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Address by Mr. James P. Grant
Executive Director of the United Nations Children's Fund (UNICEF)
to the
First International Congress of Tropical Pediatrics

Bangkok
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Accelerating the Momentum for Child Survival and Development

Cover + 12 pp + 0 b

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ACCELERATING THE MOMENTUM FOR CHILD SURVIVAL AND DEVELOPMENT

I am pleased, indeed, to address this First International Congress of Tropical Pediatrics. There are many, many familiar faces in this room today, - several distinguished veterans of successful struggles to improve the health and well-being of children from throughout the tropical regions of the world.

We meet at an important time for those of us committed to the improved health and survival of the world's children, and especially for children of the Tropics, which includes most of the developing world. The three decades between 1950 and 1980 saw more progress for these children in many ways than the previous 1,000 to 2,000 years. This is evidenced in global figures which show that in 1950 there were 70 thousand young children dying every day; by 1980 that toll had been reduced to 43 thousand young lives daily. Given the increase in population, this amounted to a halving of the infant and child mortality rates during that time period worldwide. In countries of the tropics, the reduction rates were still far greater than the global average.

The 1980s has introduced mutually opposing new influences to the world situation which produced such steady progress for children since World War II. This decade has brought both bad news and good news for the world's children.

Of major impact, the 1980s has seen severe and sustained global economic difficulties. While this has fortunately bypassed, to a large extent, India, China and our host country, the economic recession has been the worst for most countries of Africa and Latin America since the 1930s, and the majority of Asian countries have been adversely affected as well. The very recent stock market crash reminds us that, for the global economy, the worst may still lie ahead.

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The result of this decade's economic climate for much of the Third World has been a human crisis as well as an economic crisis. A disproportionate share of the resultant suffering is being borne by those least equipped to combat the effects of economic deterioration - the poor and the most vulnerable, especially children and women.

Unfortunately, this same time period has seen the rise of the global pandemic of AIDS, which clearly threatens, among those who suffer its scourge, the lives and health of women and children. Perhaps of even greater importance, thoughtless reaction to the pandemic threatens to undermine not only efforts to stop its spread, but rational prioritizing of economic resources available to social sectors as well.

A revolution for children

Fortunately, the 1980s has also brought good news. As those of us gathered at this conference are well aware, there now exists the potential for a virtual revolution in child survival and development - that which we have come to call the Child Survival and Development Revolution (CSDR). This arises from two converging forces: -

First, it is now known that the major threats to the lives and the normal growth of children can be defeated, in large measure, by informing and supporting parents themselves in such basic and inexpensive actions as getting their children immunized, using oral therapies for diarrhoeal disease, maintaining exclusive breast-feeding in the early months, applying new knowledge about when and how to introduce other foods, recognizing the danger signs of acute respiratory infection, spacing births at least two years apart, enrolling for pre-natal care if possible, monitoring the growth of children to warn of impending malnutrition, improving female literacy, providing food supplementation when necessary, and putting into practice the essentials of home hygiene.

Second, the surge in the communications capacity of virtually all nations over the last ten years has made it possible, for the first time, to put that knowledge and these techniques at the disposal of the great majrotity of the world's people. Sixty per cent of the developing world's adults can now read and write. Eighty per cent of its children now enroll in school. Radio reaches into a majority of its homes; television into a majority of its communities. Government services now reach, with varying degrees of effectiveness, into almost every community. You who are gathered in Bangkok today can be counted amongst two million doctors, 6 million nurses, and many more millions of community health workers who are now at work. And tens of thousands of non-governmental organizations, peasant co-operatives, labour unions, employers' associations, political cadres, youth organizations, women's movements, and neighbourhood associations now add up to a breadth and depth of organized resources which could be the means of informing and supporting the majority of the developing world's families in using today's knowledge.

First articulated in 1982, the Child Survival and Development Revolution had gained enough momentum that 12 months later United Nations Secretary-General Javier Pérez de Cuéllar said, "... a veritable child survival revolution has begun to spread across the world".

By 1986, the CSDR had progressed to the extent that the use of vaccines and the use of oral rehydration salts had both tripled since the beginning of the decade. These two measures alone accounted for saving the lives, in 1986, of one and one half million young children. By the middle of 1987 another major milestone had been reached - more than 50 per cent of the world's children had been immunized, as compared with 5 per cent a decade ago, and 10 per cent before the advent of the CSDR.

The challenge which lies ahead is defined, at this stage, by one fact which overwhelms other considerations - still today, and every day, 38,000 young children die, and a comparable number are crippled for life, the vast majority of them from causes for which we have long-since discovered low-cost cures and preventions such as those singled out in the CSDR. We know now what is required to prevent this tragic waste; we know that it is do-able. Our response to this challenge must capitalize on the good news while taking the bad news into account. We must ask ourselves at this point: How can we accelerate the momentum of saving children's lives and improving their well-being - despite the economic constraints of the 1980s?

Adjustment with a human face

We must advance on both fronts: on one hand, we must ensure that economic disruptions do not undermine the situation of the health of children. The cut-backs and adjustments which many countries are undertaking reflect in part the severe constraints imposed by the international economic system and in part on the way countries have re-formulated their policies in response to these pressures. It is the summation of these factors which brought forth the anguished plea from President Nyerere of Tanzania when he stated, "Must we starve our children to pay our debts?"

Our response to President Nyerere must be an emphatic "No" - Children shouldn't be required to die to pay a country's debts! Unfortunately, actual practice is all to often, still, to let children die, and many are dying each day as a consequence in the mid 1980s.

Our experience is that there must be a two-pronged response to this situation. First, we must vigorously defend the importance of social investment to the overall future of a country so that the social sectors do not carry disproportionate cut-backs, as too often has been the case. Second, and of equal if not greater importance - for those of us gathered here - because the power to act lies substantially with those of us in the health and other social sectors, is that the social sectors themselves must produce internal restructuring to put priorities on those programmes which result in the most benefit to the most vulnerable.

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

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

A gathering alliance

We must also, however, respond very specifically to the challenge presented by today's unacceptable rate of child deaths by finding ways to accelerate the awareness and use of that very knowledge which you as Pediatricians have. The technical knowledge to prevent these deaths is already available; you, as individual pediatricians, have the techniques in your hands and employ them every day to improve the health and save the lives of millions of children. As I have said to the International Pediatrics Association (IPA), the greater challenge to you as physicians to the world's children, has been how to ensure that this knowledge reaches the millions upon millions of children - in fact, the majority of the world's children - who you and your several hundred-thousand colleagues around the world will never see in your offices nor in your hospital wards.

We have seen, in the past five years, that the CSDR works - that it is capable of reaching those traditionally unreached with life-saving medical technologies. 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 is a society-wide alliance 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, voluntary organizations and people's movements, business and labour unions, professional associations and conventional health services. Only such a Grand Alliance for Children can create the informed public demand for, and practical knowledge of, those methods which could bring about the revolution in child survival and development.

Today that Grand Alliance has begun to gather; the child survival and development revolution is now underway, and as pediatricians you can pride yourselves in being among the pioneers of this revolution. The International Pediatrics Association was one of the first great organizations to formally enlist in the CSDR, when, in 1983, the IPA Congress in Manila adopted its landmark resolution committing the organization to partnership in the CSDR in order to reduce childhood mortality and morbidity.

Much has been accomplished, and yet the grim reality of current child mortality rates reminds us that much remains to be done. We must now ask: What are the next steps? As I ask this question in this fora, I know that I am posing it among partners in an alliance, among those who fight the good

fight, and that we will explore for the answers together. Your role in this revolution for child survival and development is one of leadership, and the world community looks to you for answers and direction.

As you map the next steps of this effort, I urge you to consider the goal which I spoke of with you yesterday during the opening of this Congress - the goal set by the United Nations in 1980 to halve infant mortality rates by the year 2000 in every country on this globe, or to reduce them to 50, whichever is smaller. In the tropical countries, what will it take to achieve this goal?

Progress has been varied, so far. With two decades to achieve this unprecedented goal, yearly progress for the first five years was only about half the rate necessary for such countries as Kenya, the Philippines, the Honduras and Zimbabwe. Thus, in Kenya for example, where the target IMR by 2000 is 42, infant mortality rates decreased by an average of 1.98 per cent between 1980 and 1985. In order to meet its goal, Kenya will have to achieve an annual decrease rate of 3.88 per cent until the end of the century. Zimbabwe also has a target IMR of 42, and between 1980 and 1985 the annual rate decreased by 1.75 per cent. For the rest of the century Zimbabwe must achieve annual decreases of 3.95 per cent in order to meet the goal. This clearly will require redoubled efforts. Several tropical countries have achieved annual decrease rates which are ahead of target. Among them are Costa Rica, the Barbados, Hong Kong, Kampuchea, and Mauritius. In the copy of my remarks which has been distributed to you, you will find charts listing progress since the goal was set in 1980, as well as IMR reduction rates which will be required to achieve the goal, for all countries of the developing world.

The alliance for children in action

What will it take to achieve the year 2000 goal in your country? What are some of the things that you can do to accelerate the progress of the CSDR? There are critical tasks in this movement which only you, as the doctors of the world's children, can accomplish.

-- Support the empowerment of women and families which is gained though experience and success with self-health techniques.

-- Bring others into the Grand Alliance for Children. It is you who have by far the greatest ability to draw in and involve other doctors, nurses, and midwives. Vigourously spread the word and educate others on the situation and the historic opportunity for change on a vast scale.

-- Who else but you can advocate as credibly in your own societies, to your political leaders and to national and local institutions? Given the influence that you wield, it is you who must take the lead among other professions and sectors who look rightfully to you as leaders. Are you willing to use your position to further the goals of the CSDR?

-- It is you who can set standards within the health profession. When alternative treatments exist, choose the more widely applicable low-cost practice. Promote breastfeeding, the use of oral rehydration and growth monitoring in your own practice, and press the hospitals and medical schools with which you are affiliated to do likewise;

-- Act, in your practices, your teaching, your writings, and your research to strengthen our knowledge and experience of how appropriate medical technology, through supportive social structures, can transform the death and disease patterns posed by the major cripplers and killers of children;

-- Explore the applicability of the CSDR and its social mobilization and participatory approach to other diseases, such as malaria, acute respiratory infections (ARI), iodine deficiency, etc.

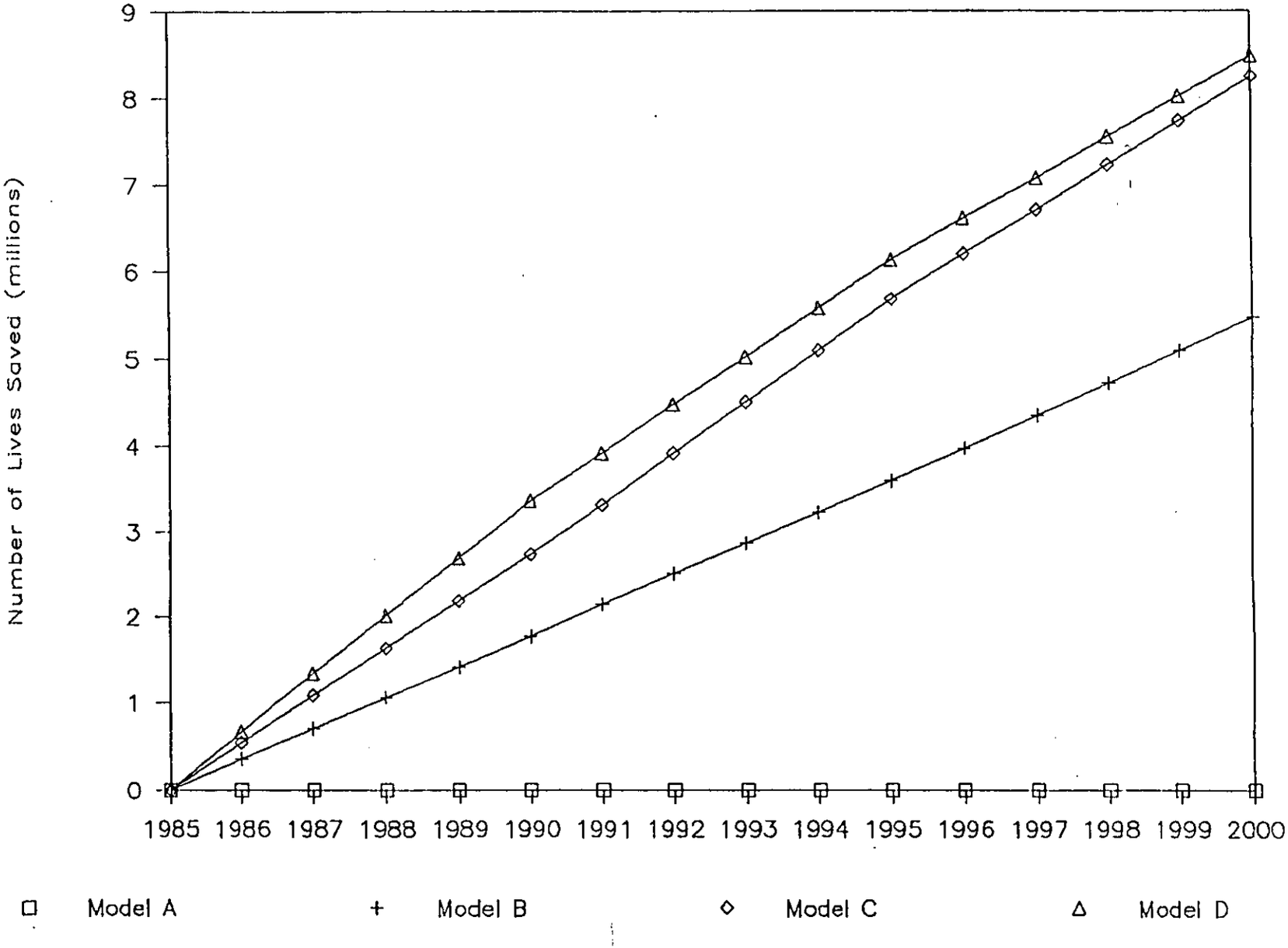
-- It is also you to whom the world must turn for ideas and for solutions to the difficult problems in extending other elements of basic health care to the previously unreachable poor of the world.

We are beginning to close the vital gap between those whom you see in your daily practices and the great majority of children who will never see a pediatrician. It has long been acknowledged that a major challenge to health professionals is to make existent techniques available to those removed from the channels of easy access. The 1980s has seen major strides in meeting this age-old challenge. Can you, in your role of leadership for children's health, channel the benefits of progress and momentum now evident at the international level, into efforts in your own countries which will achieve the United Nations Year-2000 goals for child survival? Can we make the Child Survival and Development Revolution the world's most critical revolution, a revolution which will accelerate achievement of primary health care, and the goal of Health for All by the year 2000? Can we not extend the benefits of some of your most critical knowledge to the great majority of the world's children? Can we reach the unreached?

Together, I think we can.

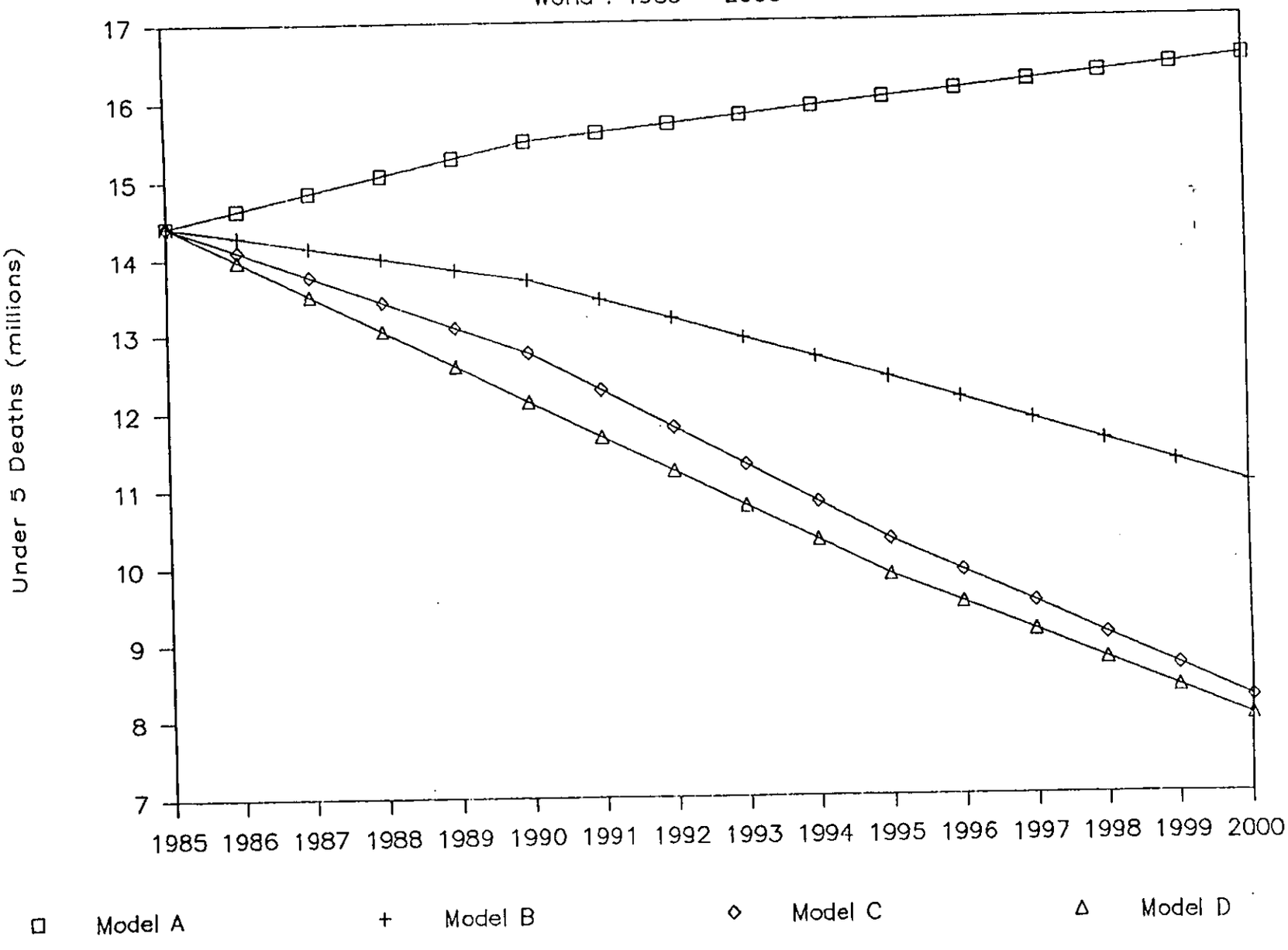
Global Estimates of Lives Saved

Children under Five: 1985 – 2000



Estimated Deaths of Children under 5

World : 1985 – 2000



GLOBAL PROJECTIONS OF DEATHS AND LIVES SAVED OF CHILDREN UNDER FIVE

(Millions)

	1985	By 1990	By 1995	By 2000
Model A				
Annual number of deaths	14.4	15.5	16.0	16.5
Annual number of lives saved	-	-	-	-
Cumulative number of deaths	-	75.3	154.3	235.7
Cumulative number of lives saved	-	-	-	-
Model B				
Annual number of deaths	14.4	13.7	12.4	11.0
Annual number of lives saved	-	1.8	3.6	5.5
Cumulative number of deaths	-	69.9	134.5	192.4
Cumulative number of lives saved	-	5.3	19.7	43.3
Model C				
Annual number of deaths	14.4	12.7	10.3	8.2
Annual number of lives saved	-	2.7	5.7	8.2
Cumulative number of deaths	-	67.1	123.5	168.9
Cumulative number of lives saved	-	8.2	30.7	66.8
Model D				
Annual number of deaths	14.4	12.1	9.9	8.0
Annual number of lives saved	-	3.4	6.1	8.5
Cumulative number of deaths	-	65.2	119.0	162.8
Cumulative number of lives saved	-	10.1	35.2	73.0

For explanations of Models see next page

UNITED NATIONS CHILDREN'S FUND FONDS DES NATIONS UNIES POUR L'ENFANCE

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Explanations of Models

Model A assumes that the 1985 Under-Five mortality rates remain constant to the year 2000.

Model B assumes that the annual rate of reduction of the Under-five mortality rates between 1980 and 1985 remain constant to the year 2000.

Model C assumes that all countries will reach their CSDR targets by the year 2000. This means that all countries will reach at least an Infant Mortality Rate of 50 by the year 2000 and that countries with an Infant Mortality Rate of less than 100 in 1980 will halve that rate by the year 2000.

Model D applies the assumptions of model C to Africa, Asia and the industrialized countries but assumes that the Central and South American countries will reach their CSDR targets by 1992, and the countries in the Middle East and North African region will reach their CSDR targets by 1990. The countries of both regions will then continue to the year 2000 at the same rate of progress as required to reach their CSDR targets.

The child survival index ie.
Percentage of those born who survive to reach the age of 5 years.

Country	Child survival index		Percentage decrease of the Under 5 mortality rate	Average annual rate of decrease of the Under 5 mortality rate			GNP per capita growth rate	
	1960	1986	1960-86	1960-80	1980-5	Projected* 1985-2000	1965-80	1980-5
Afghanistan	62.0	67.5	14.6	0.55%	0.66%	8.44%		
Mali	63.0	70.3	19.6	0.66%	1.40%	7.96%	1.4	-3.0
Sierra Leone	60.3	70.3	25.1	1.01%	1.40%	7.96%	1.1	-0.2
Malawi	63.6	73.0	25.8	1.00%	1.59%	7.34%	1.5	-0.6
Ethiopia	70.6	74.5	13.3	0.57%	0.38%	7.15%	0.2	-2.0
Guinea	65.4	74.5	26.3	1.07%	1.48%	7.19%	0.8	-1.4
Somalia	70.6	74.5	13.3	0.57%	0.38%	7.15%	-0.7	0.6
Mozambique	69.8	75.3	18.1	0.52%	1.52%	6.95%	..	-13.6
Burkina Faso	61.2	75.9	38.0	1.98%	1.18%	6.86%	1.3	-1.3
Angola	65.4	76.2	31.3	1.40%	1.50%	6.76%	..	0.1
Niger	68.0	76.7	27.1	1.11%	1.53%	6.67%	-2.1	-6.7
Chad	67.4	77.2	29.9	1.30%	1.56%	6.49%	-2.3	1.8
Guinea-Bissau	68.5	77.2	27.5	1.13%	1.56%	6.49%	-1.5	1.9
C.African Rep.	69.2	77.2	25.9	1.20%	0.84%	6.55%	-0.2	-1.5
Senegal	68.7	77.3	27.3	1.12%	1.57%	6.49%	-0.6	0.0
Mauritania	69.0	77.5	27.5	1.23%	1.62%	6.26%	0.1	-0.7
Liberia	69.7	78.9	30.2	1.30%	1.60%	6.04%	-1.4	-6.4
Rwanda	75.2	79.0	15.2	0.38%	1.43%	6.00%	1.8	-1.5
Kampuchea	78.2	79.4	5.5	-1.82%	7.15%	6.91%		
Yemen	62.2	79.6	46.0	2.33%	2.31%	5.99%	5.3	0.9
Yemen, Dem.	62.2	79.6	46.0	2.33%	2.31%	5.99%		
Bhutan	70.3	79.8	32.1	1.42%	1.57%	6.27%	..	3.4
Nepal	70.3	79.8	32.1	1.42%	1.57%	6.27%	0.1	0.8
Burundi	74.2	80.4	23.9	0.93%	1.34%	5.60%	1.9	-0.8
Bangladesh	73.8	80.7	26.4	1.05%	1.56%	5.78%	0.4	0.9
Benin	69.0	81.1	38.9	1.91%	1.77%	5.36%	0.2	0.1
Sudan	70.7	81.8	37.9	1.68%	2.20%	5.17%	(.)	-4.2
Tanzania	75.2	82.1	27.7	1.05%	1.86%	5.08%	(.)	-3.1
Bolivia	71.8	82.1	36.6	1.49%	2.52%	5.42%	-0.2	-7.0
Nigeria	68.2	82.2	43.9	2.29%	1.87%	5.02%	2.2	-7.3
Haiti	70.6	82.4	40.2	1.96%	1.89%	5.76%	0.7	-2.5
Gabon	71.2	82.6	39.5	1.91%	1.91%	4.90%	1.5	-1.2
Uganda	77.6	82.6	22.3	0.87%	1.09%	4.94%	-2.6	2.2
Pakistan	72.3	83.0	38.6	1.84%	1.85%	5.34%	2.6	2.8
Zaire	74.9	83.4	33.8	1.46%	1.89%	4.63%	-2.1	-3.8
Laos	76.8	83.4	28.4	0.99%	2.20%	5.38%		
Oman	62.2	83.4	56.2	3.08%	3.16%	4.96%	5.7	0.5
Iran	74.6	84.1	37.4	1.93%	1.19%	5.19%	..	7.1
Cameroon	72.5	84.2	42.5	2.15%	1.87%	4.35%	3.6	4.5
India	71.8	84.6	45.5	2.14%	2.90%	4.63%	1.7	3.1
Cote d'Ivoire	68.0	84.7	52.2	2.97%	2.15%	4.77%	0.9	-5.2
Ghana	77.6	85.0	33.1	1.52%	1.50%	4.03%	-2.2	-3.9
Lesotho	79.2	86.0	32.6	1.30%	2.09%	4.84%	6.5	3.4
Zambia	77.2	86.9	42.3	2.14%	1.82%	3.93%	-1.6	-4.1
Egypt	70.0	86.9	56.3	2.89%	4.02%	3.81%	3.1	1.3
Peru	78.7	87.2	44.9	2.21%	2.25%	3.92%	0.2	-4.2
Libya	73.2	87.5	53.3	2.52%	4.19%	3.27%	-1.3	-9.1
Morocco	73.5	87.5	52.8	2.71%	3.21%	3.73%	2.2	0.1
Indonesia	76.5	87.8	47.9	2.39%	2.77%	3.62%	4.8	2.3
Congo	75.9	88.1	50.5	2.93%	1.71%	3.96%	3.8	4.9
Kenya	79.2	88.3	43.5	2.10%	2.31%	3.77%	1.9	-1.7
Zimbabwe	81.8	88.3	35.4	1.52%	2.02%	3.86%	1.6	0.0
Honduras	76.8	88.8	51.7	2.64%	3.13%	3.50%	0.4	-2.6
Algeria	73.0	88.8	58.6	2.99%	4.46%	3.05%	3.6	1.7
Tunisia	74.5	89.4	58.6	3.06%	4.30%	3.11%	4.0	1.4
Guatemala	77.0	89.5	54.5	2.89%	3.16%	3.49%	1.7	-4.3
Saudi Arabia	70.8	89.5	64.2	3.86%	3.90%	3.24%	5.3	-7.3
South Africa	80.8	89.9	47.5	2.28%	2.98%	3.55%	1.1	-1.6
Nicaragua	79.0	90.0	52.6	2.48%	3.92%	3.24%	-2.1	-3.1
Turkey	74.2	90.1	61.7	3.12%	5.36%	3.12%	2.6	2.1
Iraq	77.8	90.2	55.9	3.36%	2.24%	3.79%		
Botswana	82.6	90.4	44.7	2.22%	2.26%	3.78%	8.3	7.4
Viet Nam	76.7	90.5	59.1	3.30%	3.81%	3.27%		
Madagascar	81.9	90.6	48.0	2.37%	2.83%	3.60%	-1.9	-6.1
Ecuador	81.7	91.0	51.0	2.69%	2.79%	3.61%	3.5	-2.4
Papua NG	75.3	91.0	63.7	3.88%	3.44%	3.39%	0.4	-1.6
Brazil	84.0	91.1	44.4	2.23%	2.26%	3.79%	4.3	-1.5

The child survival index ie.
Percentage of those born who survive to reach the age of 5 years.

Country	Child survival index		Percentage decrease of the Under 5 mortality rate	Average annual rate of decrease of the Under 5 mortality rate			GNP per capita growth rate	
						Projected*		
	1960	1986	1960-86	1960-80	1980-5	1985-2000	1965-80	1980-5
Burma	77.1	91.1	61.3	4.01%	2.06%	3.85%	2.4	3.3
El Salvador	79.4	91.2	57.2	3.27%	3.01%	3.54%	-0.2	-3.1
Dominican Rep.	80.0	91.4	57.2	3.31%	2.91%	3.57%	2.9	-0.8
Philippines	86.5	92.5	44.2	2.23%	1.93%	3.89%	2.3	-3.4
Mexico	86.0	92.9	49.5	2.64%	2.30%	3.77%	2.7	-2.1
Colombia	85.2	93.0	52.6	3.09%	1.84%	3.92%	2.9	-0.5
Syria	78.2	93.2	68.9	4.71%	3.07%	3.52%	4.0	-2.1
Paraguay	86.6	93.7	53.1	3.13%	2.05%	3.85%	3.9	-1.9
Mongolia	84.2	93.8	61.0	3.53%	3.63%	3.33%		
Jordan	78.2	93.9	71.8	4.89%	4.07%	3.18%	5.8	1.5
Lebanon	90.8	94.7	42.5	1.95%	2.02%	3.87%		
Thailand	85.1	94.7	64.7	3.85%	4.15%	3.16%	4.0	2.6
Albania	83.6	95.0	69.5	4.90%	2.82%	3.60%		
China	79.8	95.3	76.6	6.13%	2.59%	3.68%	4.8	8.6
Sri Lanka	88.7	95.4	59.6	3.54%	2.69%	3.65%	2.9	3.2
Venezuela	88.6	95.6	61.2	3.94%	2.47%	3.72%	0.5	-5.4
U.A.E.	76.1	95.9	83.0	7.25%	4.10%	3.18%		-7.7
Guyana	90.6	96.1	58.1	2.73%	5.36%	2.75%	-0.2	-7.3
Argentina	92.5	96.1	47.7	2.52%	2.33%	3.76%	0.2	-3.9
Malaysia	89.4	96.3	65.3	4.41%	2.44%	3.73%	4.4	1.8
Panama	89.5	96.6	67.4	4.48%	3.58%	3.35%	2.5	-0.2
Korea, Dem.	88.0	96.7	72.2	4.89%	4.47%	3.05%		
Korea, Rep.	88.0	96.7	72.2	4.89%	4.47%	3.05%	6.6	6.3
Uruguay	94.4	96.9	44.3	1.43%	5.29%	2.77%	1.4	-6.0
Mauritius	89.6	97.0	70.8	4.43%	5.29%	2.77%	2.7	2.3
Romania	91.8	97.0	63.7	4.03%	2.95%	3.56%		3.0
Yugoslavia	88.7	97.1	73.9	5.43%	3.48%	3.38%	4.1	-0.5
USSR	94.7	97.2	46.8	2.20%	3.13%	3.50%		
Chile	85.8	97.5	82.3	6.14%	8.25%	1.73%	-0.2	-3.9
Trinidad	93.3	97.6	63.4	3.94%	2.82%	3.60%	2.3	-6.0
Jamaica	91.2	97.6	72.5	5.40%	2.92%	3.57%	-0.7	-3.1
Kuwait	87.2	97.6	81.1	6.28%	6.51%	2.35%	-0.3	-6.8
Costa Rica	87.9	97.7	81.3	7.06%	2.24%	3.79%	1.4	-2.7
Portugal	88.8	97.9	81.1	6.37%	6.01%	2.52%	3.3	-0.5
Bulgaria	93.8	98.0	67.9	4.44%	3.43%	3.40%		
Hungary	94.3	98.0	65.1	3.85%	4.18%	3.15%	5.8	1.7
Poland	93.0	98.0	71.6	5.21%	2.64%	3.66%		
Cuba	91.3	98.1	78.2	6.24%	4.56%	3.02%		
Greece	93.6	98.3	73.6	4.99%	4.78%	2.94%	3.6	- 0.3
Czechoslovakia	96.8	98.3	48.1	2.32%	3.20%	3.48%		
Israel	96.0	98.4	60.0	3.91%	2.33%	3.76%	2.5	-0.7
New Zealand	97.3	98.7	52.2	2.58%	2.64%	3.66%	1.4	1.8
USA	97.0	98.7	57.3	3.41%	2.82%	3.60%	1.7	1.4
Austria	95.7	98.7	70.7	4.82%	4.07%	3.18%	3.5	1.7
Belgium	96.5	98.7	64.0	4.15%	2.82%	3.60%	2.8	0.6
German Dem.	95.6	98.7	71.4	5.24%	2.82%	3.60%		
Italy	95.0	98.7	74.8	5.25%	5.22%	2.79%	2.6	0.4
Singapore	95.0	98.8	76.0	6.17%	3.04%	3.53%	7.6	6.4
Germany, Fed.	96.2	98.8	69.5	4.23%	5.59%	2.67%	2.7	1.2
Ireland	96.4	98.8	67.8	4.28%	4.36%	3.08%	2.2	-0.3
Spain	94.4	98.9	79.8	6.37%	4.36%	3.08%	2.6	0.9
United Kingdom	97.3	98.9	58.1	3.23%	3.04%	3.53%	1.6	2.1
Australia	97.5	98.9	57.6	2.86%	4.71%	2.97%	2.0	0.9
Hong Kong	93.5	98.9	83.7	7.39%	4.71%	2.97%	6.1	4.4
France	96.6	99.0	69.7	4.69%	3.29%	3.45%	2.8	0.3
Canada	96.7	99.0	70.9	4.55%	5.11%	2.83%	2.4	0.8
Denmark	97.5	99.1	62.8	4.02%	1.89%	3.91%	1.8	2.0
Japan	96.0	99.1	76.8	6.70%	2.09%	3.84%	4.7	3.5
Netherlands	97.8	99.1	57.7	3.41%	1.89%	3.91%	2.0	0.3
Switzerland	97.3	99.1	68.1	4.39%	3.93%	3.23%	1.4	1.3
Norway	97.7	99.2	63.9	3.62%	1.89%	3.91%	3.3	3.2
Finland	97.2	99.3	73.9	5.52%	2.33%	3.76%	3.3	2.1
Sweden	98.0	99.3	63.5	3.91%	2.33%	3.76%	1.8	1.5

* Projected on the basis that the Third Development Decade IMR targets will be reached by the year 2000. ie. All countries with 1980 IMR of 100 or less will halve their IMR by the year 2000 and countries with 1980 IMR above 100 will reach 50.