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Sustainability of the World Summit for Children Goals:

Concepts and Strategies

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This paper was originally prepared as background for discussion at the workshop: ‘The World Summit Goals for Children: The Challenge of Sustainability’, International Child Development Centre, UNICEF, Florence, Italy, June 1-2, 1995. It was subsequently revised to incorporate the main conclusions of the workshop.

Executive summary

‘Sustainability’ is an elusive concept meaning many things to different people. Arising during the 1980s in response to environmental and economic concerns, the concept has been increasingly linked to the long-term viability of projects, systems, and human development.

UNICEF and sustainability

In this paper we examine sustainability as it relates to the year 2000 and mid-decade goals as articulated by the 1990 World Summit for Children. Its purpose is to address the question: Which strategies in the second half of the 1990s would strengthen efforts to achieve the Summit goals in a sustainable manner?

The paper begins by examining the rationale of the goals and criticisms about the weak incorporation of sustainability concerns into UNICEF's policies and programmes. Available data and analyses are next reviewed on progress and setbacks in achieving the goals around the world. UNICEF's internal documents as well as independent external studies are scrutinized. Based upon available evidence, we conclude that significant progress is being achieved in some goals in some countries. Gaps and setbacks, however, are also apparent, and enormous diversity exists among different goals and between countries. Only preliminary conclusions can be drawn because of limited data of uncertain quality, the restricted sources of information, and methodological constraints of available studies.

Concepts of sustainability

For any specific goal, sustainability may be defined as the capacity of a system to attain and maintain goals effectively over time with minimum external input. Sustainability can be approached on a ‘project’ basis or as an interdependent ‘system’. Project sustainability originated from donor concerns over the economic viability of projects after the withdrawal of foreign aid. Systems sustainability prioritizes the building of effective systems for the long-term delivery of services. Both approaches suggest that sustainability is reflected by effectiveness, continuity over time, and the mobilization of sufficient local resources for financial self-reliance.

Project and systems sustainability are components of sustainable development. Initially articulated to promote environmental and economic policies, the concept has evolved toward a people's focus of building human capabilities for exercising choice and equity across as well as within generations. Children are central to sustainable human development because children's development is at the heart of human capabilities, children are the most vulnerable to intra-generational inequity, and children are the human bridge across generations.

Strategies for sustainability

Strategies for sustainability must address several key questions. What is to be sustained? What

type of framework can help guide strategic thinking? And what are some programming approaches to sustainability?

The 27 Summit goals constitute a mixed bag of child health and educational conditions, actions, and outcomes. Many goals are linked to each other, some goals differ with regard to the timing of impact, the relevant target group, and the involved sector. The goals, however, provide measurable, tangible objectives that are transparent and useful for enforcement of accountability and assignment of responsibility. Sustainability requires not simply outcome goals but also process indicators that reflect human, institutional, and financial capabilities.

To guide strategic thinking, a conceptual framework is presented that considers supply and demand of goal-related activities. Sustainable achievements depend upon six factors - (1) ownership of goals, (2) political commitment, (3) the participation of the beneficiaries, and strengthening the capabilities and power of (4) human, (5) institutional, and (6) financial resources. No blueprint in managing these factors can be offered because practical application will be shaped by specific contexts. Sustainability fundamentally involves a 'way of thinking and decision-making' about these factors in unique real-world situations.

Finally, three mutually reinforcing approaches to sustainability are explored.

A *systems approach* basically adopts the earlier work on primary health care systems that focuses on effectiveness, continuity, and fiscal capacity. The approach is basically supply-oriented to enhance a delivery system's capacity for continuity of service provisioning.

A *child rights approach* uses tools like the Convention on the Rights of the Child to mobilize public pressure for sustainable action. As such, the strategy is based on normative standards, can be political, and may involve social advocacy. One challenge to a rights approach is the assignment of responsibility for rights provision in circumstances where rights depend not only on governmental desistance from abuse but positive work to create an enabling environment where children's rights can be satisfied.

An *empowerment approach* basically employs demand promotion. How can one endow capacity, resources, and thus power to agents that will for themselves achieve sustainability of goals? Since very young children depend ultimately on the commitment and care of adults and their social organizations, one challenge of an empowerment approach is to identify ways of empowering women, men, families, and local communities to undertake actions for sustainability.

These issues were discussed at a workshop organized by UNICEF and Harvard University in Florence in June 1995. Participants felt that the achievement of sustainability required changes in relevant values to generate permanent demand for goal-related activities, the development of local capacities for implementation and research, and the ultimate transfer of ownership to the people and communities.

Précis

La notion de «durabilité», concept imprécis dont la signification est variable pour différentes personnes, est apparue dans les années 80 en réponse aux préoccupations économiques et écologiques et est de plus en plus liée à la viabilité à long terme des projets et systèmes et au développement humain.

L'UNICEF et la durabilité

Le présent document examine la durabilité par rapport aux objectifs fixés pour le milieu de la décennie et pour l'an 2000, tels qu'ils ont été énoncés au Sommet mondial de 1990 pour les enfants. Il vise à répondre à la question suivante : Quelles stratégies appliquées dans la deuxième moitié des années 90 permettront de renforcer les efforts déployés en vue de la réalisation durable des objectifs du Sommet?

Ce document commence par examiner les principes fondamentaux sous-tendant ces objectifs et les critiques concernant le faible degré d'incorporation des préoccupations de durabilité dans les politiques et programmes de l'UNICEF. Ensuite, les données et analyses disponibles sur les progrès et les échecs enregistrés dans la réalisation des objectifs dans le monde seront examinées. Les documents internes de l'UNICEF et les études indépendantes externes seront également étudiés. Compte tenu des données disponibles, nous pouvons conclure que des progrès importants ont été enregistrés dans la réalisation de certains objectifs dans certains pays. Néanmoins des lacunes et des échecs sont également évidents, et on note une très grande disparité entre les pays et dans la réalisation de différents objectifs. Il n'est possible de tirer que des conclusions préliminaires en raison du nombre limité des données qui sont d'ailleurs d'une qualité incertaine, du petit nombre de sources d'information et des contraintes méthodologiques pesant sur les études disponibles.

Concepts de durabilité

Pour tout objectif spécifique, on peut définir la durabilité comme étant la capacité d'un système d'atteindre et de maintenir des objectifs efficacement dans le temps avec un apport externe minime. On peut considérer la durabilité du point de vue des «projets» ou de «systèmes» interdépendants. La durabilité des projets résultait des préoccupations des donateurs qui s'inquiétaient de la viabilité économique des projets après le retrait de l'aide étrangère. Quant à la durabilité des systèmes, elle privilégie la mise en place de systèmes efficaces pour la fourniture de services à long terme. Ces deux approches montrent l'une et l'autre que la durabilité est fonction de l'efficacité, de la continuité dans le temps et de la mobilisation de ressources locales suffisantes pour assurer l'autonomie financière.

La durabilité des projets et des systèmes fait partie du développement durable. Ce concept, qui était initialement formulé dans le but de promouvoir les politiques économiques et d'environnement, a évolué et porte essentiellement aujourd'hui sur la mise en place des capacités, pour la population, d'exercer des choix et d'assurer l'équité entre les générations et au sein de celles-ci. Les enfants sont au coeur du développement humain durable car de leur développement dépend celui des capacités de la population; les enfants sont également les plus vulnérables à l'inéquité au sein d'une même génération et ils sont les passerelles entre les générations.

Stratégies en vue de la durabilité

Les stratégies ayant pour but la durabilité doivent répondre à plusieurs questions clés. Quels sont les éléments dont il faut assurer la durabilité? Quelle sorte de cadre peut contribuer à guider la réflexion stratégique ? Et quelles approches de programmation permettent d'assurer la durabilité?

Les 27 objectifs du Sommet constituent un ensemble hétérogène de conditions, d'actions et de résultats concernant la santé et l'éducation de l'enfant. Si de nombreux objectifs sont liés entre eux, certains d'entre eux diffèrent par leur calendrier d'exécution, les groupes cibles concernés et les secteurs visés. Toutefois les objectifs constituent des buts concrets, mesurables et clairs qui contribuent au respect de l'obligation de rendre des comptes et à l'attribution des responsabilités. La durabilité exige non pas simplement des objectifs concernant les résultats mais également des indicateurs de processus qui reflètent les capacités humaines, institutionnelles et financières.

Pour guider la réflexion stratégique, on trouvera après un cadre conceptuel qui prend en compte l'offre et la demande d'activités liées aux objectifs. Les réalisations durables dépendent de six facteurs : 1) l'intéressement aux objectifs, 2) la volonté politique, 3) la participation des bénéficiaires et le renforcement des capacités et du pouvoir 4) des personnes, 5) des institutions, et 6) les ressources financières. Il n'est pas possible de fournir un schéma directeur pour ces facteurs car l'application pratique dépendra de situations spécifiques. La durabilité a trait essentiellement à «une façon de réfléchir et de prendre des décisions» concernant ces facteurs dans des situations concrètes uniques.

Finalement, trois approches de la durabilité qui se renforcent mutuellement sont examinées ci-après.

L'*approche des systèmes* s'inspire pour l'essentiel des travaux menés sur les systèmes de soins de santé primaires qui mettent l'accent sur l'efficacité, la continuité et la capacité financière. Cette approche vise essentiellement à améliorer la capacité du système d'assurer la continuité de la fourniture des services.

L'*approche fondée sur les droits de l'enfant* met à profit des instruments tels que la Convention relative aux droits de l'enfant pour mobiliser l'opinion publique en faveur d'une action durable. À ce titre, une telle stratégie repose sur des critères normatifs, peut revêtir un caractère

politique et peut éventuellement inclure le plaidoyer social. La difficulté que présente cette approche est l'identité de l'entité responsable de la mise en oeuvre de ces droits lorsque ces derniers dépendent non seulement de l'intention déclarée des gouvernements de ne pas commettre d'abus mais également d'activités favorisant un environnement propice au respect des droits de l'enfant.

L'*approche de l'autonomisation* consiste essentiellement à promouvoir la demande. Comment doter de capacités, de ressources et donc, de pouvoir, les agents qui assureront la durabilité des objectifs? Du fait que les très jeunes enfants dépendent en dernière analyse du dévouement et des soins des adultes et des organisations sociales dont ils relèvent, la tâche qui s'impose dans cette approche consiste à identifier les moyens d'autonomiser les femmes, les hommes, les familles et les collectivités locales qui mènent des actions en vue de la durabilité.

Ces questions ont été examinées lors d'un atelier organisé par l'UNICEF et l'Université Harvard en juin 1995 à Florence. Les participants ont estimé que pour parvenir à la durabilité, les valeurs pertinentes devaient être modifiées pour susciter une demande permanente d'activités liées aux objectifs, l'amélioration des capacités locales d'exécution et de recherche et le transfert, le moment venu, de la gestion à la population ou aux collectivités.

Síntesis de acción

'Sostenibilidad' es un concepto vago que significa muchas cosas según distintas personas. Este concepto, que surgió durante los años ochenta en respuesta a preocupaciones ecológicas y económicas, se ha venido vinculando cada vez más con la viabilidad a largo plazo de proyectos, sistemas y el desarrollo humano.

UNICEF y la sostenibilidad

En este documento examinamos la sostenibilidad con respecto al año 2000 y los objetivos de mitad del decenio articulados por la Cumbre Mundial en favor de la Infancia. Su objeto es contestar la pregunta siguiente: ¿Qué estrategias fortalecerían en la segunda mitad del decenio de 1990 los esfuerzos por lograr los objetivos de la Cumbre de manera sostenible?

El documento comienza por examinar la justificación de los objetivos y críticas acerca de la escasa incorporación del aspecto de la sostenibilidad en las estrategias y programas del UNICEF. Enseguida se examinan los datos y análisis disponibles sobre los avances y contratiempos en el logro de los objetivos alrededor del mundo. Se examinan detenidamente documentos internos de UNICEF y estudios independientes externos. Sobre la base de las pruebas disponibles, llegamos a la conclusión de que se está avanzando sensiblemente con respecto a algunos objetivos en algunos países. Sin embargo, también son evidentes lagunas y reveses y que existe una enorme diversidad entre diferentes objetivos y entre países. Sólo se puede llegar a conclusiones preliminares debido a que se cuenta con datos limitados cuya calidad es incierta, las fuentes de información son limitadas y hay deficiencias metodológicas en los estudios con que se cuenta.

Conceptos de la sostenibilidad

En el caso de un objetivo concreto, la sostenibilidad puede definirse como la capacidad de un sistema para lograr y mantener efectivamente sus objetivos a lo largo del tiempo con un mínimo de intervención externa. La sostenibilidad puede encararse sobre la base de 'proyectos' o como 'sistema' independiente. La sostenibilidad de los proyectos se origina en las preocupaciones de los donantes acerca de la viabilidad económica de los proyectos después de que se retire la ayuda externa. La sostenibilidad de los sistemas da prioridad a la creación de sistemas efectivos para la distribución a largo plazo de servicios. Ambos enfoques sugieren que la sostenibilidad se manifiesta mediante la efectividad, la continuidad en el tiempo y la movilización de suficientes recursos locales para la autosuficiencia financiera.

La sostenibilidad de los proyectos y sistemas son componentes del desarrollo sostenible. El concepto, articulado inicialmente para promover estrategias ecológicas y económicas, ha evolucionado hacia un enfoque popular de robustecer las capacidades humanas para ejercitar opciones y la equidad entre y dentro de las generaciones. Los niños son parte importante del desarrollo humano sostenible porque el desarrollo de los niños se sitúa en el centro de las capacidades humanas; los niños son los más vulnerables a la desigualdad entre generaciones; los

niños son también el puente humano entre generaciones.

Estrategias para la sostenibilidad

Las estrategias para la sostenibilidad deben responder a varias preguntas importantes. ¿Qué es lo que se debe sostener? ¿Qué tipo de marco puede ayudar a orientar la reflexión estratégica? Y ¿cuáles son algunos de los enfoques programáticos de la sostenibilidad?

Los 27 objetivos de la Cumbre constituyen una mezcla heterogénea de condiciones, acciones y resultados de salud infantil y educativos. Muchos objetivos están vinculados entre sí, algunos objetivos difieren respecto del momento en que surten sus efectos, el grupo a que están dirigidos y el sector afectado. Sin embargo, los objetivos establecen metas tangibles y medibles que son transparentes y útiles para imponer la rendición de cuentas y la fijación de responsabilidades. La sostenibilidad exige no sólo objetivos en cuanto a las metas que se espera alcanzar, sino también indicadores del proceso que reflejen las capacidades humanas, institucionales y financieras.

Para orientar la reflexión estratégica, a veces se presenta un marco conceptual que considera la oferta y demanda de las actividades relacionadas con los objetivos. Los logros sostenibles dependen de seis factores: 1) la posesión de los objetivos; 2) el compromiso político; 3) la participación de los beneficiarios y el robustecimiento de las capacidades y fuerza de los recursos: 4) humanos, 5) institucionales y 6) financieros. No se pueden dar orientaciones para administrar estos factores debido a que su aplicación práctica dependerá de cada contexto específico. Fundamentalmente, la sostenibilidad significa 'una manera de pensar y de adoptar decisiones' acerca de estos factores en situaciones reales particulares.

Por último, se exploran tres enfoques de la sostenibilidad que se refuerzan mutuamente.

Un *enfoque basado en los sistemas* adopta, básicamente, el trabajo anterior sobre sistemas de atención primaria de la salud que se concentra en la efectividad, la continuidad y la capacidad fiscal. El enfoque está orientado básicamente hacia la oferta para fortalecer la capacidad del sistema de distribución de ofrecer continuidad en el suministro de servicios.

Un *enfoque basado en los derechos del niño* emplea instrumentos tales como la Convención sobre los Derechos del Niño para movilizar la presión pública para lograr una acción sostenible. Como tal, la estrategia se basa en criterios normativos, puede ser política y puede incluir la promoción de intereses sociales. Un desafío al enfoque basado en los derechos es la atribución de la responsabilidad de proveer derechos en circunstancias en las que los derechos no sólo dependen de que el gobierno desista de cometer abusos sino de un trabajo positivo para crear un clima propicio en el que puedan satisfacerse los derechos de los niños.

Un *enfoque de habilitación* emplea básicamente la promoción de la demanda. ¿Cómo se puede dotar de capacidad y de recursos, y habilitar así a los agentes para que logren por sí mismos la sostenibilidad de los objetivos? Ya que los niños de muy corta edad dependen en última instancia de la dedicación y cuidado de los adultos y sus organizaciones sociales, un desafío al

enfoque de la habilitación es identificar formas de habilitar a las mujeres, los hombres, las familias y las comunidades para llevar a cabo acciones para conseguir la sostenibilidad.

Estas cuestiones se examinaron en un taller organizado por UNICEF y la Universidad de Harvard en Florencia en junio de 1995. Los participantes consideraron que el logro de la sostenibilidad exige que se hagan cambios en los valores pertinentes para generar una demanda permanente de actividades relacionadas con los objetivos, el desarrollo de las capacidades locales de aplicación e investigación y, en última instancia, la transferencia de la posesión de objetivos a la gente y las comunidades.

Introduction

The Summit goals

At the March 10, 1995 memorial celebration of the life of James P. Grant, former Executive Director of UNICEF, the First Lady of the United States, Hillary Clinton, announced that the US government would join over 150 other countries in signing the Convention on the Rights of the Child. In making the announcement, Ms. Clinton noted the deep sense of satisfaction that James Grant would have enjoyed at witnessing what he firmly believed would be the first UN convention to be universally endorsed by all governments of the world.

The Convention arguably marked one of the two major pillars of international achievement by UNICEF under James Grant's leadership. Until his death, James Grant was fiercely committed to a second goal as well: to achieving the mid-decade and year 2000 goals as articulated in the World Declaration and Plan of Action by the 1990 World Summit for Children (UNICEF 1991). One hundred and fifty nine nations, including 71 Presidents and Prime Ministers, attended the World Summit for Children, and 139 governments signed the World Declaration. Over the ensuing five years, about 100 countries have formulated National Plans of Action for achieving the goals (UNICEF 1994). No other programme commanded higher priority among UNICEF's leadership and programme staff than implementation of the Summit goals.

The rationale for the Summit goals was based on the experience of UNICEF in the 1980s that demonstrated successful strategies for translating the 'idea of investing in people into a specific set of goals' (UNICEF 1992). **Table 1** summarizes the evolution of UNICEF's programs in the 1980s beginning with GOBI-FFF (growth monitoring, oral rehydration, breast feeding, and immunization - food, female education, and family planning) that eventually were consolidated under the 'child survival and development revolution.' These programmes were selected on the basis of technical feasibility, financial affordability and on the existence of appropriate, off-the-shelf technologies. Field lessons for maximizing impact suggested that the programme should concentrate on oral rehydration and immunization. Eventually, the agency adopted the goal of universal childhood immunization (UCI) to attain at least 80 per cent coverage of basic childhood immunizations in all countries of the world. The successful achievement of UCI was announced just prior to the 1990 World Summit for Children.(UNICEF 1991).

Table 1. Evolution of UNICEF goals during the 1980s

YEAR	GOALS
1980	
	GOBI-FFF
1981	
1982	Child Survival and Development Revolution
1983	
1984	
	Oral Rehydration Therapy Focus
1985	Growth Monitoring Focus
1986	
	Universal Child Immunization Focus
1987	
1988	
1989	Convention on the Rights of the Child
1990	World Summit Goals (Year 2000)
	National Programmes of Action
	Mid-decade Goals

Source: Cesar Victora, UNICEF, Office of Evaluation & Research

Three lessons were articulated for the formulation of the Summit goals, which are presented in **Table 2**. Firstly, the world has the financial and organizational capacity to successfully bridge the gap between mass-scale problems and inexpensive solutions, as demonstrated by the success with UCI (UNICEF 1992). Secondly, the concept of 'one for all, all for one' underscored the synergy between different goals. Sustained improvements over time require that single interventions like immunization be supplemented by reinforcing human development actions. Thirdly, what was accomplished showed the critical importance of mobilizing global support for achievable targets that are quantifiable, and thus tangible for action by political leaders, national governments, the United Nations, NGOs, and the general public.

Table 2. Mid-decade, specific and overall Summit goals

MID-DECADE GOALS		YEAR 2000 GOALS	
		SECTORAL GOALS	MAJOR GOALS
CHILD HEALTH	EPI coverage ≥ 80% Elimination of neonatal tetanus Reduction of measles cases and deaths Elimination of polio in selected areas	EPI coverage ≥ 90% Elimination of neonatal tetanus Reduction of measles cases and deaths Eradication of polio Reduction of ARI deaths	Reduction in under-five mortality
	80% ORT use rate	Reduction of diarrhoea cases and deaths	
	'Baby friendly' hospitals	Exclusive breastfeeding and timely supplementation	
NUTRITION	Virtual elimination of vitamin A deficiency Universal iodization of salt	Virtual elimination of vitamin A deficiency Reduction in low birth weight Growth monitoring and promotion Dissemination of information on household food security	Reduction in malnutrition
MATERNAL HEALTH		Reduction in iron deficiency anaemia among women Access to family planning Pre-natal and delivery care Special health and nutritional needs of girls and women	Reduction in maternal mortality
OTHER HEALTH	Eradication of dracunculiasis	Eradication of dracunculiasis	
WATER AND SANITATION	Reduce water supply gap by one-fourth Reduce sanitation gap by one-tenth		Universal access to safe drinking water Universal access to sanitation
EDUCATION	Reduction of basic and primary education gaps by one-third	Expansion of early childhood development activities	Basic education for all children and complete primary education for 80% Reduction of adult illiteracy rate by half and gender equality in education
FACTS FOR LIFE		Dissemination of Facts for Life measures	
CHILD RIGHTS	Ratification of the Convention on the Rights of the Child		Protection of children under especially difficult circumstances

Why sustainability?

The Summit goals, and the earlier child survival and development revolution, have generated both widespread praise as well as sharp criticism - within and beyond UNICEF (Rifkin and Walt 1986; King 1990; LaFond 1995). Few question the accomplishments of the immunization effort of the 1980s or the ambition of the Summit goals for the 1990s. Concern, however, has come from two directions. One argues that while UNICEF's strategy can advance child survival, its very success could compromise the quality of life among the survivors. Because improved child survival would accelerate rapid population growth and unless concurrent advances are made against poverty and ecologic deterioration, UNICEF's efforts could worsen rather than improve human and ecologic sustainability. In several polemical attacks, King (1990) argued that UNICEF's child survival strategy would produce neither "sustainable health" nor sustainable development. This neo-Malthusian criticism, in our opinion, is neither ethically sound nor scientifically valid and is thus not further addressed in this paper.

A second, more legitimate criticism centers around the narrow and time-bound focus of UNICEF's strategy. Some argue that accelerated and targeted programs invariably translate into vertical interventions that generate undesirable consequences - insufficient strengthening of national systems, commandeering of limited resources, donor-driven priority setting, and usurpation of local decision-making. Short-term solutions are rarely sustainable, and time-bound strategies are ‘quick fixes’ and do not address the long and complicated process of capacity building of sustainable local systems (LaFond 1995). The old adage that ‘crash programs always crash’ captures the thrust of this critique.

For any campaign, long-term sustainability is obviously critical. The modern history of public health has a few examples of sustained success (e.g. smallpox eradication and more recently the control of polio and guinea worm) but many more cases of accelerated advance were followed by collapse (e.g. many failed family planning campaigns and the troubled malaria eradication campaign that was eventually changed to disease control). Unlike the epidemiology of smallpox, polio, and measles that makes these infectious diseases technically amenable to eradication, most child health and nutritional problems require sustained, recurring effort. Preventive and therapeutic interventions must reach new cohorts of children and mothers continuously. Moreover, internationally-initiated activities must ultimately translate into local capacity for sustaining the higher level of activity. The problem of dependence on foreign aid emerged in the 1980s and has grown in the 1990s given the decline of concessional resource flows from the North to the South. An obvious objective of any internationally-sponsored initiative must be sustainable progress by the people, communities, and the governments themselves - self-reliance in human development.

The aim of this paper is to further our understanding of sustainability in relation to UNICEF's programme strategy. Our specific objectives are: (1) to analyse the sustainability of the World Summit goals; (2) to review conceptual approaches to sustainability; and (3) to propose a strategic framework for promoting sustainability of the goals into the next century.

UNICEF and sustainability

As we approach the 21st century with Carol Bellamy as Executive Director of UNICEF, we are faced with a number of questions: What should be UNICEF's programme priorities? How can programme management be improved to achieve the agency's goals? The answers to these questions depend, in part, on an assessment of progress in attaining and sustaining the World Summit goals.

Progress and setbacks

How well has the developing world, with UNICEF's support, done in attaining the Summit goals? This is a tough question and the answer is not simple. Available evidence however, would seem to support several broad conclusions.

First, enormous progress appears to have been made in some of the Summit goals in some places. Child mortality continues its unprecedented pace of decline around the world. UNICEF has claimed that UCI and other Summit goal activities have contributed to human longevity. UNICEF reported that four out of five of UCI 'successful' countries in 1990 have either stabilized or further improved their immunization coverage **(Appendix A)** Advances have been reported in the global eradication of polio which has been eliminated from the Western Hemisphere. Guinea worm disease reportedly has been reduced by 90 per cent worldwide; eliminated in some regions. In the past decade, the use of oral rehydration therapy has increased from virtually zero to 44 per cent. Of 94 countries reporting on the elimination of iodine deficiency through salt iodization, 58 countries were 'on track' and 32 more countries with 'extra effort' were likely to achieve the mid-decade goal of universal iodization.

UNICEF reports on immunization coverage parallel data from its sister UN organization, the World Health Organization (LaForce 1995). **Table 3** summarizes WHO data on immunization progress in the 1990s classified according to a country's position at the beginning of the decade. The majority of countries that had attained UCI targets in 1990 were able to maintain or further improve their performance. Equally important, many countries that had not reached the 80 per cent level in 1990, have also been able to maintain or improve coverage. Altogether 40 countries have maintained and another 32 countries have improved upon their 1990 performance levels.

Table 3 . Developing countries classified according to UCI

and change in measles coverage in 1993 compared to 1990

Measles Immunization Coverage	Achieved UCI		Did not Achieve UCI	
Improved since 1990	**Colombia** **Dominica** **St. Lucia** **Turks & Caicos** **Iran** **Cape Verde** **Malawi** **Mauritius**		**Algeria** **Antigua & Barbuda** **Bangladesh** **Benin** **Bermuda** **Bolivia** **Bosnia** **Burkina Faso** **Cook Islands** **Cote d'Ivoire** **Croatia** **Ecuador** **Egypt** **El Salvador** **Equatorial Guinea** **Fiji** **French Polynesia** **Grenada** **Guinea** **Guyana**	**Iraq** **Kenya** **Kiribati** **Lao People's D.R.** **Lebanon** **Libya** **Macau** **Malaysia** **Malta** **Mauritania** **Mexico** **Namibia** **Paraguay** **Peru** **Reunion** **Slovenia** **T.F.Y.R.Macedonia** **Trinidad & Tobago** **Tunisia** **U.A.E.** **Wallis & Fortuna**
Stayed the same since 1990 (defined as <10% decline or increase between 1990 and 1993)	**Anguilla** **Argentina** **Bahamas** **Barbados** **Belize** **Brunei Darussai** **Cayman Is.** **Chile** **China** **Costa Rica** **Cuba** **DPR Korea** **Gambia** **Hong Kong** **India** **Indonesia** **Lesotho** **Mongolia** **Monserrat**	**Nicaragua** **Niue** **Oman** **Palau** **Philippines** **Rwanda** **St. Helena** **St. Vincent** **Samoa** **Saudi Arabia** **Seychelles** **Sierra Leone** **Singapore** **Sri Lanka** **Syria** **Thailand** **Tonga** **UNRWA** **Uruguay** **Viet Nam**	**Afghanistan** **American Samoa** **Angola** **Bahrain** **Brazil** **Cambodia** **Cyprus** **Dominican Rep.** **French Guiana** **Ghana** **Guadeloupe** **Guam** **Guatemala** **Haiti** **Honduras** **Israel** **Jamaica** **Jordan** **Korea, Rep. of** **Liberia** **Madagascar** **Mali** **Martinique** **Micronesia** **Morocco** **Mozambique**	**Nauru** **Nepal** **Neth. Antilles** **Niger** **Nigeria** **North Mariana Is** **Pakistan** **Puerto Rico** **Qatar** **St. Kitts-Nevis** **Sao Tome & Princ.** **Solomon Is** **Somalia** **Sudan** **Suriname** **Tokelau** **Turkey** **Uganda** **Vanuatu** **Venezuela** **Virgin Is (UK)** **Virgin Is (USA)** **Yugoslavia** **Zaire** **Zambia** **Zimbabwe**
Declined since 1990	**Botswana** **Burundi** **Comoros** **Congo** **Djibouti**	**Gabon** **Maldives** **Panama** **Swaziland** **Tuvalu**	**Bhutan** **Cameroon** **C.A.R.** **Chad** **Ethiopia** **Guinea-Bissau** **Kuwait**	**Myanmar** **Marshall Islands** **New Caledonia** **Papua New Guinea** **Senegal** **Tanzania** **Togo** **Yemen**

Source: WHO/EPI Information System, 1995

Major gaps and shortcomings, however, persist. Of 91 countries listed in **Table 3**, 19 showed declines of 10 per cent or greater in immunization coverage over the 1990s. About 20 per cent of the UCI countries in 1990 experienced deterioration, and about 25 per cent of the lower immunization coverage countries in 1990 slipped backwards. Slippage of immunization coverage was reported in every developing world continent.

Information on immunization appears to be more abundant than on progress of other Summit goals. Progress in the prevention and treatment of acute respiratory infections (ARI) has been reportedly mixed. Although recognition of the health significance of ARI has grown, field implementation has been slowed due in part to professional resistance (against paramedic prescription of antibiotics) and in part to prohibitive costs (expensive antibiotics). For some goals, data are simply unavailable (e.g., maternal mortality in sub-Saharan Africa.) With a few goals, the solution may remain relatively unaffordable or the problem may be intractable to available technology (e.g., the high cost of drinking water systems in some regions and the weak progress on sanitation in virtually all regions.)

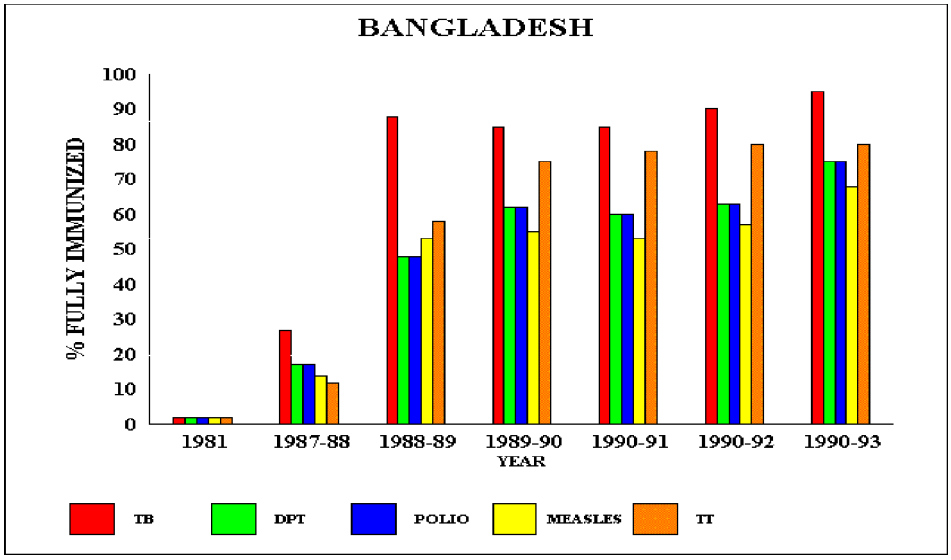
Finally, a global perspective disguises the great diversity of progress and setbacks between and within nations. The cases of Nigeria and Bangladesh illustrate the range of national experiences. **Figure 1** shows the time trends in immunization coverage in the two countries (UNICEF 1990-1995). In Bangladesh, immunization coverage of only a few percentage points in the early 1980s increased dramatically by 1990 reaching 50-90 per cent depending on the antigen, and coverage has continued to advance in the first half of the 1990s. In Nigeria, by contrast, coverage levels in the early 1980s were superior to Bangladesh's; by 1990 Nigeria's coverage approximated Bangladesh's. Over the past five years, however, coverage in Nigeria has steadily dropped, approaching levels found a decade ago.

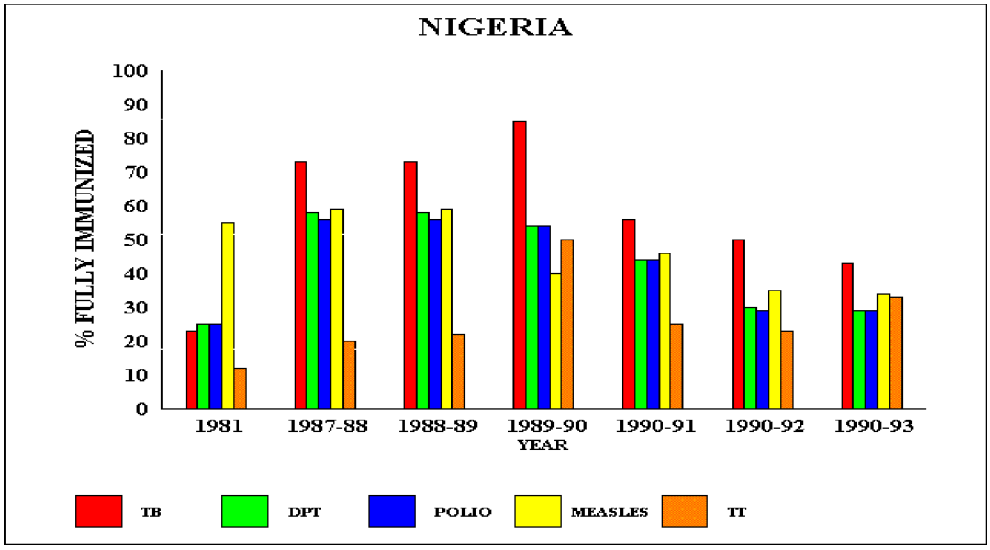
The Bangladesh and Nigeria cases illustrate the enormous range of national experiences, both positive and negative. This comparison can be multiplied many times over across the full spectrum of goals. Overall, the progress in immunization appears to have been greater than among other goals, and performance has been stronger in Asia and Latin America than in sub-Saharan Africa.

Studies of sustainability

Internal UNICEF documents show that the agency has accorded high priority to promoting sustainability as an integral part its work. This strategic priority is manifested in numerous UNICEF programme documents, agency reports to its executive board, and several independent studies. As an exhaustive review of relevant materials is not possible, this paper will cite several types of studies - internal documents, external studies of UCI and Bamako Initiative, and studies of sustainable social development.

Figure 1. Time trends in immunizations in Nigeria and Bangladesh.





Internal documents

Many UNICEF internal documents cite the importance of sustainability and capacity building in its work. These include operational documents as well as reports to the agency's governing board. **Table 4** illustrates an effort by UNICEF's Evaluation and Research Office to sensitize field offices to the importance of sustainability in programming by showing the role of key actors related to specific goals. The table encourages programme staff to target and strengthen specific actors - individuals, institutions, government, the marketplace - for sustainable action in each goal. **Appendix B** further develops these concepts.

Table 4. Critical actors matrix for achieving sustainability of mid-decade goals.

GOALS / CRITICAL ACTORS	80% EPI coverage	Universal iodization of salt	Baby-friendly hospitals	Ratification of Convention on the Rights of the Child	Promotion of primary education with gender equality
Government institutions					
Central	✓✓	✓	✓✓	✓✓	✓
Local	✓				✓✓
Marketplace					
International	✓✓				
National		✓✓	✓✓		
Social mobilization					
Movements			✓		✓
Communities					✓
Families	✓				✓✓
Non-governmental organizations					
International					
National	✓		✓✓		
Local					
Political will	✓	✓	✓	✓✓	✓✓

Source: Office of Evaluation & Research

Two reports submitted to UNICEF's executive board also reflect this policy concern: 'Sustainability, Integration, and National Capacity-Building' (1992) and more recently 'UNICEF's Health Strategy' (1995). These two policy papers underscore the importance of sustainability and propose that UNICEF help strengthen national primary health care systems, thereby building local institutional capacity. The 1992 paper outlines five key dimensions of sustainability - political, financial, managerial, technical, and cultural. Sustainability is explicitly incorporated in the 1995 health policy paper which recommends actions for health monitoring, health promotion, and essential health services.

Studies of UCI and Bamako

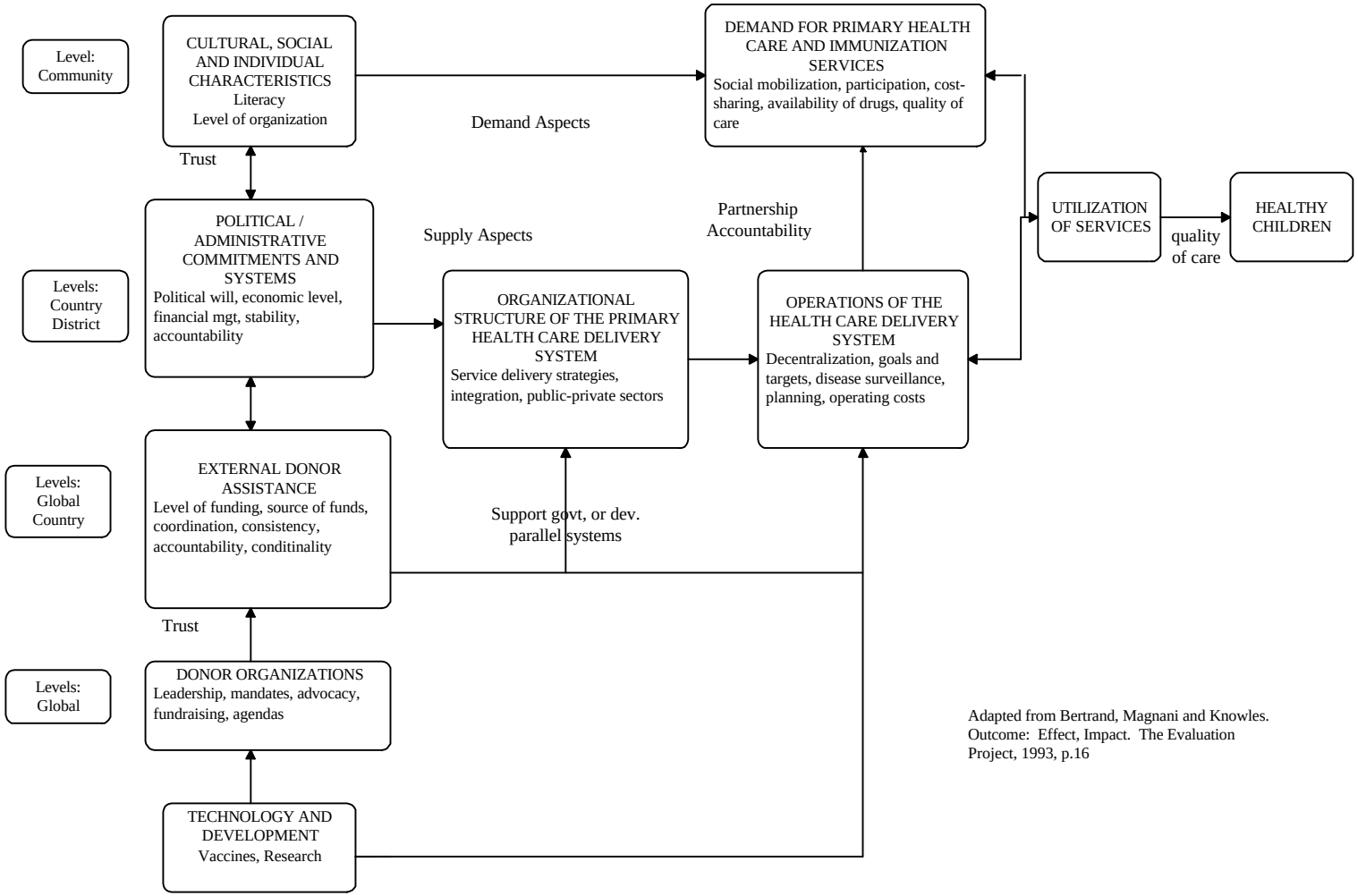
The Pan American Health Organization (PAHO) study concluded that immunization efforts in Latin America have had a markedly positive effect on national health systems - in terms of public awareness, political commitment, promotion of a 'culture of prevention,' and improved communications. The most positive benefits appear to be enhanced community participation and stronger intersectoral cooperation. Some negative aspects, however, were also identified - including 'fatigue effect' (clients rejecting household intrusion by vaccinators), politicalization (by partisan politicians), and omission of some marginalized groups (especially minorities in geographically inaccessible areas). The issue of sustainability, unfortunately, was not considered by the study.

In 1994, UNICEF's Evaluation and Research Office commissioned a six-member independent steering committee to derive the major lessons learned and to recommend how UNICEF should enhance the sustainability of UCI goals (LaForce 1995). Based upon desk-top review, interviews with 48 central and 150 field staff, and visits to six countries (Cote d'Ivoire, Ghana, Kenya, Laos, Philippines and Uganda), the Committee developed a conceptual framework of factors influencing programme sustainability (**Figure 2**). The framework is a systems approach showing how supply factors (political commitment, donor assistance, and supply organization, operations, and technology) interact with demand factors (literacy, individual characteristics and community organizations) to determine the utilization of immunization services. Possibly the main lesson learned from this exercise was that 'how you get there is as important as getting there' (Taylor M, personal communication).

Funded by a multi-donor consortium, the London School of Hygiene and Tropical Medicine undertook a five-country case study of the Bamako Initiative (McPike et al. 1992). Since its launch in 1987, the Bamako Initiative has received major backing from UNICEF to strengthen the primary health care in developing countries, especially in sub-Saharan Africa. By 1992, Bamako Initiatives were underway in some 33 countries (UNICEF 1992).

The London study group found considerable diversity in the interpretation and implementation of the Bamako Initiative. Despite this diversity, the London group confirmed the salience of Bamako's eight basic principles - national commitment to primary health care; decentralization to the district level; community management and control; cost-sharing by the community; adequacy of health sector budgets; essential drug policy; ensuring access by the poorest; and target- and time-bound management. The London group proposed three additional strategic principles - unique attributes (community financing, community participation, and national scope), programme objectives (enhance quality and accessibility), and management (improved management and programme accountability). The study concluded that the Bamako

Figure 2. An overview of systems factors related to sustainability



Adapted from Bertrand, Magnani and Knowles. Outcome: Effect, Impact. The Evaluation Project, 1993, p.16

Source: La Force (1995)

initiative demonstrated that it is possible to raise revenue through community financing capable of covering significant components of the recurring costs, that such mechanisms can improve relative affordability, and that the Bamako Initiative can advance the sustainability of primary health care in developing countries. A 1995 UNICEF publication, *The Bamako Initiative: Rebuilding Health Systems*, summarizes the lessons learned from the Bamako Initiative.

Social development

As contributions to the World Summit for Social Development (March 1995), UNICEF supported two studies that examined the sustainability of social action. After reviewing more than 200 cases of community-based initiatives, an independent task force concluded that "sustainable solutions" are possible if partnerships are formed with the people and local communities so that they can solve their own social problems (*Future Generations*, 1995). A second study, *Profiles in Success: People's Progress in Africa, Asia and Latin America* (UNICEF, 1995), reported on eleven national success stories in sustainable social development. The case studies demonstrated that sustainable social development was achievable, despite economic constraints, through political will and commitment, equity-oriented social policies, and mobilization of resources for social services.

An assessment

These reports and studies, within and beyond UNICEF, demonstrate that concerns over sustainability are widely shared within the agency. Many internal documents emphasize the building of sustainability into World Summit goal strategies. Especially reassuring are three independent external studies of the Bamako and the UCI initiatives. Taken as a whole, they suggest that implementation of the World Summit goals at a minimum has not been detrimental to sustainability and at a maximum may have provided a stimulus for sustained action.

There are several caveats to this generally positive assessment, however. First, the available data are limited and of questionable quality. Only two international sources have released data of scale and scope - UNICEF and WHO. Little information has come from independent sources. In some countries, where independent data have been generated, (e.g., immunization coverage reported in the Indian National Health Survey), the UNICEF and WHO estimates have not been validated (Census Commissioner 1995). Most of the publicly available information comes from UNICEF's annual *State of the World's Children* reports and the more recently published *The Progress of Nations*. Even at the time of the UCI announcement in 1990, there were concerns - within and beyond UNICEF - over data misreporting or even falsification. Because of UNICEF's organizational stake in advancing the World Summit goals, there is a credibility problem that can only be bridged by ensuring adequate research and evaluation by external groups. Sample surveys, now being undertaken by UNICEF's field offices, can improve only somewhat this data and analysis imbalance.

Secondly, the several external studies undertaken are methodologically restricted. The assessments mostly deal with the health sector, and two focus exclusively on immunization; fewer studies have been done in other goal-related sectors. The Bamako evaluation found it difficult to categorize which programme components constituted a Bamako Initiative. The PAHO study, involving qualitative solicitation of views by diverse respondents, had no comparison or control group. The final recommendation of the UNICEF sustainability steering committee noting that sustainability consists of a complex web of supply and demand factors shedding little light on practical strategies. Perhaps most importantly, there has simply been insufficient time since 1990 (five years) to empirically observe, document, and assess sustainability over time.

Thirdly, UNICEF's policy articulation about sustainability, however genuine, say little about how operational, personnel, and budgetary decision-making are actually made in a highly decentralized field organization. It is possible to interpret the policy statements as strategic deflection of external criticism, even as internal operations ignore sustainability in favour of rapid, visible results. Sustainability is a vague concept for which practical field translation remains problematic. Even if decision-makers were to prioritize sustainability in field action, precisely how to do so remains unspecified. This practical problem of how to strengthen sustainability in programming actions deserves more future attention.

Finally, none of the studies squarely address the question of whether the Summit goals provide the most strategically-effective approach to sustainable progress for children. In other words, the studies do not pose the counterfactual question. Would similar investments in another strategy, besides the Summit goals, contribute even more to sustainable progress?

Concepts of sustainability

What do we mean by sustainability? Despite widespread use, the term 'sustainability' is a subjective concept that means many things to different people. The term has a brief and recent history. It entered into common usage in the 1970s in the economics and environmental literature for describing the capability of a process or outcome 'being maintained at a certain rate or level' (Oxford 1989). In the 1980s, public concerns grew over the role of human activity and modern technology in powerfully disturbing the ecosystem and compromising the sustainability of our planet. In response, the concept of 'sustainable development' was promulgated by the Brundtland Commission on Environment and Development (1987). With the release of its report, *Our Common Future*, the Brundtland Commission coined the term 'sustainable development,' which it defined as 'development that meets the needs of the present without compromising the ability of future generations to meet their own needs.' For nearly a decade, the concept of sustainability has grown in popularity and usage.

Three distinctive schools of thinking on sustainability can be identified. Each is relevant to the Summit goals, and each has roots that reach back into history shaped by developments in the last decade. Our formulation of these schools is necessarily arbitrary but we believe it captures reasonably well the diversity of thinking about sustainability in development. The three schools are: (1) project sustainability, (2) systems sustainability, and (3) sustainable human development.

Project sustainability

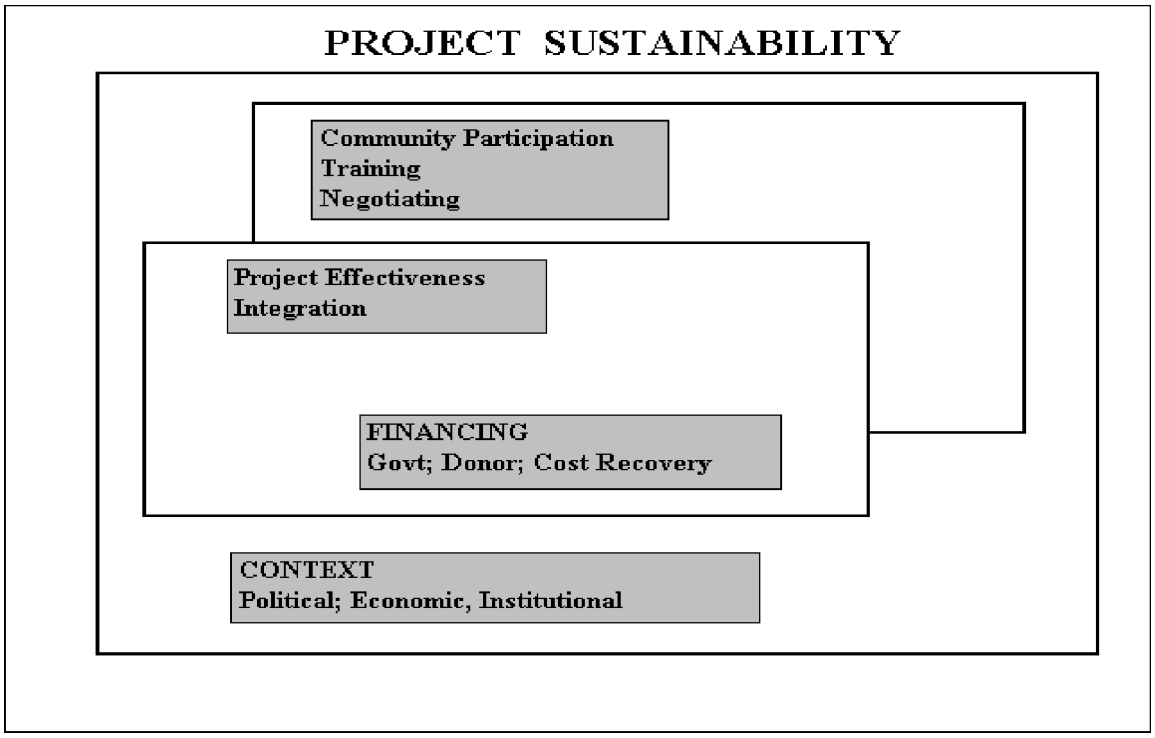
The 1980s has been called 'the lost decade of development.' Economic recession gripped much of the developing world, and the consequent structural adjustment policies enjoyed, at best, mixed success. In many developing countries, especially in sub-Saharan Africa, personal incomes declined and the public sector shrank. Negative economic growth was experienced in 50 of 78 developing countries; average income in Africa and Latin America fell by more than 10 per cent (UNICEF 1992). Social sector systems were profoundly affected by the fiscal crises, leading to a contraction of public expenditures. The public health budgets in African countries were hardest hit. In real terms, the budget for the health ministry in Uganda in the latter half of the 1980s, for example, was only 17 per cent of its earlier 1970 level. Tanzania experienced a cutback of 30 per cent in health expenditures between 1980 and 1985 (UNICEF 1992). At the same time, a declining long-term trend of concessional resource transfers from North to South became evident. Accustomed to funding projects for 3-5 years before turning them over to national control and support, donor agencies became increasingly concerned over the 'sustainability' of donor-supported projects after withdrawal of external financing (de Ferranti 1985; Bossert 1990; Ashford 1992; Haws 1992; DeWinter 1993).

Several streams of social research reflected this donor concern. The World Bank focused on the economic viability of projects, promoting strategies like cost recovery through user charges (de Ferranti 1985). The population field became concerned over the financing of family planning services, and several studies examined cost-recovery mechanisms, including user fees for what had been earlier free or highly subsidized contraceptive services (Ashford 1992; Haws 1992). In the health sector, bilateral donors like the United States Agency for International Development

(USAID) and the Danish International Development Agency (DANIDA) also supported studies on project sustainability (Bossert 1990; DeWinter 1993). Concerns about sustainability in UNICEF parallelled these donor trends.

Most of the studies viewed sustainability in economic terms. How would a project be financed after donor withdrawal? Perhaps the most comprehensive study was by Bossert (1990). **Figure 3** summarizing his approach identifies both internal project factors as well as broader contextual factors in determining project sustainability. Internal project factors include demonstrated effectiveness, integration of new activities into established structures, mobilizing community participation, and training of project staff. Successful projects must also be able to mobilize local funding through commanding public expenditure priorities as well as developing cost-recovery mechanisms. Internal factors, according to Bossert, are usually shaped at the project's outset in the initial negotiation process. Recognizing that projects are not isolated activities. Bossert also calls for understanding the broader political, economic, and institutional contexts within which projects operate. Bossert concludes that no universal guideline can be applied because the determinants of project sustainability are specific with regards to time, location, people, and institution. Project flexibility and adaptability are important for accommodating and anticipating diversity and change. In project design and implementation a long-range view should be adopted.

Figure 3. Project sustainability



Source: Bossert (1990)

Systems sustainability

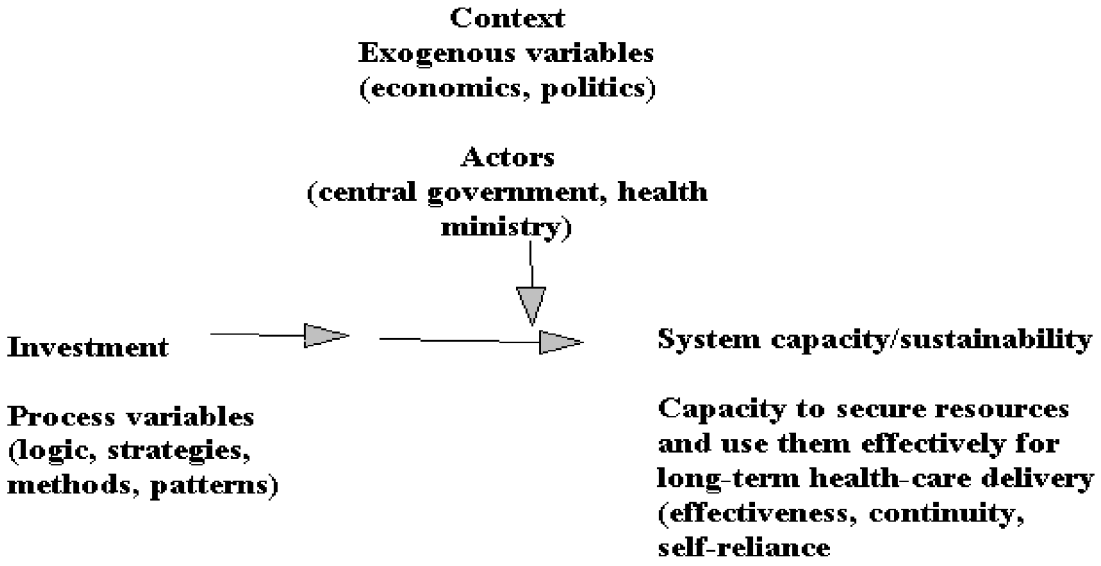
The Bossert study showed that the ultimate sustainability of an individual project depends upon the viability of an entire system within which the project is imbedded. Two groupings of health research adopted a systems approach to sustainability. The first approach values sustaining primary health care as an ultimate objective. Such an approach was adopted by groups at the London School of Hygiene and Tropical Medicine, Save the Children (UK), and the Canadian Public Health Association (LaFond 1995; Smithson 1994; Canadian Public Health Association 1990). A second approach considers the entire health sector - including but beyond primary health care - as an inter-related system that can be reformed through policy change. Sectoral reform studies have been undertaken by groups at Harvard, Maryland, the World Bank, and in some developing countries like Mexico (Berman 1995; Brinkeroff and Goldsmith 1992; World Bank 1993; and Frenk 1994).

Whether one calls the approach primary health care sustainability or health sectoral reform, the approaches are similar in that both consider an entire system rather than an individual project. LaFond (1995) defines a system's sustainability as 'the capacity of the health system to function effectively over time with minimum external input.' Another definition with an institutional perspective is: 'sustainability is the ability of a system to produce benefits valued sufficiently by users and other stakeholders (actors other than users with an interest in what the systems does) to ensure enough resources to continue activities with long-term benefits' (Brinkeroff and Goldsmith 1992). Under either definition, desirable attributes of the system sustainability include effectiveness, continuity over time, and the mobilization of sufficient local resources for financial self-reliance.

Figure 4 presents LaFond's (1995) framework for health systems sustainability. This framework characterizes sustainability as dependent upon the social and political context and investment decisions. Contextual factors include the political and economic climate as well as the interests and actions of key actors - government, health ministry, donors, and the people. Investment strategies are reflected by process variables including programme strategy, design, and management. In an application of this sustainability framework in Viet Nam, Guldner and Rifkin (1993) focus on health policy development in a country undergoing rapid economic transitions. Sustainability in Viet Nam, they argue, requires a health policy and regulatory framework that would shape a coherent health care system. The system's functions could be improved through better information, coordination, integration, and sound fiscal policies. The involvement of the community should be promoted to ensure participation, consumer demand, and fiscal viability.

Figure 4

FACTORS INFLUENCING THE PROCESS OF HEALTH SYSTEM DEVELOPMENT

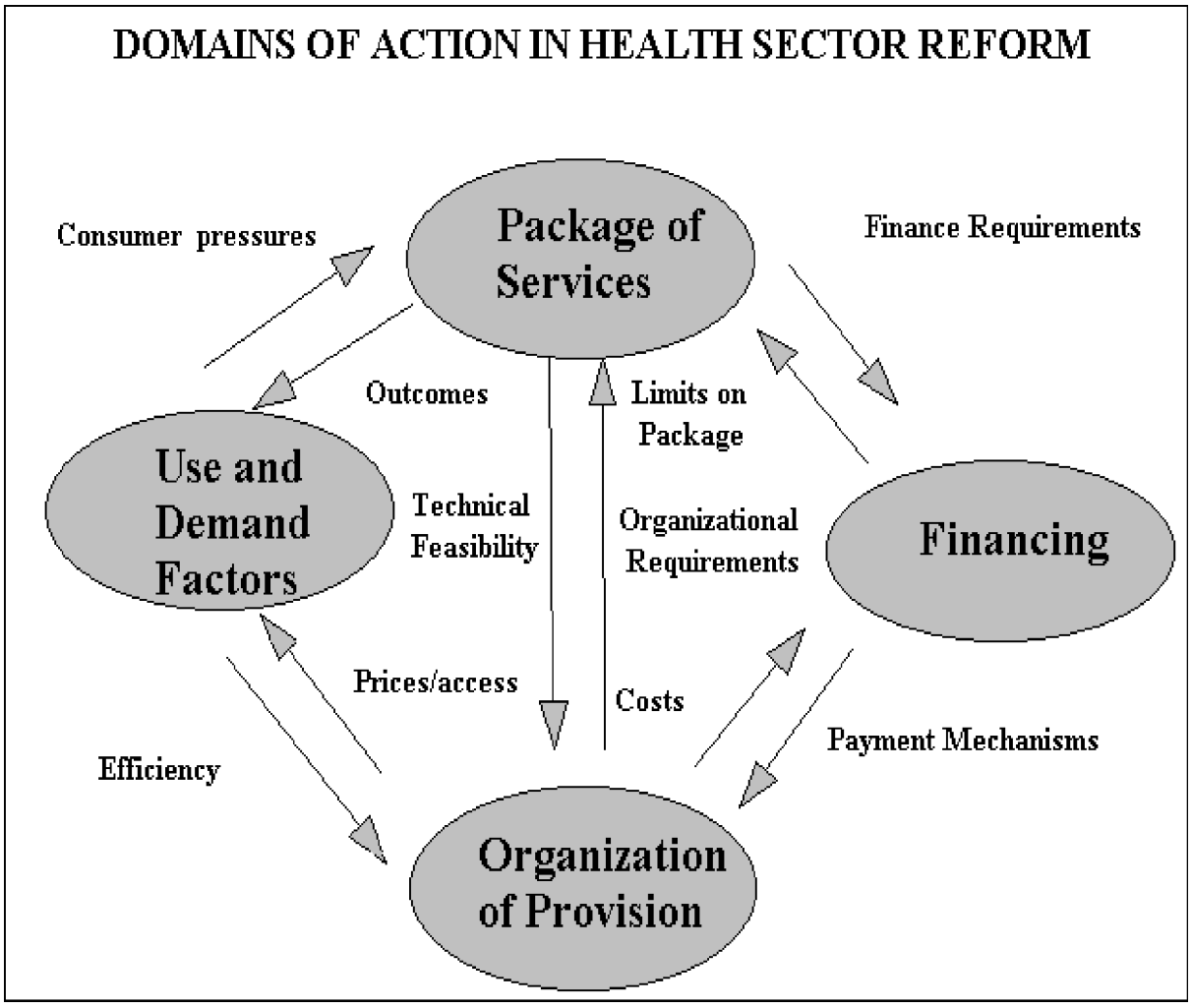


So
urc
e: La Fond (1995)

Most health sector reform work has been pursued by the World Bank, culminating in its 1993 World Development Report *Investing in Health.* Building upon a project approach, the World Bank adopts a cost-effectiveness framework for health policy by estimating the burden of disease, comparing interventions, and recommending a basic package of core preventive and curative services for enhancing the sector's effectiveness, efficiency, and equity. The Bank's work sharply focuses on economic policies. Little institutional analyses are undertaken, community perspectives are not included, and the challenge of long-term sustainability is not explicitly addressed.

In contrast, Berman (1995) explicitly addresses sustainability as a key part of sectoral policy reform. He defines sectoral reform as 'sustained, purposeful and fundamental changes in the health sector.' Berman's four domains of health sector reform are shown in **Figure 5** - demand factors, package of services, the organization of provision, and financing. These four components, Berman argues, are tightly linked - by institutional actors with diverse roles and interests and by functional areas performing specific aspects of the system's processes. Changes in the behaviour of actors or in the functions of any single component necessarily impact upon other actors and components. For understanding these interactions, Berman describes new descriptive and analytical tools (burden of disease, health accounts, political mapping) that have recently become available. In managing the reform process, all four components must be orchestrated through a process of harmonious change.

Figure 5



Source: Berman (1995)

Sustainable human development

These project and systems approaches to sustainability in the health sector parallelled broader evolution of the concept of sustainability in development. Just as each project is imbedded in a sectoral system, so too is a sector part of a society's overall socioeconomic development.

'Sustainable development' as articulated by the Brundtland Commission crystallized widespread concerns in the 1980s over environmental pollution and the depletion of natural resources due to undirected, expansive economic growth and rapid population growth. In a single phrase, sustainable development was able to integrate concerns over environment, population, and development. The term was also able to encapsulate such concepts as

‘sustainable agriculture.’ The Commission, furthermore, focused public attention on human needs - bringing together concerns over global equity in meeting the basic needs of the rural poor (who often must spoil their local environments for generating livelihoods), with the concerns of the urban rich (who through their over-consumption are increasingly threatened by global as well as local environmental change, including global warming.) Sustainable development was described by the Commission as a "process of change in which the exploitation of resources, the direction of investments, the orientation of technological development, and institutional change are all in harmony, and enhance both current and future potential to meet human needs and aspirations." Key features of sustainable development are its future orientation and the value it accords to intergenerational equity.

Perhaps to balance the Brundtland Commission's heavy focus on environmental and economic policy, Anand and Sen (1994) in pioneering work subsequently disseminated by the United Nations Development Programme (UNDP) through its Human Development Report (1994) introduced the newer concept of ‘sustainable human development.’ Moving beyond environment, sustainable human development focuses on promoting equitably people's human capabilities.

Anand and Sen (1994) note that as sustainable development claims to value ‘human life itself,’ the approach must aim to enable all individuals to enhance their full human capabilities. The UNDP measures this concept through the Human Development Index, which reflects attainments in universal basic education, optimal life expectancy, and adequate income capabilities. Moreover, the authors argue that intergenerational equity is impossible, indeed indefensible on ethical grounds, without intragenerational equity - promoting equitably the human capabilities of people today. Put simply, how can we argue for preserving the quality of life and physical environment for future people if people today are denied these very same human capabilities? To Anand and Sen, distributional equity within and across generations constitutes the core principle of sustainable human development. The ‘ethics of universalism of life claims’ should accord equal priority to equity today as against future generations. This concept of sustainable human development is clearly fundamental to strategies for children, who are the human bridges across generations.

Strategies for sustainability

Conceptually, the sustainability of UNICEF's Summit goals rests somewhere between project and systems sustainability. UCI can be classified as 'project' oriented in that it is single purpose, focused on a specific objective, in a specific geographical area, or among a specific community. The Summit goals also have systems dimensions as the goals are imbedded in various systems or sectors. Because the goals promote children's human capabilities as well as intra- and inter-generational equity, the goals are linked to sustainable human development. All three concepts of sustainability - project, systems, human development - are thus relevant to UNICEF's strategy.

Before considering specific strategies, an analysis of the Summit goals themselves may be important to clarify the strategic issues involved.

Goals for sustainability

A natural yet fundamental question is: What is to be sustained? UNICEF's overall mandate for children can be interpreted in many basic ways - nurturing children, their families, local communities, nations - and imbued with certain values like equity and sustainability. The Summit goals, therefore, are both an ends in themselves as well as a means of achieving broader objectives.

As a group, the 27 Summit goals summarized in **Table 2** convey a powerful message of priorities on child health, education, and development. As a group, the goals adopt a strong universalist minimalist approach: Every child ought to have these basic minimums. The specific goals, however, represent a rather mixed bag. Some goals are desirable attainments in addressing certain **conditions** (e.g., virtual elimination of tetanus); others identify a specific program **action** (e.g., 90 per cent immunization coverage); still others specify a desired **outcome or impact** (e.g., reduction of under five mortality). Moreover, the goals vary with regard to target group, the time dimension of impact, and sectoral involvement.

Linkage across goals - **Table 5** organizes the goals into three categories (condition, action, and outcome). The linkage between condition-action-outcomes is illustrated by the goal of reducing infant mortality by 33 per cent or to 50 per l,000, whichever is lower. This outcome obviously links to the action goal of achieving 90 per cent immunization. The proposed immunization activity, moreover, is expected to reduce certain health conditions, like the eradication of polio or the virtual elimination of tetanus. Another example would be the goal of reducing under 5 mortality by 33 per cent or to 70 per l,000. This goal overlaps with three other mortality goals - 95 per cent reduction of measles mortality, 50 per cent reduction of diarrhoea mortality, and 33 per cent reduction of mortality from ARI. How do these disease-specific goals relate to overall mortality reduction goals? The mortality targets, moreover, are linked to the goals of changing health conditions like the near eradication of measles and the reduction of

diarrhoea incidence by 25 per cent. The goal of 100 per cent access to clean drinking water and sanitation would presumably affect diarrhoea incidence and under 5 child mortality as well.

Analytically, the links between condition-action-outcome goals are not precise. For some problems, the links may be obvious; for others, they are presumed. The goal of 50 per cent reduction of moderate and severe malnutrition may be presumed to be due to breast feeding, early supplementation, and immunization. The connection between reduction of diarrhoea incidence, diarrhoea mortality and the water and sanitation goals are not explicit. Surprisingly, the goal referring to use of antibiotics for ARI goals is not specified. **Appendix C** further discusses the links (or lack of) between the goals.

How secure are the assumptions that the proposed actions would change the relevant conditions to result an expected outcome? Available evidence suggests considerable uncertainty. Studies of mortality trends, for example, have shown that mortality change is a complicated long-term secular process. Simplistic linear translation of interventions against specific diseases generating expected impact have been very difficult to document in real-world situations. Complexity is due to the interplay between socio-economic and health care determinants of health status, and also to complex interaction between diseases, called co-morbidity. Murray and Chen (1994) have postulated that much of the secular change in mortality may be attributed to the build up of 'health assets' rather than the impact of recurring health interventions. Such assets include broad based knowledge, education, empowerment of the child's caretaker, and changing health behaviour. Once a family has knowledge of disease prevention and treatment and its members begin to change their behaviour (e.g., hand washing), economic factors or health service interventions will have a different impact on survival. Theories of these fundamental secular processes, like health assets, lie beyond the technological and disease focus of the Summit goals.

Table 5. Summit goal analysis

Health Action	Health Conditions	Heath Outcomes
Infants		IMR decline 33% or 50 (Whichever is lower)
Tetanus mothers 90%		
Tetanus child 90%	Virtual elimination	
Polio 90%	Eradication	
DPT 90%		
BCG 90%		
Children <5		
		U5M decline 33% or 70
Measles 90%	Toward eradication	(Whichever is lower)
W/S access 100%	diarrhoea incidence decline	Measles mortality decline
ORT Usage 80%	25%	95%
		Diarrhoea mortality decline 50%
Breastfeeding		
Supplementation	Malnutrition mod/severe decline 50%	ARI mortality decline 33%
	Vit A deficiency/blindness elimination	
Children	Iodine deficiency elimination	
Protection/Children in Difficult Circumstances		
Basic Education 100%		
Completion 80%		
Adults		
Antenantal services 100%		
Obstetrical services 100%	Iron deficiency decline 33%	
Referral services 100%		
Family planning 100%		MMR decline 50%
Pregnant/lactating women		
Education		
	Illiteracy decline 50%	

Time dimension

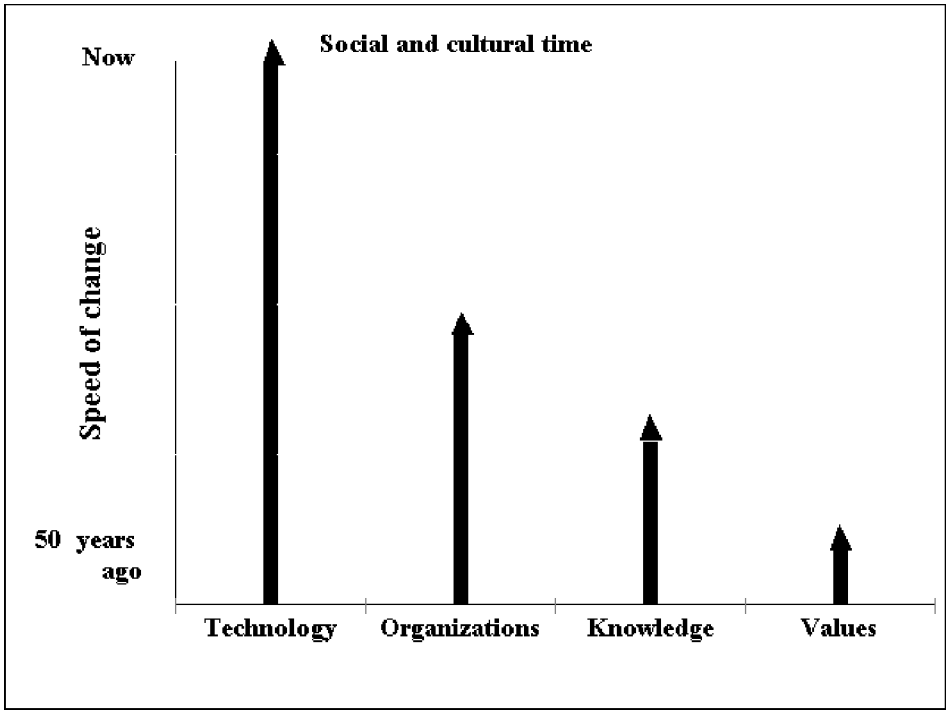
All goals are to be achieved by the year 2000, or earlier at mid-decade. Some goals, however, have a once-for-all eradication impact, while others will require recurring effort for sustained achievement. If successful, the eradication of polio (and measles which is less likely) would generate infinite benefits into the future. Like smallpox eradication, immunization with these antigens would not be required in the future. Although tetanus is also targeted for 'virtual eradication,' the control of tetanus, an ever-present pathogen in the environment, will require continuous coverage with vaccines. For other conditions, activities, the interventions must be sustained to protect new cohorts of children and women.

The time implications of the various goals suggest that most goals will depend upon a sustained institutional capacity for continuous action into the future. In a few selected goals, for example polio eradication, a one-time effort may be feasible. The nature of how sustainability is defined, therefore, differs between goals. At the ICDC Workshop (UNICEF-Harvard, 1995), there was wide acknowledgment of issues related to timing. **Figure 6** was proposed to illustrate the different speeds of change of the components of sustainability. For example, while technological change has been extremely fast in recent years, organizational changes have been slower. Changes in knowledge have been even less rapid, and values are likely to change least of all. Goals that depend basically on technology - such as salt iodization - are more appealing to the aid industry and will be achieved more rapidly. True sustainability, however, is more likely to arise from value changes - such as gender equity in education. As pointed out by an ICDC Workshop participant "the least attainable goals are likely to have the most sustainable outcomes" (Chen M, personal communication).

Target group

Although the beneficiary group of the goals is most children, the targeted population is complex. For children under 5 years of age, health and nutrition are the two primary concerns. For children between 5-10 years, the focus shifts to primary education. Special attention is accorded to all children under 'especially difficult circumstances.' Among adults, there is exclusive concentration on the reproductive health of women, except for the goal of reducing adult illiteracy.

Figure 6. Speed of change in terms of social and cultural time



Source: Karl-Eric Knuttson

The important point about targeting is that selectivity will prioritize and channel resources to some groups, for some activities, and not to others. The grouping of beneficiaries will also have implications for the types of institutions involved (government department, NGOs, etc.). Strategies for sustainability will be affected by the people and institutions involved in resource and capacity strengthening.

Sectoral focus

Sectoral involvement and institutional mediation are also shaped by the goals. The overwhelming bulk of the goals relate to health, nutrition, and family planning services. Some are targeted services, like immunization; others are broader services like maternal-child health and safe motherhood; still others depend primarily upon changes in health-seeking behaviour, like breast feeding, supplementation, and family planning. It is important to recognize that sectors beyond health are also involved, including education and social protection. Food fortification to prevent micronutrient deficiency will require the engagement of industry and even commercial groups. Water and sanitation will involve governmental units beyond the health ministry, such as municipal governments for construction of infrastructure and systems operations which could be private, community-based, or public sector. The critical actors matrix in **Appendix B** further develops these issues.

At the ICDC Workshop, it was noted that the goals were not as multi-sectoral as was envisaged, and that programmes need to consider the child as a part of and influenced by society, rather than in isolation. For example, there has been growing emphasis within UNICEF to

consider the roles and responsibilities of men as fathers and husbands in helping achieve the goals.

It is important to underscore that despite the analytical imprecision, the goals are mostly easily **measurable**, thus they make for **transparency** which in turn helps with **accountability** of responsible parties. They should be seen, therefore, less as an analytically coherent group of goals and more as effective instruments for motivating relevant parties and holding them responsible for achieving tangible outcomes. As such, they are able to communicate to the public, political leaders, and bureaucrats concrete, desirable achievements. Practical translations of these dimensions of goals must come from **real experiences** in the field. One illustration is the spectacular advances made in immunization coverage in Northeastern Brazil, as reported by Tendler (1994).

Framework for sustainability

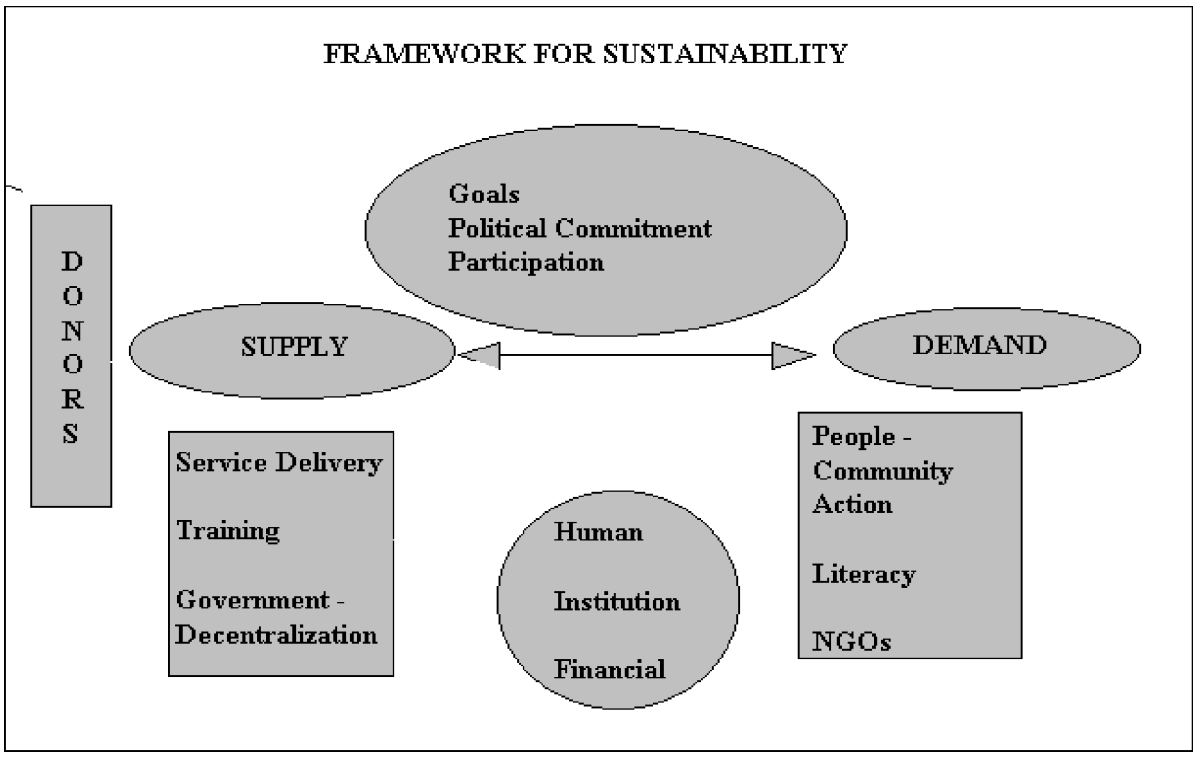
In **Figure 7**, we present a framework for sustainability in which progress is basically an **empowerment process** wherein the people, communities, institutions, governments, and civil society are able to achieve human development with minimum external support. The framework, like others, considers the Summit goals in a supply and demand framework. Service provision, or supply, is provided by both public and private sector systems, including the support of external donors. Client demand is driven by people and their local community organizations. This framework is applicable across the relevant sectors of the Summit goals - health, nutrition, education, water and sanitation, social protection. In this framework, sustainability must address the following elements in the relevant sectors:

1. Explicit goals
2. Political commitment
3. Community participation
4. Human resources
5. Institutional capacities
6. Financial viability

Detailed descriptions of these elements are derived from earlier concepts of systems sustainability that will not be repeated here. In strategies for sustainability, the framework can be used to address several basic questions:

1) How are each of these elements affected by a particular UNICEF investment strategy? Perhaps the most important aspect of investment strategies is **sensitivity** to the range of these elements in making investment decisions.

Figure 7



2) In focusing on a specific goal, which invariably is a project or subsystem within a larger system, how much attention should be devoted to the underlying larger system? Investment decisions here face a **trade-off** between highly-focused versus broader and longer-term investments. An explicit diagnosis of the context of the systems is critical for finding the right balance in targeted versus broader investments.

3) What can be done under **unfavourable contexts** - political and economic? Forty seven countries or one-third of the developing world are currently experiencing 'complex emergencies'. Most developing countries in sub-Saharan Africa and much of Latin America have yet to recover from economic recession and structural adjustment. Given the country specific situation, what feasible steps can be taken towards achieving Summit goals?

Approaches to sustainability

Many approaches can be employed to strengthen sustainability. Explicitly analysing the goals, employing a systematic framework, and asking a comprehensive set of strategic questions would all help in achieving sustainability. Three approaches to sustainability are presented below. These are complementary and not mutually exclusive. Each offers a particular view or approach to sustainability that maintains a strong focus on long-term, sustained, positive change.

Systems approach

A systems approach considers sustainability from the point of view of specific sectors like health and education. While focus on projects and sub-systems is feasible, its basic emphasis is on investments that strengthen the overall system. Work is required with public and private supply systems as well as means for promoting appropriate demand from people and communities. A systems approach tends to be biased towards the supply side of the equation focusing on the capacity of the delivery system to meet client demands. Examples are primary health care systems or health sector reform approaches.

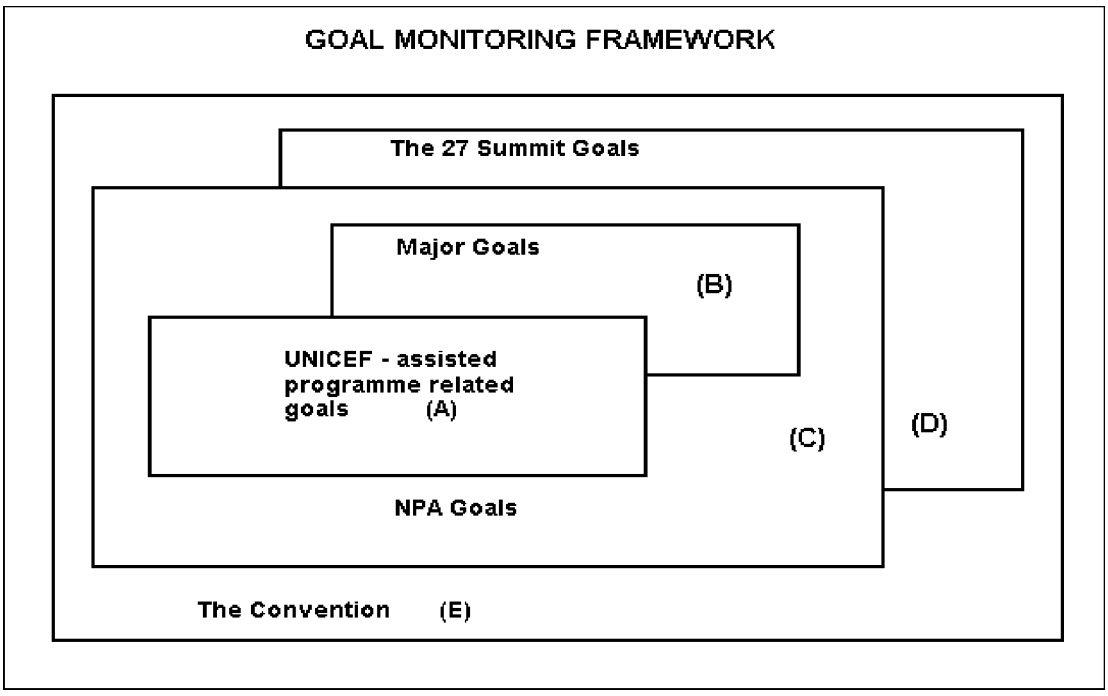
At the ICDC Workshop (UNICEF-Harvard, 1995), several participants pointed out the importance of capacity building for achieving systems sustainability. It was argued that vertical, goal-oriented programmes can also build local capacity. The need for building research capacity in less developed countries was also singled out as being crucial for systems sustainability. It was noted, however, that staff at UNICEF and some other agencies had a somewhat ambivalent attitude towards research due to the length of time required for completing conventional research. The need for UNICEF to be more strategic in terms of research and to managed its resources more carefully was stressed.

Participants at the workshop also stressed the need to consider the demand side of systems sustainability, by considering the individual, the households and the communities, as well as the private sector. The need to develop indicators for assessing the demand side - as well as for the supply side - was emphasized.

Child rights approach

In **Figure 8** the linkages between the Summit goals and the Convention on the Rights of the Child are diagrammed. All of the goals can be interpreted to form part of the Convention, which covers rights beyond the specific goals. A rights approach is basically normative and ethical, not over-focused on sectors or systems. A rights approach focuses on shaping the normative expectations of the public and through legal and other means ensuring compliance.

Figure 8



Source: UNICEF, NY

There was ample discussion at the ICDC Workshop on the importance of the Convention on the Rights of the Child for sustainability. Although agreeing on its usefulness, several participants argued that the term 'rights' may create a certain narrow focus, and that the term 'normative/advocacy approach' is preferable because it encompasses not only rights but also cultural, religious and other factors that influence norms and behaviours.

Empowerment approach

An empowerment approach focuses on strengthening people, local communities, and the supply systems to attain and sustain the Summit goals. Empowerment of people and local institutions involves knowledge, information, resources, and social mobilization. Institutional empowerment focuses on the skills, relationships, and functions of government, NGOs, and the academic community. Gender becomes a critical dimension of empowerment because parents are the primary carers and nurturers of children.

An empowerment-sustainability matrix **(Table 6)** was proposed at the ICDC Workshop. The horizontal axis refers to resources, relationships and institutions required for reaching sustainability. The vertical axis highlights issues related to empowerment, namely access, participation and control. For example, applying the matrix to girls' education highlights the importance of both the supply and the demand side, such as the value of the girl child and the participation of parents. By laying out the different issues of access, control and participation relative to resources, relationships and institutions, the gaps and needs for improvement to sustain girls' education over time becomes apparent.

Table 6. Empowerment-sustainability matrix.

	Resources (demand, supply) (assets, information, services, etc)	**Relationships** (implicit, explicit) (class, gender, etc)	**Institutions** (structure, organization) (markets, alternatives, etc)
Access			
Participation (decision-making)			
Control (ownership)			

Source: M. Chen and M. Elias

Conclusions

The ICDC Workshop participants identified three positive attributes intrinsically linked to sustainability: values, capacities and ownership. Changing relevant societal values is essential for sustainable change. Skill capacity, institutional capacity, fiscal capacity as well as research capacity must be built. Ultimately, the challenge of sustainability is **ownership**. Whatever the strategy, the key question is who will own the Summit goals. For UNICEF to promote the sustainability of the goals, it must promote and transfer ownership of the goals to the people and communities, institutions and systems, and governments and other agencies. It is these groups that ultimately must own the aspirations promulgated at the 1990 World Summit for Children.

Actors and institutions form a series of concentric circles. A child depends on his/her family; the family on its community; these, on various governmental and non-governmental institutions. National programmes are influenced by the global context. Some distressing aspects of national and global environments were expressed by Workshop participants. How is sustainability to be achieved in countries that are in conflict, or at such poverty levels as to find primary health care unaffordable, or where dependence on foreign aid must now change?

The 'genius' behind the Summit goals is that they mix all three questions: What kind of world do we want? What kind of world can we get? How can we get there? The goals are simultaneously normative, tactical and strategic. They contain an overarching element of universal advancement of children with specific feasible programme objectives as well as some strategies for implementation. When initially stated, the blending together of all three questions may have had enormous advantages, but management and implementation at the present stage may require some sorting through. Several participants at the Workshop argued that the goals should be made more flexible and some of the proposed time frames reassessed. Also, the views of different actors and national specificities should be taken into account.

The ICDC Workshop participants proposed a host of sustainability processes that should be examined, including political will and commitment, mobilization of resources, the capacity of people and their organizations, and the ultimate transfer of ownership of the goals. The identification of key indicators to gauge these processes is a major priority as these can guide programme design, monitoring and evaluation.

UNICEF's Executive Board policy review document stresses that for sustainability to be achieved, the demand for services must be created, and national capacity must be built. Both of these factors have to be translated into action at country level. In order to move forward, UNICEF must make a strong commitment to research and develop the demand side of its activities, as well as transfer ownership and priority setting of programmes to the specific countries. The ICDC Workshop illuminated these links that need further exploration, and form the basis of practical translation into programme management.

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APPENDIX A

State of the world's children 1995: Update of mid-decade goals and their progress

Mid-Decade Goal	Achievement	Gaps
Immunization against 6 major vaccine preventable diseases to reach 80% coverage	66 developing nations that have achieved 80% coverage by end of 1990 - 30% have decreased coverage; 50% remain stable; Sustaining immunization levels is an important achievement	In 20% of the countries the coverage has declined
Neo-natal tetanus to be virtually eliminated	50 out of 100 are on target to achieve the goal by the end of 1995. 32 countries need major renewal efforts to stay on course	Of the 18 countries in which the goal is unlikely to be met, 12 are in sub-Saharan Africa
Measles deaths to be reduced by 95% and cases by 90%	Of 102 countries, the goal will be reached in over 54, with an additional 38 that could reach it with extra effort	Of the 10 nations unlikely to reach the goal, 7 are in sub-Saharan Africa Although average coverage is high at 70%, there is a marked difference between regions. 27 countries have experienced slips in immunization levels by 5 percentage points or more.
Elimination of polio in selected countries	43 out of 55 developing nations are on track to achieve the goal. China, Viet Nam, the Philippines, Iran, Pakistan, Syria, India and Bangladesh have all held immunization days.	Need to sustain the effort of polio vaccine coverage to eliminate the disease.
Achievement of 80% ORT as part of diarrhoeal disease control Acute Respiratory Infections	From use levels close to zero, ORT use has increased to 44% in the developing world, 44 countries are on target, 17 have already reached the goal, and 7 countries are close to the 80% goal Much less progress reported in reducing child death from pneumonia	Few national campaigns against the disease have been mounted. Internal resistance is strong against who should dispense antibiotics, etc. Expensive intervention
Virtual elimination of vitamin A deficiency	Of 67 nations, 35 will come close to eliminating the problem, 32 others have not begun preventive action as yet, but this scenario is changing rapidly.	
Virtual elimination of iodine deficiency by universal salt iodization	Of 94 countries, 58 are on track. An additional 32 nations will reach the goal with accelerated effort	
Promoting baby-friendly hospitals and breast-feeding	72 countries that allowed infant formulas have banned them. 57 out of 102 nations have undertaken initiatives to promote breast-feeding in all hospitals	
Virtual elimination of guinea worm disease	Data shows that a number of countries have drastically reduced the number of cases of guinea worm disease. Overall, a reduction of nearly 90% since 1980 is estimated	
Universal ratification of the Convention on the Rights to the Child	167 countries have ratified the convention, 9 more have signed on. 46 nations have fulfilled the commitment to report in detail on the implementation of the convention	14 nations including USA and Saudi Arabia have neither signed nor ratified the convention document

APPENDIX B
Sustainability of Summit goals: A critical actors matrix

The achievement and sustainability of different Child Summit goals require the joint efforts of different combinations of critical actors. Some of the main actors include:

Government institutions. The involvement of central (national) as well as local (state or province, district, municipality, village) institutions may be required. For example, legislation is often needed for specific goals, and the involvement of local health services or schools may be essential.

Marketplace. Some goals (e.g., salt iodization, Baby-Friendly Hospitals, food fortification with vitamin A) require the strong participation of the private sector.

Social Mobilization. This is an essential component of many goals. National movements, organized communities and families have a major role in goals related to education and child rights, among others.

Non-governmental organizations. In many countries these play a major role in services provision. They will have to be involved in health, child rights and education goals.

Political will. For several goals, political will may be the major limiting factor. Unless politicians and administrators in key positions can be won over, achievement and sustainability of the goals will be unlikely.

Table 4 presents possible combinations of different critical actors required for reaching and sustaining selected MDGs. This table is provided as an example only and should not be taken as definitive. It must also be adapted to specific country circumstances. Although it may be argued that some degree of involvement by all critical actors is required for all goals, the ticks in the Table highlight the minimal combination of actors for reaching some of the MDGs. A double tick refers to a particularly important role.

The five MDGs listed in Table 4 were chosen to represent different combinations of critical actors. The exercise should be expanded to incorporate the remaining MDGs and year 2000 goals.

80 per cent EPI coverage. The central government must pass the legislation, procure the vaccines and organize vaccination efforts, which the local institutions will implement. The international marketplace must produce and sell the vaccines at affordable prices. Families must be involved to bring their children to vaccination centers and to demand vaccinations as a basic child right. National NGOs, such as medical societies must also be involved. Finally, political will is necessary to put child health and vaccination high in the political agenda.

Universal iodization of salt. Compared to others, this goal involves few actors. The central government must legislate on the compulsory fortification of salt with iodine, for which political will is necessary. The national salt producers have to accept the legislation and join in the national effort. A governmental institution should be in charge of periodically testing salt to ensure compliance.

Baby-Friendly Hospitals. Depending on the country, hospitals will be owned by the government, by NGOs or by the private sector. The contribution of these sectors is therefore essential. National movements for women's rights and breastfeeding promotion, as well as health professionals societies (doctors, nurses, midwives, etc) must also be involved.

Ratification of the Convention on the Rights of the Child. The central government will have to ratify the Convention, but pressure from national movements supporting child rights is essential. Political will plays a major role.

Promotion of primary education with gender equality. Several actors must be involved for reaching this goal. Central and local government participation is essential since legislation may have to be passed and primary schools are often public. Private schools and those run by NGOs must also be brought in. Social mobilization is essential, involving movements for education promotion and teachers' associations at national and community levels, as well as a strong commitment by families towards sending their children - particularly girls - to school. Political will also plays a major role.

This exercise shows that the approach to achieving and sustaining the World Summit Goals will vary according to each goal. It will also vary from country to country. The construction of a critical actors matrix by a knowledgeable team may help identify areas for priority action.

APPENDIX C
Links between the World Summit goals

The World Summit or year 2000 goals are separated into major and sectoral goals. In addition, a number of goals were also believed to be achievable by 1995 (the Mid-Decade Goals). **Table C1** lists the major year 2000 goals.

Mid-decade and year 2000 goals are a natural development of the goal-oriented approach that characterized UNICEF strategies since the 1980s. During that decade, UNICEF policy included identifying goals that were technically feasible, financially affordable and that relied on readily available (off the shelf) appropriate technology. The GOBI strategy in the early 1980s (growth monitoring, oral rehydration, breastfeeding and immunization) and later expanded to include the FFF component (female education, food supplementation and family planning), were clear forerunners of the goals for the 1990s.

When examining the relationships between major and sectoral year 2000 goals, and between these and mid-decade goals, it becomes clear that while in several instances there is a clear sequence from one group of goals to another, at other times such logic is unclear. **Tables C2** and **C3** show the relationships between the goals. These tables are simplified since goals in different sectors may interact but they provide a framework for examining these relationships. Note that some of the goals have been rearranged for presentation in the table. For example, women's goals included some pertaining to health, nutrition and education; these have been allocated to the corresponding sections.

Health sector goals

The first major health goal is the reduction in under-five mortality. Mid-decade and sectoral goals contributing to this reduction include interventions in immunizations, diarrhoea and ARI case-management, and breastfeeding promotion. Goals from other sectors (i.e., prevention of vitamin A deficiency, improved water and sanitation, women's education, etc) may also contribute to reducing under-five mortality.

Several MDGs refer to immunization. These include both coverage goals (e.g., reaching 80 per cent of children with the basic vaccines) as well as impact goals (e.g., eradicating polio or neonatal tetanus). MDGs are very similar to year 2000 goals in this sector. For example, the vaccine coverage goals specifies 80 per cent achievement by 1995 and 90 per cent by the year 2000. Polio eradication is expected for selected areas in 1995 and for the whole world by 2000. For neonatal tetanus, the ultimate goal of eradication is expected to be reached by 1995 so that in fact there is no year 2000 goal. Vaccine-preventable diseases, however, are not major killers of children. The two main causes of childhood death in less developed countries - pneumonia and diarrhoea - are unlikely to be greatly reduced by immunization. The possible exception is measles, a disease that contributes to deaths due to either pneumonia or diarrhoea.

Goals related to diarrhoea, breastfeeding and acute respiratory infections (ARI) will also contribute to mortality reduction. The diarrhoea goal is a reduction in mortality of 50 per cent and in diarrhoea incidence of 25 per cent. ORT is the corresponding MDG, but it does not affect incidence, only severity and case-fatality of the episode. The achievement of breastfeeding and water/sanitation goals, however, is likely to reduce diarrhoea incidence. The reduction of deaths due to acute respiratory infections is one of the year 2000 goals but there is no corresponding MDG whereas a possible intermediate goal would be achieving antibiotic treatment for a given proportion of pneumonia cases. The expansion of the Baby-Friendly Hospitals Initiative is the MDG related to breastfeeding promotion.

While most year 2000 goals refer to impact (either on a disease or on a behaviour such as breastfeeding), MDGs include a mixture of impact and process indicators, the latter including the provision of Baby-Friendly Hospitals and the achievement of a given coverage with ORT or immunizations.

There are no MDGs regarding women's health, but sectoral year 2000 goals include reduction in iron deficiency anaemia, access to family planning, pre-natal and delivery care and special attention to health and nutritional needs of girls and women. Unlike most health goals, the latter is not phrased in a way that allows easy quantification. The overarching women's health goal is reduction in maternal mortality by half.

Nutrition sector goals

MDGs in the nutrition sector include two micronutrients, vitamin A and iodine, as well as a partial target of reducing malnutrition by one fifth while the major year 2000 goals refers to a reduction by half. Eradication of vitamin A deficiency, an impact indicator, is both a MDG and a sectoral year 2000 goal. The sequence for iodine is more logical, the MDG being related to a process indicator (provision of iodized salt) and the year 2000 goal to its health impact.

There are three other sectoral nutrition goals, relating to prevention of low birth weight, growth monitoring and improving food production to promote household food security. These goals have no corresponding MDGs.

Another nutrition goal, related to iron deficiency, was mentioned above under women's health while breastfeeding was discussed under health due to its large impact on under-five mortality.

Water and sanitation sector goals

Goals in this sector are straightforward. The major year 2000 goal is the universal access to safe drinking water and adequate sanitation. Sectoral goals are the same, and MDGs are partial targets. The eradication of dracunculiasis is both a MDG and a year 2000 goal. It is not clear whether this goal should be included in the water and sanitation or in the health sector. This goal does not quite fit in the general picture, since this disease does not particularly affect children nor can it be expected to have an important impact on overall mortality, although it can be effectively

eradicated by relatively simple measures.

Education goals

The major education goals for the year 2000 include universal access to basic education by children resulting in completion of primary school by 80 per cent of them, and reduction of adult illiteracy rate by half or more. These are also sectoral goals, and the MDG is a partial achievement of the child education goal.

There is considerable duplication regarding the education goals. For example, both major goals are also sectoral goals (in the health sector, for example, major goals are not also sectoral goals). There is overlap between the gender equality issue mentioned in all basic education and adult literacy goals and the women's sector goal referring to education.

A final sectoral goal in education is to promote the acquisition of knowledge, skills and values for better living by the general population. Wide dissemination of the *Facts for Life* messages is part of this effort.

Child health and nutrition goals may also contribute to achievement of the basic education goals since healthier and better-nourished children will have improved learning.

Child Rights goals

In this sector, the ratification of the Convention on the Rights of the Child is the MDG and the protection of children under especially difficult circumstances is the sectoral and major goal.

Conclusions

The manner in which the goals are stated and logically organized may affect whether they are achieved and sustained. A close examination of MDGs, sectoral and major goals shows that these are not always consistent. Close attention to eventual gaps and duplications is required.

Table C1. Major year 2000 goals

- Reduction in under-five mortality by one third
- Reduction in maternal mortality by half
- Reduction in malnutrition among under fives by half
- Universal access to safe drinking water and sanitation
- Basic education for all and complete primary education for 80% of children
- Reduction of adult illiteracy rate by half and gender equality in education
- Protection of children under especially difficult circumstances

Table C2. - Links between health and nutrition goals

MID-DECADE GOALS	YEAR 2000 GOALS	
	SECTORAL GOALS	MAJOR GOALS
EPI coverage ≥ 80% Elimination of neonatal tetanus Reduction of measles cases and deaths Elimination of polio in selected areas	EPI coverage ≥ 90% Elimination of neonatal tetanus Reduction of measles cases and deaths Eradication of polio	Reduction in under-five mortality by one third
80% ORT use rate	Reduction of diarrhoea cases and deaths	
"Baby friendly" hospitals	Exclusive breastfeeding and timely supplementation	
	Reduction of ARI deaths	
	Reduction in iron deficiency anaemia among women Access to family planning Pre-natal and delivery care Special health and nutritional needs of girls and women	Reduction in maternal mortality by half
Virtual elimination of vitamin A deficiency Universal iodization of salt Reduction in malnutrition by one fifth	Virtual elimination of vitamin A deficiency Virtual elimination of iodine deficiency disorders Reduction in low birth weight Growth monitoring and promotion Improving food production for household food security	Reduction in malnutrition by half

Table C3. - Links between goals in other sectors.

MID-DECADE GOALS	YEAR 2000 GOALS	
	SECTORAL GOALS	MAJOR GOALS
Reduce water supply gap by one fourth	Universal access to safe drinking water	Universal access to safe drinking water and to sanitary means of excreta disposal
Reduce sanitation gap by one tenth	Universal access to sanitary means of excreta disposal	
Eradication of dracunculiasis	Eradication of dracunculiasis	
Reduction of basic and primary education gaps by one third	Expansion of early childhood development activities	Basic education for all children and complete primary education for 80%
	Universal access to primary education with special emphasis for girls and accelerated literacy programmes for women	Reduction of adult illiteracy rate by half and gender equality in education
	Reduction of adult illiteracy rate	
	Dissemination of Facts for Life measures	
Ratification of the Convention on the Rights of the Child	Protection of children under especially difficult circumstances	Protection of children under especially difficult circumstances