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Geneva
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"In Partnership for Health for All"

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"In Partnership for Health for All"

I am greatly honoured to speak to you today, and to do so not so much as the executive head of another agency, but as a colleague in the common struggle in which we have been engaged for 40 years. Our institutions and our staff have together pioneered, suffered setbacks, and shared satisfactions over successes with many countries. The accomplishments to which WHO and UNICEF have contributed have helped over the years to so improve the health of children that under-5 deaths have been reduced from some 70,000 a day in 1950 to 43,000 in 1980, and some 38,000 today. These reductions in infant and child mortality have been achieved despite a 25 per cent increase in births during this period and despite the global economic difficulties of the 1980s. We foresee, with continued close collaboration of our two agencies with developing countries in advancing primary health care in the years immediately ahead, that that tragic toll can be reduced still further to some 30,000 daily by the closing days of 1990 and be accompanied by an even greater reduction of births as parents gain confidence that their first children will survive.

Given the extraordinary - indeed, unparalled - breadth and depth of collaboration between UNICEF and WHO, some may find it surprising that this is the first time in my seven years of tenure as Executive Director of the Children's Fund that the Chief Executive Officer of either agency is addressing the Executive Board of the other. But perhaps that is reflective of the important reality that the relationship between WHO and UNICEF is not one simply of ceremony and summitry, but of real partnership engaged in and embraced at every level of our two organizations. There is no question but that WHO has, throughout our history, been UNICEF's closest collaborator, and, I would think, UNICEF has been WHO's most consistent colleague.

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The Joint Committee on Health Policy (JCHP), drawn from our two governing bodies, for example, is the only body of its kind in the multilateral system. Begun as a coordinating mechanism between UNICEF and the Interim Board of WHO while WHO as we know it was still forming, JCHP has been charged, over the years, with not only reviewing common policies, but also with encouraging new and important initiatives. It played, for example, a major part in the process which culminated in the historic declaration at Alma Ata of Primary Health Care - and the potential it provides for achieving Health For All by the Year 2000 - the monumental hallmark, and continuing central objective, of WHO/UNICEF collaboration.

At the secretariat level the collaboration has been frequent and close - exemplified by the wide-ranging day-and-a-half meeting Dr. Halfdan Mahler, your truly outstanding Director-General, and I had in 1980, my first year as Executive Director of UNICEF. Over the years, our two organizations have participated together in many path-setting activities. Our more dramatic collaborations, of course, date back to the great campaigns against yaws, malaria, trachoma, and smallpox. But new standards are being set today, as we work together to advance primary health care with particular attention to those leading edges most directly affecting children and mothers. The global EPI and CDD Programmes pioneered and established by the WHA are now being supported strongly in some 80 countries by UNICEF in terms of materials and social mobilizations. The consequences are impressive: the lives of several thousand children are already being saved each day. The hopes expressed by the WHA that intensification of such activities would serve as entry points for strengthening primary health care are, thanks to constant attention, being borne out in country after country. We have also sought in the 1980s to maintain and step up our support of the entire primary health care sector. The WHO/UNICEF Joint Nutrition Support Programme (JNSP), is the largest joint programming exercise in the U.N. system. Our combined efforts in the Joint Essential Drug Programme are resulting in the supply of appropriate, affordable medicines, as well as training, to sizeable populations who would otherwise suffer from illnesses for which we have long since discovered cures. Similarly, our collaborations have contributed significancly toward the Water Decade goals of providing adequate clean water for all by the year 1990. We are now increasing our combined efforts toward control of Acute Respiratory Infections (ARI). Over the last 18 months, UNICEF has signed four collaborative agreements with WHO at the regional level in working toward our common goals.

Any reflection on our mutual support in complementary endeavours must highlight the 1978 conference held in Alma Ata, where the principles of Primary Health Care (PHC) were codified after extensive preparatory work by the JCHP. Needless to say, these principles continue to comprise the core of our work. We continue to take guidance and direction from the basic PHC percepts, many of which, as you are all too aware, remain under implemented despite the progress of recent years.

If I may speak on a personal basis, what was achieved at Alma Ata was a personal as well as a world-health landmark. As some of you may know, my father, Dr. John B. Grant, was a pioneer in international public health. He

set up the first school of 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 and later to become the founding Chairman of the Executive Board of UNICEF. Another frequent visitor was Dr. Andrea Stampar who was to become, as you know, the first chairman of the WHA. They shared the 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 for food and education as well as for health services. I can 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. I remember 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.

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. 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. Working together with the Chinese, these early public health figures helped in the establishment of experimental urban and rural teaching districts with populations of over 100,000 designed to demonstrate how to bring the benefits of health knowledge to all rather than just the privileged few. Furthermore, they innovated the use of village health workers who incorporated into the health system such practices as integrated health education, vaccination, water testing and purification, and first aid.

Alma Ata represented an historic codification of acceptance of these basic principles - an acceptance of tremendous importance, but the implementation of which has, as Dr. Mahler repeatedly reminds us, still lagged far more than it should. Otherwise, we would not still have more than 1,000 mothers dying daily in childbirth, and more than 20,000 children dying daily from two such readily preventable causes as dehydration from diarrhoea and the six diseases covered by EPI.

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.

Changing conditions

The world in which our organizations are operating today has undergone major changes since we embarked on the Health For All (HFA) plan in 1979. 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 institutions. 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.

It is quite possible that the 1980s will be remembered as "the decade of rude awakenings". More change is being forced upon more institutions - whether governments (rich or poor), corporations, and international organizations (including those of the U.N. family) - than perhaps at any other time in recent history. Even the seemingly most secure and stable have been compelled to relinquish previously held expectations of invulnerability and adjust to new realities. Thus a majority of countries - from the United States and United Kingdom to Mexico and Brazil to Nigeria and Tanzania - have been forced to alter massively their assumptions, and for many, including my own country, the United States, further "rude awakenings" probably still lie ahead. Particularly unfortunate is the fact that, from country after country, reports indicate that women and children have been bearing a disproportionate burden of the recession and adjustment to it - from the loss of incomes and employment to often particularly severe cut-backs in government support services for mothers and children.

Adjustment with a human face

The cut-backs and adjustments which many countries are undertaking reflect in part the severe constraints imposed by the international economic system and in part on the way countries have re-formulated their policies in response to these pressures. "Must we starve our children to pay our debts?" is the stark way in which President Nyerere of Tanzania stated the issue. The World Health Assembly posed the same issue less dramatically last May, stating that "...the crisis facing the world economy endangers the possibility of reaching the goal of Health For All by the year 2000".

Our response to President Nyerere must be an emphatic "No", even though actual practice is all too often, still, to let children starve. Our experience is that there must be a two-pronged response to this situation. First, we must vigorously defend the importance of social investment to the overall future of a country so that the social sectors do not carry disporportionate cut-backs, as too often has been the case. Your WHA resolution on this topic correctly calls upon organizations to:

> "...apply criteria of social justice in formulating adjustment policies in order to avoid a deterioration in the health of the people."

I am pleased to be able to say that we can now begin to see growing evidence of an international rhetorical consensus supporting the view that alternatives need to be formulated. I will cite one particular authority - Jacques de Larosière, the just-retired Managing Director of the IMF - who, in his address to ECOSOC in Geneva last summer, stated:

> "Adjustment that pays attention to the health, nutritional and educational requirements of the most vulnerable groups is going to protect the human condition better than adjustment that ignores them. This means, in turn, that the authorities have to be concerned not only with whether they close the fiscal deficit but also with how they do so."

Second, and of equal if not greater importance because the power to act lies substantially with those of us in the social sectors, is that the social sectors themselves must produce internal restructuring to put priorities on those programmes which result in the most benefit to the most vulnerable.

The opportunity for a re-ordering of priorities within the health sector is perhaps best illustrated by a statement made by Dr. Mahbub-ul-Haq, then Pakistani Minister for Finance, Planning and Economic Affairs at the Annual Meetings of the World Bank and IMF in Seoul (October 1985):

> "Must we spend a good part of our development budgets to provide facilities for the rich and privileged? I discovered from my own experience that it took only the postponement of one expensive urban hospital to finance the entire cost of an accelerated immunization and health care programme for all our children."

It is obvious that the importance of PHC becomes even greater under these circumstances. Ideally, ways should be found to expand PHC activities even in times of retrenchment - and a growing number of countries, I am glad to say, are actually doing so (and probably finding it politically sound in the process). As another major encouraging example, along with Pakistan, of "adjustment with a human face", Indonesia, faced with sharply reduced oil revenues, has managed to retrench in health as well as all other sectors, and yet has managed to significantly expand its funding for accelerating EPI and completing by 1988 most posyandus (multipurpose health posts for every 100 small children - encompassing EPI, CDD, growth monitoring, family planning and pre-natal care) by cutting back on new hospital construction.

The challenge now before us is to move from a consensus on principles for better adjustment practices to concrete actions. We must broaden the adjustment process so as to include a minimum floor for basic human needs; we must restructure the health, education and social sectors so as to meet these needs; and, in the broader scope, we must restructure the economy so as to emphasize employment policies and action which provide both increased output and more income for the disadvantaged.

Mobilizing all for Health For All

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, one family in 80 had a television, while today four out of five families own TVs. Almost every village today has a primary school. 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) which can also serve as a leading edge for advancing PHC generally. The actual medical techniques are, of course, familiar to you, and include immunization against six child-killing diseases, Oral Rehydration Therapy, a return to the practice of breastfeeding with proper weaning, growth monitoring, female literacy, food supplementation, 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 trebled since 1983.

We are seeing from experience the validity of the WHA conclusions in 1982 that intensification of CDD activities - and I would add EPI activities - can become an entry point for PHC when consciously programmed to do so.

And in the spirit of Alma Ata, we are finding that these activities are helpful not only in accelerating the improvement in health of tens of millions of children but also in advancing generally the principles of PHC, most notably in the following four arenas.

One pronounced result of CSDR in a growing number of countries has been the elevation of public health and child health in the political sphere to where it now receives greater attention from the top leaders of the State, and of decision-makers and opinion-makers. A side benefit is that this political commitment has the potential of both attracting additional funding for and facilitating multisectoral co-operation for child health actions.

In another arena, we are finding social mobilization of virtually an entire society is possible to promote universal child immunization and ORT. We see heads of state, governors, teachers, radio and television, the press, non-governmental organizations, religious structures and common citizens taking an active role - and their participation can then be expanded to other PHC priority areas.

In a third arena, we are witnessing strong intersectorial linkages among various sectors of a society. We have noticed that in several countries, successful EPI has led to the establishment or strengthening of primary health care structures with sectors like education and water supply and sanitation, buttressing them with mutually supportive contributions.

What we are seeing is that through a concerted national effort, the behaviour of parents can be changed - so that, for example, when a child is dying of diarrhoeal dehydration, parents know to treat him or her with ORT; or such that a mother will breastfeed her child for the proper length of time, and wean it onto foods of appropriate nutrition; or that parents will insist on their children being fully immunised. This type of change in behaviour has far-reaching implications for those affected. Not only do they acquire specific techniques for maintaining health and saving lives, but they are also empowered by personal and community participation in processes which improve their own lives. Change in behaviour is a key element for achieving the goal of Health For All, and social mobilization is a very potent means of affecting that change.

A fourth major outcome has been the unprecedented and growing commitment to international cooperation for child health and survival. Active partners now include not only WHO, UNICEF, the World Bank and UNDP, as would be expected, but increased participation by major bilateral aid programmes, religious organizations and a wide range of key private organizations, such as the International Pediatrics Association, the League of Red Cross and Red Crescent Societies and the World Federation of Public Health Associations.

As a society organizes to ensure that health benefits of the 1980s are made available to the entire population, alliances are formed that grow and strengthen. As these networks are put to use, they not only accelerate the progress of primary health care and of basic services generally, but they also become an invaluable foundation for progress in a broad range of additional social challenges - including population stabilization, the role of women, literacy, nutrition, sanitation, etc. Resources for the improvement of health are being multiplied by unleashing the tremendous but underutilized potential of recipient-participation.

Reaffirmed commitment to common goals

If necessity is the mother of invention, it is perhaps our current economic crisis that has given birth to this new potential for social mobilization as an outreach to the most neglected. In effect, the severe conditions we are facing actually can serve to accelerate application of the very principles developed at Alma Ata. In short, these are unique times of both economic hardship and the possibility of significantly improving the lives of masses of the world's poor. It is therefore especially important that WHO and UNICEF - working together - reaffirm our support for the many urgent efforts aimed at achieving the common goals of Health for All and Child Survival and Development.