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Address by Mr. James P. Grant
Executive Director of the United Nations Children's Fund (UNICEF)
to the
VI International Congress
of the
World Federation of Public Health Associations
and the
199th Annual Meeting of the American Public Health Association

"Keeping the Promise: Progress and Prospects"

Atlanta, Georgia
13 November 1991

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"Keeping the Promise: Progress and Prospects"

It is a great honour for me to participate in this International Congress of the WFPHA and the Annual Meeting of the APHA. I still recall with pleasure having been asked to be the Hugh Leavell lecturer at your 3rd International Congress in Calcutta ten years ago. That Congress was a memorial conference dedicated to my father, Dr. John Grant, who devoted his life to the provision and modernization of health services in China, India, Europe and the Americas. So you can understand it is a great personal joy for me to again have the opportunity to address you.

Aside from my personal pride, I am also particularly gratified to be with you once again as there are few organizations whose concern for excellence and equity in health equals that of the WFPHA and the APHA. The American Public Health Association for more than 100 years and the WFPHA since its founding have been in the forefront of the struggle to achieve sound public health practices and policies. For UNICEF, you are leading partners in our efforts to create a "Grand Alliance" for the health and well-being of children.

Since that meeting in Calcutta, and even since the last time I talked with you in Mexico City in 1987, important changes have come about in the world and significant lessons have been learned. It would be difficult to make a precise balance sheet of the progress in health since the historic Alma Ata Declaration of 1978, but for children there have been significant

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developments that give great promise for the future. Perhaps the most important lesson we have learned is that it is possible and realistic to think about reaching all children -- not just the sons and daughters of the elite, not just the privileged, not just city-dwellers. The attainment of Universal Child Immunization (UCI) -- that is over 80 per cent child immunization by the end of 1990, quadrupling coverage from the 20 per cent of only a decade before -- is undoubtedly the most dramatic proof of what we can now do.

This is a significant accomplishment not only in itself -- for the 12 million lives saved since the immunization effort began -- but for what we have learned. It is far more than a medical or scientific success story; it is a health education success 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, if the political will is there and social mobilization activates whole communities, as well as families and parents.

Effectively communicated to mothers and families, utilizing modern and traditional channels of communication, knowledge is transformed into acceptance of health interventions and techniques. Such acceptance brings not only changed behaviour at the individual level but demand for health services at the social level. A critical threshold of empowerment and participation is crossed when individuals seeking to improve the health of their families demand action, and take action themselves.

In this era of democratization in the world, politicians and public officials -- including those responsible for health systems -- ignore such civic demands at their peril. We have just seen a provocative example of that in the elections here in the United States last week, where health care was an issue of major concern to voters, and has leapt to the forefront of the national agenda.

To a large extent, it was the impending success of the immunization effort that encouraged the international community to set a much broader range of goals for the 1990s. Over a period of two years, during 1989 and 1990, members of the health and development community from around the world articulated an agenda for maternal health and child survival that drew heavily upon the strategies and structures established for UCI. These became the goals endorsed by heads of state and government at the World Summit for Children last year.

As you perhaps know, the World Summit was the largest gathering of heads of state and government in history. It was the first summit of the post-Cold War period, bringing together leaders from North, South, East and West. They committed their governments to a Plan of Action, a remarkably specific document on what needs to be done for children over the decade. They agreed on strategies to reach 27 quantifiable goals by the year 2000, with periodic reviews and international monitoring of progress along the way. National Programmes of Action to implement these objectives are now being drafted and we expect approximately 100 countries to have completed them by the end of this year, as required by the Summit's Plan of Action.

Reinforcing these national commitments is the Convention on the Rights of the Child which came into force in record time last year, on the eve of the Summit. One hundred nations have now ratified this Magna Carta, this Bill of Rights for children, and another 41 have signed it, signifying their intention of making it the law of their lands. It provides a solid legal and ethical framework for our efforts to improve children's lives and outlines the adult world's responsibilities toward the young. It converts needs into rights. Many of its holistic and mutually reinforcing precepts contribute to the health and survival of children and their mothers.

The Convention's Committee on the Rights of the Child, comprised of ten leading experts on children who serve in their individual capacities, held its first session in Geneva last month. It will begin receiving reports from governments this coming year on how successfully they are implementing the various articles of the Convention. This procedure in effect monitors the Programmes of Action governments are now undertaking on behalf of their children.

So, the goals agreed to at the World Summit for Children, the National Programmes of Action, and the Convention on the Rights of the Child have established a process -- worldwide -- for moving societies and governments toward the objectives to which they are now committed for the health and well-being of children and mothers. As you can see, there is momentum building, and the new international climate brought on by the end of the Cold War can help us make the most of it. The 1990s may well prove to be one of those rare "windows of opportunity" that open in history only two or three times a century to permit quantum leaps of human progress. It would be foolish — and tragic — to allow the window to slam shut without doing all that we can do for children, for the future, for ourselves.

Ten years ago, the gap between what was known and could be done with low-cost, simplified techniques was wider with respect to children than for any other major group in society; today this gap is rapidly narrowing. We have learned high impact ways of getting health knowledge out to people in the most remote areas of the world and programmes for doing so are increasingly underway. We must narrow the gap still further, focusing particularly where the disparities are the greatest -- Africa, South Asia, parts of Latin America, and among the growing numbers of poor in the industrial world.

At the heart of bridging the gap is informing and motivating people with the knowledge they need to improve their own health, while empowering them to make certain that the services they need are available to them.

We have seen a revolution in our capacity for communication, through traditional as well as modern means. At the World Conference on Education for All last year, virtually all governments agreed to strengthen what we call the "Third Channel" -- that is, all the means of informing and educating people, in addition to formal and non-formal education. Never has our capacity for reaching people with health messages been greater, and we must refine our communication skills so that these messages are understandable and fully relevant to peoples' lives.

Many of you may already be familiar with Facts for Life, published by WHO, UNICEF and more than one hundred NGOs concerned with children, with the authoritative advice of fifty of the world's leading health experts. It contains ten essential messages for the health of children, with an accompanying text that instructs communicators of all kinds how to utilize this information to get it out fully to parents and others in the community responsible for the health of children. Facts for Life has already been adapted into 120-some languages and cultures -- it is a process that will continue throughout the 1990s, augmenting the efficacy of other programmes now underway and gathering momentum.

For much of the world, reaching the year 2000 goals for children will require compressing into ten years the work of several decades. Thanks to the debt crisis, economic setbacks and austerity programmes of the 1980s -- that "lost decade" for much of the developing world -- social gains slowed or reversed themselves in country after country. Education and health care budgets were cut, in rich as well as in poor nations. Among the lessons learned is that protecting the most vulnerable is not a luxury to be dispensed with in hard times, but a vital investment in economic growth and future productivity.

"Adjustment with a human face", we call it, and more recently, "development with a human face" -- the notion that investing in people, the establishment of safety nets during difficult transitions, the cushioning of the most needy from the effects of austerity programmes, is as vital to recovery and growth as macroeconomic stability. We have seen that in the most successful countries -- the newly industrializing countries of Asia, for example -- investment in people, in the basic health and education of children and women, came early and was sustained even amidst periodic economic downturns. And from the experiences of countries as diverse as Costa Rica and Cuba, Sri Lanka and China, we have learned that high per capita income is not a precondition for attaining high levels of human development; what is key is the political will and the popular support to maintain well-targeted, efficient basic services, viewing them as long-term, high-yield investments rather than drains on the public treasury. In support of primary health care in these times of fiscal austerity, health institutions and systems are being restructured in order to reach out to the unreached, through decentralization, community management and financing schemes, retraining of TBAs, training of paramedics, formation of cadres of basic health, nutrition, water and sanitation workers, and other participatory approaches tapping local resources and initiative.

Although our workshop is well-stocked with proven, low-cost interventions that could save up to 80 per cent of the 40,000 children who die each day, further technological advances could greatly accelerate progress toward the Health for All goals. Take immunization. If we had a heat-stable vaccine against a wide variety of diseases that could be administered orally in a single dose right after birth, instead of having to reach and inject babies up to five times during their first year of life with vaccines that require maintenance of an elaborate cold chain -- and if we could do so at low cost -- we could achieve our goal of universal child immunization and free resources for tackling other more complex public health problems. The scientific and

medical research community is taking a strong role in the international effort to improve children's vaccines. "The Children's Vaccine Initiative" which originated at an international meeting of health experts on the eve of the World Summit, produced a declaration asserting both the technical feasibility and public health urgency of accelerated vaccine development in this decade. I know this audience will agree that it is especially important that today's sophisticated resources of medical research be used to solve the problems of the world's poor, rather than focusing solely on the more glamourous "rich-prone" diseases.

Even with technological progress, reaching the poorest of the poor represents a major challenge, and I know you are concerned about the fact that even in industrial countries we are slipping back in providing the kind of health care that is available but increasingly out of the reach of many families. New York City and Washington, D.C., now have immunization levels for under-one-year olds that are significantly lower than those in Calcutta. This reflects a problem upon which we all must act -- the right to health care enshrined in the Convention on the Rights of the Child applies to children in rich as well as in developing countries.

There are lessons to be learned from the experiences of the developing world -- synergy is possible in both directions between industrial and developing countries. The problems and some of the ways of solving them in the Third World overlap with those we are encountering in the United States and other industrial nations -- street children, drugs, AIDS. Young people in developing countries learn through the popular media about jeans and rock -- and, unfortunately, the "sophistication" of smoking cigarettes; we must reach their ears and minds with messages promoting healthy lifestyles.

We have also learned that as industrial and developing countries alike are searching for ways to finance health systems, increased emphasis must be given to prevention of ill health. I remember that Bill Foege, when he was heading the CDC in the early '80s, used to point out that medical interventions to add a single year to the life expectancy of the average American male would cost more than $10 billion annually. But, he said, you could add eleven years -- today it would be somewhat less -- if we would do four cost-free things: stop smoking, moderate alcohol intake, watch the quality and quantity of food intake, and do a moderate amount of exercise.

The progress in recent years in these four areas is largely due to massive public education campaigns leading -- especially in the richer nations -- to a heightened sense of individual responsibility for and control over one's own health and even to a new culture of personal well-being and fitness. Policy makers are coming to see that prevention through health education is the practical, affordable, long-term solution.

These are the kinds of changes we are learning about in the industrialized countries that can make a difference in the developing countries as well. One other I should mention: an opportunity has opened for us as a result of a call WHO, UNICEF and many of your associations made years ago. It now appears 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.

Over the next year, we must turn around the practice of hospitals that do not support breastfeeding. Unfortunately, hospitals remain centres of cure and not centres of health education. Hospitals can and must be converted into lighthouses of knowledge giving off strong beams of health education, beginning with birth itself, beginning with empowering mothers to breastfeed and knowledge of the benefits of breastfeeding. Hospitals must become "baby friendly" by educating mothers to care for their infants. Together with WHO and a wide coalition of activists we are beginning a global campaign that will certify as "baby-friendly" hospitals that practice ten steps for successful breastfeeding. The campaign could help save a million infant lives a year, reduce breast and uterine cancer among mothers, and provide enormous financial savings to families and societies as a whole.

The agenda we have before us is ambitious — but it is realistic, doable. Reaching the goals of primary health care for all and the specific year 2000 goals for children will require the synergy of government action and community cooperation, nothing less than a social movement imbued with the ethic of putting "children first". Present priorities clearly must be changed. As stipulated in the World Summit Plan of Action, children should receive a "first call" on a nation's resources, in good times and in bad. By putting children first, we can help overcome many of the other problems of society, in both the developing world and in the industrialized countries, ranging from lagging economic growth to overpopulation and the degradation of the environment. The resulting advances for children can be the cutting edge to a future world in which people are better prepared to solve their own problems.

Each one of you, in your own spheres of activity, and through your influential organizations, can:

- promote the efforts needed during this decade to meet the goals for children outlined at the World Summit;

- support the process of developing National Programmes of Action for children;

- encourage hospitals to become "baby friendly";

- urge your government to ratify and implement the Convention on the Rights of the Child, if it has not already done so (in the case of APHA members, why not set yourselves the goal of working to get the United States to sign and ratify the Convention in time for next year's annual meeting?);

- advocate, in the industrial countries, for foreign aid that works, that helps developing nations make the investments in people that need to be made;

- and in the political arena, encourage political leaders to "keep the promise" — especially in providing health care for all citizens, particularly the children who need an equitable, healthy start in life and only get one chance at it.

It is exactly people such as you gathered in this room -- the public health officials, physicians, researchers and educators who will usher our societies into the third millenium -- who hold the potential to turn our unprecedented opportunities into realities throughout the world. I urge each of you -- and your organizations -- to be true leaders in the growing movement for children and the future of the world.

GOALS FOR CHILDREN AND DEVELOPMENT IN THE 1990S

(The following is the list of goals endorsed by the World Summit for Children, after deleting certain goals that are repeated.)

I. Reduction of Mortality

1. Between 1990 and the year 2000, reduction of infant and under-5 child mortality rate by one-third or to 50 and 70 per 1000 live births respectively, whichever is less.
2. Between 1990 and the year 2000, reduction of maternal mortality rate by half.

II. Women's Health and Education

3. Special attention to the health and nutrition of the female child, and pregnant and lactating women.
4. Access by all couples to information and services to prevent pregnancies which are too early, too closely spaced, too late or too many.
5. Access by all pregnant women to prenatal care, trained attendants during child birth and referral facilities for high risk pregnancies and obstetric emergencies.

III. Nutrition

6. Between 1990 and the year 2000, reduction of severe and moderate malnutrition among under-5 children by half.
7. Reduction of the rate of low birth weight (2.5 kg or less) to less than 10%.
8. Reduction of iron deficiency anaemia in women by one-third of 1990 levels.
9. Virtual elimination of iodine deficiency disorders.
10. Virtual elimination of vitamin A deficiency and its consequences, including blindness.
11. Empowerment of all women to exclusively breast-feed their child for four to six months and to continue breast-feeding with complementary food well into the second year.
12. Growth promotion and its regular monitoring to be institutionalised in all countries by the end of the 1990s.
13. Dissemination of knowledge and supporting services to increase food production to ensure household food security.

IV. Child Health

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

V. Water and Sanitation

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

VI. Basic Education

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

VII. Children in Difficult Circumstances

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

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