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Remarks by Mr. James P. Grant
Executive Director of the United Nations Children's Fund (UNICEF)
to the
National Commission to Prevent Infant Mortality
hearing on
"International Infant Mortality Comparisons"

New York
1 February 1988

[Remarks delivered on behalf of Mr. Grant by
Ms. Karin Lokhaug, Deputy Executive Director (Operations)]

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[Remarks delivered on behalf of Mr. Grant by

Ms. Karin Lökhaug, Deputy Executive Director (Operations)]

I am most honoured to address this Commission on behalf of the Executive Director of UNICEF, Mr. James P. Grant, who sends his heartfelt regret that he is unable to participate personally in deliberations before this Commission. On his behalf I also extend the warm greetings of the Secretary-General of the United Nations, Mr. Javier Pérez de Cuéllar, who has asked Mr. Grant to convey to you his warm greetings and to express his regret that he is unable to take part in this phase of the vital work of this Commission.

The Executive Director considers this hearing on "International Infant Mortality Comparisons" to be extremely important, and he highly commends both the purpose of the Commission - to reduce infant mortality - and your effort to learn from the positive experiences of other countries. I am pleased to share with you his contribution.

A "Grand Alliance for Children"

In the three hours of this morning's hearing on infant mortality comparisons, nearly 5,000 young children will die in the world. By day's end the toll will be 38,000. The same was true yesterday; the same will be true tomorrow. Equally bad or even worse, comparable numbers will be crippled for life, and many more will be dragged down the nutritional ladder over a sustained period until the stunting of their growth is irremediable and their chances for normal mental development are lost forever.

The lives of the great majority of these children who die will be lost to diseases for which we have long-since discovered low-cost cures or preventions. More than 100,000 child lives will be lost this week, for example, to readily preventable diarrhoeal dehydration and to immunizable diseases alone.

The success of countries like Sri Lanka and China in reducing child mortality prove that progress is possible despite great odds - even severe economic hardships. Their success has shown what is possible even in low income countries when the needs of children are high on a country's political agenda over a period of two and three decades. Experience in the 1980s has shown, moreover, in the approach which we have come to call the potential for a "Child Survival and Development Revolution (CSDR)", that we are now capable of dramatic improvements in this arena within the short period of 5 to 10 years.

We have seen in this revolution for child health that the coupling of extremely low-cost/high-impact medical technologies capable of preventing the vast majority of child deaths with the rapidly expanding capacities to communicate with those who need to know in order to benefit from modern health progress, can combine to effect historically unprecedented results.

The bottom line of the CSDR is that lives are being saved. In 1987 two interventions - universal immunization of children against the six main child-killing diseases, and the wide-scale use of the remarkably simple oral rehydration therapy to combat the lethal effects of diarrhoeal dehydration - alone accounted for saving the lives of 2 million young children and for saving a comparable number from lives of crippling disability due to the side effects of childhood diseases. A discussion of these and the other health techniques employed in the CSDR can be found in UNICEF's annual report, The State of the World's Children, 1988. At the heart of the CSDR approach, and of relevance in applying the lessons of these experiences to industrialized countries and to combatting AIDS in all countries, is the use of social support and communication systems which empower parents - and mostly women - to take far greater control of their own health and that of their children. An historically unique potential in terms of saving lives and improving the health of children is within our grasp.

If the challenge is to be met on the scale which is now urgently needed and clearly possible, it will be met by a social movement rather than by a medical movement alone. And what is needed are society-wide alliances of all those who could communicate with and support parents in doing what can now be done - teachers and religious leaders, mass media and government agencies, the private sector, voluntary organizations and people's movements, business and labour unions, professional associations and conventional health services. Only such "Grand Alliances for Children" can create the informed public demand for, and practical knowledge of, those methods which could bring about dramatic reduction in today's still-unacceptable child mortality rates. This Commission holds tremendous potential to galvanize such efforts.

Infant Mortality Rates (IMR)

As we look seriously toward waging an all-out effort to reduce infant mortality, it is essential to be very clear about the tools we have for comparing the situation of children from one region, and from one social structure, to another, as well as the tools we have for measuring progress over time. As Sir William Petty said in the 17th Century, "To measure is the first step to improve". When we measure infant mortality rates (IMR) we compute the annual number of deaths of infants under a year of age, per 1,000 live births. The indicator we acquire obviously reflects a quite different strength or weakness than that which we quantify in the far more commonly used indicator of per capita gross national product (GNP). While the latter has been widely used to measure the performance of individual countries over time and to compare performances among countries, it is commonly acknowledged that GNP alone does not and cannot capture all features of social behavior.

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

Under-5 Mortality Rates (U5MR)

While UNICEF continues to publish and use IMRs as a main social indicator, the organization now gives greater emphasis to Under-5 Mortality Rates (U-5MR), as U-5MRs better reflect the performance of a country's health system, while IMR alone can be significantly affected by comparatively narrow factors, such as the nutritional status of the mother, immunization against neo-natal tetanus, or the infant delivery system. I am convinced, in fact, that child health and mortality are more effectively impacted when a society actually addresses the factors reflected in U-5MRs. Since 1987, UNICEF has ranked the countries of the world according to their U-5MR level, and it is hoped that U-5MR will be adopted by countries for national and subnational analyses and presentations over the next few years so that it quickly becomes the standard form used when discussing child mortality. In order to achieve a better "20-20 vision" in the analysis of a country, U-5MR ought to be used in

conjunction with GNP. And where U-5MR data has not yet been collected, IMRs should be used. Both should be used as analytical tools where available.

Child mortality reduction rates

The use of U-5MRs and IMRs encompasses a whole new dimension when we compare data over time, in the same vein that the rate of change of per capita GNP is highly relevant to policy makers. For example, from Japan's GNP growth rate in the 1970s - when its per capita GNP level was catching up with that of Europe - it was clear that that lower-GNP society was very dynamically on the right growth-of-output path. Similarly, we can determine progress and predict trends in infant and child mortality (and, thereby, in child health) through analysis of IMR and U-5MR reduction rates. And again, using these reduction rates in conjunction with GNP change rates is like opening both eyes to the situation. Just as a 1 to 2 per cent per capita GNP growth rate (which is the standard for most low income developing countries) is considered a useful but slow rate of GNP progress, a reduction rate of 1 to 2 per cent in IMRs or U-5MRs can be seen as a step in the right direction, but a slow step.

Interestingly enough, Japan, Hong Kong, Taiwan and Singapore - which showed the highest GNP growth rates of the last generation - also showed the fastest decline of IMRs, at 6 or 7 per cent a year. Others, such as China, Costa Rica, Chile, Cuba, Italy, Poland, Portugal and Spain are examples of countries which have reduced their child mortality rates by an average of 5 to 7 per cent annually since 1960 while their per capita GNP growth rates improved at a substantially slower rate.

On one of the charts attached to this statement is a table listing all countries in order of their U-5MR ranking, and also showing their child mortality reduction rates and other relevant data such as number of births and deaths, and per capita GNP. In order to have in hand the tools for analysis and to stimulate awareness, all countries ought to ask every state or province and every city to compute its IMRs and U-5MRs and their reduction rates.

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

Other relevant questions also arise when there are sharp changes in child mortality reduction rates over different periods of time. Thus, the USSR, which had IMR reduction rates exceeding 7 per cent per annum in the 1950s, dropped to a reduction rate of 1.3 between 1960 and 1985 despite an IMR which today is the level of 23.

Child mortality - progress in the United States

It is noteworthy that the U.S. has continued to improve, having gone from an IMR of 47 in 1940 to 27.8 in 1950 to 10.6 in 1985. However, as the members of this Commission are aware, since 1950 most industrialized countries have improved faster.

In 1986 the U.S. ranked first among the industrialized countries in the world in its per capita GNP, yet despite its wealth and advanced medical technology, it ranked only 22nd among the countries of the world in its IMR and 23rd in its U-5MR. Many countries in Europe including the German Democratic Republic, Ireland and Spain, as well as Japan, Australia and even Hong Kong and Singapore, which are still considered developing countries, now have IMRs and U-5MRs below those of the U.S. In the first half of this century, the United States reduced its IMR by more than 3 per cent per annum - a rate of progress as high as any other country in the world. Since 1950, however, the rate of progress in this country has slowed. Between 1950 and 1960, the rate of reduction fell below 1 per cent - less than almost every other industrialized country. Between 1960 and 1985 it went back to a 3 per cent rate of progress, but many other industrialized countries were registering rates greater than 4 per cent, with countries such as Japan, Spain, Italy and Portugal registering more than 5 per cent.

International child mortality reduction goals

Child mortality indicators have a powerful role to play in the actual work of reducing infant and child deaths and disabilities, and at this crucial juncture in such work, the stakes are huge. If child mortality rates of 1985 continued to the year 2,000, the total number of deaths, due largely to preventable causes, would add up to 235 million - equal to more than half the population of Latin America or of Africa.

The United Nations in 1980 set a monumental goal - it called for all countries to halve their child mortality rates by the year 2000, or to reduce them to 50 per 1,000, whichever was less. To achieve this goal would mean that child deaths would be reduced to 177 million globally by the target date, which would translate to 58 million child lives saved by the end of this century. Furthermore, a comparable number would be saved from lives of crippling disability as a result of childhood diseases. The chart attached to this statement lists the rate of past progress in improving child survival for every country, as well as the Year 2000-goal for each country, and the rate of progress it will have to achieve annually in order to reach that goal.

It is important to note, parenthetically, that successful reduction of child mortality rates in the Third World has been associated recently in many countries with reduced population growth. After infant mortality rates drops below 100 or so, fertility rate reduction accelerates and the number of births begins to exceed the child lives saved. Thailand offers a good example of this relationship - between 1960 and 1986 the IMR dropped by more than half, from 103 to 41. During the same interval fertility rates also dropped by more than half, from 6.3 to 3.0. If 1960 child death and birth rates had prevailed

in 1986, there would have been 96,000 more child deaths and 1.1 million more births. This greater reduction in births is due in part to the family-participation, self-health approach which has recently been quite successful as countries reach that crucial point when IMRs have been reduced to about 100. Before this crucial point is reached, reduction of child deaths is due to factors external to the family (such as elimination of famines or eradication of a disease). Reductions below the 100 level are due more to measures requiring family participation. Such measures as adequate family spacing and encouraging women to wait until they are fully mature before bearing children are means to both child survival and population control goals. This correlation is also due, in part, to a change in attitude associated with successful self-health techniques: as parents become more confident that they do, in fact, have some power to effect the health of their children, and more confident that their two or three children will survive, they are more willing to limit family size. As we look to the end of the century, strange as it may seem to some, one of the principal means of slowing population growth will be to achieve the U.N. Year-2000 child mortality goals.

At first glance, this task of better than halving infant mortality globally before the end of the century may seem hopeless, just as the task of improving the poor child mortality ratings throughout the U.S. might, at first, appear overwhelming. We are, however, armed now with the recent 1980s experience of the CSDR - experience which proves we are capable of achieving goals we would barely have dreamed only a few years ago. Today, historically unprecedented possibilities are within our grasp. These possibilities will become realities, however, if - and this is the big caveat - if the popular and political will exist to make them happen - to mobilize society at every level to prioritize social services appropriately. And they will become realities only where political foresight is sufficient to place the needs of children at the top of the political agenda.

The very establishment of this Commission stands as a milestone for the future of the United States by focusing governmental efforts at the national level toward the protection of this country's most precious resource. But perhaps of even greater importance, the national commitment to child survival to which this Commission is a living testament, should shine as an example throughout the world. Your role in this revolution for child survival and development is one of leadership, and the world community looks to you now for answers and direction. Similar bodies should be instituted in every country in the world. This pioneering group is called upon to set a rigorous pace - may your efforts be emulated throughout the world and until preventable child deaths have ceased.

We meet at a moment of breakthrough in child-health and in the well-being of the world's poorest which seemed like wishful thinking only a short time ago. Indeed, there is a miracle in the making, and we are participating in it together. Already the lives of 40,000 young children are saved each week as a result of this peaceful revolution for children. And it is well within our grasp to, by the turn of the century, save from death and disability 100 million young children. I am convinced that this historic potential can be realized; it can be realized if we work together, even more actively, for the children - and the future - of this nation and of the world.

CHILD MORTALITY RATES
(U-5MR)

Country	Under 5 mortality rate *		Average annual rate of reduction of the Under 5 mortality rate			GNP per capita (U.S.\$)	GDP per capita growth rate		Annual no. of births/infant and child deaths (0-4) (thousands) 1986
	1960	1986	60-80	80-85	85-2000		1985	65-80	
	Required**								
Afghanistan	380	325	0.55	0.66	8.44	...	1.4	-3.0	863/ 280
Algeria	370	297	0.66	1.40	7.96	150	1.1	-0.2	421/ 125
Sierra Leone	397	297	1.01	1.40	7.96	350	1.5	-0.6	174/ 52
Malawi	364	270	1.00	1.59	7.34	170	0.2	-2.0	384/ 104
Ethiopia	294	255	0.57	0.38	7.15	110	0.8	-1.4	2228/ 568
Guinea	346	255	1.07	1.48	7.19	320	-0.7	0.6	292/ 74
Somalia	294	255	0.57	0.38	7.15	280	-13.6		226/ 58
Mozambique	302	247	0.52	1.52	6.95	160	1.3	-1.3	651/ 161
Burkina Faso	388	241	1.98	1.18	6.86	150		0.1	342/ 82
Angola	346	238	1.40	1.50	6.76	470	-2.1	-6.7	427/ 101
Niger	320	233	1.11	1.53	6.87	250	-2.3	1.8	324/ 76
Chad	328	228	1.30	1.56	6.49	80	-1.5	1.9	228/ 52
Guinea-Bissau	315	228	1.13	1.56	6.49	180	-0.2	-1.5	37/ 8
C.African Rep.	308	228	1.20	0.84	6.55	260	0.1	-0.7	117/ 27
Senegal	313	227	1.12	1.57	6.49	370	-0.6	0.0	309/ 70
Mauritania	310	219	1.23	1.62	6.26	420	-1.4	-6.4	98/ 21
Liberia	303	211	1.30	1.60	6.04	470	1.8	-1.5	110/ 23
Rwanda	248	210	0.38	1.43	6.00	280			323/ 68
Kampuchea	218	206	-1.82	7.15	6.91	...			318/ 66
Yemen	378	204	2.33	2.31	5.99	550	5.3	0.9	339/ 89
Yemen, Dem.	378	204	2.33	2.31	5.99	530			104/ 21
Bhutan	297	202	1.42	1.57	6.27	160		3.4	54/ 11
Nepal	297	202	1.42	1.57	6.27	160	0.1	0.8	677/ 137
Burundi	298	196	0.93	1.34	5.60	230	1.9	-0.8	225/ 44
Bangladesh	282	193	1.05	1.56	5.78	150	0.4	0.9	4428/ 854
Benin	310	189	1.91	1.77	5.36	260	0.2	0.1	213/ 40
Sudan	293	182	1.68	2.20	5.17	300	(.)	-4.2	996/ 181
Tanzania	248	179	1.05	1.86	5.08	290	(.)	-3.1	1184/ 212
Bolivia	282	179	1.49	2.52	5.42	470	-0.2	-7.0	284/ 51
Nigeria	318	178	2.29	1.87	5.02	800	2.2	-7.3	5015/ 895
Haiti	294	176	1.96	1.89	6.76	310	0.7	-2.5	278/ 49
Gabon	288	174	1.91	1.91	4.90	3670	1.5	-1.2	43/ 7
Uganda	224	174	0.87	1.09	4.94	230	-2.6	2.2	810/ 141
Pakistan	277	170	1.84	1.85	5.34	380	2.6	2.8	4211/ 716
Zaire	251	166	1.48	1.89	4.63	170	-2.1	-3.8	1394/ 232
Laos	232	166	0.99	2.20	5.38	...			165/ 27
Oman	378	166	3.08	3.16	4.96	6730	5.7	0.5	58/ 10
Iran	254	159	1.93	1.19	5.19	...		7.1	1601/ 286
Cameroon	275	158	2.15	1.87	4.35	810	3.8	4.5	438/ 89
Togo	305	157	2.68	2.00	4.24	230	0.3	-5.6	138/ 22
India	282	154	2.14	2.90	4.63	270	1.7	3.1	22477/3455
Cote d'Ivoire	320	153	2.97	2.15	4.77	660	0.9	-5.2	463/ 71
Ghana	224	150	1.52	1.50	4.03	380	-2.2	-3.9	683/ 99
Lesotho	208	140	1.30	2.09	4.84	470	6.5	3.4	65/ 9
Zambia	228	132	2.14	1.82	3.93	390	-1.6	-4.1	333/ 44
Egypt	300	131	2.89	4.02	3.81	610	3.1	1.3	1629/ 214
Peru	233	128	2.21	2.25	3.92	1010	0.2	-4.2	708/ 91
Libya	266	125	2.52	4.19	3.27	7170	-1.3	-9.1	167/ 21
Morocco	265	125	2.71	3.21	3.73	560	2.2	0.1	755/ 95
Indonesia	235	122	2.39	2.77	3.62	530	4.8	2.3	5020/ 614
Congo	241	119	2.93	1.71	3.96	1110	3.8	4.9	80/ 10
Kenya	208	118	2.10	2.31	3.77	290	1.9	-1.7	1182/ 139
Zimbabwe	182	118	1.52	2.02	3.86	680	1.6	0.0	431/ 51
Honduras	232	112	2.64	3.13	3.50	720	0.4	-2.6	184/ 21
Algeria	270	112	2.99	4.46	3.05	2550	3.6	1.7	938/ 105
Tunisia	255	106	3.06	4.30	3.11	1190	4.0	1.4	226/ 24
Guatemala	230	105	2.89	3.16	3.49	1250	1.7	-4.3	340/ 36
Saudi Arabia	292	105	3.86	3.90	3.24	8850	5.3	-7.3	495/ 52
South Africa	192	101	2.28	2.98	3.55	2010	1.1	-1.6	1272/ 128
Nicaragua	210	100	2.46	3.92	3.24	770	-2.1	-3.1	145/ 14
Turkey	258	99	3.12	5.36	3.12	1080	2.8	2.1	1486/ 147
Iraq	222	98	3.36	2.24	3.79	3020			689/ 67
Botswana	174	96	2.22	2.26	3.78	840	8.3	7.4	57/ 5
Viet Nam	233	95	3.30	3.81	3.27	...			1835/ 175
Madagascar	181	94	2.37	2.83	3.60	240	-1.9	-6.1	458/ 43
Ecuador	183	90	2.69	2.79	3.61	1160	3.5	-2.4	347/ 31
Papua NG	247	90	3.88	3.44	3.39	680	0.4	-1.6	132/ 12
Brazil	160	89	2.23	2.26	3.79	1640	4.3	-1.5	4039/ 359
Burma	229	89	4.01	2.06	3.85	190	2.4	3.3	1192/ 106
El Salvador	206	88	3.27	3.01	3.54	820	-0.2	-3.1	222/ 20
Dominican Rep.	200	86	3.31	2.91	3.57	790	2.9	-0.8	201/ 17
Philippines	135	75	2.23	1.93	3.89	580	2.3	-3.4	1757/ 132
Mexico	140	71	2.64	2.30	3.77	2080	2.7	-2.1	2587/ 183
Colombia	148	70	3.09	1.84	3.92	1320	2.9	-0.5	873/ 61
Syria	218	68	4.71	3.07	3.52	1570	4.0	-2.1	502/ 34
Paraguay	134	63	3.13	2.05	3.85	860	3.9	-1.9	132/ 8
Mongolia	158	62	3.53	3.63	3.33	...			69/ 4
Jordan	218	62	4.89	4.07	3.18	1560	5.8	1.5	170/ 10
Lebanon	92	53	1.95	2.02	3.87	...			80/ 4
Thailand	149	53	3.85	4.15	3.16	800	4.0	2.6	1290/ 68
Albania	164	50	4.90	2.92	3.60	...			84/ 4
China	202	47	6.13	2.59	3.68	310	4.8	8.6	19914/ 942
Sri Lanka	113	46	3.54	2.69	3.65	380	2.9	3.2	417/ 19
Venezuela	114	44	3.94	2.47	3.72	3080	9.5	-5.4	558/ 25
U.A.E.	239	41	7.25	4.10	3.18	19270		-7.7	35/ 1
Guyana	94	39	2.73	5.36	2.75	500	-0.2	-7.3	26/ 1

* Under-5 Mortality Rate (U-5MR) is the annual number of deaths of children under 5 years of age per 1,000 live births.

** REQUIRED MORTALITY RATES are based on U.N. goal set in 1980 to either halve child mortality rates by the year 2000 in every country or to reduce them to 50 per 1000 live births, whichever is less.

Country	Under 5 mortality rate _a		Average annual rate of reduction of the Under 5 mortality rate			GNP per capita (U.S.\$)	GNP per capita growth rate		Annual no. of births/infant and child deaths (0-4) (thousands) 1986
	1960	1986	60-80	80-85	85-2000		1985	65-80 80-85	
	Required**								
Argentina	75	39	2.52	2.33	3.78	2130	0.2 -3.9	733/ 29	
Malaysia	106	37	4.41	2.44	3.73	2000	4.4 1.9	448/ 16	
Panama	105	34	4.48	3.58	3.35	2100	2.5 -0.2	80/ 2	
Korea, Dem.	120	33	4.89	4.47	3.05	...		615/ 21	
Korea, Rep.	120	33	4.89	4.47	3.05	2150	6.6 6.3	975/ 33	
Uruguay	56	31	1.43	5.29	2.77	1650	1.4 -6.0	58/ 2	
Mauritius	104	30	4.43	5.29	2.77	1090	2.7 2.3	28/ 1	
Romania	82	30	4.03	2.95	3.56	2560	3.0	396/ 12	
Yugoslavia	113	30	5.43	3.48	3.38	2070	4.1 -0.5	362/ 11	
USSR	53	28	2.20	3.13	3.50	4550		5207/ 147	
Chile	142	25	6.14	8.25	1.73	1430	-0.2 -3.9	272/ 7	
Trinidad & T	67	25	3.94	2.82	3.60	6020	2.3 -6.0	30/ 1	
Jamaica	88	24	5.40	2.92	3.57	940	-0.7 -3.1	63/ 2	
Kuwait	128	24	6.28	6.51	2.35	14480	-0.3 -6.8	68/ 2	
Costa Rica	121	23	7.06	2.24	3.79	1300	1.4 -2.7	78/ 2	
Portugal	112	21	6.37	6.01	2.52	1970	3.3 -0.5	172/ 4	
Bulgaria	62	20	4.44	3.43	3.40	4150		138/ 3	
Hungary	57	20	3.85	4.18	3.15	1950	5.8 1.7	132/ 3	
Poland	70	20	5.21	2.64	3.66	2050		637/ 13	
Cuba	87	19	6.24	4.56	3.02	...		181/ 3	
Greece	64	17	4.99	4.78	2.94	3550	3.6 -0.3	145/ 2	
Czechoslovakia	32	17	2.32	3.20	3.48	5820		232/ 4	
Israel	40	16	3.91	2.33	3.76	4990	2.5 -0.7	94/ 2	
New Zealand	27	13	2.58	2.64	3.66	7010	1.4 1.8	80/ 1	
USA	30	13	3.41	2.82	3.60	16690	1.7 1.3	3789/ 48	
Austria	43	13	4.82	4.07	3.18	9120	3.5 1.7	93/ 1	
Belgium	35	13	4.15	2.82	3.60	8280	2.8 0.6	122/ 2	
German Dem.	44	13	5.24	2.82	3.60	7180		240/ 3	
Italy	50	13	5.25	5.22	2.79	6520	2.8 0.4	658/ 8	
Singapore	50	12	6.17	3.04	3.53	7420	7.8 6.4	43/ 1	
Germany, Rep.	38	12	4.23	5.59	2.67	10940	2.7 1.2	636/ 7	
Ireland	36	12	4.28	4.36	3.08	4850	2.2 -0.3	79/ 1	
Spain	56	11	6.37	4.36	3.08	4290	2.6 0.9	580/ 7	
United Kingdom	27	11	3.23	3.04	3.53	8460	1.6 2.1	743/ 8	
Australia	25	11	2.86	4.71	2.97	10830	2.0 0.9	249/ 3	
Hong Kong	65	11	7.39	4.71	2.97	6230	8.1 4.4	94/ 1	
France	34	10	4.89	3.29	3.45	9540	2.8 0.3	765/ 8	
Canada	33	10	4.55	5.11	2.83	13680	2.4 0.8	384/ 4	
Denmark	25	9	4.02	1.89	3.91	11200	1.8 2.0	56/ 1	
Japan	40	9	6.70	2.09	3.84	11300	4.7 3.5	1522/ 14	
Netherlands	22	9	3.41	1.89	3.91	9290	2.0 0.3	173/ 2	
Switzerland	27	9	4.39	3.93	3.23	16370	1.4 1.3	70/ 1	
Norway	23	8	3.62	1.89	3.91	14370	3.3 3.2	49/ 0	
Finland	28	7	5.52	2.33	3.76	10890	3.3 2.1	63/ 0	
Sweden	20	7	3.91	2.33	3.76	11890	1.8 1.5	87/ 1	

**CHILD MORTALITY RATES
(IMR)**

Country	Infant mortality rate*		Average annual rate of reduction of the infant mortality rate Required**		
	1980	1986	60-80	80-85	85-2000
Afghanistan	215	185	0.51	0.52	8.48
Mali	210	171	0.60	1.21	8.01
Sierra Leone	225	171	0.95	1.21	8.01
Malawi	208	153	0.96	1.58	7.34
Ethiopia	175	151	0.60	0.39	7.14
Guinea	208	150	1.15	1.50	7.18
Somalia	175	151	0.60	0.39	7.14
Mozambique	174	144	0.45	1.56	6.94
Burkina Faso	220	141	1.77	1.20	6.85
Angola	208	140	1.49	1.47	6.77
Niger	191	137	1.14	1.49	6.88
Chad	195	134	1.37	1.39	6.54
Guinea-Bissau	188	134	1.19	1.39	6.54
C. African Rep.	183	134	1.19	0.99	6.50
Senegal	180	134	0.97	1.51	6.50
Mauritania	185	129	1.28	1.59	6.27
Liberia	180	124	1.32	1.65	6.03
Rwanda	146	124	0.35	1.36	6.03
Kampuchea	146	132	-1.88	7.32	6.85
Yemen	214	123	2.03	2.05	6.07
Yemen, Dem.	214	123	2.03	2.05	6.07
Bhutan	188	130	1.31	1.29	6.36
Nepal	186	130	1.31	1.29	6.36
Burundi	152	116	0.89	1.29	5.62
Bangladesh	158	121	0.83	1.24	5.88
Benin	185	112	1.94	1.65	5.40
Sudan	170	108	1.57	2.02	5.23
Tanzania	146	107	0.98	1.55	5.18
Bolivia	167	113	1.21	2.24	5.51
Nigeria	190	107	2.31	1.56	5.12
Haiti	197	119	1.91	1.70	5.82
Gabon	171	105	1.88	1.59	5.00
Uganda	133	105	0.81	0.90	5.00
Pakistan	163	111	1.32	1.65	5.40
Zaire	146	100	1.38	1.66	4.70
Laos	153	113	0.95	1.78	5.51
Oman	214	104	2.61	2.86	5.06
Iran	169	109	1.78	1.22	5.18
Cameroon	163	96	2.08	1.54	4.45
Togo	182	95	2.67	1.56	4.39
India	165	101	1.66	2.31	4.83
Cote d'Ivoire	200	102	2.69	1.97	4.83
Ghana	132	91	1.38	1.23	4.12
Lesotho	149	102	1.20	1.96	4.89
Zambia	135	82	1.95	1.59	4.00
Egypt	179	88	2.41	3.30	4.05
Libya	160	85	2.23	2.47	3.84
Morocco	163	85	2.22	2.85	3.84
Indonesia	139	76	2.15	2.57	3.68
Congo	143	75	2.68	1.49	4.04
Kenya	124	74	1.93	1.98	3.88
Zimbabwe	110	74	1.40	1.75	3.95
Honduras	144	71	2.43	2.89	3.58
Algeria	168	76	2.56	4.13	3.17
Tunisia	159	74	2.59	3.66	3.32
Guatemala	125	61	2.46	3.08	3.52
Saudi Arabia	170	74	3.02	3.25	3.46
South Africa	135	75	2.06	2.60	3.67
Nicaragua	140	64	2.52	3.86	3.26
Turkey	190	79	2.88	4.55	3.40
Iraq	139	71	2.72	1.81	3.93
Botswana	119	69	2.03	1.84	3.92
Viet Nam	156	68	3.11	2.80	3.61
Madagascar	109	61	2.12	2.36	3.75
Ecuador	124	64	2.42	2.49	3.71
Papua NG	165	64	3.55	3.20	3.48
Brazil	116	65	2.16	2.23	3.80
Burma	153	64	3.70	1.43	4.06
El Salvador	142	61	3.08	3.08	3.52
Dominican Rep.	125	67	2.21	2.64	3.68
Philippines	80	46	2.04	1.96	3.88
Mexico	92	48	2.45	2.24	3.79
Colombia	93	47	2.86	1.59	4.00
Syria	135	50	3.66	3.34	3.43
Paraguay	86	42	2.98	1.31	4.10
Mongolia	109	46	3.11	3.32	3.44
Jordan	135	46	3.97	3.97	3.22
Lebanon	68	41	1.73	1.73	3.96

* INFANT MORTALITY RATE is the annual number of deaths of infants under one year of age per 1,000 live births.

** REQUIRED MORTALITY RATES are rates required after 1985 to achieve the U.N. goal set in 1980 to either halve 1980 infant mortality rates by the year 2000 in every country or to reduce them to 50 per 1,000 live births, whichever is less.

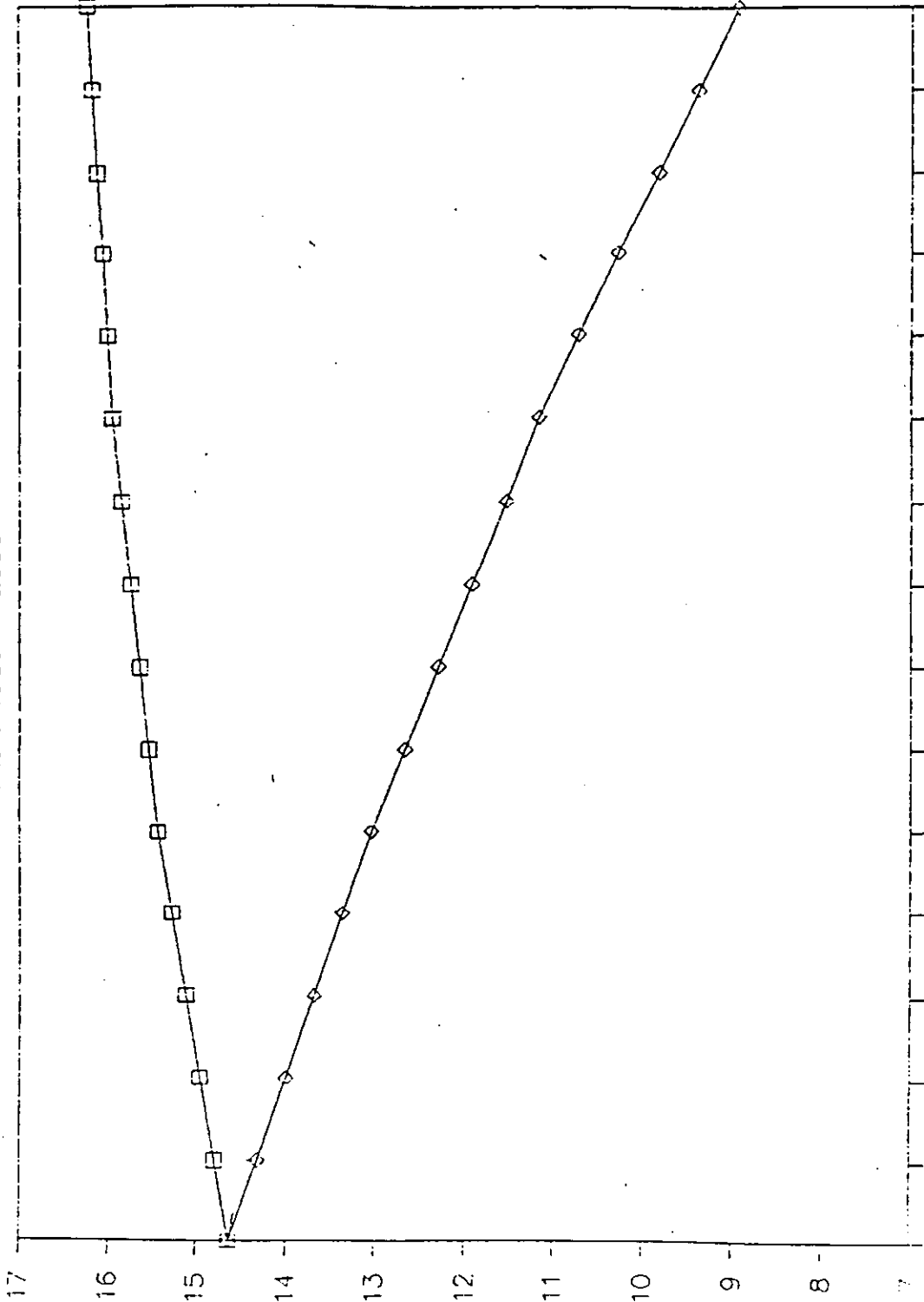
Country	Infant mortality rate*		Average annual rate of reduction of the infant mortality rate Required**		
	1960	1986	60-80	80-85	85-2000
Thailand	103	41	3.36	3.29	3.45
Albania	122	41	4.56	2.18	3.81
China	150	34	6.40	2.09	3.84
Sri Lanka	70	34	2.29	3.93	3.23
Venezuela	81	36	3.35	1.51	4.03
U.A.E.	145	33	6.01	3.58	3.35
Guyana	69	31	2.45	4.71	2.97
Argentina	61	33	2.34	2.20	3.81
Malaysia	73	27	4.04	2.64	3.66
Panama	69	23	4.24	2.92	3.57
Korea, Dem.	85	25	4.77	3.34	3.43
Korea, Rep.	85	25	4.77	3.34	3.43
Uruguay	50	27	1.49	4.76	2.95
Mauritius	70	24	3.69	4.66	2.99
Romania	69	24	4.24	2.92	3.57
Yugoslavia	92	27	5.00	6.97	2.19
USSR	38	23	1.89	2.33	3.76
Chile	114	20	5.87	8.34	1.70
Trinidad & T	54	21	3.78	2.52	3.70
Jamaica	62	19	4.84	2.76	3.62
Kuwait	89	20	5.62	4.71	2.97
Costa Rica	84	18	5.88	5.34	2.75
Portugal	81	18	5.71	5.34	2.75
Bulgaria	44	15	3.63	1.98	3.88
Hungary	51	18	3.70	4.56	3.02
Poland	62	18	5.05	2.89	3.58
Cuba	62	15	5.50	5.59	2.67
Greece	53	12	4.52	7.79	1.90
Czechoslovakia	26	14	1.82	3.58	3.35
Israel	33	14	3.55	4.07	3.18
New Zealand	23	11	2.81	1.59	4.00
USA	26	10	3.41	3.29	3.45
Austria	37	10	4.74	4.71	2.97
Belgium	31	9	4.63	5.59	2.67
German Dem.	37	9	5.47	3.58	3.35
Italy	44	11	4.93	7.22	2.10
Singapore	36	9	5.34	3.58	3.35
Germany, Rep.	31	9	4.25	5.11	2.83
Ireland	31	9	4.25	5.11	2.83
Spain	46	9	6.12	5.11	2.83
United Kingdom	23	9	3.20	3.58	3.35
Australia	21	10	3.18	3.93	3.23
Hong Kong	44	9	6.29	3.58	3.35
France	29	8	5.18	4.36	3.08
Canada	28	8	4.56	3.93	3.23
Denmark	22	7	4.37	2.33	3.76
Japan	31	6	6.55	5.59	2.67
Netherlands	18	8	3.41	2.33	3.76
Switzerland	22	7	4.37	2.33	3.76
Norway	19	7	3.67	2.33	3.76
Finland	22	6	4.93	5.59	2.67
Sweden	16	6	3.41	5.59	2.67

Estimated Deaths of Children under 5

World : 1985 - 2000

(Millions)

Annual Cumulative
Year 2000 1985-2000
16.2 234.6



1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000

□ Model A

The 1985 under five mortality rates remain constant to the year 2000

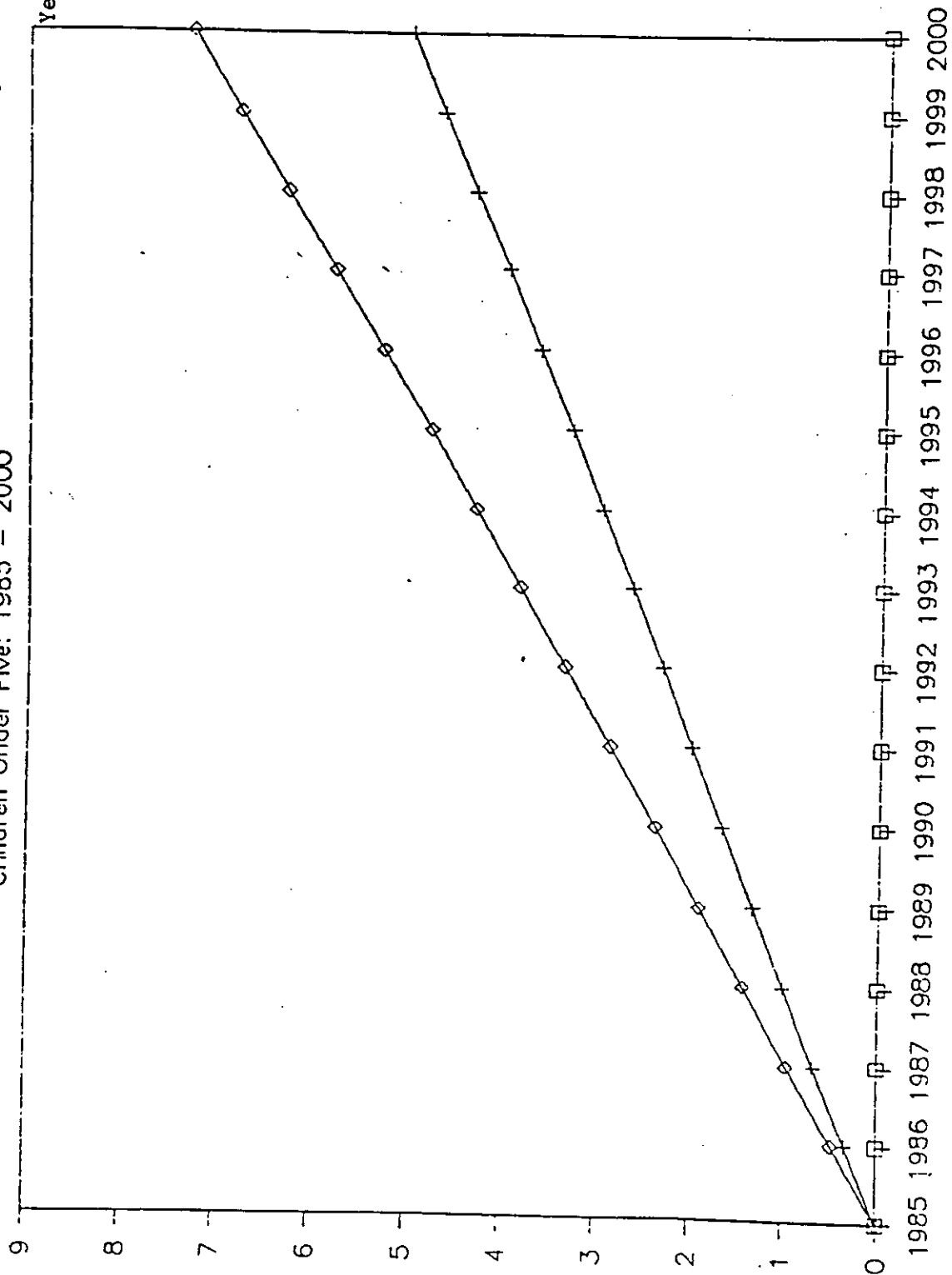
◇ Model B

All countries will reach their CSDR targets by the year 2000 i.e. at least an under five mortality rate of 70 and countries with USMR of less than 140 in 1980 will halve that rate.

Global Estimates of Lives Saved

Children Under Five: 1985 - 2000

(Millions)
Annual Cumulative
Year 2000 1985-2000



Number of Lives Saved (millions)

+ Model A

o Model B

The annual rate of reduction of the under five mortality rates between 1980 and 1985 remains constant to the year 2000.

All countries will reach their CSDR targets by the year 2000 i.e. at least an under five mortality rate of 70 and countries with USMR of less than 140 in 1980 will halve that rate.

GLOBAL PROJECTIONS OF DEATHS AND LIVES SAVED OF CHILDREN UNDER FIVE

	1985	BY 1990	BY 1995	(Millions) BY 2000
Model A				
Annual number of deaths	14.6	15.4	15.9	16.2
Annual number of lives saved	-	-	-	-
Cumulative number of deaths	-	75.5	154.2	234.6
Cumulative number of lives saved	-	-	-	-
Model B				
Annual number of deaths	14.6	13.0	11.2	8.9
Annual number of lives saved	-	2.4	4.8	7.3
Cumulative number of deaths	-	68.4	128.0	177.1
Cumulative number of lives saved	-	7.2	26.3	57.7

For explanations of Models see graphs.