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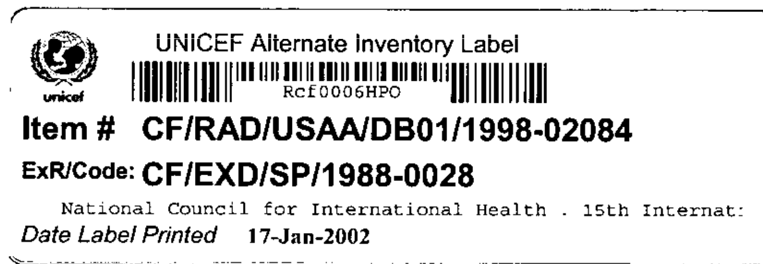
Address by Mr. James P. Grant
Executive Director of the United Nations Children's Fund (UNICEF)
to the
National Council for International Health
15th International Health Conference

"Ten Years after Alma Ata:
Health Progress, Problems and Future Profiles"

Washington, D.C.
20 May 1988

[Talloires Declaration and tables attached]



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It is, indeed, an honour to initiate this discussion on achievements since Alma-Ata and on what lies ahead in Primary Health Care, as we commemorate a decade of intense global health activity which has taken its direction from the principles codified in the visionary Declaration of Alma-Ata.

If I may begin from a personal perspective, what was achieved at Alma Ata was a personal as well as a world-health landmark. As our chairman mentioned in his kind introduction, my father, Dr. John B. Grant, was a pioneer in international public health. One of the first MPH graduates from Johns Hopkins, he set up the first school of public health in China, and later helped establish the first public health training institution in India. In my boyhood days, our household guests included such now-legendary figures as Dr. Ludwik Rajchman, then head of the Health Secretariat of the League of Nations, the precursor of WHO, and later to become the founding Chairman of the Executive Board of UNICEF. Another frequent visitor was Dr. Andrea Stampar, who was to become the first chairman of the World Health Assembly. They shared the then rare conviction that modern health knowledge must be made available to all, rather than just to a few, and that the achievement of this required the involvement of many sectors and not just the health system. I can well remember Dr. Stampar's strong statements on land reform and on the imperatives of assuring peasants the basic income needed to pay for food and education as well as for health services. I remember them discussing the basic principles which, 45 years later, were to be embodied as underlying principles at Alma Ata for achievement of Health For All through Primary Health Care, and most notably the following three: First, that the use made of medical knowledge and techniques for health protection depends on social organization. In the China of the 1930s, for example, the immediate social problem was overwhelmingly that of how to overtake the vast lag between existing knowledge and its use in the community setting.

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A second basic principle repeatedly discussed was that a vertical medical system cannot be truly effective, or even stand by itself, unless it is integrated in other activities in society in a concerted attack on the problems of health, development and social reconstruction. On this my father and his associates emphasized the need to increase income through such means as new agricultural practices and land tenure reform. They all stressed the need for basic literacy and education and their potential for synergism with health activities.

A third principle was that successful organization implies reliance upon economically practical strategies for serving the entire population rather than just the relatively well-off minority, and that this necessarily meant in low income societies the major participation of the communities and families themselves in the health system. Working together with the Chinese, these early public health figures pioneered in the establishment of experimental urban and rural teaching districts with populations of over 100,000. These were designed to demonstrate how to bring the benefits of health knowledge to all rather than just the privileged few - at a cost of less than 50 cents per capita in urban areas and 30 cents per capita in rural areas - and to provide medical school students with teaching districts to parallel the teaching hospitals pioneered by Johns Hopkins a generation earlier. Furthermore, they innovated the systematic use of farmers as village health workers who, after achieving a rudimentary basic literacy, were trained to do health education, vaccination, first aid, water testing and purification and reporting of vital statistics on births and deaths. These innovations provided the basis for what later became the Chinese "barefoot doctor" primary health care system of the 1960s and 1970s.

Alma Ata 45 years later represented an historic codification of acceptance of these then-revolutionary basic principles - an acceptance of tremendous importance. What have we learned since Alma Ata? What are the key lessons of the past decade? I submit that they include these:

1. That insights of the Declaration can be trusted for practical guidance; Primary Health Care works; and

2. Despite the validity of the Declaration, as Dr. Mahler has repeatedly emphasized, countries have been slow to move from rhetorical acceptance of Primary Health Care to its effective application. Earlier this month at the WHA, Dr. Mahler said most health systems are still "sick health" systems, i.e. systems for curing the sick rather than for preserving health.

Otherwise, we would not still have more than 1,000 mothers dying daily in childbirth, and 38,000 under-5 children dying daily, including more than 20,000 children dying daily from just two such readily preventable causes as dehydration from diarrhoea and the six diseases covered by the Expanded Programme of Immunization (EPI).

Why are we moving so slowly in putting these principles into action? First, these techniques are not a cure for cancer or heart disease or AIDS - dramatic accomplishments which would capture the headlines of the media and thus the attention of the world. But I would also venture to suggest that medical schools are slow to adopt (let alone demand) textbooks written from this perspective; doctors are slow to adapt to low-technology practices and simpler approaches; and many vested interests in high-cost treatments offer resistance. Furthermore, we are all aware that, even with the best of intentions, it often takes many different approaches and many repetitions of an educational message before people are actually motivated to change their long-standing practices.

Are there prospects for accelerating the implementation of primary health care? I would reply in the affirmative, and also say that the prospects are encouraging even in these difficult times. But there are many, many problems between where the world is today and Health For All in the year 2000.

Changing conditions

The world in which this gathering of international health leaders assembles today has undergone major changes since we embarked on the Health For All (HFA) plan at Alma Ata a decade ago. Two of these changes are particularly notable. They make the case for primary health care still more compelling. One, of course, is the dramatic change in the global economic climate and the consequent need for major adjustments by most countries - and, one might add, most sectors and institutions within them, such as those involved in health. The first years of the 1980s saw the world move from a strong and growing economy that could lift many from the deprivations of poverty and offer new opportunities for establishing the role and rights of all people in their societies, to a world in which the number of hungry and malnourished - mostly children and women - has increased. I will return to this issue of economics in a moment.

The second major dimension that has had a profound impact since Alma Ata on the direction of our work is the realization that economic and technical developments of recent years have vastly increased the capacity to communicate. There is today a rapid and continuing increase in our ability to communicate with the world's poor. For example, in Egypt in 1979, only one family in 80 had a television, while today four out of five families own TVs. The great majority of villages in the world today have a primary school. Hundreds of thousands of farmers', women's and other organizations have come into existence. And since Alma Ata, literally millions of health auxiliaries have been trained. Accompanying this expansion, the international community has also developed a whole new perception of what can be done with programme communication as a powerful tool for educating and mobilizing.

This new capacity gives us the potential to take newly developed, improved or rediscovered low-cost/high-impact medical techniques and knowledge readily at our disposal and accelerate the application of PHC principles. UNICEF has

called this approach the potential for a Child Survival and Development Revolution (CSDR) - one which can also serve as a leading edge - a Trojan Horse - for advancing PHC generally. The actual medical techniques are, of course, familiar to you, and include immunization against the six main child-killing diseases, Oral Rehydration Therapy (ORT), a return to the practice of breastfeeding with proper weaning, growth monitoring, female literacy, food supplementation with Vitamin A, iron, iodization, etc., and family spacing. Combining the new capacity to communicate with these techniques and technologies has allowed the mid-1980s to see, in many countries, a very sharp expansion of the immunization and ORT programmes in particular. Vaccine use for the EPI diseases has quintupled since 1983, and whereas at the time of the Alma Ata conference a decade ago only 5 per cent of the world's children were immunized against the six targeted diseases, in August 1987, WHO reported that vaccination coverage had exceeded 50 per cent of the world's children.

In the successes of several countries in child survival and development activities - most notably in increased immunization coverage and improved diarrhoeal disease control and in bringing child health higher on the national political agenda - populations and their governments have had the opportunity to glimpse - not in theory, but through actual practice - the potential of utilizing the principles of PHC. Thus, for example, when a country has mobilized several sectors to attain the goal of universal immunization for its children, political will has been activated to "mobilize the country's resources", as promoted by the Declaration.

Such efforts have given countries a "hands on" experience, which, as the Declaration advocates, "...requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate". Following the path indicated by the Declaration, these accelerated programmes have involved "in addition to the health sector, all related sectors and aspects of national and community development", and have required "the co-ordinated efforts of all those sectors".

Once a country learns how to mobilize for health ... learns to organize networks for alternate means of health education and provision of services ... and discovers means to utilize previously untapped resources for health - such as human resources, or buying in bulk and organizing distribution of health supplies - that knowledge can be naturally designed into broader application.

Turkey is one among many recent country examples. During the first expanded immunization programme in 1985, immunization of over 4 million children almost quadrupled national coverage, to 80 per cent. This was made possible by bringing together the health services, the mass media, press and electronic media, over 200,000 teachers, more than 50,000 imams, thousands of volunteers from non-governmental organizations, and the President, the Prime Minister and every provincial governor (vali) and district administrator

(kaymakan). Besides the immediate gain of preventing disease and saving child lives, the programme set child health much higher on the nation's agenda. Turkey's positive experience opened doors for a new commitment which has developed into a sustained approach. New policies include permanently expanded immunization facilities which, after a temporary dip, now virtually maintain coverage at 1985 levels. But the effort also catalysed other primary health care action. Most hospitals now use oral rehydration therapy as standard practice. New mass approaches are being used to combat acute respiratory infections. The rectors of all 22 medical faculties and the heads of paediatric departments are strengthening child survival strategies in all medical and nursing curricula. Retraining programmes are being set up for all practising doctors and nurses. Primary school materials have been rewritten and supplemented for health education purposes.

Similarly, in Indonesia, we have seen the cutting edge of child survival activities accelerate extensive community involvement in provision of maternal and child health care. This was acknowledged internationally last month by both WHO and UNICEF, which awarded, respectively, the Sasakawa Health Prize and the Maurice Pate Award to the PKK, a national women's organization, for their role in strengthening and voluntarily staffing the posyandu system which has just expanded (three years ahead of schedule) to provide five basic health services (growth monitoring, immunization, oral rehydration therapy, prenatal care and family planning) to women and children for 85 per cent of the population at the ratio of one center per 100 children younger than 5 years of age in 200,000 village centers. In keeping with the principles of Alma Ata, this has been a brilliant example of allocating a nation's limited resources during a period of budgetary retrenchment to meet the health needs of all of the people, rather than just the privileged few.

UNICEF's specialized vantage of the rapidly expanding application of the principles of Alma-Ata to children highlights a particular element of the overall picture of primary health care. But it has been an important element with perhaps even far broader application. It has been "learning by doing", and we anticipate that as countries, communities, organizations and individuals are empowered by taking a greater role in ensuring their own health and well-being, they will design new ways to use that capacity for other purposes as well. As a dramatic demonstration of this new potential in the 1980s, the lives of millions of children - reaching 2 million in 1987 alone - have been saved, and the cripplings of millions more prevented, by nations which, through sharply increased social mobilization, have put today's low-cost solutions at the disposal of the majority of families.

Where next?

At this midpoint moment in the achievement of Alma Ata's Year 2000 goals, we look not only at the lessons and accomplishments since targets were set. Like Janus, we face in two directions at once, and the purpose of our backward glance is to clarify our focus and frame our vision of the future. Today, as we ask "What are the next steps?", we look both with increasingly grounded

trust to the Declaration for direction and to the fact that, while the means are now proven, hundreds of millions of families remain unreached by the potential of Primary Health Care.

The next steps cannot be taken on a single narrow path; as an international community, we must pursue several courses at once.

Our further progress requires an intelligent and creative response to the global environment in which we pursue the betterment of health. We are all aware that the 1980s have brought actual economic and social regression to major areas of the world, most notably to Latin America and Africa. And we are aware that the burden of suffering has been borne disproportionately by the most vulnerable groups, including women and children. President Nyerere of Tanzania spoke to this a few years ago with the anguished plea, "Must we starve our children to pay our debts?" I regret to say that actual practice has all-too-often answered with a "yes", and possibly some millions have died as a consequence. Remedial actions are in process, but still too little, and still too late. Mike Faber of the Institute of Development Studies (IDS) in Sussex recently depicted the situation with this 1980s version of the story of Sisyphus: "The Third World debtor is the Sisyphus of the modern age - but with this difference from the tragic hero of antiquity: every time this Sisyphus' rock rolls down to the bottom of the mountain, he finds that it has become heavier, and each time that Sisyphus looks up at the top, behold the mountain has become higher!"

Furthermore, we see arms expenditures still rising - now to more than one trillion dollars. Environmental degradation is still accelerating, as is so usefully documented and analysed in the "Brundtland Report", Our Common Future: the Report of the World Commission on Environment and Development. AIDS is a new problem - an actual threat in itself - but also a great threat to other essential programmes as increasingly large sums are diverted to the necessary fight against this new and growing danger.

Today I would like to touch on two aspects of the current global situation which have received far too little attention, and which may, in fact, contain keys to ultimately securing the political will required for effectively addressing the needs of the most vulnerable. The first is that the emerging economic crises of the Western industrial world involve far more difficult circumstances than surface appearances indicate. The United States needs to reduce its great deficit by more than one hundred billion dollars a year if it is not to acquire the altered standard of living, status, and power of a debtor society in the world community.

The economic crisis of the West has been largely concealed and ameliorated in the mid-1980s by virtue of the U.S., with its borrowed money, becoming the "engine of growth" for much of the world. But this has been at the cost of more than doubling its national debt and shifting from being the world's largest creditor nation to the world's largest debtor. This is a role which is no longer sustainable. The October stock market plunge was one manifestation of the weakened economic foundation, and, frankly, candid discussion of this problem has been restrained by the U.S. elections.

A choice of moving backward or forward

We are faced with two alternatives. For the United States to get out of its present situation through recession and devaluation would bring incalculable disaster to the entire world. It would constitute a modern day Samson bringing down the pillars of the temple.

There is another alternative, however: to do it through growth - to design the entire progressive restructuring of the imbalances between the United States deficit and the Japan/Western Europe surpluses in the context of global growth. The prospect of restructuring through growth is not new; it has, however, been interpreted primarily within the context of the United States, Japan and Western Europe. It will not work within that limited framework. This is because the democratic political processes in the United States, Japan and Western Europe at this point do not allow the rapidity of structural response within each society which would be needed to restructure the Western industrial world within an acceptable time frame. Domestic pressures slow the opening of the Japanese market; fears of inflation hobble German planners; and creeping protectionism is seen in the United States.

Restructuring through growth does have the potential to work, and could help us avoid major catastrophic economic upheaval. But it can work if - and only if - as the Overseas Development Council has described in its recent Agenda 1988, we can involve the Third World in a major way with this restructuring. Restoration of growth to the Third World, particularly in Latin America, would provide additional export markets of more than US$100 billion annually for the industrial countries, thereby vastly facilitating the restructuring in the industrial North while enabling Latin America and Africa, particularly, to regain their economic footing.

Furthermore, a recent study conducted for the World Institute for Development Research (WIDER) by Professor Jeffrey Sachs of Harvard University indicated that restructuring of Japanese and German surpluses through foreign aid and other financial transfers to the Third World would have a far more rapid and beneficial impact on the global restructuring than comparable expenditures devoted to domestic expansion. The study showed that a US$25 billion expansion of expenditures within the Japanese economy would benefit the U.S. balance of payments by US$2 billion, but that a comparably increased expenditure on foreign aid would benefit the U.S. balance of trade by US$9-11 billion dollars - a five times more beneficial impact - as well as significantly increasing Third World markets for other industrial nations.

So we are seeing the entry into our calculations of a really major new factor of crisis for the North which highlights the depths of our global interdependence today. While the reverse situation of Southern dependency on the North has long been all-too-evident, today it is becoming undeniable that in order to address the problems of the North, the North will be required to focus on restoring development momentum in the South.

The other major new area which warrants heightened attention is that the USSR and the socialist countries, too, are nations in crisis. This, of course, is one of the major reasons for General Secretary Gorbachev's initiatives to restructure the context of socialist policy. The positive implications of this can already be detected in the arms race - nuclear and conventional - as well as in regional areas of conflict, such as we see in Afghanistan and other areas. And its implications can be seen in hopeful prospects for increased Soviet participation in the United Nations, where the USSR has now paid its back debts. Major possibilities are opening for a whole new participation by the socialist countries in the United Nations and its associated Bretton Woods institutions.

In short, both industrial East and industrial West have increasingly inescapable reasons for a global restructuring. The time may soon be coming for a call by the North as well as the South, and by the West as well as the East, for a new global economic order - an "NGEO".

Once the political will is in place, the means are available to support an effective new policy. First, the debt issue needs to be managed to stop the financial haemorrhage of massive net capital flows from the South to the North. Jim Robinson of American Express, Percy Mistry of Oxford and others have proposed do-able processes. Second, new capital flows are needed to restore developmental momentum. Again, major opportunities exist, as through increasing the leverage for private borrowing by the multilateral banks, and through increased official development assistance, particularly from Japan and Western Europe, but also from a U.S. aid programme which restructures the current aid mix, now increasingly distorted for military/security purposes of declining relative importance. But the political will for these actions must first come from a clearer vision by leadership in the North, and particularly in the U.S., Japan and the Federal Republic of Germany, of the severity of the economic crisis of the industrial West and of the contributions needed and available from a new economic and social dynamism in the South. Americans in this conference have a major opportunity - and responsibility - to promote this clearer vision, both in party platforms before the November election, and to policy-makers immediately after the U.S. elections.

Sustaining progress for people

Our second avenue of approach for the years ahead involves redoubled commitment to and acceleration of social sector programmes that work. And it implies a tremendous creative challenge: to adapt new and successful methods - such as the breakthroughs in the field of maternal and child health experienced in the CSDR - to new areas of health and social development. For today I will focus on the child health sector where we now have the clearest vision of what needs to, and can, be done.

The potential for progress in child health in the context of Primary Health Care was confirmed recently (mid March) at a meeting in Talloires, France, convened by the international Task Force on Child Survival (often referred to as the "Bellagio Group"), which gathered a dozen health ministers

and health secretaries from most major developing countries of the world (Brazil, China, Colombia, India, Mexico, Nigeria, Pakistan); heads of major international organizations such as Barber Conable of the World Bank, Halfdan Mahler of WHO, and myself; plus major bilateral aid agency administrators such as Margaret Catley-Carlson of CIDA (Canada), Carl Tham of SIDA (Sweden), and Alan Woods of USAID; and private leadership from the Rockefeller Foundation and Rotary International (which has almost doubled its goal of raising US$120 million to support the world-wide polio immunization effort, and has accomplished this ahead of its original target date!). Out of this review of the world immunization/child survival effort came the exciting conclusion that, with a modest additional amount of political will, it is do-able - by the end of this century - in twelve years - to reduce the 1980 child death rate by more than half, saving from death or disability in this process well over one-hundred million children over the period, while slowing population growth as well, as families gain the confidence that the children they have will live. Such historic progress will be possible, however, only if - armed with the new low-cost/high-impact health tools, and our new ability to communicate with the world's poor - we double child mortality reduction rates of the first half of the 1980s [see required reduction rates for all countries on table attached].

The "Declaration of Talloires" [attached] begins with the statement:

> "Remarkable health progress has been achieved during the past decade. Global recognition that healthy children and healthy families are essential for human and national development is steadily increasing. Consensus has been reached on the strategy for providing essential community primary health programmes. The international community has become engaged in partnership with national governments in the creation of successful global programmes, ensuring the availability of financial support and appropriate technologies."

The Declaration proposes Year 2000 health goals which received consensus approval of participants at Talloires. Of these goals, a useful "short-list" of do-able Year 2000 goals could be capsulized to include:

1) halving 1980 under-5 mortality rates, or reducing them to 70 per 1,000 live births, whichever is less;

2) eradication of polio (endorsed by The World Health Assembly earlier this month);

3) achieving universal primary education (to which I would add 80 per cent literacy among women of child-bearing age);

4) achieving less than 1 per cent severe malnutrition; and

5) promoting expanded coverage of water supply and sanitation.

Special attention needs to be given to analyze these goals on a country-by-country basis. The attached table, which includes child mortality reduction rates required to reach the Year 2000 goal, is a useful tool toward these ends. You will see that the table lists not only child mortality information, but GNP data as well.

Measuring the progress of a society through the use of both per capita GNP and social indicators is like seeing with two eyes instead of one. Anyone looking at society through just one eye likely misses a great deal. Although levels of per capita GNP and physical well-being usually show a close correlation, the number of striking exceptions indicates, on one hand, that low income and the worst consequences of absolute poverty need not go hand in hand. Comparing per capita GNP with IMR as a social indicator, we see in Sri Lanka and China, for example, that while the GNPs per capita are comparable to or less than that of the United States at the time of the American Revolution, IMRs in Sri Lanka and China have progressed to a level comparable to that of the U.S. as recently as just after World War II and are less than half that of developing countries such as Turkey, Algeria, Tunisia and Brazil, which currently have per capita incomes several times higher. Conversely, a high GNP in a country can mask conditions of human suffering. Thus, Brazil has a per capita GNP more than 5 times greater than that of Haiti, yet in Northeast Brazil, the IMR is the same as Haiti's. Washington, D.C. which has one of the highest per capita GNPs in the United States, also shows the apparent inconsistency of having one of the highest - if not <u>the</u> highest - infant mortality rates of any major population grouping in the United States.

While the use of IMRs and reduction rates may be most urgently needed for developing countries, interesting and relevant questions are raised by comparing rates of change within a country. Thus, for example, a contrast between the experiences of Puerto Rico and Washington illustrates a significant dynamic. Low income Puerto Rico has moved impressively from an IMR of 63 in the early 1950s to 15 today. During the same time period, Washington moved from an IMR of 30 in 1950 to 21 today; infant mortality for its black community is among the worst for major black communities in the United States. This poor showing exists despite the fact that, next to Alaska, Washington enjoys the highest per capita GNP in the country.

It is, quite frankly, inexcusable that the richest and most powerful country in the world - and particularly its capital city - should rank so poorly in ensuring the survival and development of its children. At federal, state, and community levels, this society ought to ensure that knowledge regarding self-health behaviours reaches the entire populace, and that adequate nutrition, health services and early-childhood development <u>information and resources</u> are readily available to all women and families.

Why should the District of Columbia - one of the wealthiest political entities of this country - have an infant mortality rate among the worst in the nation...higher than that of Mississippi and Puerto Rico - and worse than Havana, Hong Kong and Singapore - with their vastly lower income levels? Why should infant mortality among the black community in the District be so much

higher than for the black community nationally? Why does Newark, with a much higher infant mortality rate in 1960, now have a much lower rate than Washington, D.C. today?

Frankly, the key lies in the relative weakness - some might say "lack" - of democracy in the District of Columbia, with its very limited political franchise. Effective competitive democracy is child and mother prone - democratic contestants tend to compete to provide basic services for low income voters, e.g., the effective enfranchisement of the blacks of Newark by civil rights reform in the late 1950s and the 1960s underlies the dramatic improvements in Newark which were not paralleled in Washington.

A Grand Alliance for Children

It is clear by now that if such goals as those mapped out in Talloires are to be reached, they will be achieved by a social movement rather than by a medical movement alone. And what is needed is a society-wide alliance of all those who could communicate with and support parents in doing what can now be done - medical professionals, teachers, and religious leaders, mass media and government agencies, voluntary organizations and people's movements, business and labour unions, professional associations and conventional health services. Only such a Grand Alliance for Children can create the informed public demand for, and practical knowledge of, those methods which could bring about a revolution in child survival and development.

Today that Grand Alliance has begun to gather, and people in the health field need to give special attention to collaborating with and supporting others who have joined.

The forces which have already gathered include a broad spectrum of supporters. Last year the Organization of African Unity (OAU) Summit of Heads of State declared 1988 the Year of the African Child, and they pledged themselves to far-reaching activities on behalf of African children. This year they have invited the Executive Director of UNICEF to address their 25th anniversary Summit, which will meet next week in Addis Ababa. Again, issues related to the health and well-being of children and women figure high on their agenda. Similarly, Peru just this week completed historically unprecedented legislation, supported by every political party in the country, which will require, by national law, the reduction of infant mortality by at least 15 points before the end of 1990.

This Grand Alliance must especially manifest itself in the active participation of the people most affected. One innovative mechanism for accomplishing this is the Bamako Initiative proposed by the African Ministers of Health less than a year ago. The Bamako Initiative is essentially a plan for district management of maternal and child health services throughout Africa which will be bolstered by a supply of low-cost essential drugs which are paid for by recipients, yet supplied on a dependable basis through considerable initial external financing.

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A related arena in which the support of all in the health field - especially those concerned with the health and well-being of children - is urgently needed is efforts to achieve an international "Convention on the Rights of the Child". The Convention, which is targeted for passage, hopefully, by the United Nations General Assembly during the fall of 1989, represents an opportunity to establish global norms not only to discern which rights children should be assured of, but in the responsibilities of governments to protect those rights. Ratification of the Convention, in itself, will not mean that children's rights will be met nor that our responsibilities toward children will be fulfilled. Rather, it will mark a milestone in the journey toward these ends - a milestone along the path toward honoring child rights for all peoples. It will establish an important global standard.

Approval of the Convention on the Rights of the Child by the General Assembly in 1989 will not occur automatically. It will require an all-out effort by all people involved in issues having to do with the health and well-being of children, including, particularly, leadership activism from the non-governmental community. And, once endorsed by the General Assembly, it will be up to people of concern in every country to secure ratification of the Convention by each national Government.

People must take the lead

In any civilization, morality must be brought into step with capacity. Today this means, at the least, that the mass deaths of 38,000 children every day from largely preventable causes must be placed alongside slavery, colonialism, racism and apartheid on the shelf reserved for those things which are simply no longer acceptable to humankind. But we must remember that none of these achievements have originated with governments; they have begun with people acting voluntarily to demand change.

A small group of Quakers started the campaign against slavery; Mahatma Gandhi was a courageous pioneer in the fight to end colonialism; Martin Luther King stands as a symbol for the struggle to end racism in America; Nelson Mandela for the fight to end apartheid. They, in turn, were joined and supported by thousands and then millions - and only then did government policies begin to respond.

The new ethic of compelling effective responses to the "loud emergencies" (e.g., Kampuchea in 1975-80 and Ethiopia/Africa in 1984-85) similarly was people-led - aroused public opinion made it good politics for governments to respond generously...and poor politics not to.

Similarly, the initial pilot projects that proved the viability of primary health care, beginning with the Tinghoren rural county project in China in the late 1920s, were overwhelmingly the result of private initiatives at the outset.

Each of us in our respective fields has this responsibility - to see that morality does not lag far behind humanity's capacity. We professionals concerned with health, thanks to the scientific and technological advances of recent years, have a whole new capacity - and a whole new credibility in advocacy because of our increased ability. Our challenge is how to ensure that this capacity is used ... that people are empowered with self-health knowledge ... and that governments and communities are compelled to fulfill the human rights - including meeting basic human needs - of the world's children.

The 1990s will be difficult years ... for all countries, all societies, and the world as a whole. But it can also be an historically constructive decade 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.

DECLARATION OF TALLOIRES

12 March 1988 - Talloires, France

PROTECTING THE WORLD'S CHILDREN:

AN AGENDA FOR THE 1990's

Remarkable health progress has been achieved during the past decade. Global recognition that healthy children and healthy families are essential for human and national development is steadily increasing. Consensus has been reached on the strategy for providing essential community primary health programmes. The international community has become engaged in partnership with national governments in the creation of successful global programmes, ensuring the availability financial support and appropriate technologies. These include:

- immunization programmes, which now protect more than 50% of infants in developing countries with polio or DPT vaccines, preventing some 200,000 children from becoming paralyzed with polio and over a million children from dying each year from measles, whooping cough, or neonatal tetanus;

- diarrhoeal diseases control programmes which now make life-saving fluids (particularly oral rehydration salts) available for 60% of the developing world population, the use of which may be preventing as many as 1 million deaths annually from diarrhoea;

- initiatives to control respiratory infections which hold promise in the years ahead of averting many of the 3 million childhood deaths from acute respiratory infections each year in developing countries not prevented currently by immunization;

- safe motherhood and family planning programmes which are so important in protecting the well-being of families.

Progress to date demonstrates that resources can be mobilized and that rapid and effective action can be taken to combat dangerous threats to the health of children and mothers, particularly in developing countries.

This progress is the result of:

- enthusiastic world-wide agreement for the development of health strategies based on primary health care;

- the commitment of national governments, multi- and bilateral development agencies, non-governmental organizations, private and voluntary groups and people in all walks of life to give priority to these programmes;

- co-ordinated action by the sponsors of the Task Force for Child Survival: UNICEF, the World Bank, UNDP, WHO and the Rockefeller Foundation.

We, The Task Force For Child Survival, conveners of the meeting "Protecting the World's Children - An Agenda for the 1990s" in Talloires, France on 10-12 March 1988:

1. **EXPRESS** appreciation and admiration for the efforts made by the developing countries to reduce infant and child deaths through primary health care and child survival actions.

2. **COMMIT OURSELVES** to pursue and expand these initiatives in the 1990s.

3. **URGE** national governments, multi- and bilateral development agencies, United Nations agencies, non-governmental organizations and private and voluntary groups to commit themselves to:

- increase national resources from both developing and industrialized countries devoted to health in the context of overall development and self-reliance;

- improve women's health and education, recognizing the importance for women themselves, recognizing women's contribution to national development and recognizing that mothers are by far the most important primary health care workers;

- accelerate progress to achieve Universal Childhood Immunization by 1990 and to sustain it thereafter;

- accelerate progress to eliminate or markedly reduce as public health problems the other main preventable causes of child and maternal mortality and morbidity, striving to reach sustained universal coverage of children and mothers by the year 2000;

- assure the development of new vaccines and technologies and their application, particularly in developing countries, as they become appropriate for public health use;

- promote expanded coverage of water supply and sanitation;

/....

- pursue research and development, including technology transfer, in support of the above actions.

4. SUGGEST that the following be considered by national and international bodies as targets to be achieved by the year 2000:

- the global eradication of polio;
- the virtual elimination of neonatal tetanus deaths;
- a 90% reduction of measles cases and a 95% reduction in measles deaths compared to pre-immunization levels;
- a 70% reduction in the 7.4 million annual deaths due to diarrhoea in children under the age of 5 years which would occur in the year 2000 in the absence of oral rehydration therapy, and a 25% reduction in the diarrhoea incidence rate;
- a 25% reduction in case/fatality rates associated with acute respiratory infection in children under 5 years;
- reduction of infant and under five child mortality rates in all countries by at least half (1980-2000), or to 50 and 70 respectively per 1000 live births, whichever achieves the greater reduction;
- a 50% reduction in current maternal mortality rates.

Achievement of these targets would result in the avoidance of tens of millions of child deaths and disabilities by the year 2000, as well as a balanced population growth as parents become more confident their children will survive and develop. The eradication of poliomyelitis would, with the eradication of smallpox, represent a fitting gift from the 20th to the 21st centuries.

5. DRAW world attention to the potential for enlarging upon the successes outlined above to encompass low cost, effective initiatives to:

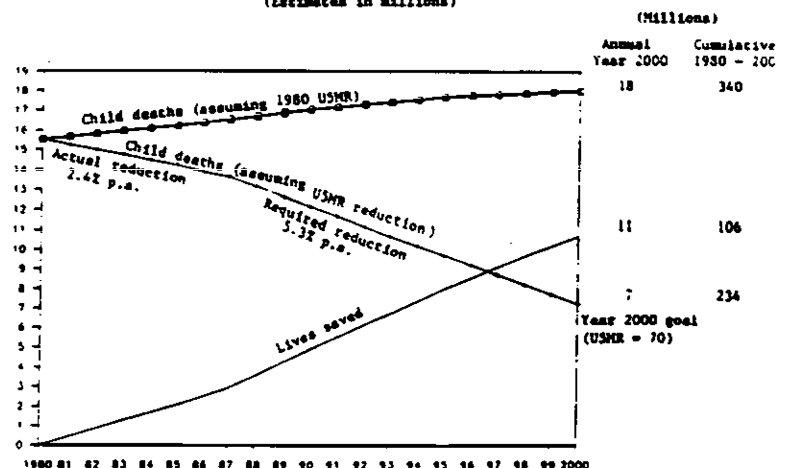
- improve the quality and coverage of educational services to obtain universal primary education and 80% female literacy, and
- virtual elimination of severe malnutrition of under five children while also significantly reducing moderate and mild malnutrition in each country.

6. WELCOME the progress being made in drafting the Convention on Rights of the Child and join the United Nations General Assembly in urging completion of the Convention in 1989, the 10th anniversary of the International Year of the Child.

We are convinced that vigorous pursuit of these initiatives aimed at protecting the world's children will ensure that children and mothers - indeed whole families - will benefit from the best of available health technologies, making an essential contribution to human and national development and to the attainment of Health For All By The Year 2000.

ALTERNATIVE GLOBAL PROJECTIONS OF CHILD DEATHS AND LIVES SAVED

Children under five years of age: 1980-2000
(Estimates in millions)



Projection A deaths
The 1980 under-five mortality rates remain constant to the year 2000.

Projection B deaths
Up to 1987 the under-five mortality rates are as estimated by the United Nations Population Division. From 1987, countries make sufficient progress to reach their CSDR targets by the year 2000 i.e. either an under-five mortality rate of 70 or half their 1980 rate whichever is lower.

Projection C lives saved
The difference between projection A deaths and projection B deaths.

Country	Under 5 mortality rate*		Average annual rate of reduction of the Under 5 mortality rate			GNP per capita (U.S. $)	GNP per capita growth rate		Annual no. of births/infant and child deaths (0-4) (thousands)	Total Fertility Rate		
					Required**							Average annual rate of reduction
	1960	1986	60-80	80-85	85-2000	1985	65-80	80-85	1986	1960	1986	60-86
1 Afghanistan	380	325	0.55	0.66	8.44	...			863/ 260	7.0	6.7	0.16
2 Mali	370	297	0.66	1.40	7.96	150	1.4	-3.0	421/ 125	6.5	6.7	-0.14
3 Sierra Leone	397	297	1.01	1.40	7.96	350	1.1	-0.2	174/ 52	6.1	6.1	-0.01
4 Malawi	364	270	1.00	1.59	7.34	170	1.5	-0.6	384/ 104	6.9	7.0	-0.08
5 Ethiopia	294	255	0.57	0.38	7.15	110	0.2	-2.0	2228/ 568	6.7	6.7	-0.00
6 Guinea	346	255	1.07	1.48	7.19	320	0.8	-1.4	292/ 74	6.4	6.2	0.12
7 Somalia	294	255	0.57	0.38	7.15	280	-0.7	0.6	228/ 58	6.6	6.6	0.00
8 Mozambique	302	247	0.52	1.52	6.95	160		-13.6	651/ 161	5.7	6.1	-0.25
9 Burkina Faso	388	241	1.98	1.18	6.86	150	1.3	-1.3	342/ 82	6.5	6.5	0.00
10 Angola	346	238	1.40	1.50	6.76	470		0.1	427/ 101	6.4	6.4	-0.01
11 Niger	320	233	1.11	1.53	6.67	250	-2.1	-6.7	324/ 76	7.1	7.1	-0.02
12 Chad	326	228	1.30	1.56	6.49	80	-2.3	1.8	228/ 52	6.0	5.9	0.07
13 Guinea-Bissau	315	228	1.13	1.56	6.49	180	-1.5	1.9	37/ 8	5.1	5.4	-0.24
14 C.African Rep	308	228	1.20	0.84	6.55	260	-0.2	-1.5	117/ 27	5.7	5.9	-0.15
15 Senegal	313	227	1.12	1.57	6.49	370	-0.6	0.0	309/ 70	6.7	6.5	0.09
16 Mauritania	310	219	1.23	1.62	6.26	420	0.1	-0.7	98/ 21	6.9	6.9	-0.02
17 Liberia	303	211	1.30	1.60	6.04	470	-1.4	-6.4	110/ 23	6.3	6.9	-0.37
18 Rwanda	248	210	0.38	1.43	6.00	280	1.8	-1.5	323/ 68	6.8	7.4	-0.30
19 Kampuchea	218	206	-1.82	7.15	6.91	...			318/ 66	6.3	4.8	1.01
20 Yemen	378	204	2.33	2.31	5.99	550	5.3	0.9	339/ 69	7.0	6.9	0.03
21 Yemen. Dem.	378	204	2.33	2.31	5.99	530			104/ 21	7.0	6.6	0.20
22 Bhutan	297	202	1.42	1.57	6.27	160		3.4	54/ 11	5.9	5.4	0.36
23 Nepal	297	202	1.42	1.57	6.27	160	0.1	0.8	677/ 137	5.9	6.0	-0.07
24 Burundi	256	196	0.93	1.34	5.60	230	1.9	-0.8	225/ 44	5.7	6.4	-0.46
25 Bangladesh	262	193	1.05	1.56	5.78	150	0.4	0.9	4428/ 854	6.7	5.7	0.60
26 Benin	310	189	1.91	1.77	5.36	260	0.2	0.1	213/ 40	6.8	7.0	-0.11
27 Sudan	293	182	1.68	2.20	5.17	300	(.)	-4.2	996/ 181	6.7	6.4	0.14
28 Tanzania	248	179	1.05	1.86	5.08	290	(.)	-3.1	1184/ 212	6.9	7.1	-0.13
29 Bolivia	282	179	1.49	2.52	5.42	470	-0.2	-7.0	284/ 51	6.6	6.1	0.30
30 Nigeria	318	178	2.29	1.87	5.02	800	2.2	-7.3	5015/ 895	6.9	7.1	-0.13
31 Haiti	294	176	1.96	1.89	5.76	310	0.7	-2.5	278/ 49	6.2	5.6	0.35
32 Gabon	288	174	1.91	1.91	4.90	3670	1.5	-1.2	43/ 7	4.1	4.9	-0.76
33 Uganda	224	174	0.87	1.09	4.94	230	-2.6	2.2	810/ 141	6.9	6.9	0.01
34 Pakistan	277	170	1.84	1.85	5.34	380	2.6	2.6	4211/ 716	7.2	5.5	1.02
35 Zaire	251	166	1.46	1.89	4.63	170	-2.1	-3.8	1394/ 232	5.9	6.1	-0.10
36 Laos	232	166	0.99	2.20	5.38	...			165/ 27	5.7	5.5	0.10
37 Oman	378	166	3.08	3.16	4.96	6730	5.7	0.5	58/ 10	7.2	6.9	0.13
38 Iran	254	159	1.93	1.19	5.19	...		7.1	1801/ 286	8.1	5.3	1.60
39 Cameroon	275	158	2.15	1.87	4.35	810	3.6	4.5	435/ 69	5.7	5.8	-0.07
40 Togo	305	157	2.68	2.00	4.24	230	0.3	-5.6	138/ 22	6.2	6.1	0.04
41 India	282	154	2.14	2.90	4.63	270	1.7	3.1	22477/3455	5.8	3.9	1.55
42 Cote d'Ivoire	320	153	2.97	2.15	4.77	660	0.9	-5.2	463/ 71	6.6	6.6	-0.01
43 Ghana	224	150	1.52	1.50	4.03	380	-2.2	-3.9	663/ 99	6.5	6.5	-0.01
44 Lesotho	208	140	1.30	2.09	4.84	470	6.5	3.4	65/ 9	5.8	5.8	0.01
45 Zambia	228	132	2.14	1.82	3.93	390	-1.6	-4.1	333/ 44	6.6	6.8	-0.08
46 Egypt	300	131	2.89	4.02	3.81	610	3.1	1.3	1629/ 214	7.1	4.5	1.76
47 Peru	233	128	2.21	2.25	3.92	1010	0.2	-4.2	708/ 91	6.9	4.6	1.50
48 Libya	268	125	2.52	4.19	3.27	7170	-1.3	-9.1	167/ 21	7.2	7.0	0.11
49 Morocco	265	125	2.71	3.21	3.73	560	2.2	0.1	755/ 95	7.2	4.6	1.72
50 Indonesia	235	122	2.39	2.77	3.62	530	4.8	2.3	5020/ 614	5.4	3.7	1.49
51 Congo	241	119	2.93	1.71	3.96	1110	3.8	4.9	80/ 10	5.9	6.0	-0.06
52 Kenya	208	118	2.10	2.31	3.77	290	1.9	-1.7	1182/ 139	8.2	8.0	0.05
53 Zimbabwe	182	118	1.52	2.02	3.86	680	1.6	0.0	431/ 51	6.6	6.6	0.01
54 Honduras	232	112	2.64	3.13	3.50	720	0.4	-2.6	184/ 21	7.4	5.9	0.87
55 Algeria	270	112	2.99	4.46	3.05	2550	3.6	1.7	938/ 105	7.4	6.5	0.48
56 Tunisia	255	106	3.06	4.30	3.11	1190	4.0	1.4	226/ 24	7.2	4.3	1.93
57 Guatemala	230	105	2.89	3.16	3.49	1250	1.7	-4.3	340/ 36	6.9	5.9	0.59
58 Saudi Arabia	292	105	3.86	3.90	3.24	8850	5.3	-7.3	495/ 52	7.3	6.9	0.18
59 South Africa	192	101	2.28	2.98	3.55	2010	1.1	-1.6	1272/ 128	5.8	5.0	0.46
60 Nicaragua	210	100	2.48	3.92	3.24	770	-2.1	-3.1	145/ 14	7.3	5.6	1.01
61 Turkey	258	99	3.12	5.36	3.12	1080	2.6	2.1	1486/ 147	6.0	3.7	1.80
62 Iraq	222	98	3.36	2.24	3.79	3020			689/ 67	7.2	6.2	0.54
63 Botswana	174	96	2.22	2.26	3.78	840	8.3	7.4	57/ 5	6.4	6.5	-0.05
64 Viet Nam	233	95	3.30	3.81	3.27	...			1835/ 175	7.0	3.9	2.26
65 Madagascar	181	94	2.37	2.83	3.60	240	-1.9	-6.1	458/ 43	5.8	6.1	-0.19
66 Ecuador	183	90	2.69	2.79	3.61	1160	3.5	-2.4	347/ 31	6.9	4.8	1.43
67 Papua NG	247	90	3.88	3.44	3.39	680	0.4	-1.6	132/ 12	6.3	5.4	0.58
68 Brazil	160	89	2.23	2.26	3.79	1640	4.3	-1.5	4039/ 359	6.2	3.6	2.08
69 Burma	229	89	4.01	2.06	3.85	190	2.4	3.3	1192/ 106	5.9	3.8	1.69
70 El Salvador	206	88	3.27	3.01	3.54	820	-0.2	-3.1	222/ 20	6.9	5.2	1.03
71 Dominican Rep	200	86	3.31	2.91	3.57	790	2.9	-0.8	201/ 17	7.3	3.8	2.49
72 Philippines	135	75	2.23	1.93	3.89	580	2.3	-3.4	1757/ 132	6.6	4.1	1.83
73 Mexico	140	71	2.64	2.30	3.77	2080	2.7	-2.1	2587/ 183	6.7	4.2	1.83
74 Colombia	148	70	3.09	1.84	3.92	1320	2.9	-0.5	873/ 61	6.7	3.7	2.28
75 Syria	218	68	4.71	3.07	3.52	1570	4.0	-2.1	502/ 34	7.5	6.9	0.28

* Under 5 Mortality Rate (U5MR) is the annual number of deaths of children under 5 years of age per 1.000 live births.

** REQUIRED MORTALITY RATES are those rates required in 1985 either to halve 1980 child mortality rates by the year 2000 in every country or to reduce them to 70 per 1000 live births. whichever is less.

Table 1: CHILD MORTALITY RATES: U5MR

Country	Under 5 mortality rate*		Average annual rate of reduction of the Under 5 mortality rate		Required**	GNP per capita (U.S. $)	GNP per capita growth rate		Annual no. of births/infant and child deaths (0-4) (thousands)	Total Fertility Rate		Average annual rate of reduction
	1960	1986	60-80	80-85	85-2000	1985	65-80	80-85	1986	1960	1986	60-86
76 Paraguay	134	63	3.13	2.05	3.85	860	3.9	-1.9	132/ 8	6.6	4.6	1.40
77 Mongolia	158	62	3.53	3.63	3.33	...			69/ 4	5.7	4.9	0.59
78 Jordan	218	62	4.89	4.07	3.18	1560	5.8	1.5	170/ 10	7.2	7.3	-0.07
79 Lebanon	92	53	1.95	2.02	3.87	...			80/ 4	6.4	3.5	2.26
80 Thailand	149	53	3.85	4.15	3.16	800	4.0	2.6	1290/ 68	6.4	3.0	2.93
81 Albania	164	50	4.90	2.82	3.60	...			84/ 4	5.7	3.4	1.99
82 China	202	47	6.13	2.59	3.68	310	4.8	8.6	19914/ 942	5.9	2.2	3.75
83 Sri Lanka	113	46	3.54	2.69	3.65	380	2.9	3.2	417/ 19	5.1	3.0	2.01
84 Venezuela	114	44	3.94	2.47	3.72	3080	0.5	-5.4	558/ 25	6.5	3.9	1.95
85 U.A.E.	239	41	7.25	4.10	3.18	19270		-7.7	35/ 1	6.9	5.6	0.79
86 Guyana	94	39	2.73	5.36	2.75	500	-0.2	-7.3	26/ 1	6.0	2.9	2.76
87 Argentina	75	39	2.52	2.33	3.76	2130	0.2	-3.9	733/ 29	3.1	3.3	0.26
88 Malaysia	106	37	4.41	2.44	3.73	2000	4.4	1.8	448/ 16	6.7	3.5	2.48
89 Panama	105	34	4.48	3.58	3.35	2100	2.5	-0.2	60/ 2	5.9	3.2	2.30
90 Korea. Dem.	120	33	4.89	4.47	3.05	...			615/ 21	5.6	3.7	1.53
91 Korea. Rep.	120	33	4.89	4.47	3.05	2150	6.6	6.3	975/ 33	5.4	2.5	2.85
92 Uruguay	56	31	1.43	5.29	2.77	1650	1.4	-6.0	58/ 2	2.9	2.7	0.33
93 Mauritius	104	30	4.43	5.29	2.77	1090	2.7	2.3	26/ 1	5.7	2.5	3.08
94 Romania	82	30	4.03	2.95	3.56	2560		3.0	396/ 12	2.0	2.4	-0.66
95 Yugoslavia	113	30	5.43	3.48	3.38	2070	4.1	-0.5	362/ 11	2.7	2.0	1.12
96 USSR	53	28	2.20	3.13	3.50	4550			5207/ 147	2.5	2.4	0.22
97 Chile	142	25	6.14	8.25	1.73	1430	-0.2	-3.9	272/ 7	5.1	2.5	2.66
98 Trinidad & T	67	25	3.94	2.82	3.60	6020	2.3	-6.0	30/ 1	5.0	2.7	2.30
99 Jamaica	88	24	5.40	2.92	3.57	940	-0.7	-3.1	63/ 2	5.5	3.0	2.25
100 Kuwait	128	24	6.28	6.51	2.35	14480	-0.3	-6.8	68/ 2	7.4	5.9	0.88
101 Costa Rica	121	23	7.06	2.24	3.79	1300	1.4	-2.7	78/ 2	7.0	3.3	2.79
102 Portugal	112	21	8.37	6.01	2.52	1970	3.3	-0.5	172/ 4	3.1	2.1	1.41
103 Bulgaria	62	20	4.44	3.43	3.40	4150			138/ 3	2.2	2.2	-0.02
104 Hungary	57	20	3.85	4.18	3.15	1950	5.8	1.7	132/ 3	1.8	1.8	0.06
105 Poland	70	20	5.21	2.64	3.66	2050			637/ 13	2.7	2.2	0.70
106 Cuba	87	19	6.24	4.56	3.02	...			181/ 3	4.7	2.0	3.27
107 Greece	64	17	4.99	4.78	2.94	3550	3.6	-0.3	145/ 2	2.2	2.1	0.17
108 Czechoslovakia	32	17	2.32	3.20	3.48	5820			232/ 4	2.4	2.1	0.51
109 Israel	40	16	3.91	2.33	3.76	4990	2.5	-0.7	94/ 2	3.9	2.9	1.06
110 New Zealand	27	13	2.58	2.64	3.66	7010	1.4	1.8	60/ 1	3.8	1.9	2.70
111 USA	30	13	3.41	2.82	3.60	16690	1.7	1.4	3789/ 48	3.3	1.9	2.14
112 Austria	43	13	4.82	4.07	3.18	9120	3.5	1.7	93/ 1	2.8	1.6	2.06
113 Belgium	35	13	4.15	2.82	3.60	8280	2.8	0.6	122/ 2	2.7	1.6	1.90
114 German Dem.	44	13	5.24	2.82	3.60	7180			240/ 3	2.5	1.9	0.97
115 Italy	50	13	5.25	5.22	2.79	6520	2.6	0.4	658/ 8	2.6	1.6	1.78
116 Singapore	50	12	6.17	3.04	3.53	7420	7.6	6.4	43/ 1	4.9	1.7	4.05
117 Germany. Rep.	38	12	4.23	5.59	2.67	10940	2.7	1.2	636/ 7	2.5	1.4	2.19
118 Ireland	36	12	4.28	4.36	3.08	4850	2.2	-0.3	79/ 1	4.0	3.0	1.09
119 Spain	56	11	6.37	4.36	3.08	4290	2.6	0.9	580/ 7	2.9	2.1	1.19
120 United Kingdom	27	11	3.23	3.04	3.53	8460	1.6	2.1	743/ 8	2.8	1.8	1.69
121 Australia	25	11	2.66	4.71	2.97	10830	2.0	0.9	249/ 3	3.3	1.9	2.00
122 Hong Kong	65	11	7.39	4.71	2.97	6230	6.1	4.4	94/ 1	5.3	1.9	3.90
123 France	34	10	4.69	3.29	3.45	9540	2.8	0.3	765/ 8	2.9	1.9	1.63
124 Canada	33	10	4.55	5.11	2.83	13680	2.4	0.8	384/ 4	3.6	1.7	2.87
125 Denmark	25	9	4.02	1.89	3.91	11200	1.8	2.0	56/ 1	2.6	1.5	2.15
126 Japan	40	9	6.70	2.09	3.84	11300	4.7	3.5	1522/ 14	2.0	1.8	0.42
127 Netherlands	22	9	3.41	1.89	3.91	9290	2.0	0.3	173/ 2	3.1	1.5	2.89
128 Switzerland	27	9	4.39	3.93	3.23	16370	1.4	1.3	70/ 1	2.5	1.5	2.04
129 Norway	23	8	3.62	1.89	3.91	14370	3.3	3.2	49/ 0	2.9	1.6	2.23
130 Finland	28	7	5.52	2.33	3.76	10890	3.3	2.1	63/ 0	2.6	1.6	1.71
131 Sweden	20	7	3.91	2.33	3.76	11890	1.8	1.5	87/ 1	2.3	1.5	1.64