma Ata and perhaps pressed by hard economic realities to do more with less...perhaps spurred creatively by the synergistic combination of new health knowledge and the means to communicate it -- many countries in the developing world did "mobilize...their resources", as promoted by the Alma Ata Declaration, and some of them did so on a truly extraordinary scale. While progress has been made on a number of fronts, immunization has been the biggest "success story", an accomplishment Dr. Nakajima and I plan to formally announce at United Nations headquarters in New York on October 8th.

UCI: the greatest global collaboration in history

You will recall that in 1977, the World Health Assembly challenged the countries of the world to achieve universal child immunization (UCI) by the year 1990 -- defined as 80 per cent of all children under one year of age. At the time, many considered the goal unrealistic and over-ambitious, given the

fact that fewer than 15 per cent of children were then being immunized in the poor countries. Health professionals such as yourselves can appreciate the many difficulties that must be overcome in order to reach infants with vaccines five times during their first year of life -- under the best of circumstances. But reaching them under the harsh conditions prevailing in much of the developing world requires a truly heroic effort...although still at a remarkably low cost.

The heroic effort was made and by the end of 1990, the goal was reached. Today, more than 100 million infants in the developing countries are being effectively reached with six vaccines during their first year of life -- totalling approximately half a billion contacts every year between children and organized delivery systems functioning, all too often, under extremely adverse conditions. In many parts of the developing world, the reach of the UCI system exceeds that of the postal service, which we tend to think of as the "universal" government service par excellence.

As a result, the lives of some 8,000 children a day are being saved. That is more than 12 million young lives since the campaign began and some three million saved in 1990 alone. Unquestionably, the UCI mobilization is the largest international collaboration in peacetime ever recorded and is, in the opinion of many, the greatest public health success story in history.

Social mobilization: the key to success

The UCI story is a remarkable story of societies organizing, educating, communicating and mobilizing to apply modern medical advances to prevent unnecessary child deaths and suffering. It is a story of people coming to demand immunization for their children as an essential part of the nurturing culture of the family and community. It is a story of personal involvement by presidents and prime ministers...of health workers carrying cold boxes across deserts and through rugged mountain passes...of mothers walking many miles to have their babies vaccinated...of religious leaders and teachers incorporating health messages into their teaching...of combatants agreeing to lay down their weapons to take part in El Salvador's immunization campaigns. It is a story of harnessing modern and traditional communications media for health. It is a story of political will translated into cost-effective social action during times of crisis and austerity, of education translated into empowerment, of broad inter-sectorial collaboration and effective international co-operation. Collaboration, in fact, carried far beyond the traditional boundries of governments, international assistance agencies and medical societies such as yours. Rotarians, Lions, Jaycees and other NGOs brought massive private sector involvement -- countless local groups of women, scouts, adolescents, etc. -- everyone joined in.

Permit me to note, at this point, that Japan ranks high among the largest suppliers of vaccines and syringes, as well as the vehicles used to transport them, in UNICEF-assisted programmes throughout the Third World. An accelerated Japanese research programme in the field of vaccines could do even more. I am thinking, in particular, of the development of more heat stable vaccines to combat polio, single slow release vaccines against tetanus toxoid,

replacing the need for multiple innoculations, and especially of a heat-stable "Children's Vaccine" conferring permanent immunity against the major child-killing diseases through a single, oral dose administered shortly after birth -- these could revolutionize the child survival revolution before decade's end.

In short, what has been accomplished in immunization provides us with a model of the "do-able", a platform for strengthening primary health care systems, a foundation on which other health interventions and measurements are being "piggy-backed", providing a momentum of confidence and organization for pursuing a broad range of goals for children and families in the 1990s.

The Convention on the Rights of the Child

While Alma Ata declared the importance of health education and social mobilization, and experiences of the CSDR proved the potential of empowering families and communities with health knowledge and the support to put that knowledge to use, another recent development -- the entry into force of the Convention on the Rights of the Child -- brought this issue a second giant step further. It is a step which contributes greatly to our hope for improving the situation of children within this decade. It also provides health professionals with a major new asset for advocacy efforts on behalf of children's integral well-being.

The Convention on the Rights of the Child, which came into force last September after having been approved by the United Nations General Assembly in November 1989 -- the speediest entry into force of any human rights treaty -- codifies for the first time the broad range of children's rights and society's obligations toward the young. In the area of health, the Convention not only asserts children's right to health services and health education. It also commits nations which ratify the Convention "to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast-feeding, hygiene and environmental sanitation and the prevention of accidents..." Echoes of the Declaration of Alma Ata reverberate through the Convention.

To date, 94 countries in the industrial and developing worlds have ratified the Convention and are working to bring their legal codes -- and most importantly, their actual practice -- into line with its provisions. Japan, which issued its own Declaration of Children's Rights in 1959 and already has far-reaching legislation on the books for the protection of children and mothers, was one of the Convention's earliest signatories of its interest to ratify and I am very encouraged by the growing interest among many sectors of Japanese society in its prompt ratification. Prime Minister Kaifu himself has expressed the hope that ratification of the Convention would come as quickly as possible. I trust that JAIH will help expedite the ratification process, using your prestige to promote popular awareness of the Convention's precepts and working, over the long term, to ensure that these precepts are fully implemented. For this is a key step in establishing a global ethic for children -- one that transcends national boundaries and makes children everywhere the responsibility of all of us. Consider, for example, how

childhood immunization, once the exclusive domain of national or even local health authorities, has become a global responsibility -- with benefits, I might add, that accrue to all. The eradication of smallpox some 15 years ago at a cost of less than US$100 million now saves hundreds of millions of dollars annually to industrialized nations no longer required to protect their own population. Similar benefits can be expected from the eradication of polio before the year 2000, and measles soon to follow in the early years of the next century. Our global village surely benefits whenever we stoop to help children!

The World Summit for Children

The international community took a great stride toward implementing the Convention and working together more broadly in the human development arena on the last two days of September 1990. Held at United Nations headquarters, the World Summit for Children was the first truly global summit, in which the leaders of all nations were invited to participate. 71 Heads of State or Government did attend -- including Prime Minister Kaifu -- making it by far the largest such gathering in history. And another 88 countries were represented at ministerial or other high level. Never before had leaders from North and South, East and West sat together around a single table.

In the new atmosphere created by the end of the Cold War, the leaders were able to agree that children should have a high priority or, as stated in their Plan of Action, children should have a "first call" on the resources of society for the essentials of their survival, protection and development. To the Japanese, who have long placed children's well-being high on the list of national priorities -- achieving, for example, the lowest rates of infant and under-five mortality in the world and the highest rates of educational achievement -- this may not sound like anything new; but for much of the world, where instead of being the most protected, children are the most vulnerable, application of the "first call" principle would, in fact, represent a breakthrough of historic proportions.

But the leaders attending the World Summit did not just issue lofty, abstract pronouncements as politicians are wont to do. Drawing on lessons learned from countries like your own, and on tested principles such as those adopted at Alma Ata, they set a series of 27 quantified goals for children to be achieved by the year 2000, outlining strategies for attaining them. And in order to ensure accountability, they called for establishment of an international mechanism, including UNICEF, to monitor progress periodically throughout the decade, beginning in 1992. The leaders promised to draw up National Programmes of Action -- by the end of this year in industrial as well as developing countries -- for implementing the World Summit Plan of Action.

I understand that Japan is working on its National Programme of Action even as we meet here today. Let us not forget that the Declaration signed by Prime Minister Kaifu last September in New York commits Japan not only to a series of goals for Japanese children (paragraph 34-i), but also to a reassessment of the adequacy of governmental assistance abroad (paragraph 34-iii and 35-i) where your resources are so critical to enabling the poorer countries to fulfill these objectives for children.

Summit goals

A useful "short-list" of Summit goals to be achieved by the year 2000 includes:

* reduction of infant and child mortality by one-third (including reduction by 50 per cent in the deaths due to diarrhoea among under-fives), and eradication of polio and guinea worm;

* reduction of maternal mortality by one-half;

* reduction of malnutrition by one-half by such means as empowering all women to breastfeed their children for at least four to six months, and by elimination of iodine deficiency and vitamin A deficiency;

* universal access to safe drinking water and to sanitary means of excreta disposal;

* 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... (permit me to note, here, that these last two points were the ones on which Prime Minister Kaifu placed the most emphasis in his important intervention during the World Summit);

* and the last major goal: improved protection of children in especially difficult circumstances, including for those caught up in armed conflicts.

What "keeping the promise" will mean

To date, 108 heads of state or government have personally put their signatures to the World Summit Declaration and Plan of Action, committing themselves and their governments to meeting the Summit goals. No other document in history bears the signature of so many world leaders and their solemn commitment for specific action. In the past, we often said that political will was the key ingredient needed to make the recipe for human development work; with the World Summit, now for the first time, political will has been engaged at the highest level and the world has every right to expect that the promises made to children will be kept.

If the 27 targets set at the World Summit are reached, the lives of some 50 million young children will be saved during this decade, and comparable numbers will be able to avoid the stunting and wastage of body and mind resulting from childhood malnutrition and disease. As we know from the experience of Japan and, more recently, the newly industrializing countries of Asia, investments made today in the health and education of children produce handsome returns in productivity and economic growth down the line -- in fact, making such investments is one of the conditions for development. And it is important always to remember that a reduction in child deaths contributes importantly, at a certain point, to an actual slowing in population growth rates, as parents become confident that the first children they have will live, and they take the decision to limit their family size.

Indeed, if all of India -- whose infant mortality rate is 96 -- enjoyed the low infant mortality rate of the state of Kerala, i.e., 26, there would be three million fewer infant deaths in that country. A similar lowering of birth rate to the Kerala level associated with this improved life expectancy would mean 10 million fewer births each year in India. There is not sufficient public awareness regarding this relationship between the lowering of child death rates and slowing population growth -- even in Japan, which has seen such success in family planning coupled with maternal and child health care. Would this not be a fruitful area of public education for an organization like JAIH?

Gearing up for a decade of action

I am happy to inform you that, almost every day now, we are receiving reports of progress toward implementation of Summit goals from both developing and industrial countries. As I mentioned earlier, governments are working on their National Programmes of Action for children and it is a particularly opportune time for non-governmental organizations and diverse grassroots constituencies to weigh in with suggestions and demands. In much of the Third World -- not to mention Central and Eastern Europe -- the Plans of Action stand to benefit greatly from the move toward fundamental reform aimed at making economies more efficient, societies more democratic and the human being more central to the development process. And it is to be hoped that the reduction of international tensions resulting from the end of the Cold War and the resolution of regional or civil conflicts will enable governments -- in rich and poor countries alike -- to cut military budgets and devote a considerable portion of the savings to human development. Recent indications that Japan and Germany will consider increasing aid to developing countries that reduce their military spending and efficiently address human needs are most welcome. But will this "peace dividend" primarily go to building more hospitals with modern equipment and heavy maintenance costs which may be valuable but may also dramatically reduce funds for PHC and public health as has so often happened in the past? Or will it be primarily invested in the PHC programmes which we all know so well will yield maximal benefit and contribute to reaching the Summit Goals for the 1990s?

The need for more and better-targeted ODA

In the case of the developed countries, the Summit Plan of Action calls on their governments to "re-examine their development assistance budgets to ensure that programmes aimed at achievement of goals for the survival, protection and development of children will have a priority when resources are allocated" (paragraph 34iii). It is estimated that the developing countries themselves will provide two-thirds of the approximately US$20 billion in additional funds that will soon be needed each year to finance the drive to meet the year 2000 goals for children. That means that an extra six to seven billion dollars a year will be needed from the industrialized world -- through debt-relief, reallocation of current assistance, or increases in aid. This US$6-7 billion is really quite a small sum if you consider that it is as much as the world spends on the military every three days and less than half of what the Japanese spend each year on alcoholic beverages.

As members of the influential Japan Association for International Health, you are well-positioned to advocate for the concept of a compact between donors and developing nations. As shifts are made in spending priorities in the poor countries to fund low-cost, high-impact human development programmes, the industrialized world's aid budgets -- less than a quarter of which go for health and education today (and a much smaller percentage to primary health care and primary education) -- should undergo a corresponding shift in favour of sustainable human development.

In 1989, Japan became the world's largest donor. Utilizing this global power responsibly is a major challenge. Joining forces with other donor countries and international agencies to work toward commonly shared goals -- such as the year 2000 goals for children -- is certainly one way to maximize impact. In this context it should be noted that Japan's governmental contributions to child survival and development activities through UNICEF increased from approximately US$5 million in 1981 to US$22 million this year. Private contributions from Japan now total more than US$15 million. These voluntary contributions now place Japan tenth among UNICEF's contributors; they are well-appreciated. I should point out, however, that of the major UNICEF donors, Japan devotes the smallest percentage of its ODA -- one-quarter of one per cent -- to children's support through UNICEF as compared to the global DAC average of 1.5 per cent. How much more good you could accomplish as a nation were you to achieve the world average of 6.7 per cent of overseas assistance devoted to health in place of your present level of 2.6 per cent. Even within your present funding level, a shift in health allocation towards programmes contributing to achieving the 1990s goals could have substantial impact. This is a situation JAIH might wish to address as part of its advocacy agenda.

At the same time, I would like to commend your government's recent initiative to host a summit-level gathering of African leaders in Tokyo in 1993 -- not only because Africa is the continent most in need of international assistance, but because there is now consensus among Africans that investment in human development, in the framework of fundamental economic and political reform, must be high, if not at the top of their agendas for the 1990s. Africa's Bamako Initiative for community financing and management of primary health care is an example of effective reform worthy of increased international support.

Sharing the Japanese miracle

One key to Japan's economic miracle was, initially, investment in primary health care and basic education. In the 1920s and 1930s, my father, Dr. John B. Grant, visited your country frequently from China where he was the representative of the Rockefeller Foundation for The Far East. He consistently advocated an approach to public health based on social organization, i.e., that use made of medical knowledge depends on social organization; health care integrated with other social actions at the community level; universal care with essential services for all segments of society; and consistant attention to health education aimed at self-reliance for healthy living. For these efforts your government honored him with the

Order of the Sacred Treasure in 1961 in recognition of the contribution these ideas made to public health in Japan in the 1920s and 1930s. How relevant these ideas are even today as the developing world endeavors to repeat your miracle. So it seems only logical that a Japanese foreign assistance budget reflecting these same priorities would greatly enhance the effectiveness of aid and make a real difference to countries which in the past may have received funding primarily to build big hospitals, acquire sophisticated laboratory equipment or install turn-key projects which, by their very nature, cannot address the most pressing needs of poor populations.

Japan is uniquely qualified, because of its own experience and expertise, to help other countries in the field of health. All Third World health systems and poor families could greatly benefit, for example, from a standardized boshi techo! Indeed, we in UNICEF have tried to learn from you and placed great emphasis on regular monthly checkups of growing infants and children, providing relevant nutrition advice along with timely immunization and other necessary, simple interventions. I believe that there is a need for more research with regard to the Japanese experience in this field. We can also learn a lot from the experience of other countries in East and Southeast Asia which have had remarkable achievements in the health sector.

Consider the global problem of iodine deficiency, with over 800 million people living in deficient areas -- 200-300 million with goitre and 6 million cretins, in addition to millions more affected by neurological and mental deficits. Japan is the major world supplier of iodine (less than 10% of which is used for human consumption -- the rest goes for industrial uses). For a mere US$5 million to US$10 million annually over the next decade, your country could assure supply of this critical nutrient to every country where iodine deficiency disease is found, thus enabling the accomplishment of one World Summit goal just with your own effort. What a unique opportunity to contribute to world health as well as education and learning as emphasized by Prime Minister Kaifu!

New credibility with new capacity

I believe, thanks to the scientific and technological advances of recent years...thanks to the experience we have gained using health education and social mobilization as tools for development...thanks to the strengthened political will symbolized by the World Summit for Children...and thanks to the vastly improved global climate that has emerged following the end of the Cold War -- we professionals concerned with health have a whole new capacity, and a whole new credibility in advocacy because of our increased capacity. Our challenge is how to ensure that this capacity is used...that people are empowered with basic health knowledge...and that governments and communities are compelled to fulfill the human rights -- including meeting basic human needs -- of the world's children.

You are an important part of the increased capacity -- each in your role as individual professionals and more so as a respected organization. But, as other important organizations in your country, your voice must be heard in the offices of decision makers, where resources are allocated and important

development priorities are established. Your voice can give substance to the basic concept of the Summit — putting children first — and you can help ensure that this great nation is in the forefront of the march to Health for All — rich and poor alike.

Recently, Dr. Nakajima wrote: "We cannot allow governments' economic debts to become debts in human lives...We must strive to reduce debt and the economic burdens that weigh so heavily on certain countries, especially on the poor and disadvantaged. Let us build on the improved international relations and the demands of people everywhere for a better life to carve out a 'dividend for health'." I can only second the Director-General of WHO's eloquent appeal.

The 1990s will be difficult years...for all countries, all societies and the world as a whole. But for the reasons I have outlined here today — and the dedication of groups like JAIH is one of those reasons — it can also be the most momentous decade for health...for children...for the most vulnerable...for the great majority of the world's people. You in this room — whose life work is devoted to these issues — are in the vanguard of tomorrow's world...a kind of world worthy of the third millenium.