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Address by Dr. Nyi Nyi
Director of Programme Division
United Nations Children's Fund (UNICEF)
on behalf of
UNICEF Executive Director James P. Grant
at the
13th World Conference of the World Organization of Family Doctors

Vancouver, Canada
11 May 1992

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Детский Фонд Организации Объединенных Наций 联合国儿童基金会 منظمة الأمم المتحدة للطفولة

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It is an honour and pleasure for me to be with you here today, speaking on behalf of UNICEF's Executive Director, Mr. James P. Grant. Regrettably, he had to be in South Asia for the inauguration of our new regional office in Kathmandu, and for meetings with government leaders, including three heads of state. But Jim specifically asked me to tell you how highly he values WONCA as a partner in what we at UNICEF call the Grand Alliance for Children. Your organization is making a significant contribution to long-term efforts to strengthen primary health care systems -- and improve family and community well-being -- around the world. We warmly congratulate you for all the superb work you are doing and urge you to redouble your efforts in this most challenging decade of the 1990s.

We are living through a special time. The year 2000 is fast approaching with all its weighty symbolism as a divide between past and future -- beckoning and daring us to make the new millennium, the 21st century, a new beginning for humankind. We have an opportunity, over the remaining years of the 20th century, to redress many of the injustices and tackle many of the problems which have long vexed and diminished us, and which today call into question not only our quality of life, but our very survival.

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The end of the Cold War, among other recent, epoch-making developments, has opened new possibilities. But will we truly "seize the day"? Will we replace the East-West conflict with global co-operation, or will a North-South -- a rich world-poor world -- conflict emerge to hold us back from the quantum leaps of progress that could otherwise be made? Will we have the courage and vision to beat our swords into ploughshares of human development, and use them to eradicate the poverty that condemms one billion among us to half-lives of deprivation and explosive resentment? Will we act decisively to end the apartheid of gender, just as we have begun to end the apartheid of race? Will we act in time to halt and reverse the degradation of our natural environment? Will we use the excellent tools and knowledge provided us by modern science to improve the lives, not just of the privileged, but of everyone, as we are now capable of doing?

These are some of the burning questions of our times. Although many of them may seem far-removed from your daily practices, the truth is that the issues and realities they describe are shaping the environment in which you work every day. They simply cannot be resolved without your involvement, without a change in awareness and the participation of vast numbers of people like yourselves: the compassionate, knowledgable "do-ers" of society. For now more than ever, effective democratic participation by people -- and the accountability of governments to people -- will be needed to establish a new and more meaningful world order.

As we roll up our sleeves to tackle the many challenges of the 1990s, a quick look backwards might be useful. The postwar period saw rapid social and economic progress throughout the industrial world, and most of the developing world made significant social gains in the 1960s and 1970s. Progress for the most part then stalled in the 1980s due to the prolonged economic recession -- the longest since the 1930s -- blocking advances in most of the developing countries and slowing growth in the industrial economies.

During the "lost development decade" of the 1980s, per capita income dropped more than 10 per cent in Latin America and sub-Saharan Africa. Under the impact of the debt crisis, the flow of resources from rich to poor nations was reversed and by the latter half of the decade, billions of dollars were going from the developing to the industrialized countries every year. Structural adjustment programmes adopted as a kind of "shock therapy" for ailing economies led to sharp reductions in public social expenditures, especially in health and education. This left Uganda in 1989 with less than 17 per cent of the health sector budget it had in 1970, and Tanzania's health spending dropped 30 per cent between 1980-85 -- to cite just two examples. The deterioration of health and education infrastructures, combined with cutbacks or elimination of government food subsidies and other family support payments, hit the most vulnerable -- the poor, women and children -- the hardest. Referring to the terrible toll of the crisis on children, then-President of Tanzania Julius Nyerere asked: "Must our children pay our debts with their lives?" It was to precisely to spare the children -- and the poor in general -- that UNICEF issued its urgent call, in the mid-1980s, for "adjustment with a human face", for measures to protect the most vulnerable during the development process.

The distribution of suffering was unequal on a global scale as well: while only one of 28 industrialized countries registered negative economic growth rates over the decade, 49 out of 86 developing countries saw their economies shrink. Nevertheless, the crisis also left its mark on the industrial world, where disparities between rich and poor increased in almost every country; unemployment remained high; severe cutbacks in government social programmes were instituted; homelessness, drug abuse and crime soared; and the cost of medical care skyrocketed.

With all the changes that have taken place over the past few years, the 1990s represent a "window of opportunity" for resuming and accelerating the pace of progress that dropped off in the 1980s. It is useful, when looking at the formidable list of items on the world's pending social agenda, to see how far we have come already:

* Thirty years ago, the average under-5 mortality in the world was 200 per 1,000 live births. Since 1960, the global child mortality rate has fallen by 50 per cent, to 100. The infant mortality rate has also been approximately halved in that period, down from 130 to 70. This means that this year, some 16 million children will live who would have otherwise died, if the child death rates of 1960 still prevailed.

* In 1960, average life expectancy in the world was 52 years. Today, global life expectancy now averages 65. In 25 developing countries, it is above 70 years.

What these figures do not tell us, however, is the fact that the rate of progress is greater in the developing countries than it is in the industrial world — in other words, the gap between the rich and poor world is narrowing on a number of social fronts. For example: Africa, the least-developed continent, nevertheless had an improvement of 12 years in life expectancy between 1960 and 1990, while North America gained only six years, half as many. Moreover, a look at the rates of decline in child mortality reveals that decline accelerates as rates fall. In countries with very high child mortality -- over 140 per 1,000 live births -- the rate of decline in under-5 mortality is about 2 per cent per year; it increases to 3 per cent per year in countries with child mortality rates between 70 and 140, and speeds up to nearly 4 per cent when child mortality rates are between 20 and 70, and to more than 4 per cent per year when they drop below 20. In other words, there is a dynamic of progress that tends to accelerate over time, gaining momentum as earlier gains accumulate.

Also significant is the synergism at work behind the numbers. One would think that the child health revolution that has made these advances possible would have a destabilizing effect on population. The opposite turns out to be true. Birth rates fall most rapidly when child mortality rates are low. Parents tend to have smaller families when they become confident their first children will survive. The "extra" children who are living today because of the deaths we have averted are now outnumbered by the children who were not born due to declining fertility rates. Today, the population of the world would be greater by about 150 million if 1960 birth and death rates still prevailed. Along with family planning, female education and economic development, efforts to ensure child survival are helping to slow population

growth and reduce stress on our overburdened environment. This needs to be communicated -- urgently -- to those whose justifiable concern about overpopulation and the environment leads them to the unjustifiable (and, I must say, immoral) conclusion that we must withhold interventions such as immunization and oral rehydration therapy that are saving child lives on a massive scale. This is bad demographics and bad ethics.

Where significant improvements in child survival have taken place, they almost invariably reflect gains made in women's education, improvements in access to and delivery of health services -- including oral rehydration therapy and vaccination -- and successful family planning programmes. Modern science and medicine have placed at our disposal low-cost technologies and knowledge needed to ensure health for all by the year 2000 through primary health care -- that goal endorsed by WHO and UNICEF at Alma Ata in 1978. And the remarkable communications revolution of recent decades has given us the means to disseminate awareness of, and stimulate demand for, these advances in virtually every corner of the globe. To paraphrase the historian Arnold Toynbee, ours is the first generation in history that can dare to dream of extending the benefits of modern civilization to all, rather than just to rich countries or elites within countries.

Well, it is no longer a dream, as the trends I have cited indicate. The greatest proof we have to date of what can be accomplished came last year, when the heads of UNICEF and WHO certified to the United Nations Secretary-General attainment of universal child immunization. By the end of 1990, the world had achieved the goal, set five years before, of immunizing 80 per cent of the world's under one year olds against the six major child killing and crippling diseases. That's more than 100 million infants being vaccinated at least five times during their first year of life...some half a billion contacts between families and health delivery systems. Anyone even vaguely familiar with the difficult conditions prevailing in most Third World countries will appreciate the accomplishment of immunizing four out of every five babies before their first birthday, a feat which involves keeping vaccines constantly cold while being transported over rugged terrain to remote jungle villages and mountain hamlets, and ensuring that the population is receptive to immunization when you get there. Since the acceleration of the Expanded Programme on Immunization in 1985, some 15 million lives have been saved -- three million last year alone -- and a similar number of life-long disabilities have been prevented. In country after country, primary health care systems have been strengthened and extended thanks to the immunization effort -- an effort in which the entire fabric of society becomes mobilized, from presidents and prime ministers to local communities, health ministries to mothers, through radio and television as well as village schoolteachers and religious leaders. Now an array of additional interventions are being "piggy-backed" on the EPI infrastructure, from vitamin A tablets to prevent child deaths and blindness, to anti-tetanus vaccinations and breastfeeding support for mothers, to "safe-sex" and family planning information.

It was the impending success of the immunization effort, more than anything else, that gave the world's leading physicians, public health experts and humanitarian agencies of the United Nations system the confidence to set -- in 1988-89 -- new targets in the health for all effort. These targets for radically improving the health and well-being of children and mothers by the

year 2000 could have remained in the realm of wishful-thinking -- the sad fate of many internationally-set goals. But by happy coincidence, the development of a detailed, do-able agenda for children came just as the Cold War was ending and the international community was seeking new modes of global co-operation to tackle social problems long relegated to the "back burner" of international priorities.

In this propitious atmosphere, two major breakthroughs took place -- both of them in 1990. First, the Convention on the Rights of the Child -- that "Magna Carta", that "Bill of Rights" for children which had languished in draft form for a decade in UN committees -- was approved by the General Assembly of the United Nations, going into force as international law in September 1990. To date, 115 nations have embraced it as the law of the land. The Convention converts children's needs (including the need for health care) into rights -- a truly astounding ethical advance for humankind! Now we must push for ratification of the Convention where it has not yet been ratified (the United States, for example, where the initial step of signing has not even been taken); and we must push for compliance with its provisions where it has already been ratified.

The second great breakthrough of 1990 was the World Summit for Children. As you will recall, it was the first global summit ever held, the first time the leaders of East and West, North and South met to discuss anything -- and, significantly, they chose the subject of children for their deliberations. They agreed on a principle that, if fully implemented, would lead to a fundamental shift in priorities worldwide: the principle that children's essential needs should be given a "first call" on society's resources. This essentially means that, whether times are good or bad, whether there is war or peace, things must be organized to ensure that all children get their basic needs met. What was unusual about the World Summit for Children is that the heads of state and government were willing to go beyond lofty rhetorical pronouncements and make commitments to meet a series of measurable goals within a specific timeframe, with mechanisms put in place to monitor progress along the way. I am attaching a list of the 27 year 2000 goals to the distribution copy of my remarks, but suffice it to say here that they add up to a comprehensive, ambitious but realistic agenda that not only could save some 50 million young lives by decade's end, but could radically improve the quality of life for many millions more. Already some 120 countries -- most of them developing countries -- have issued or are preparing to issue National Programmes of Action (NPAs) to "keep the promises" made at the summit. Many of the industrial countries have lagged in the preparation of their NPAs, which is a special source of concern inasmuch as their Programmes of Action are supposed to cover both their own children and development assistance benefitting children in the developing countries.

Whether or not they specifically cite the Convention or the World Summit documents, the savvy office-holder or candidate knows that it's good politics -- and good economics, too -- to place children high on their agenda. Never before have children's issues figured so prominently in the political life of so many nations. Take the current presidential race in the United States, for example -- all the contenders, without exception, have been vying to be viewed as the most pro-child.

But because, in practice, the most serious problems facing children are primarily the problems of the poor and the relatively powerless, the gap between rhetoric and action remains large. You as family physicians and leaders in public health can contribute to bridging that gap. You can do it, of course, on a one-to-one basis with your patients -- you already do that. But you can also do it by continuing to speak out, using the influence you have as respected authorities to shape the public debate on what the emerging new world order should look like. You must not allow society to forget that a quarter of a million children will die this week and next -- 14 million this year -- and that more than half of them could be saved through timely application of simple, low-cost technologies and knowledge. You must not allow society to forget the stark disparities that currently doom a child in the inner cities of London or Washington, D.C. to more than twice the risk of dying before reaching his or her first birthday than a baby lucky enough to be born in other parts of those modern capital cities.

Immersed as you are in your daily whirlwind of activity, you may not realize the extent to which what you do sets the pace. The tools you have developed, the experience you have gained over the years, have given the potential to radically reduce child mortality and illness. Where they have already been made, these gains must now be sustained; they must be extended to the places where they have yet to reach. What you do in your own practices has enormous influence.

What can you do to help keep the great promise of the World Summit for Children?

* Take immunization, that basic tool of paediatrics. The achievements of 1990 cannot obscure the fact that coverage remains shockingly low in parts of most countries. Many children in high coverage areas do not receive the full cycle of immunizations by their first birthday. Coverage for one-year-olds in Zimbabwe is higher than for two-year-olds in the United States. Diseases such as measles, once nearly eradicated in developed countries, are making comebacks. A re-commitment to universal immunization is needed. And you can help push for new and improved vaccines so that we can have earlier injections, fewer injections, and more antigens in those fewer injections.

* To the extent that you promote the use of oral rehydration therapy in your practices and in the hospitals with which you are affiliated, ORT will gradually become part of the established household culture for treating diarrhoea. Over three million young lives could be saved each year and countless others spared the pain of IV therapy. Millions of dollars in unneeded IVs and antibiotics could be put to better use educating and empowering families to treat diarrhoea themselves.

* The growth monitoring that is routine practice for all of you needs to massively break into public health and the communities of the world. Japan has just issued a new and improved version of its excellent boshi techo, which permits tracking of the individual child's health from prenatal days to school-days, covering all sorts of vital indicators.

* To the extent that you take seriously the slogan "breast is best" and help make your own practices and health institutions truly

"baby-friendly", breast-feeding can make a dramatic come-back, with a major impact on the survival and development of children. Now, according to the latest studies, you can even tell mothers they'll be at much lower risk for breast and uterine cancer, and their pre-term children will have higher IQs -- if they breast-feed. New beneficial properties of breastmilk are being discovered all the time. It is especially encouraging, then, that infant-food manufacturers have agreed to the goal of stopping donations of infant formula to maternity wards and hospitals in the developing countries by the end of 1992, but maternity institutions in both the industrial and developing world must adopt practices which empower women to breast-feed their babies and avoid dependence on less-nutritious prepared formulas. That is why WHO and UNICEF launched the Baby-friendly Hospital Initiative earlier this year. You can link up with this effort by helping see to it that the hospitals and maternity centres in your area adopt the "Ten Steps to Successful Breast-feeding" which I've attached to the distribution copy of this speech. My colleague, Janet Nelson, will be explaining the Initiative in a workshop later today and will suggest ways each of you and WONCA can get involved.

* As family physicians, you are in an excellent position to educate parents and children in self-health and prevention. You can become the first line of defense against the so-called "life-style diseases" or the "diseases of affluence" which are now wreaking havoc on health systems in industrial and developing countries alike. Couldn't each of you find ways to combine your private practices with community-based public health service to reach the unreached? Just two weeks ago, the Mayor of New York announced creation of 20 new community health centers to serve the poor with "a family-doctor approach". Mayor Dinkins said <u>all</u> children deserve a doctor who knows their name.

* I mentioned the National Programmes of Action a few minutes ago. Each one of you, when you return to your country after this conference, should inquire about the status of your government's NPA to implement the goals of the World Summit for Children. Where they have not yet been drafted, you and the professional organizations to which you belong can lobby for the approval of solid NPAs and for their rigorous application where they have been issued.

* Finally, you can encourage more young doctors to take the family- and primary care path. After decades of specialization and micro-specialization, there seems to be a gradual return to primary care among medical school graduates. Primary care may be a less lucrative field, but the rewards of being of service are, as you know, many.

So there is a role for each and every one of us, in our own daily spheres of activity and as advocates for children and human development. In closing, I would like to throw out a challenge to WONCA as an organization. In addition to the vital work you are doing in so many countries, would it not also be possible for you to "adopt" a country, a region or sub-region of the developing world with the objective of helping upgrade the health system within a specific time-frame? I have no doubt that after five or six years of concentrated efforts, your support will have made a visible difference and that country or region will be in a better position to meet its own health

needs. Should this proposal interest you, UNICEF stands ready to help identify potential beneficiaries and work with you on needs assessments and monitoring of progress along the way. We could greatly intensify our collaboration and partnership this way.

But whatever you think of this idea, your continued leadership is needed in the 1990s if we are to be prepared to meet the new challenges of the 21st century. The children -- our children -- are counting on us.

Year 2000 goals

The following is the full list of goals, to be attained by the year 2000, which were adopted by the *World Summit for Children* on September 30 1990. After widespread consultation among governments and the agencies of the United Nations, these targets were considered to be feasible and financially affordable over the course of the decade ahead.

Overall goals 1990-2000

- ◯ A one-third reduction in under-five death rates (or a reduction to below 70 per 1,000 live births whichever is less).
- ◯ A halving of maternal mortality rates.
- ◯ A halving of severe and moderate malnutrition among the world's under-fives.
- ◯ Safe water and sanitation for all families.
- ◯ Basic education for all children and completion of primary education by at least 80%.
- ◯ A halving of the adult illiteracy rate and the achievement of equal educational opportunity for males and females.
- ◯ Protection for the many millions of children in especially difficult circumstances and the acceptance and observance, in all countries, of the recently adopted Convention on the Rights of the Child. In particular, the 1990s should see rapidly growing acceptance of the idea of special protection for children in time of war.

Protection for girls and women

- ◯ Family planning education and services to be made available to all couples to empower them to prevent unwanted pregnancies and births which are 'too many and too close' and to women who are 'too young or too old'.
- ◯ All women to have access to pre-natal care, a trained attendant during childbirth and referral for high-risk pregnancies and obstetric emergencies.
- ◯ Universal recognition of the special health and nutritional needs of females during early childhood, adolescence, pregnancy and lactation.

Nutrition

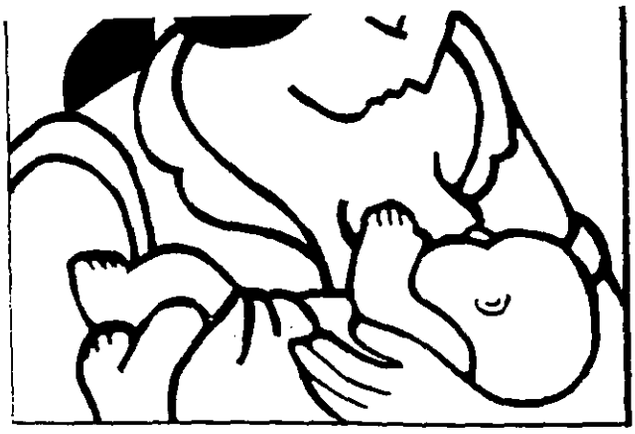
- ◯ A reduction in the incidence of low birth weight (less than 2.5 kg.) to less than 10%.
- ◯ A one-third reduction in iron deficiency anaemia among women.
- ◯ Virtual elimination of vitamin A deficiency and iodine deficiency disorders.
- ◯ All families to know the importance of supporting women in the task of exclusive breastfeeding for the first four to six months of a child's life and of meeting the special feeding needs of a young child through the vulnerable years.
- ◯ Growth monitoring and promotion to be institutionalized in all countries.
- ◯ Dissemination of knowledge to enable all families to ensure household food security.

Child health

- ◯ The eradication of polio.
- ◯ The elimination of neonatal tetanus (by 1995).
- ◯ A 90% reduction in measles cases and a 95% reduction in measles deaths, compared to pre-immunization levels.
- ◯ Achievement and maintenance of at least 90% immunization coverage of one-year-old children and universal tetanus immunization for women in the child-bearing years.
- ◯ A halving of child deaths caused by diarrhoea and a 25% reduction in the incidence of diarrhoeal diseases.
- ◯ A one-third reduction in child deaths caused by acute respiratory infections.
- ◯ The elimination of guinea worm disease.

Education

- ◯ In addition to the expansion of primary school education and its equivalents, today's essential knowledge and life skills could be put at the disposal of all families by mobilizing today's vastly increased communications capacity.



Ten steps to successful breast-feeding

Every facility providing maternity services and care for newborn infants should:

1. Have a written breast-feeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breast-feeding.
4. Help mothers initiate breast-feeding within a half-hour of birth.
5. Show mothers how to breast-feed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless *medically* indicated.
7. Practise rooming-in – allow mothers and infants to remain together – 24 hours a day.
8. Encourage breast-feeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breast-feeding infants.
10. Foster the establishment of breast-feeding support groups and refer mothers to them on discharge from the hospital or clinic.

From: **Protecting, Promoting and Supporting Breast-feeding: The Special Role of Maternity Services**
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