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Executive Director of the United Nations Children's Fund (UNICEF)
at
Risks Old and New: A Global Consultation on Health

"Mobilization for Revolutionary Progress in Health"

The Carter Center – Atlanta, Georgia
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1946- 40 Years for Children
1986 Au service des enfants

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MOBILIZATION FOR REVOLUTIONARY PROGRESS IN HEALTH

Mr. President,
Distinguished Participants:

This Consultation occurs at a time of continuing severe global economic difficulties, which not only slow economic growth in many parts of the world but which are also leading to massive retrenchment in public services in those most seriously affected countries. Progress in preserving the lives of our children is now slowing after four decades of historically unprecedented improvement which witnessed more progress for children as a whole in many than the preceding 2,000 years. Between the end of World War II and 1980, for example, child death rates in the developing countries were reduced by half.

Some pioneering developing countries as different as China and Sri Lanka and South Korea demonstrated the possibility, where above-average political will to do so has prevailed, of achieving infant and child mortality rates comparable to those of Europe and North America in mid-century while their per capita incomes were still at those of the United States and Western Europe in the late 18th century.

But in the 1980s, that world-wide progress has not been maintained despite the fact that China and India have continued their momentum. In country after country, there is evidence of rising levels of malnutrition, in some cases of rising infant mortality, and many indications of a decline in other indicators of child welfare, particularly among the poor and vulnerable.

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In Ghana, to select a particularly severe example, real government health expenditures per capita have declined by more than 80 per cent by 1984; attendance at hospitals and clinics dropped by about one-third between 1979 and 1984. Child malnutrition had risen by one-third between 1980 and 1984, to the point that 45-50 per cent of the children under 5 are moderately malnourished. Infant mortality rates are noticeably higher than 10 years ago.

The post World War II era has been the first in human history in which it has been possible to think seriously in terms of bringing the basic essentials of health and nutrition to all humanity. Will the 1980s mark the moment that that opportunity was lost, at least for this century? Or will current difficulties serve rather as a spur to new levels of creativity in advancing toward the goal of primary health care for all by the year 2000? And might we find ways to address the widespread health problems of industrial societies that threaten to wipe out the net gains in health that they have made in the past century...and thus, perhaps, help developing societies avoid those problems as they enter the industrial world?

Unfortunately, the likelihood is for losing this historic opportunity - and this was so even before the global recession deepened. But there is new hope if these dark times generate new creativity and new initiatives, as we saw in the United States with the New Deal arising from the dark depression days of the 1930s, and in the world community with the United Nations, the Bretton Woods institutions and the Marshall Plan arising from the ashes of World War II.

Health begins with people

This creativity must begin with principles of health care and public health services which we have known in theory for years but which we have been slow to apply in practice, one of the original pioneers of primary health care. I can remember my father, one of the original pioneers of primary health care, articulating such principles in China in the 1930s - while most countries are still slow in fully applying them today.

The first principle is that the use made of medical knowledge and the efficiency of health protection depends chiefly upon social organization. The immediate social problem is to overtake the lag between modern knowledge and its use in the setting of a community. A dramatic "new risk" example of this lag is the 1,000 persons who die prematurely in the United States each day because of smoking; dramatic world-wide examples would include not only smoking (cancer deaths in the Third World are exceeding those in the industrial world in the 1980s), but also, in the "old risk" category, the more than 4 million needless deaths from dehydration from diarrhoea when there is a largely effective new home remedy.

A second basic principle is that, important as is the introduction of effective health systems, a vertical medical system cannot be truly effective, or even stand by itself, unless it is integrated in other activities in society in a joint attack on the problems of development and social

reconstruction. Health is not simply a "sector", a responsibility of the Health Ministry alone; it must be an explicit goal to be achieved through all sectors with mass citizen participation - through education, through better nutrition, and through national and local community leadership.

A third principle is that successful organization implies reliance upon economically practical strategies for serving the entire population rather than just the relatively well-off. Many here can recite examples in your own countries of the establishment or expansion of major hospitals whose operational costs led to the curtailment of health clinics and preventive services, and we are well aware of the needless competition of American hospitals to each have tremendously expensive diagnostic equipment.

Reflecting these principles, the Alma Ata Conference in 1978 of the world's health professionals, sponsored by the World Health Organization and UNICEF with the active participation of non-governmental organizations, articulated the concept of Primary Health Care. By seeking to apply those basic principles of health care which my father and his contemporaries articulated a half century ago, we can transform the health of peoples even at low income levels. Countries and regions as different as China, South Korea, Sri Lanka, Kerala and Taiwan have demonstrated - with a modest increase in financial resources and a sustained strong political will - how to reach the many rather than just the largely urban, relatively better-off minority. Through this approach, developing country governments, organizations and communities themselves, with help from UNICEF and our partners in the World Health Organization, other agencies of the United Nations system, and many bilateral and private voluntary organizations, have been determined, particularly since the Alma Ata Conference on Health for All through Primary Health Care, to sharply reduce, by half and more, those grim, needless statistics of death and disablement.

While many countries have since paid more than just lip service to promoting primary health care (e.g., millions of village health workers have been trained), the majority of health resources still are not applied to achieving it. Furthermore, the health sector has been reluctant to aggressively seek the involvement of other sectors in health promotion, or to shift health knowledge from the traditionally conservative health professional to the general public. In the great majority of countries - industrialized as well as developing - far too much emphasis remains on cure rather than prevention. Even within the curative sector and despite the growing emphasis of recent decades on reaching the poorer majority, the more affluent minority still benefit disproportionately. Regretfully, in many countries the global recession has reversed this emphasis.

A climate for revolution

In such an environment - with economic deterioration exaccerbating the reticence of the health structure to address the needs of the poor and most vulnerable - is there any possibility of recapturing the past modest momentum of health and nutrition progress, especially with respect to protecting and

even accelerating progress for the world's poorest billion people from the old risks of malnutrition, infectious disease and lack of sanitation? And can we ever hope to reduce, in the industrialized countries - and avoid, in the developing countries - the damage to health induced by the new risks associated with economic development?

The answer is yes. Or at least, "yes, if".

The possibilities exist today because of one central new development of recent years - largely a by-product of the development progress of the past decades - that now holds forth the prospect for major breakthroughs even in these lean times. Vigorous use of this new development is already saving the lives of more than one million small children each year; truly vigorous support could mean annually saving the lives of 5 million small children - more than 10,000 each day - by 1990, and improving the health of more than 100 million more while also decreasing population growth and dramatically improving the well-being of women.

What is this new development? It is the new capacity - the major new potential - to communicate with the poor majority in developing countries. Indeed, it is the revolution in social communications and organization which has occurred in recent times and which only now is beginning to be increasingly used for social benefit. An almost incredible transformation has taken place in virtually every country with respect to the capacity to communicate, no matter how poor or under-developed. With the help of development cooperation programmes and international institutions like WHO, UNFPA, UNDP, the World Bank and UNICEF, but largely through the efforts of their own countries, people are now far, far better organized. In small villages and towns, they have banded together as farmers or women or factory workers or retailers. They have set up training programmes and schools to the point that most young mothers in their 20s and 30s can now read and write. With increased incomes, they bought equipment and supplies. They linked up with other groups in other communities and set up networks. They equipped themselves with radios in almost every home, and at least a television or two in every village, and frequently in many homes, with the result that people throughout a country can know what is going on and how to do things. Religious structures - whether Christian, Islamic or Buddhist - have a whole new capacity to communicate. And, perhaps to the surprise of those in the "developed" world, it now seems that people in such less-developed areas as Africa, South Asia and north-east Brazil - while they still have per capita incomes lower than those of our Europeans or North Americans of two centuries ago - now have a capacity to communicate not achieved in the industrialized world until the mid 20th century - just one generation ago.

Children are the first frontier

The revolutionary potential of these advances on the condition of life for the masses is now being most dramatically experienced in the field of child health, as the evolution in the capacity to communicate in low-income communities coincided with the realization that major, grossly underutilized

technological advances of recent years could bring about revolutionary improvement in the well-being of children - a Child Survival and Development Revolution - at extremely low cost...a cost so low that virtually all countries could afford them with a modicum of international cooperation, if only they are combined with the new capacity to communicate with the poor who are most in need of these technological advances.

These new, improved, rediscovered or newly appreciated technologies, which are detailed in UNICEF's annual report, The State of the World's Children, 1986, include:

-- The recently discovered oral rehydration therapy consisting of a remarkable simple treatment with salts, potassium and glucose (sugar) in water - costing only a few cents, which can be applied by parents at home for a child suffering from diarrhoeal dehydration, the number one child killer that claims nearly 5 million lives annually. No wonder Britain's Lancet described this as "potentially the most important medical advance of this century".

-- Recent advances in vaccines, now costing only fifty cents to immunize a child for life against tetanus, measles, polio, whooping cough, diptheria and tuberculosis which cripple and kill several millions of children every year.

-- The recently appreciated, through scientific analysis, merits of breastfeeding and improved weaning practices.

-- Growth monitoring through frequent charting (usually monthly) of weights that enables the mother to detect the early signs of malnutrition and in a surprising majority of cases deal with it through means within the parents' own control.

-- Better family spacing of children, which alone could reduce the infant toll by half.

To be effective, all of these measures require that parents be aware of and use them, whether it is to mix oral rehydration formulas at home or to bring a child the three or four times necessary for full immunization against six killer diseases. We all know how difficult it is to have people adopt new practices, and this is particularly true of mothers from low income and often illiterate families who may be reluctant to bring their children for vaccination, a process which the mother probably doesn't understand in the first place and particularly so after the child runs a fever after each immunization visit, as is often the case.

This, of course, is where the new capacity to communicate with parents is so important, using all channels intensively to reach the parents and local communities. Empowering parents, and particularly mothers, with present knowledge and technologies is the key to unlocking the potential for a revolution in child health. But, and I stress the but, the responsibility for

turning that key rests with the whole of society, for the mother cannot act alone. Need I remind all of us who have given up smoking how much societal support we required?

...and lives are being saved

It has been exhilirating to see how fast this potential has advanced in the just three and one half years since first articulated with respect to primary health care.

Colombia, for example, is a country which has been pioneering since 1983 in pulling this whole group of ideas together. Beginning in 1984, Colombia started on the immunization front. The key was leadership from the top for all sectors of society to be persuaded to participate. President Betancur talked to the media, including the leading opposition papers. He persuaded the press and the radio and television stations to co-operate, and then he recruited the Church and the Red Cross, the Rotarians, the Lions, the Scouts, schoolteachers, businessmen, and all of his government ministries. Together, they set out to do what had never been done before in history - in one 3-month period, through three national immunization days, to immunize the great majority of the children of a country against five major diseases then killing and crippling more than tens of thousands of Colombian children each year. There were more than 10,000 TV spots; virtually every parish priest devoted three sermons to the importance of families immunizing their children; every school teacher was involved; etc. For the children of the world, with more than 10,000 dying each day from these six diseases, this accomplishment in Colombia was far more significant than even man's landing on the moon 15 years before.

The Campaign began in June, 1984. By the end of that August more than three-quarters of the under-fives had been fully immunized. Repeated again last fall with particular emphasis on the most vulnerable under-twos, the total rose to over 80 per cent...sufficient in most areas to provide "herd" immunization - a process which, I should mention, President Carter joined in supporting by visiting Colombia for the third and final Day over Thanksgiving weekend. So many children were reached that the "campaign" approach has been able to give way to on-going PHC infrastructures which have been vastly bolstered by the intensive efforts of the past two years.

Colombia illustrates the use of communications with a vengeance. The results demonstrated how spectacularly we can, if a country will only mobilize fully, defend children against these brutal mass killers and cripplers. The great majority of Colombian children now have been immunized and a significant start made on teaching millions of mothers how to use oral rehydration therapy, thereby saving the lives of more than 10,000 children a year who would have died only two short years ago while simultaneously saving many millions of dollars for Colombians and greatly strengthening the Primary Health Care system. Similar techniques are beginning to be used in country after country, with each country tailoring the approach to fit the particular structures and cultures of that country.

It is particularly fascinating to watch as these efforts become politically relevant as well as socially. It becomes good politics for leaders to apply these techniques. It is sufficiently good politics that last year in El Salvador all the feuding factions were persuaded to lay down their arms for the Sundays of February 3rd, March 3rd, and April 23rd and pick up their children - and immunize them. When Salvadorians realized that more children died in that war-torn country from not being immunized than all the people who had been killed in all the fighting the year before, they understood the magnitude of the tragedy. And they were willing to co-operate - or, at least, to not shoot at each other - to allow a National Immunization Campaign to go forward. And so the government, and the guerrillas, and dozens of private groups (including notably the Church and the Red Cross) all set out to protect children, rather than to catch them in the crossfire. A second annual round of this campaign - beginning again with a "National Day of Tranquility" - began last month.

Turkey launched its child survival revolution just last September, with a national immunization week for 5 million under-fives vulnerable to the six diseases which in 1984 took the lives of more than 30,000 small children, and crippled tens of thousands more. Within three months, using and improving on many of the same techniques as Colombia, with imams - more than 50,000 - taking the lead in each mosque just as Colombian priests had in their churches, and with the active participation of 95,000 village teachers who returned from summer vacations two weeks early for the purpose, some 85 per cent of all young Turks were fully immunized against these dread diseases.

These success stories are not alone. They are being joined by others - in Burkina Faso, China, the Dominican Republic, Ecuador, India, Nigeria, Pakistan, Peru, Egypt and many others. In Egypt, the toll of more than 100,000 small children annually from the dehydration from diarrhoea has been more than halved in just three years. In early 1983, less than one percent of Egyptian mothers were using oral rehydration therapy, by early 1986 this percentage had risen to over 60 per cent. And massive new efforts are beginning - such as in India, where more than 1 million children died last year as a consequence of not being immunized, but where a programme is now underway to achieve universal immunization of Indian children by 1990 as a "living memorial" to the late Indira Gandhi.

People taking charge

The Child Survival and Development Revolution rests upon one central foundation embodied in the concept of Primary Health Care: that people can and ought to be enabled to take far greater care of themselves. Indeed, there is very much a common tie between these sets of problems affecting the developing countries and the concerns of many people in North America and Europe and other developed countries. The essence of all of this is a new respect for the capacity of the individual and the importance of governments enhancing and encouraging use of that capacity. Consistent with this, these new technologies are much more relevant to the family - enabling people to take action - than to big institutions with experts in "white coats"

intervening. The same is true on new agricultural technologies of relevance to subsistence farmers which are becoming available; the potential for a comparable food security revolution for poor farmers in Africa is just now becoming visible on the horizon.

Our strategy to accelerate child survival and overall well-being through low cost measures brings far-reaching changes to parents lives - and especially to mothers - that stretch beyond the area of health of their children. It provides parents with a technical and psychological capacity to begin to control important events in their lives; it contributes to emotional tranquillity, substantial financial savings and a major time release in their lives as the thrust of child death and continuous illness is greatly eased.

Empowering parents with knowledge of techniques for child protection is the key to unlocking not only a health revolution but the potential for parents - and, again, especially for women - to develop greater confidence in their abilities to control life events as they realize that their own actions can make a major difference as to whether their children live or die. This knowledge alone can act as a springboard and mark the beginnings of a major frontier of progress towards educating and empowering women to be proactive rather than reactive and to have confidence in their abilities to do more for themselves in other spheres of life - not only as mothers but as food producers, traders, midwives, agents of community development and other roles.

Fostering such a climate of realistic hope and possibility is an imperative if we are to contribute effectively to improving the condition of the poor, who too often are afflicted by a sense of powerlessness and fatalistic acceptance of life events.

The challenge has many similarities in a wealthy country, like the United States, as in a poor country, like Niger. Better health today, in this country, comes far more from what you can do for yourself than from what some giant research hospital does to you. We could spend tens of billions of dollars more on curative facilities and measures in order to add perhaps one more year to the life expectancy of the average North American or European male. But, as our co-host today, the Centers for Disease Control, has said, that same average male, at virtually no cost, could add some ten years to his life expectancy. How? By not smoking, by drinking in moderation, by controlling the quantity and quality of the food he consumes, and by reasonably exercising. This revolution is starting in the industrialized countries, but is far more advanced among the better educated and affluent and, regretfully, lags most among the poor who need it most as we see from surveys which show the most smoking and least breastfeeding among lower income, lower education-level families.

In effect, what I am saying is that the major frontier for progress even in difficult economic times lies with educating and empowering individuals to do more to help themselves. The implications of this empowerment go far beyond my immediate objective of saving children's lives, important as that may be. Other areas - like women's development and population stablization in

the developing countries, and reducing the damage from tobacco, alcohol and drug abuse in industrialized (and industrializing) societies - clearly offer great opportunities for applying this national social mobilization approach to accelerating progress. Indeed, the widespread public "uprising" against drunken driving in the United States - and the national governmental, corporate, media and institutional support that these efforts have engendered - is an example of a spontaneously ignited social mobilization with people in the lead and government following.

The Child Survival and Development Revolution is today making the kind of progress that warrants a sense of optimism - a conviction that something can be done to change the tragedies that we heretofore considered unchangeable. The principles we are practicing, and the approaches that are being pioneered, are applicable for adult health as well as children's, and for new risks as well as old, not to mention a broad range of non-health areas in which progress is long overdue.

To make a revolution

The Child Survival Revolution began with technological advances that triggered our realization that significant progress could be accomplished if only people could be educated and motivated to make use of those advances. But available and appropriate technologies are perhaps the easiest dimension of the problem today. While we seek still more new and improved technologies, such as a malaria vaccine (hopefully within 5 years), better vaccines, such as the new, much more heat-stable freeze-dried measles vaccine or a one-dose replacement of the current three-dose polio vaccine, and better weighing scales for growth monitoring, the biggest current problem is overcoming the lag between modern medical knowledge, particularly low-cost means such as ORT and immunization, and its widespread use in a community setting.

Thus the real challenges, both in Child Survival and in other areas of opportunity for health progress, are in securing two basic factors:

> The first is political will, which often depends upon early enthusiasm by a Head of State and other national leaders, but needs to be translated into action by bureaucracies and technocracies in both the public and private sectors, and initially encouraged and later sustained by the indispensable popular will that makes it good politics for governments to undertake and continue these efforts - and bad politics for them not to.
>
> The second necessary factor is mobilization on a very broad front of action to overcome this lag. Enlistment of the formal health sector is not nearly enough. Fortunately, today, as a result of general developmental progress, mass methods of advocacy and communications, enlistment of education, agriculture and other sectors within and outside government, strategic alliances with religious, professional, and community service groups are available - not to control mass public demand, but to catalyse it and unleash its energies...if only they can be mobilized - as on the lines of several recent successes in low and middle income societies.

On the Child Survival front, immunization is a prime example that gives encouragement to our expectations. The World Health Organization and UNICEF share a commitment to the goal of assuring access to immunization for all the world's children by the year 1990. Little more than just one year ago, most considered this to be an unreachable, utopian goal within the given 1990 timeframe. But the application of these broader, low cost, more activist, and, yes, more political approaches to health have given us and our partners new optimism, and a determination that we can reach that 1990 goal - saving thereby more than 10,000 small children's lives a day and preventing the crippling of an equal number - if, together, we can enlist enough governmental and citizen leaders to make it happen.

Achievement of that goal, of course, is of monumental importance to the survival, health and vitality of the world's children. But perhaps of even greater importance, in the long run of history, will be the means by which we are achieving that goal: the mobilization of whole societies - not by fear or regimentation or at great expense, but by hope, participation and communication - to take advantage of an opportunity, and thus for people to begin to take control of their own lives.

The potential of this experiment goes far beyond the tasks of child survival. It certainly has implications on many of the risks - old and new - which this Consultation is addressing. Together, and in partnership with the vast array of allies who have taken up this challenge, we can make this possibility a reality.

Mr. President, I would close by quoting one who was a true pioneer in dreaming possibilities and making them realities - especially in regard to the conditions of the poor and vulnerable. As Hubert Humphrey would exhort us:

"The challenge is urgent;
The task is large;
The time is now."